

# CookChildren's<sup>SM</sup>

## Health Plan

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[www.cookchp.org](http://www.cookchp.org)

# STAR

## PROVIDER MANUAL

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



January 2009

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# I INTRODUCTION

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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 STAR members of all ages with quality health care 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.

The STAR Provider Reference Guide is designed to be a useful reference guide when working with CCHP. It will help you answer questions regarding eligibility verification, claims processing, benefit information and who to call for additional information.

The entire staff of CCHP is pleased to be associated with you and look forward to improving the health care of STAR members throughout the Tarrant Service Area.

Cook Children's Health Plan

# I INTRODUCTION

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## 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 CHIP product which provides low cost insurance for children unable to enroll in Medicaid and unable to afford traditional commercial insurance. As of September 1, 2006, CCHP has contracted with the State of Texas Health and Human Services Commission (HHSC) to expand the health plan's outreach. The service area for the CCHP Medicaid STAR 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. Please do not hesitate to call on us if we can assist you in some way.

# I INTRODUCTION

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## 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 Reference Guide, an orientation or a current provider directory.

#### Contracting

Main Number - 682-885-4485  
Toll free - 800-964-CCHP (2247)  
Fax - 682-885-2148

# I INTRODUCTION

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

## 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>	Medicaid 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	866-838-7612
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Dental Services - Members may call 800-252-8263 to locate a dental provider for children under age 21 as part of the THSteps program.

## Other Important Information

ACS Provider Hotline 800-645-7164

HHSC 800-964-2777

(HHSC is responsible for determining Medicaid eligibility and enrolls and/or disenrolls individuals)

CHIP/Medicaid Outreach Program 877-543-7669 (877-KIDS-NOW)

## Access on the World Wide Web

Cook Children's Health Plan [www.cookchp.org](http://www.cookchp.org)

Texas Health & Human Services

Commission [www.hhsc.state.tx.us/medicaid/mc/about/faq.htm](http://www.hhsc.state.tx.us/medicaid/mc/about/faq.htm)

CCHP Eligibility and Claim Status [www.cookchildrenshealthplan.org](http://www.cookchildrenshealthplan.org)

## 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). 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 COVERED SERVICES**

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### **COVERED SERVICES**

CCHP participates in the STAR program as a primary HMO through the CCHP product. At a minimum, the CCHP must provide a benefit package to Members that includes fee-for-service (FFS) services currently covered under the Medicaid program. Please refer to the current Texas Medicaid Provider Procedure Manual for a more inclusive listing of limitations and exclusions that apply to each benefit category.

- Ambulance services
- Audiology services, including hearing aids for adults (hearing aids for children are provided through the PACT program and are a non-capitated service)
- Behavioral Health Services, including:
  - Inpatient and outpatient mental health services
  - Outpatient chemical dependency services for children (under age 21)
  - Detoxification services
  - Psychiatry services
- Counseling services
- Birthing center services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Medical check-ups and Comprehensive Care Program (CCP) Services for children (under 21) through the Texas Health Steps Program
- Optometry, glasses and contact lenses, if medically necessary
- Podiatry
- Prenatal care
- Primary care services
- Radiology, imaging and X-rays
- Specialty provider services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision Services

## II COVERED SERVICES

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### NON COVERED SERVICES

The following is a list of services which are not covered by STAR Medicaid. These services include but are not limited to:

- Autopsies
- Cosmetic surgery
- Biofeedback therapy
- Bladder stimulators (pacemaker)
- Breast implants
- Infertility
- Intestinal bypass surgery or gastric stapling for the treatment of morbid obesity
- Mammoplasty for gynecomastia
- Procedures and services considered experimental or investigational
- Prosthetic and orthotic devices
- Routine circumcision for members age one year and older
- Treatment of flatfoot conditions
- Sex change operations
- Silicone injections
- Sterilization reversal
- Acupuncture
- Faith healing
- Services not approved by your PCP; and
- Services that are not medically necessary

### BENEFITS

STAR Members are provided with three enhanced benefits compared to the traditional, fee for service Medicaid coverage:

- waiver of the three-prescription per month limit;
- waiver of the 30-day spell-of-illness limitation under fee for service; and
- inclusion of an annual adult well check for patients 21 years of age and over.

### VALUE ADDED CCHP SERVICES

The following is a list of services provided by CCHP in addition to the STAR Medicaid program:

- **Obesity Reduction Program** – Cook Children’s Health Plan will provide a structured program for members suffering from obesity (BMI  $\geq$  95% for age or 85% and significant comorbidities) including registration and payment for Weight Watchers classes. The Member must be referred to the program by the Member’s Primary Care Physician.
- **Sports/School Physicals** –Cook Children’s Health Plan members will be eligible for a sports or school physical once every 12 months.
- **First Aid Kit** – Cook Children’s Health Plan 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.

## II COVERED SERVICES

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- **Prepared Childbirth Classes** – Cook Children’s Health Plan will provide coverage for up to \$70.00 for prepared childbirth Lamaze and breast feeding classes.
- **Prenatal Dental Benefit** – Cook Children’s Health Plan will provide a structured dental program to pregnant women that includes up to \$500 of basic and major dental services.
- **Over the Counter Drug Benefit** – Cook Children’s Health Plan will provide a maximum of \$15.00 in reimbursement for over the counter medication for all new member.
- **Safety Package** – Cook Children’s Health Plan will provide all member 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.
- **Expanded Behavioral Health Facility-Based Benefit-** Intensive Outpatient Programming, Partial Hospitalization and Short-term Residential Treatment Services flexed from the Acute Inpatient Benefit. Intensive Outpatient: is delivered primarily at a facility and consists of clinical programming that is 4-6 hrs per day with a minimum of 3 times per week. This is usually reimbursed from the inpatient behavioral health benefit not the outpatient benefit. A member could receive 2 days of PHP treatment every one day of inpatient benefit. Members can access this behavioral health value added service by contacting the behavioral health hotline.

Call CCHP to find out more about obtaining these services at (682) 855-2247 or (800) 964-2247.

### COORDINATION WITH NON-MEDICAID MANAGED CARE COVERED SERVICES

All members in the Cook Children’s Health Plan STAR program are eligible for the following services available through the state’s fee-for-service Medicaid program (See list below). Because these services are not available through Cook Children’s Health Plan Star, providers should call (800) 862-2247 to initiate a referral for the following services. A referral for these services should always be documented in the member’s medical record.

#### Dental Services:

**Dental Services:** Dental services for STAR and STAR SSI members are covered from birth through the age of 20 years under the Texas Health Steps Program (THSteps). Dental services are covered from 6 months of age through 20 years of age. Children should have their first dental checkup at 6 months of age and every 6 months thereafter. Services include all medically necessary dental treatment (ex: exams, cleanings, x rays, fluoride treatment, and restorative treatment) Children under the age of 6 months can receive dental services on an emergency basis.

**Dental Services - continued**

## II COVERED SERVICES

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Members may self-refer to participating dentists in the THSteps Dental Program. Members or providers may call 1-877-847-8377 for a list of THSteps dental providers.

First Dental Home (FDH) – the FDH program is for children from the age of 6 months through 35 months. The purpose of this program is to establish a dental home for these children and reduce the incidence of Early Childhood Caries. FDH is offered by dentists who have been trained and certified by the Department of State Health Services. These children may be seen as frequently as every 3 months depending on their caries risk. To find a certified FDH provider go to <http://www.tmhp.com/OPL/providerManager/AdvSearch.aspx>  
Or call 1-877-847-8377

**Case Management for Children and Pregnant Women (CPW):** Case management services are available to assist eligible children with a health condition or health risk and pregnant women with a high risk condition in access to medical, social, educational and other services. To be eligible for case management services, a child or woman must be eligible for Medicaid and:

- A pregnant woman with a high-risk condition defined as a woman who is pregnant and has one or more high-risk medical and/or personal/psychosocial conditions during pregnancy. The woman must be in need of services to prevent illness(es) or medical condition(s), to maintain function or to slow further deterioration of the condition and desire case management services; or
- A child (birth through 20 years of age) with a health condition or health risk. Children with a health condition are defined as children with a health condition/health risk or children who have, or are at risk for, a medical condition, illness, injury, or disability that results in limitation of function, activities, or social roles in comparison with healthy same-age peers in the general areas of physical, cognitive, emotional, or social growth and development.

To make a referral, call 1-877-847-8377 or consult the CPW provider list at [www.dshs.state.tx.us/caseman/providerRegion.shtm](http://www.dshs.state.tx.us/caseman/providerRegion.shtm). Additional information about this program is also available at this website.

**Early Childhood Intervention:** Early Childhood Intervention (ECI) is a statewide program for families with children, birth to three years old, with disabilities and developmental delays. ECI teaches families how to help their children reach their potential through education and developmental services. Services are provided in the child's natural environment, such as home, daycare, or grandparent's home. Families with children enrolled in Medicaid, or whose income is below 200% of the Federal poverty Level, do not pay for ECI services. Federal law requires providers to refer children to ECI within two (2) business days of identifying a developmental disability or delay. To make a referral, providers may call the ECI Care Line at 1-800-250-2246 to identify an ECI program in the member's area. ECI educational resource materials are available to providers by calling CCHP Provider Services or Care Management.

## II COVERED SERVICES

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For information about ECI resources available to providers, call:

- ECI Care Line 1-888-754-0524
- CCHP Care Management Department 1-800-862-2246; or,

Additional resource information available online at [www.eci.state.tx.us](http://www.eci.state.tx.us)

A medical diagnosis or a confirmed developmental delay is not needed to refer. As soon as a delay is suspected, providers may refer a child to ECI, even as early as birth. The local program conducts developmental screenings and assesses the child for developmental delay and eligibility. After a child is accepted and enrolled, an individual treatment plan is developed, and services are initiated. When a child is not accepted into the program, ECI staff refer the family to other resources.

The Individual Family Service Plan (IFSP) may include screenings/assessments and services, such as physical, occupational, and speech/language therapy; nutrition services; psychological services; social work services; activities to increase cognitive and self-help skills; family education and counseling; vision; and, case management.

Posters and brochures are available for providers by calling CCHP Provider Services.

**Vendor Drugs:** The state administered Texas Medicaid Vendor Drug Program (VDP) makes payment for prescriptions of covered outpatient drugs only to pharmacy providers contracted with the Texas Vendor Drug Program. The only drugs eligible for VDP reimbursement are listed in the current Texas listing of National Drug Codes. Members may obtain their prescriptions from any Medicaid enrolled pharmacy of their choice. STAR program members may receive unlimited medically necessary prescriptions.

Questions about the Vendor Drug Program should be directed to 1-800-435-4165.

**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;

## II COVERED SERVICES

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- 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.

**School Health and Related Services (SHARS):** SHARS is a Medicaid financing program and is a joint program of the Texas Education Agency and the Texas Health and Human Services Commission (HHSC). The program allows local school districts/shared services arrangements to obtain Medicaid reimbursement for certain health-related services provided to students in special education. School districts/shared services arrangements receive federal Medicaid money for SHARS services provided to students who meet all three of the following requirements. These students must:

- Be eligible for Medicaid;
- Meet eligibility requirements for Special Education described in the Individuals with Disabilities Education Act (IDEA); and,
- Have Individual Educational Plans (IEPs) that prescribe the needed services.

Services include: assessment, audiology, counseling, school health services, medical services, occupational therapy, physical therapy, psychological services, speech therapy, and special transportation.

**Texas Agency Administered Programs and Case Management Services:** Texas Department of Family and Protective Services (TDFPS) – CCHP works with TDFPS to ensure that the at-risk population, both children in custody and not in custody of TDFPS, receive the services they need. Children who are served by TDFPS 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 TDFPS;
- Schedule medical and behavioral health services appointments within fourteen (14) days unless requested earlier by TDFPS;
- Refer suspected cases of abuse or neglect to TDFPS.

A member in the custody of TDFPS 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.

**Medical Transportation through Texas Department of Transportation:** The Medical Transportation Program (MTP) provides transportation services to Medicaid eligible clients that have no other means of transportation by the most cost-effective means. MTP can reimburse for gas if the member has an automobile but no funds for gas.

**Mental Health Targeted Case Management:** The priority populations targeted for case management services include the following: substance abuse, mental retardation, autism,

## II COVERED SERVICES

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pervasive developmental disorder, children at risk of removal from a preferred environment, children determined by a school system to have serious emotional disturbance, children at risk of disruption of a preferred living situation due to psychological symptoms or those with a functional impairment – Global Assessment Function of 50 or less. Services include advocacy, access, linkage, monitoring, crisis intervention and referral, planning and coordination of services.

**Mental Health Rehabilitation:** Rehabilitative services provided to persons, regardless of age, who have a single severe mental disorder (excluding mental retardation, pervasive developmental disorder or substance use disorder) or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*.

**THSteps Medical Case Management:** The THSteps Medical Case Management provides assistance to eligible clients in gaining access to medically necessary medical, social, educational and other services. Goals include reducing morbidity and mortality among children, encouraging use of cost-effective health care and health-related care, making referrals to appropriate providers, and discouraging over-utilization or duplication of services. Clients must meet the following eligibility requirements:

- Age 1-20 years of age;
- Have special health care needs, be medically complex or be medically fragile;
- Determined to have a health condition or risk;
- Referred by one of the following: PCP, other health providers, an appropriate local/state agency, themselves or their families.

THSteps Medical Case Management Hotline 1-877-THSteps or 1-877-847-8377

**Texas Commission for the Blind Case Management:** Case Management services are provided to visually impaired Medicaid eligible clients under sixteen (16) years of age. To contact the Department of Assistive Rehabilitative Service Division for Blind Services call 1-800-628-5115.

**Tuberculosis Services Provided by the Department of State Health Service – approved providers (Directly Observed Therapy and Contact Investigation):** All confirmed cases of Tuberculosis (TB) must be reported to the Local Tuberculosis Control Health Authority (LTCHA) using the most recent DSHS forms and procedures within one (1) day of diagnosis for a contact investigation. Providers must document members' referrals to LTCHA in their medical records and notify CCHP of the referrals. CCHP must coordinate with the LTCHA to ensure that all members with confirmed or suspected TB have a contact investigation and receive directly observed therapy. Providers must report to DSHS or the LTCHA any member who is non-compliant, drug resistant or who is or may be posing a public health threat. CCHP must cooperate with the local LTCHA in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Texas Health and Safety Code.

## II COVERED SERVICES

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**Department of Aging and Disability Services (DADS) Hospice:** DADS manages the hospice program. Members are disenrolled from CCHP upon enrollment into hospice. Medicaid hospice provides palliative care to all Medicaid eligible clients who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal illnesses run their normal courses. Services include medical and support services designed to keep clients comfortable and without pain during the

last weeks and months before death. When clients elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness.

# III PROVIDER RESPONSIBILITIES

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## 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:

<b>Primary Care</b>	<b>Adult</b>	<b>Children</b>
Preventative	Within 90 days	Within 14 days of enrollment for newborns. Within 60 days for all other children
Routine Services	Within 14 days	Within 14 days of request
Urgent Care	Within 24 hours	Within 24 hours
Emergency Care	Upon presentation	Upon presentation
Office Wait Time	0-30 minutes on average for scheduled appointments	0-30 minutes on average for scheduled appointments
<b>Specialty Care</b>		
Routine Care	Within 30 days of request	
Prenatal Care (routine)	Within 14 days	
Prenatal (high risk or New Members in 3 <sup>rd</sup> 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.

### III PROVIDER RESPONSIBILITIES

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**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 services (emergency room or ambulance).

### **III PROVIDER RESPONSIBILITIES**

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#### **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 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:

### III PROVIDER RESPONSIBILITIES

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“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.”

A Spanish version of the Client Acknowledgment Statement is available in the Provider Enrollment and Responsibilities section of the Texas Medicaid Procedures Manual.

#### **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 Texas Medicaid STAR, 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 STAR or CHIP Member without written, signed documentation that the Member has been notified of the pay status.

The provider may accept a Member as a private pay patient pending eligibility determination for STAR. If the Member does not become eligible retroactively, the provider may bill the Member as a private pay patient. If the Member becomes eligible for STAR, the provider must refund any money paid by the Member and file claims to CCHP for services rendered.

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: \_\_\_\_\_

# **III PROVIDER RESPONSIBILITIES**

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## **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.

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.

## **OB/GYN SERVICES:**

Cook Children's Health Plan does not limit the selection of an OB/GYN to their PCP's network.

## **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

### III PROVIDER RESPONSIBILITIES

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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 a prior authorization when performed by an in-network provider. All out-of-network referrals MUST receive prior authorization from the CCHP 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 care; and behavioral health services.

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

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

**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 care. To facilitate continuity of care, CCHP instructs members to notify their PCP as soon as possible after receiving emergency care. Providers are not required to notify CCHP Care Management about emergency care 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**

### **III PROVIDER RESPONSIBILITIES**

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**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 – CCHP has contracted with a vision provider for vision screenings. A vision screening is an examination by an optometrist or other provider to determine the need for and to prescribe corrective lenses and frames. The providers for these services are listed in the provider directory. Members may call the vision provider indicated on the member's ID card. No referral is needed for a vision screening, however, for medical diagnosis the member should be referred to an ophthalmologist by the PCP.

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.

#### **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

### **III PROVIDER RESPONSIBILITIES**

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consulting provider send his/her opinion to the PCP and CCHP. The PCP will notify the member of the consultant's opinion and recommendations.

#### **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.**

#### **Enrollment**

The Medicaid enrollment broker, MAXIMUS, processes all enrollments for the STAR managed care plans. Medicaid eligibles may enroll by phoning MAXIMUS toll free at (800) 964-2777 or by completing an enrollment form and mailing it to MAXIMUS. If MAXIMUS processes the enrollment by the 15<sup>th</sup> of the month, the request will be effective the first day of the following month. If the enrollment is processed after the 15<sup>th</sup> day of the month, the request will be effective the first day of the second month.

#### **Newborn Process**

Newborns are eligible for STAR program benefits from the date of birth if the baby is born to a mother enrolled in the STAR program and the baby is Medicaid eligible at the time of birth. A newborn must be in TANF or TANF related category to be enrolled at birth. Newborns must stay in the mother's health plan at the time of delivery for at least 90 days. Once a newborn's birth is reported, the STAR program will assign the newborn an ID number. This can take up to a few weeks. Claims submitted for the newborn must be filed using the newborn child's medicaid ID number. Claims filed using the mother's medicaid ID number may cause a delay in reimbursement.

#### **Automatic Re-enrollment**

If a member loses Medicaid eligibility but becomes eligible again within six (6) months or less, the member will automatically be enrolled in the same health plan the member was enrolled in prior to losing their Medicaid eligibility. The member will also be re-enrolled with the same PCP as they had before. 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.

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#### **Disenrollment**

A member may be disenrolled from a STAR Medicaid HMO when the member:

- dies;
- moves out of the service area; and
- loses Medicaid eligibility

An HMO may recommend disenrollment of a member from the HMO when:

- there is a breakdown in the provider-patient relationship;
- the member habitually seeks routine care from non-participating providers or from the emergency room
- the member allows another person to use his/her member identification card to obtain medical services

For requesting disenrollment of a member, providers should contact CCHP at 1-800-964-2247.

#### **Span of Eligibility**

Members can change health plans by calling the Texas Medicaid Managed Care Program Helpline at 1-866-566-8989. However, a member **cannot** change from one health plan to another plan during an inpatient hospital stay.

If a member calls to change health plans on or before the 15<sup>th</sup>, the change will take place on the first day of the next month. If they call after the 15<sup>th</sup> of the month, the change will take place the first day of the second month after that. For example:

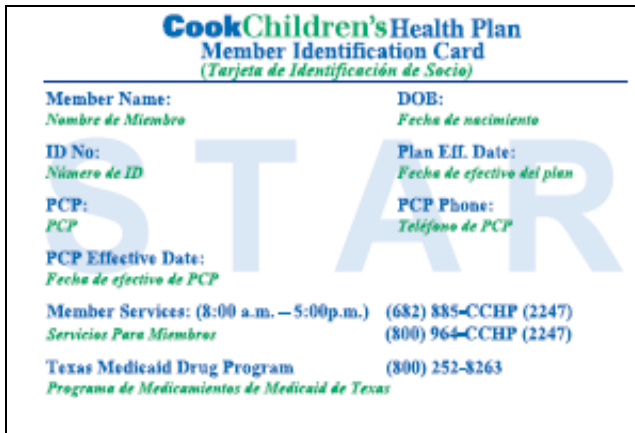
- If a request for plan change is made on or before April 15, the change will take place on May 1.
- If a request for plan change is made after April 15, the change will take place on June 1.

#### **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. CCHP recommends that providers verify eligibility through all available means prior to providing care to members.

#### **Verifying Eligibility**

### III PROVIDER RESPONSIBILITIES



#### Medicaid Identification Cards (Form 3087)

Each Medicaid HMO member should have a Cook Children's STAR identification card and a Form 3087 from the Texas Human and Human Services or a Form 1027-A. Form 3087 is the Medicaid Identification Form that is mailed to all Medicaid eligible members each month. Form 1027-A is a temporary Medicaid Identification. The form or letter will indicate the month of eligibility and whether the member is a STAR or Traditional Medicaid number.

The Cook Children's STAR ID card identifies the HMO and PCP that have been selected by the member. The card includes the following essential information:

- Member Name
- Member Identification Number
- Primary HMO's Telephone number
- Primary Care Provider's name and telephone number

While the ID card does identify the member, it does not confirm eligibility. This is because member eligibility can change on a monthly basis without notice. PCPs should not treat any member whose identification materials identify a different PCP or HMO.

#### Call Health Plan

Just as with commercial HMOs, the member identification card, Form 3087, and Form 1027 for Medicaid HMO members do not guarantee eligibility. Additionally, enrollment forms and membership rosters do not guarantee eligibility. 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 (882) 885-2247  
Toll Free Number (800) 964-2247

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#### **AIS line/TexMedNet**

TexMedNet is a web-based system which allows providers to verify eligibility. TexMedNet may be accessed using TDHconnect, a windows based software application that is available free from TMHP. To submit an eligibility inquiry, the user must enter the member identification number, date of birth or social security number. TexMedNet will supply benefit limitations, other insurance information, and last service date for eyeglasses, dental, hearing aids, and screening services. Eligibility inquiries can be made 24 hours per day, 7 days per week. To enroll in the TexMedNet program, please contact the TMHP or visit their website at [www.eds-tmhp.com/tmnclaim.thm](http://www.eds-tmhp.com/tmnclaim.thm).

#### **Automated Inquiry System (AIS)**

The Automated Inquiry System (AIS) is available twenty-four (24) hours per day, seven (7) days per week for verification of eligibility for STAR members. The system can be reached at any of the following phone numbers: (800) 925-9126, (512) 345-5948, or (512) 345-5949.

#### **Benefits**

STAR Members are provided with three enhanced benefits compared to the traditional, fee for service Medicaid coverage:

- waiver of the three-prescription per month limit;
- waiver of the 30-day spell-of-illness limitation under fee for service; and
- inclusion of an annual adult well check for patients 21 years of age and over.

#### **Value Added Services**

**Obesity Reduction** – Cook Children’s Health Plan will provide a structured program for members suffering from obesity (BMI  $\geq$  95% for age or 85% and significant comorbidities) including registration and payment for Weight Watchers classes. The member must be referred to the program by the member’s Primary Care Physician.

**Sports/School Physicals** – Members are eligible for sports or school physical once every 12 months under the age of 19.

**First Aid Kit** – Cook Children’s Health Plan 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.

**Prepared childbirth classes** – Cook Children’s Health Plan will provide coverage for up to \$70 for prepared childbirth Lamaze and breast feeding classes.

**Prenatal Dental Benefit** – Cook Children’s Health Plan will provide a structured dental program to pregnant women that includes up to \$500 of basic and major dental services.

### **III PROVIDER RESPONSIBILITIES**

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**Over the Counter Drug Benefit** – Cook Children’s Health Plan will provide a maximum of \$15.00 in reimbursement for over the counter medication for all new members.

**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.

**Expanded Behavioral Health Facility-Based Benefit** - Intensive Outpatient Programming, Partial Hospitalization, and Short-term Residential Treatment Services flexed from the Acute Inpatient Benefit. Intensive Outpatient: is delivered primarily at a facility and consists of clinical programming that is 4-6 hrs per day with a minimum of 3 times per week. This is usually reimbursed from the inpatient behavioral health benefit not the outpatient benefit. A member could receive 2 days of PHP treatment for every 1 day of inpatient benefit. Members can access this behavioral health value added service by contacting the behavioral health hotline.

**Sports/School Physicals** – Members under the age of 19 are eligible for sports or school physical once every 12 months.

#### **MEMBER RIGHTS:**

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

To respect dignity, privacy, confidentiality and nondiscrimination. That includes the right to:

- be treated fairly and with respect; and
- know that your medical records and discussions with your providers will be kept private and confidential.

To a reasonable opportunity to choose a health care plan and primary care provider (the doctor or health care provider you will see most of the time and who will coordinate your care) and to change to another plan or provider in a reasonably easy manner. That includes the right to:

- be informed of how to choose and change your health plan and your primary care provider;
- choose any health plan you want that is available in your area and choose your primary care provider from that plan;
- change your primary care provider;
- change your health plan without penalty; and
- be educated about how to change your health plan or your primary care provider.

To ask questions and get answers about anything you don’t understand. That includes the right to:

- have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated; and
- be told why care or services were denied and not given.

### **III PROVIDER RESPONSIBILITIES**

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To consent to, or refuse treatment, and actively participate in treatment decisions. That includes the right to:

- work as part of a team with your provider in deciding what health care is best for you; and
- say yes or no to the care recommended by your provider.

To utilize each available complaint and appeal process through the managed care organization and through Medicaid, and receive a timely response to complaints, appeals and fair hearings. That includes the right to:

- make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan;
- get a timely answer to your complaint;
- access the plan's appeal process and the procedures for doing so; and
- request a fair hearing from the state Medicaid program and request information about the process for doing so.

To timely access to care that does not have any communication or physical access barriers. That includes the right to:

- have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care;
- get medical care in a timely manner;
- be able to get in and out of a health care provider's office, including barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act;
- have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, assist with a disability, or help you understand the information; and
- be given an explanation you can understand about your health plan rules, including the health care services you can get and how to get them.
- To not be restrained or secluded when doing so is for someone else's convenience, or is meant to force you to do something you don't want to do, or to punish you.

#### **MEMBER RESPONSIBILITIES:**

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

To learn and understand each right you have under the Medicaid program. That includes the responsibility to:

- Learn and understand your rights under the Medicaid program;
- ask questions if you don't understand your rights; and
- learn what choices of health plans are available in your area.

To abide by the health plan and Medicaid policies and procedures. That includes the responsibility to:

- Learn and follow your health plan rules and Medicaid rules;
- Choose your health plan and a primary care provider quickly;

### **III PROVIDER RESPONSIBILITIES**

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- make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan;
- keep your scheduled appointments;
- cancel appointments in advance when you can't keep them;
- always contact your primary care provider first for your non-emergency medical needs;
- be sure you have approval from your primary care provider before going to a specialist; and
- understand when you should and shouldn't go to the emergency room.

To share information relating to your health status with your primary care provider and become fully informed about service and treatment options. That includes the responsibility to:

- tell your primary care provider about your health;
- talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated; and
- help your providers get your medical records

To actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:

- work as a team with your provider in deciding what health care is best for you;
- understand how the things you do can affect your health;
- do the best you can to stay health; and
- treat providers and staff with respect.

#### **Marketing Guidelines**

The following STAR Provider Marketing Policy is consistent with Health and Human Services Policies and Procedures.

#### **CCHP Provider Marketing Policy for STAR**

Providers are prohibited from marketing and participating in STAR Program enrollment activities. All Medicaid recipients are to be enrolled in the STAR Program by the Enrollment Broker (Maximus) via the official State enrollment form, or by calling the STAR Program help line at 1-800-964-2777.

Providers are permitted to educate their patients about the STAR Program. The following policies are required for use when educating patients about the STAR Program:

- Providers may inform their patients regarding the plans in which they participate.
- Providers may inform their patients of the benefits, services, and specialty care providers offer through the plans in which they participate.
- At the patients' request, providers may give patients the information necessary to contact a particular health plan.
- Providers may distribute or display written health educational materials or health related posters (no larger than 16 x 24) developed by the health plan or third party and approved by HHSC. Distribution and/or display of all materials submitted by

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all contracted health plans is required. These materials may have the health plan's name, logo, and phone number.

- Providers may display plan stickers (no larger than 5"x 7") 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." Stickers must have the STAR logo affixed.

#### **Providers are prohibited from the following:**

- Providers are not allowed to stock, reproduce or handle enrollment forms.
- Providers or their staff may not assist recipients in filling out enrollment forms or making a decision on selecting a health plan.
- Health Plan specific, non-health related materials or banners are NOT allowed in provider offices.
- Providers shall not make false, misleading or inaccurate statements relating to services, benefits or providers or potential providers.
- Providers may not recommend one plan over another.

#### **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.

#### **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  
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:

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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 investigation
- 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.

#### SPECIAL ACCESS REQUIREMENTS

##### **General Transportation and Ambulance/Wheelchair Van**

The Medical Transportation Program (MTP) provides categorically eligible Medicaid and Children with Special Health Care Needs (CSHCN) recipients with the most cost-effective means of transportation to appointments for their covered medical and dental care services within the reasonable proximity of their residence. MTP may also pay for an attendant if a provider documents the need, the client is a minor, or there is a language barrier. Call MTP toll-free at 1-877-MEDTRIP (1-877-633-8747) during the normal business hours of 8:00a.m. to 5:00p.m. weekdays at least two working days in advance of the trip. If the trip requires extended travel beyond the neighboring county, please call at least five working days in advance.

Depending on the client's medical need and location, MTP can arrange for transportation by mass transit, van service, taxi, or airplane. MTP can reimburse gas money if the client has an automobile but no funds for gas. In addition, for clients under twenty-one (21) years of age, MTP can assist with meals and lodging for medical services when an overnight stay is medically necessary.

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#### **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 a 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 a four tiered education and training program on cultural competency described below:

**Tier I – Employee Training** - Integrate training on Cultural Competency into CCHP’s new employee orientation and training programs and annual employee re-training;

### **III PROVIDER RESPONSIBILITIES**

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**Tier II – Provider Training** - Develop a block of training on cultural competency as it relates to culturally effective health care services for initial and ongoing network provider education and training;

**Tier III – Newsletters** - Develop educational information on cultural competency for inclusion in member and provider newsletters and correspondence; and,

**Tier IV – Member Handbook** - Provide education and training for our diverse member population through inclusion of information in the Member Handbook and ongoing member health education programs.

This four tiered educational approach, combined with augmenting continuing education programs will improve the cultural awareness, sensitivity and competence of CCHP staff and affiliated providers of care.

#### **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. CCHP will co-ordinate language translation services with the provider as needed.

##### In-house Translation Services

CCHP employs bilingual staff members in the Member Services, Claims, and Care Management departments. Spanish translation services are available by contacting CCHP Monday through Friday from 8:00 – 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. This service is available to our members 8:00–5:00PM Monday through Friday, excluding holidays. 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.

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

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CCHP members can access the CyraCom translation services by calling the main number to CCHP. CCHP staff will conference in a CyraCom translator who can facilitate the communication. Network providers who encounter a CCHP member who cannot speak English may also contact CCHP for translation services. Either an in-house CCHP translator will be provided via telephone or a CyraCom translator will be conferenced in to assure that effective communication occurs. Providers are made aware of services available through information included in the Provider Manual and periodic Provider Newsletters.

#### 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 member's is: [www.cookchp.org](http://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 and Member Services Hotline/Call Center 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

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 (6<sup>th</sup>) 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

### **III PROVIDER RESPONSIBILITIES**

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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). TIS employs 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 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 STAR.

#### Services for the Visually Impaired

CCHP also provides alternative communication services for members/families who 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.
- 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 Quality Management 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.

### **III PROVIDER RESPONSIBILITIES**

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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.

#### **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;

### **III PROVIDER RESPONSIBILITIES**

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- 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 care 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).
  - 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

### **III PROVIDER RESPONSIBILITIES**

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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.

#### **COORDINATION WITH TEXAS DEPARTMENT OF FAMILY & PROTECTIVE SERVICES (TDFPS)**

Coordination must occur between TDFPS and foster parent for the care of a child who is receiving services from or has been placed in the conservatorship of TDFPS as outlined in HHSC/MC contract. MCO must also inform provider of the following:

- Providing medical records to TDFPS
- Scheduling medical and behavioral health appointments within 14 days unless requested earlier by TDFPS and
- Recognition of abuse and neglect, and appropriate referral to TDFPS

Providers should make the appropriate referral to TDFPS when abuse or neglect is suspected or confirmed.

#### **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?

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

### **III PROVIDER RESPONSIBILITIES**

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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. **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.** 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.

## **IV TEXAS HEALTH STEPS (THSteps)**

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### **TEXAS HEALTH STEPS (THSteps)**

Refer to the *Texas Medicaid Provider Procedures Manual* for information regarding THSteps.

#### **Children of Migrant Farmworkers**

Children of Migrant Farmworkers due for a THSteps medical checkup can receive their periodic check up on an accelerated basis prior to leaving the area. A check up performed under this circumstance is considered an exception to periodicity.

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

**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 Care – Members are instructed to call their PCP as soon as possible after receiving emergency care. 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**

CCHP requires notification from providers after a member's first prenatal visit. Notification includes all prenatal and postpartum care.

**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

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# CARE MANAGEMENT

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- 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
- 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

## V CARE MANAGEMENT

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- 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 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.

### **NOTICES OF ACTION**

CCHP must notify members and providers when it takes an Action. An action includes the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service. Only the CCHP Medical Director or the physician designee may render a denial for lack of medical necessity (adverse determination).

### **APPEALS**

#### **Standard Appeal**

When CCHP denies or limits a covered benefit (Action), the member or his or her authorized representative may file an Appeal within thirty days from receipt of the Notice of Action. The member may request that any person or entity act on his or her behalf with the member's written consent. A health care provider may be an authorized representative. Appeals received orally must be confirmed by a written, signed appeal by the member or his or her authorized representative, unless an expedited resolution is requested. Within five business days of receipt of the appeal request, CCHP sends letter

## V CARE MANAGEMENT

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acknowledging receipt of the appeal request. The member may continue receiving services during the appeal if the appeal is filed within ten days of the Notice of Action or prior to the effective date of the denial, whichever is later. The member is advised in writing that he or she may have to pay for the services if the denial is upheld. If the appeal resolution reverses the denial, CCHP will promptly authorize coverage. The Standard Appeal Process must be completed within thirty calendar days after receipt of the initial written request for appeal. The timeframe for a standard appeal may be extended for a period of up to fourteen calendar days if the member or his or her representative requests an extension or if CCHP shows there is need for additional information and how the delay would be in the best interest of the member. CCHP provides the member or his or her authorized representative with a written notice of the reason for the delay. Appeals are reviewed by individuals who were not involved in the original review or decision to deny and are health care professionals with appropriate clinical expertise in treating the member's condition or disease. CCHP provides a written notice of the appeal determination to the appellant. If the appeal decision upholds the original decision to deny a service, members receive information regarding their right to request an external review (Fair Hearing).

### **Expedited Appeal**

Members or their authorized representatives may request an expedited appeal either orally or in writing within thirty days (or ten days to ensure continuation of currently authorized services) from receipt of the Notice of Action or the intended effective date of the proposed Action. If CCHP denies a request for an expedited appeal, CCHP transfers the appeal to the standard appeal process, makes a reasonable effort to give the appellant prompt oral notice of the denial, and follows up within two calendar days with a written notice. Investigation and resolution of expedited appeals relating to an ongoing emergency or denial of a continued hospitalization are completed (1) in accordance with the medical or dental immediacy of the case and (2) not later than one business day after receiving the request for expedited appeal. Except for an expedited appeal relating to an ongoing emergency or denial of continued hospitalization, the time period for notification to the appellant of the appeal resolution may be extended up to fourteen calendar days if the member requests an extension or CCHP shows that there is a need for additional information and how the delay is in the member's best interest. If the timeframe is extended by CCHP, CCHP provides the member with a written notice acknowledging receipt of the request for expedited appeal and the reason for the delay. When the timeframe is extended by the member, CCHP sends a letter acknowledging receipt of the expedited appeal request and the request for an extension. An individual who was not involved in the original review or decision to deny and is a health care professional with appropriate clinical expertise in treating the member's condition or disease renders the appeal determination. CCHP provides the appellant a written notice of the appeal resolution. If the appeal decision upholds the original decision to deny a service, members receive information regarding their right to request an external review (Fair Hearing).

**State Fair Hearing Information****Can I ask for a State Fair Hearing?**

If the member disagrees with the health plan's decision, the member has the right to ask for a fair hearing. The member may appoint, in writing, a representative. A provider may be a member's representative. The member or member representative must ask for the fair hearing within 90 days of the date on the health plan's letter. If the member does not ask for the fair hearing within 90 days, the member may lose his/her right to a fair hearing. To request a fair hearing, the member or member representative contacts the health plan either in writing (address for health plan) or by telephone (number for health plan))

The member has the right to continue any service he/she is now receiving until the final hearing decision if the members requests the fair hearing within ten days from receipt of the hearing notice from the health plan. If a Fair Hearing is not requested within ten days from receipt of the hearing notice, the services being appealed will be discontinued. You do not have a right to a Fair Hearing if Medicaid does not cover the service you requested.

If the member asks for a fair hearing, the member will get a packet of information letting the member know the date, time and location of the hearing. Most fair hearings are held by telephone and the member or the member's representative may tell why he/she asked for the service.

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

**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.

## **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 4<sup>th</sup> to 6<sup>th</sup> 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.
- 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 4<sup>th</sup> to 6<sup>th</sup> 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;

## **V CARE MANAGEMENT**

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- 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, 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
<b>PREVENTION</b>		
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> <a href="http://www.ahrq.gov/clinic/cpsix.htm">http://www.ahrq.gov/clinic/cpsix.htm</a> <i>Guide to Clinical Preventive Services, Third Edition: Periodic Updates</i> <a href="http://www.ahrq.gov/clinic/gcpspu.htm">http://www.ahrq.gov/clinic/gcpspu.htm</a> Recommended Adult Immunization Schedule by Vaccine and Age Group <a href="http://www.cdc.gov/nip">http://www.cdc.gov/nip</a>
Preventive Services for Children	National Immunization Program (CDC), the National Vaccine Advisory Committee, AAP Committee on Practice and Ambulatory	Recommended Childhood and Adolescent Immunization Schedule <a href="http://www.cdc.gov/nip">http://www.cdc.gov/nip</a> Recommendations for Preventive Health Care (RE9535) <a href="http://aappolicy.aappublications.org">http://aappolicy.aappublications.org</a>  <i>Also:</i> Bright Futures website: <a href="http://brightfutures.aap.org">http://brightfutures.aap.org</a>  3 <sup>rd</sup> Edition Guidelines ( <i>Free Download</i> )

Topic	Source	Link
	Medicine, and Cook Children's Health Care System Clinical Excellence Committee	<a href="http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html">http://brightfutures.aap.org/3rd Edition Guidelines and Pocket Guide.html</a>  <i>or to purchase:</i> I. <i>BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS SET</i> AVAILABLE FOR PURCHASE AT: <a href="http://www.aap.org/bst/showdetl.cfm?&amp;DID=15&amp;Product_ID=3757&amp;CatID=132">http://www.aap.org/bst/showdetl.cfm?&amp;DID=15&amp;Product_ID=3757&amp;CatID=132</a>
Perinatal Care	American College of Obstetricians and Gynecologists	<i>Guidelines for Perinatal Care, Fifth Edition</i> available for purchase at <a href="http://sales.acog.com/acb/stores/1/product1.cfm?SID=1&amp;Product_ID=242">http://sales.acog.com/acb/stores/1/product1.cfm?SID=1&amp;Product_ID=242</a>
<b>CARDIOVASCULAR HEALTH</b>		
Prevention, Detection, Evaluation, and Treatment of High Blood Pressure	National Institutes of Health (NIH), and National Heart, Lung and Blood Institute	<a href="http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf">http://www.nhlbi.nih.gov/guidelines/hypertension/jnc7full.pdf</a>
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: <a href="http://www.nhlbi.nih.gov/guidelines/cholesterol/index.htm">http://www.nhlbi.nih.gov/guidelines/cholesterol/index.htm</a> Executive Summary <a href="http://www.nhlbi.nih.gov/guidelines/cholesterol/atp_iii.htm">http://www.nhlbi.nih.gov/guidelines/cholesterol/atp_iii.htm</a>
Early Identification And Treatment Of Children With Hyperlipidemia	Cook Children's Health Care System Clinical Excellence Committee	<a href="http://intranet.cchcs ldap/SiteCollectionDocuments/Hyperlipidemia%20Clinical%20Guideline%20R02-07.pdf">http://intranet.cchcs ldap/SiteCollectionDocuments/Hyperlipidemia%20Clinical%20Guideline%20R02-07.pdf</a> Copies available on request from CCHP
<b>CHRONIC ILLNESS</b>		
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 <a href="http://www.nhlbi.nih.gov/guidelines/asthma/index.htm">http://www.nhlbi.nih.gov/guidelines/asthma/index.htm</a>
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 <a href="http://www.nhlbi.nih.gov/health/prof/lung/asthma/astpreg.htm">http://www.nhlbi.nih.gov/health/prof/lung/asthma/astpreg.htm</a>
Medical Care in Diabetes	American Diabetes Association	Standards of Medical Care in Diabetes <a href="http://care.diabetesjournals.org/cgi/content/full/28/suppl_1/s4">http://care.diabetesjournals.org/cgi/content/full/28/suppl_1/s4</a>

# VI

# QUALITY MANAGEMENT

Topic	Source	Link
<b>BEHAVIORAL HEALTH</b>		
Diagnosis and Management of Adults with Major Depression	Colorado Clinical Guidelines Collaborative	CorpHealth, Inc. Clinical Guidelines for the Management of Depression <a href="http://www.corphealth.com/products/quality.htm">http://www.corphealth.com/products/quality.htm</a>
Diagnosis, Evaluation and Treatment of ADD/ADHD	American Academy of Pediatrics	CorpHealth, Inc. uses the National Attention Deficit Disorder Association guideline for ADHD. CorpHealth provider resource link: <a href="http://www.corphealth.com/providers/resources.htm">http://www.corphealth.com/providers/resources.htm</a> NADDA website: <a href="http://www.add.org">www.add.org</a> PDF Guideline: <a href="http://www.add.org/pdf/GuidingPrinciples021206Rev[1].pdf">http://www.add.org/pdf/GuidingPrinciples021206Rev[1].pdf</a>
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 <a href="http://www.psych.org">www.psych.org</a> <a href="http://www.psychiatryonline.com/pracGuide/pracGuideTopic_8.aspx">http://www.psychiatryonline.com/pracGuide/pracGuideTopic_8.aspx</a>
<b>Health Literacy</b>		
Recognizing and Responding to Health Literacy Problems of Adult and Pediatric Patients.	Various	<p>Agency for Healthcare Research &amp; Quality : Literacy and Health Outcomes Summary: <a href="http://www.ahrq.gov/clinic/epeccsums/litsum.pdf">http://www.ahrq.gov/clinic/epeccsums/litsum.pdf</a> Full Report: <a href="http://www.ahrq.gov/downloads/pub/evidence/pdf/literacy/literacy.pdf">http://www.ahrq.gov/downloads/pub/evidence/pdf/literacy/literacy.pdf</a></p> <p>American College of Physicians Foundation Website: <a href="http://www.foundation.acponline.org/index.htm">http://www.foundation.acponline.org/index.htm</a> Video: <a href="http://www.foundation.acponline.org/hl/hlvideo.htm">http://www.foundation.acponline.org/hl/hlvideo.htm</a></p> <p>American Medical Association Foundation: Website: <a href="http://www.ama-assn.org/ama/pub/category/8115.html">http://www.ama-assn.org/ama/pub/category/8115.html</a> Video: <a href="http://www.ama-assn.org/ama/pub/category/8035.html">http://www.ama-assn.org/ama/pub/category/8035.html</a></p> <p>California Health Literacy Initiative: Website: <a href="http://cahealthliteracy.org/">http://cahealthliteracy.org/</a></p> <p>Harvard School of Public Health: Health Literacy Studies <a href="http://www.hsph.harvard.edu/healthliteracy/">http://www.hsph.harvard.edu/healthliteracy/</a></p> <p>Health Resources &amp; Services: Health Literacy <a href="http://www.hrsa.gov/healthliteracy/">http://www.hrsa.gov/healthliteracy/</a></p> <p>Institute for Healthcare Advancement: Health Education</p>

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

## **VII BEHAVIORAL HEALTH**

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### **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 provider 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 provider meets all current and future Texas and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the STAR program and shall cooperate with CCHP to enable it to monitor compliance with these requirements. Provider 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. 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 provider must coordinate a Member's care with specialist providers after referral. In situations where no participating specialist provider is available to provide the service, provider shall discuss and obtain 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 present at a primary care setting.

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

## VII BEHAVIORAL HEALTH

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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 Provider Reference Guide;
- ✓ Participating in CCHP and LifeSynch quality improvement and utilization management activities.

## VII BEHAVIORAL HEALTH

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### **Behavioral Health Covered Services**

#### Inpatient Mental Health Services:

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

- Inpatient and outpatient mental health services for children under 21 years of age
- Outpatient chemical dependency services for children under 21 years of age
- Inpatient mental health services are limited to:
  - 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 for serious mental illness, provided on an outpatient basis, are subject to the following:

- Detoxification services
- Psychiatry services
- Counseling services for all ages
- Outpatient chemical dependency services

#### Behavioral Health Value Added Services

Behavioral health value added services are available for members under 21 years of age. These services include intensive outpatient programming, partial hospitalization, and short-term residential treatment services flexed from the acute inpatient benefit. These services must be medically necessary and be preauthorized behavioral services. All services must be performed at participating facilities within the participating provider network. These services are defined as follows:

- Intensive outpatient services – These services are delivered primarily at a facility and consist of clinical programming that is 4-6 hours per day with a minimum of 3 times per week. This is usually reimbursed from the inpatient behavioral health benefit not the outpatient benefit.
- Partial hospitalization – These services would be allowed for behavioral health treatment and a member could receive 2 days of partial hospitalization treatment for every 1 day of inpatient benefit.

## VII BEHAVIORAL HEALTH

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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 members all covered 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 STAR 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

## **VII BEHAVIORAL HEALTH**

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(“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 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 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. 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**

## VII BEHAVIORAL HEALTH

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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)
- 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).

## VII BEHAVIORAL HEALTH

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**Depression screening tools are available on the following websites:**

Assessments.com has a large selection:	<a href="http://www.assessments.com/default.asp">http://www.assessments.com/default.asp</a>
Children's Depression Scale (CDS)	<a href="http://www.swin.edu.au/victims/resources/assessment/affect/cds.html">http://www.swin.edu.au/victims/resources/assessment/affect/cds.html</a>
Children's Depression Inventory (CDI)	<a href="http://www.cps.nova.edu/~cphhelp/CDI.html">http://www.cps.nova.edu/~cphhelp/CDI.html</a>
Children's depression screening tools:	<a href="http://www.mgh.harvard.edu/madiresourcecenter/schoolpsychiatry/screening_depression.asp">http://www.mgh.harvard.edu/madiresourcecenter/schoolpsychiatry/screening_depression.asp</a>
Available on the Lexapro website and developed by A John Rush, MD.	<a href="http://www.lexapro.com/english/understanding_depression/screener.aspx??PlacementGUID=68067DB2-32CB-4592-A105-1EA5D457F851">http://www.lexapro.com/english/understanding_depression/screener.aspx??PlacementGUID=68067DB2-32CB-4592-A105-1EA5D457F851</a>
Available on the AstraZeneca website, the Mood Disorder Questionnaire (MDQ).	<a href="http://www.isitreallydepression.com/mini_c/isitreallydepression/index2.asp">http://www.isitreallydepression.com/mini_c/isitreallydepression/index2.asp</a>
Available tools that can be opened and saved	<a href="http://projects.ipro.org/index/ami_ktools">http://projects.ipro.org/index/ami_ktools</a>
Zung Self-rating Depression Scale	<a href="http://www.fhma.com/documents/zung.pdf">http://www.fhma.com/documents/zung.pdf</a>
University of Michigan screen	<a href="https://www.mentalhealthscreening.org/screening/welcome.asp">https://www.mentalhealthscreening.org/screening/welcome.asp</a>
Beck Depression Inventory II (BDI-II)	<a href="http://harcourtassessment.com/cgi-bin/MsmGo.exe?grab_id=164&amp;page_id=6433792&amp;query=Beck%2A&amp;hiword=Beck%2A">http://harcourtassessment.com/cgi-bin/MsmGo.exe?grab_id=164&amp;page_id=6433792&amp;query=Beck%2A&amp;hiword=Beck%2A</a>
Hamilton Depression Rating Scale (HAM-D)	<a href="http://healthnet.umassmed.edu/mhealth/HAMD.pdf">http://healthnet.umassmed.edu/mhealth/HAMD.pdf</a>
Website with available depression scales	<a href="http://www.oqp.med.va.gov/cpg/MDD/MDD_cpg/content/appendices/mdd_app1_fr.htm">http://www.oqp.med.va.gov/cpg/MDD/MDD_cpg/content/appendices/mdd_app1_fr.htm</a>
MOS depression items for patients under age 60	<a href="http://www.rand.org/health/surveys/core/mos.shortform.pdf">http://www.rand.org/health/surveys/core/mos.shortform.pdf</a>
Center for Epidemiologic Studies Depression Scale (CES-D)	<a href="http://www.chcr.brown.edu/pcoc/cesdscale.pdf">http://www.chcr.brown.edu/pcoc/cesdscale.pdf</a>
CES-D available to use without permission	<a href="http://patienteducation.stanford.edu/research/cesd10.pdf">http://patienteducation.stanford.edu/research/cesd10.pdf</a>

# VIII COMPLAINT & APPEAL PROCESS

## MEDICAID MANAGED CARE COMPLAINT/APPEAL PROCESS

<b>MEDICAID PROVIDER COMPLAINT/APPEAL</b>	
Provider Complaints/Appeals to Cook Children's Health Plan.	Providers that wish to file a complaint about CCHP or one of our members can do so by calling CCHP at (800) 964-2247 or (682) 885-2247. CCHP will fully and completely respond to all Medicaid provider complaints/appeals received by CCHP within 30 days of receiving the complaint.
Provider Complaint Process to HHSC.	When filing a complaint with HHSC, providers must submit a letter to the following address: Texas Health and Human Services Commission Re: Provider Complaint Health Plan Operations, H-320 PO Box 85200 Austin, TX 78708

<b>MEDICAID MEMBER COMPLAINT/APPEAL PROCESS</b>	
<b>Member Complaint Process</b>	
Member's Right to File Complaints.	Members or the Member's authorized representative (Member) have the right to file a complaint either orally or in writing.
Requirements and timeframes for filing a complaint.	The Member may file a complaint with CCHP either orally or in writing. They may also file a complaint directly with HHSC. CCHP will resolve all complaints within 30 days from the date the complaint is received.
Availability of assistance in the filing process.	If the Member needs help in filing a complaint the Member can contact Member Services and a Member Advocate can help the Member to file a complaint.
Toll-free numbers that the enrollee can call to file a complaint.	Member can file a complaint by calling (800)-964-2247 or (682) 885-2247.
<b>Member Appeal Process</b>	
What can I do if the health plan denies or limits my Member's request for a covered service?	You may ask CCHP for another review of this decision.
How will I be notified if services are denied?	If services are denied, CCHP will send you a letter explaining why the service was denied.
Timeframes for Appeals – including option to extend up to 14 calendar days in Member requests an extension; or the MCO shows that there is a need for additional information and how the delay is in the Member's interest, If MCO needs to extend, Member must receive written notice of the reason for delay.	All requests for appeal shall be completed no later than 30 calendar days after CCHP received your request unless you feel 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 completed within 1 working day.

## VIII COMPLAINT & APPEAL PROCESS

When does Member have the right to request an appeal – include option for the request of an appeal for denial of payment for services in whole or in part.	A Member can request an appeal of a denial upon receipt of notification of a service denial or a denial in whole or in part of a claim for services rendered.
Include notification to the Member that in order to ensure continuity of current authorized services, the Member must file the appeal on or before the later of: 10 days following the MCO’s mailing of the notice of the action, or the intended effective date of the proposed action.	If the Member wishes to continue to receive services while the appeal is pending, the appeal must be requested on or before 10 days following CCHP’s mailing the notice of action or the intended effective date of the proposed action.
The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.	If the appeal decision is adverse to the member, the member may be required to pay the cost of the services furnished during the appeal process.
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.	If CCHP receives an oral request for an appeal, the request must be confirmed by a written signed appeal by the Member.
Can someone from Cook Children’s Health Plan help me file an appeal?	Yes, a Case Manager can assist you with filing the appeal.
Member’s option to request a State Fair Hearing at any time during or after the plan’s appeal process.	The Member has the right to request a Fair Hearing at any time during or after the appeal process.
<b>Member Expedited MCO Appeal</b>	
How to request an expedited appeal (must be accepted orally or in writing)	To request an expedited appeal, call the CCHP Care Management Department at (800) 862-2247 or write to CCHP at PO Box 2488, Fort Worth., TX 76101-2488.
Timeframes	Members must exhaust the HMO’s Expedited Appeal process before making a request for an expedited Fair Hearing. After the HMO receives the request for an Expedited Appeal, it must hear an approved request for a Member to have an Expedited Appeal and notify the Member of the outcome of the Expedited Appeal within 3 business days, except that the HMO must complete investigation and resolution of an Appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one (1) business day after receiving the Member’s request for Expedited Appeal is received.
What happens if the MCO denies the request for an expedited appeal?	If the appeal does not meet the criteria for an expedited appeal, the appeal will be processed in accordance with the first level appeal process.
Who can assist me with filing an appeal?	A Case Manager can assist you in filing an appeal.
<b>Member request for State Fair Hearing</b>	
Can I ask for a State Fair Hearing?	If the Member disagrees with the health plan’s decision, the Member has the right to ask for a fair hearing. The Member may appoint, in writing, a representative. This representative may be a provider,

## VIII COMPLAINT & APPEAL PROCESS

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	<p>a friend, a relative, legal counsel or another spokesman. The Member or Member's representative must ask for the fair hearing within 90 days of the date on the health plan's letter. If the member does not ask for the fair hearing within 90 days, the member may lose his/her right to a fair hearing. To request a fair hearing, the Member or Member representative contacts the health plan either in writing at PO Box 2488, Fort Worth, TX 76113-2488 by telephone at: 1-800-964-2247.</p> <p>The Member has the right to continue any service he/she is now receiving until the final hearing decision if the member requests the fair hearing within ten days from receipt of the hearing notice from the Health Plan.. If a fair hearing is not requested within ten days from receipt of the hearing notice, the services being appealed will be discontinued.</p> <p>The Member does not have a right to a fair hearing if Medicaid does not cover the service requested.</p> <p>If the Member asks for a fair hearing, the Member will get a packet of information letting the Member know the date, time and location of the hearing. Most fair hearing are held by telephone and the Member of the Member's representative may tell why he/she asked for the service.</p> <p>HHSC will give the member a final decision within 90 days from the date of the member asked for the hearing.</p>
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# IX BILLING

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## 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: CCHP9  
Receiver Type Code: D

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

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

**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 physician's office. CCHP does not require that the member receive approval from the health plan or the PCP prior to accessing emergency care. To facilitate continuity of care, CCHP instructs members to notify their PCP as soon as possible after receiving emergency care. Providers are not required to notify CCHP Care Management about emergency care 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.**

# **IX BILLING**

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## **CO-PAYMENTS**

Medicaid Managed Care Members do not have any Co-Payment responsibility.

## **BILLING MEMBERS**

CCHP reimburses Medicaid Allowable. 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 Medicaid HMO 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 Medicaid claims. If the member becomes eligible, the provider must refund any money paid by the client when a Medicaid claim is filed.

As stated in the HHSC rules, providers are not allowed to bill Medicaid members for claims denied or not received by the Medicaid HMO 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 DATA/CLAIMS APPEALS**

Medicaid 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 Medicaid 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, such as documentation from the Clearing House or proof of mailing as timely filing documentation.

**COORDINATION OF BENEFITS** – HHSC flags information when a member has other insurance coverage. CCHP is secondary. The claim should be filed to the primary insurance company for payment. When provider receives payment from the primary carrier, a copy of that EOB should be attached to the claim and submitted to CCHP for secondary payment. Texas Health Steps should be billed directly to CCHP, even if the member has other insurance.

## **IX BILLING**

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110-day rule – If the primary care insurance company has not responded or delayed payment or denial of a provider’s claim for more than 110 days after the date of the claim was billed, CCHP considers the claim for reimbursement. The following information is required:

Name and address of the Primary Carrier

Date the carrier was billed (used to calculate filing deadline)

Statement signed and dated by the provider that no disposition has been received from the carrier within 110 days of the date the claim was billed.

### **CLAIMS PAYMENT**

All Provider claims that are clean and payable must be paid within thirty (30) days from the date of claim receipt. Interest will be paid on clean claims not paid within thirty (30) days.

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 twenty (120) days from the date of disposition to appeal a denied claim.

### **SPECIAL BILLING**

CCHP offers the following value added services for STAR members that require special billing:

- School Physicals do not need to be given by the member’s primary care physician. The provider should bill the Health Plan using diagnosis code: V70.3.
- Prepared childbirth classes are billed to the Health Plan listing the member’s STAR ID#, name, classes taken and billed amount. This should be sent to Cook Children’s Health Plan, PO Box 2388, 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

# **IX BILLING**

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Providers can view claims status at: [www.cookchildrenshealthplan.org](http://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 with 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 authorization number must be on the claim, if applicable.
- Remember to add the correct modifiers for THSteps/EPSTDT exams.
- When billing for inpatient services, be sure to list each inpatient day as a separate line item.
- Always provide correct TPI# and NPI#.

## **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

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](http://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 PREAUTHORIZATION REQUEST FORM COMPLETION GUIDE

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

➤ **CCHP PREAUTHORIZATION 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.\*\***

# COOK CHILDREN'S HEALTH PLAN



## Pregnancy Notification



Please complete this form for notification by call or fax within one business day of the initial office prenatal visit or at the time of pregnancy diagnosis.  
Please call or fax for authorization if your pregnant patient requires a hospital stay with or without delivery. Thank you.

**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:	OB Phone #:
Office Contact:	OB Fax #:
Gravida/Para/AB/Living:	Expected Delivery Facility:
Expected Date of Delivery (EDC):	Last Menstrual Period (LMP):
Previous prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, where:
Date of First OB Prenatal Office Visit:	Weeks Gestation at 1 <sup>st</sup> OB visit:
<b>RISK FACTORS:</b>	
<input type="checkbox"/> <b>PROBLEMS WITH THIS PREGNANCY:</b>	
<input type="checkbox"/> NONE <input type="checkbox"/> Abnormal Lab(s)/sonogram(s) <input type="checkbox"/> Advanced Maternal Age <input type="checkbox"/> Decreased Fetal Movement <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Hyperemesis Gravidarum <input type="checkbox"/> Incompetent Cervix <input type="checkbox"/> Infection/GBS/HIV <input type="checkbox"/> IUGR <input type="checkbox"/> Late Prenatal Care <input type="checkbox"/> Multiple Gestation <input type="checkbox"/> No Prenatal Care <input type="checkbox"/> Oligo/Polyhydraminos <input type="checkbox"/> PIH (pregnancy > BP) <input type="checkbox"/> Placenta Previa <input type="checkbox"/> Pre-Eclampsia <input type="checkbox"/> Preterm Labor <input type="checkbox"/> Repeat Pregnancy < 12 months <input type="checkbox"/> SAB/Miscarriage <input type="checkbox"/> STD/Herpes <input type="checkbox"/> Substance Exposure [i.e. smoking] <input type="checkbox"/> Threatened AB <input type="checkbox"/> Vaginal Bleeding <input type="checkbox"/> Young Maternal Age <input type="checkbox"/> OTHER: _____	
<input type="checkbox"/> <b>PROBLEMS WITH PREVIOUS PREGNANCY:</b>	
<input type="checkbox"/> NONE <input type="checkbox"/> Anemia <input type="checkbox"/> Birth defect(s) <input type="checkbox"/> C/Section <input type="checkbox"/> DIC <input type="checkbox"/> Eclampsia <input type="checkbox"/> Ectopic <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> HELLP syndrome <input type="checkbox"/> Low Birth Wt <input type="checkbox"/> Preterm Delivery <input type="checkbox"/> SAB/Fetal Loss <input type="checkbox"/> Stillborn/Neonatal or Infant Death <input type="checkbox"/> OTHER: _____	
<input type="checkbox"/> <b>UNDERLYING MEDICAL PROBLEMS:</b>	
<input type="checkbox"/> NONE <input type="checkbox"/> Asthma <input type="checkbox"/> Blood/Sickle Cell/HIV <input type="checkbox"/> Diabetes (IDDM) <input type="checkbox"/> Gall Bladder <input type="checkbox"/> High BP (CHTN) <input type="checkbox"/> Immune Disorder <input type="checkbox"/> Obesity <input type="checkbox"/> Pyelonephritis <input type="checkbox"/> Trauma Injury <input type="checkbox"/> UTI(s) <input type="checkbox"/> OTHER: _____	
<input type="checkbox"/> <b>OTHER RISK FACTORS/PROBLEMS:</b>	
<input type="checkbox"/> NONE <input type="checkbox"/> Education <input type="checkbox"/> Financial <input type="checkbox"/> Housing <input type="checkbox"/> Social/Psych Issues <input type="checkbox"/> Transportation <input type="checkbox"/> OTHER: _____	
<b>Medications:</b> <input type="checkbox"/> NONE <input type="checkbox"/> Yes [If Yes, list]:	

**CCHP OB Care Authorization Number:** \_\_\_\_\_

# COOK CHILDREN'S HEALTH PLAN



## Delivery Notification



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

**Inpatient/Delivery Authorization Number:** \_\_\_\_\_

**Nursery/NICU Authorization Number:** \_\_\_\_\_

**COOK CHILDREN'S HEALTH PLAN**

**SPECIALIST AS A  
PRIMARY CARE PHYSICIAN AGREEMENT**

THIS SPECIALIST AS A PRIMARY CARE PHYSICIAN SERVICES AGREEMENT ("Agreement") is made as of this \_\_\_ day of \_\_\_\_\_, 2002 ("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 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 Corphealth 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 Corphealth 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 Corphealth 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 Corphealth, Inc. as described:			
<input type="checkbox"/> 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).			
<input type="checkbox"/> My health information from _____ to _____			
<input type="checkbox"/> Information concerning my treatment with (provider name, location) _____			
<input type="checkbox"/> 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:			
<input type="checkbox"/> Coordination of Care			
<input type="checkbox"/> Appeal or Complaint Process			
<input type="checkbox"/> Legal Purposes			
<input type="checkbox"/> Other _____			
<i>Corphealth does not use patient information for marketing purposes.</i>			
NOTICE TO PATIENT			
You may refuse to sign this form. You do not have to sign this form to receive services or treatment, except:			
<ul style="list-style-type: none"><li>• 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.</li><li>• 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.</li></ul>			
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 Corphealth Privacy Office. A request to revoke an authorization will not affect any actions taken before Corphealth 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:	Corphealth, Inc. Attn: Privacy Office 1300 Summit Ave, Suite 600 Fort Worth TX 76102	Or Fax to: (817) 335-9100	
<i>All authorizations are subject to approval by Corphealth, Inc.</i>		<i>A copy must be placed in patient file.</i>	