

**Provider**

# ANNUAL COMMUNICATION

December 2019

Information and updates for Texas Children's Health Plan providers.



**Texas Children's<sup>®</sup>  
Health Plan**

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PERMIT NO. 1167  
N. HOUSTON, TX

Member Services Department  
P.O. Box 301011  
Houston, TX 77230-1011

**Texas Children's<sup>®</sup>  
Health Plan**



# CLINICAL PRACTICE GUIDELINES

Texas Children's Health Plan, with the guidance of its Clinical & Administrative Advisory Committees, develops or adopts evidence-based clinical practice guidelines. These practice guidelines: (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; and (2) Consider the needs of Texas Children's Health Plan enrollees.

Texas Children's Health Plan has Clinical Practice Guidelines in place including, but not limited to the following:

## Allergy Guidelines:

- Allergy Diagnostic Testing
- Allergen Immunotherapy

## Asthma Guidelines:

- Pediatric Asthma Care Guidelines
- Adult Asthma Care Guidelines

## Behavioral Health Guidelines:

- American Academy of Child and Adolescent Psychiatry Practice Parameters
- American Academy of Child and Adolescent Psychiatry - Practice Parameter for the Assessment and Treatment of Children and Adolescents With Attention-Deficit Hyperactivity Disorder
- American Academy of Child and Adolescent Psychiatry - Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorders
- American Academy of Pediatrics - ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
- American Psychiatric Association - Practice Guideline for the Treatment of Patients with Major Depressive Disorder
- Institute for Clinical Systems Improvement, Health Care Guideline: Major Depression in Adults in Primary Care

## State Behavioral Health Guidelines:

The following are adult and child utilization management guidelines mandated by the state of Texas. These are recommended assessment guidelines and are foundational to the Texas Children's Health Plan behavioral health program. Texas Children's Health Plan will provide any of these resources in hard copy format upon request.

- Child Texas Recommended Assessment Guidelines (TRAG) [dshs.state.tx.us/mhprograms/RDMCAtrag.shtm](https://dshs.state.tx.us/mhprograms/RDMCAtrag.shtm)
- Adult Texas Recommended Assessment Guidelines (TRAG) [dshs.state.tx.us/mhprograms/RDMTRAG.shtm](https://dshs.state.tx.us/mhprograms/RDMTRAG.shtm)

## Diabetes Guidelines:

- Diabetes Standards of Care
- Diabetes Standards of Care Change Summary
- Diabetes Care for Transition

## Neuropsychology Guidelines:

- Neuropsychological Testing Guidelines

## Otitis Guidelines:

- AAP Otitis Media with Effusion

## Obesity Guidelines:

- NHLBI Obesity Guidelines for Adults

## Pediatric Echocardiogram Guidelines:

- Pediatric Echocardiogram Guidelines
- Training Guidelines for Pediatric Echocardiogram

## Pharyngitis:

- Pharyngitis Practice Guidelines

## Preventative Care Guidelines:

- Texas Health Steps Periodicity Schedule
- Recommended Immunization Schedule Age 0-18
- Catch-up Immunization Schedule Age 0-18
- AAP Bright Futures Periodicity Schedule
- Adult Immunization Schedule
- Adult Preventative Services

Clinical practice guidelines are reviewed every 2 years and updated as needed. Texas Children's Health Plan disseminates the guidelines to the provider network and, upon request, to members. These guidelines are available on the Texas Children's Health Plan website, Provider Portal (Health Trio), or by FAX upon request by calling the Provider Information Line at 832-828-1004 or toll-free at 1-800-731-8527.

## 2019 QUALITY IMPROVEMENT PROGRAM

Texas Children's Health Plan has a Quality Improvement (QI) Program in place with the goal of safe, high quality health care and service for its members regardless of their source of eligibility. The QI Program strives to include the full range of care and services offered through the health plan in its annual goals and objectives for quality improvement. This includes monitoring for quality of care and service, safety, coordination and continuity of care, and the availability and accessibility of medical and behavioral health services. The QI program operates through a committee structure comprised of health plan staff, physicians, healthcare providers, and behavioral healthcare practitioners participating in or advising the Quality Committee (QC) or subcommittees that report to the QC. The Texas Children's Health Plan Board of Directors approved the authority, responsibilities, and specific duties as described in the 2019 QI Program Description. Annually the Texas Health & Human Services Commission (HHSC) and the National Committee for Quality Assurance (NCQA) require Texas Children's Health Plan to report the results of designated performance measures,

including the Healthcare Effectiveness Data & Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. The Quality Department would like to thank all the practitioners who every year support Texas Children's Health Plan HEDIS medical record data collection.

In 2018, Texas Children's Health Plan met national benchmark rates above the 95th percentile for the following measure: Avoidance of Antibiotic Treatment (STAR adults); measures above the 90th percentile included: Adolescent Well Care (STAR & CHIP). Measures at or above the 75th percentile included: Chlamydia Screening (STAR), Asthma Medication Ratio (STAR), Appropriate Treatment for Upper Respiratory Infection (STAR), Nutrition and Physical Activity Counseling (CHIP), Childhood Immunization Status (CHIP), and Timely Postpartum Care (CHIP).

Areas with rates at the 50th percentile or below and need continued improvement include: 7 Day Follow-up After Hospitalization for Mental Illness (STAR & CHIP); Follow-Up Care for Children Prescribed ADHD Medications (STAR & CHIP);

Comprehensive Diabetes Care (STAR & CHIP); Childhood Immunization Status (STAR); Well Child Visits in the First 15 Months of Life (STAR & CHIP); BMI Percentile ages 3-17 (STAR), and Timely Initiation of Prenatal Care (CHIP).

The Texas Children's Health Plan Quality Department has teams that identify and implement interventions to address needed improvements in HEDIS rates. The teams and/or workgroups are from various health plan departments, such as Quality, Care Management, Provider Network Management, Member Services and Marketing and Communications.

Information on the Texas Children's Health Plan Quality Improvement Program, annual goals, and progress toward goals is available upon request. You may request information by calling the Provider Information Line at **832-828-1004** or toll-free at **1-800-731-8527**.

## PHARMACY

The Texas Children's Health Plan Pharmacy Department works with Navitus, our pharmacy benefits manager, to provide pharmacy benefit services to our STAR, STAR Kids, and CHIP members. Our purpose is to provide accessible pharmacy care and ensure that services are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting, and meet professionally recognized standards of pharmacy care.

The Texas Children's Health Plan Pharmacy Department works to partner with physicians to provide cost-effective care geared toward the goal of improving and maintaining the health of our members.

Texas Children's Health Plan provides its outpatient pharmacy drug benefit utilizing the Vendor Drug Program Formulary, which is extensive and includes generic and branded products. The Texas Medicaid and CHIP Formularies can be accessed at the following web address: [txvendordrug.com/formulary](http://txvendordrug.com/formulary)

Preferred drugs are medications recommended by the Texas Drug Utilization Review Board for their efficaciousness, clinical significance, cost effectiveness, and safety. The Texas Preferred Drug List (PDL) is published every January and July by the Texas Medicaid / CHIP Vendor Drug Program. The Texas Formulary Preferred Drug List (PDL) products are available to providers when prescribing for patients covered by the pharmacy benefit plan without prior authorization, although they may be subject to clinical prior authorization. The Preferred Drug List (PDL) is available for download at: [txvendordrug.com/pdl](http://txvendordrug.com/pdl)

Additionally, both the Texas Medicaid Formulary and the corresponding Preferred Drug List (PDL) are available on the Epocrates drug information system. The service is free and provides instant access to information through the internet or smart phone about the products on the Texas Medicaid Formulary. Information about accessing the Texas Medicaid Formulary and the Preferred Drug List (PDL) via Epocrates can be viewed at:

[txvendordrug.com/formulary/epocrates](http://txvendordrug.com/formulary/epocrates)

Texas Children's Health Plan highly encourages our network practicing prescribing practitioners and pharmacists to provide expert commentary regarding the Texas Medicaid Formulary. Please submit comments or suggestions regarding the formulary to:  
[Managed\\_Care\\_UMCM@hhsc.tx.us](mailto:Managed_Care_UMCM@hhsc.tx.us)

Texas Children's Health Plan has contracted with a Pharmacy Benefit Manager (PBM) called Navitus Health Solutions. Navitus is responsible for the following:

- Texas Children's Health Plan's network of pharmacies
- Pharmacy claim concerns
- Administration of the Texas Medicaid and CHIP drug formulary
- Prior authorization for non-preferred medications on the Texas Medicaid Formulary
- Prior authorization for HHSC specialty drugs cross-referenced to the Texas Medicaid Formulary
- Program Administration of Clinical Edits
- Administration of Quantity Limits
- Provider request for peer-to-peer review of prior authorization denials
- Coordination of Benefits at retail point of sale
- Receipt and payment of pharmacy claims
- Complaints from pharmacies and pharmacy reimbursement concerns

Navitus has contracted with more than 95% of the current Vendor Drug Program pharmacy providers in Texas. The Navitus pharmacy network includes the national chain pharmacies (e.g. Walgreen's, CVS, HEB, Walmart, Target, and Kroger), as well as a large number of independent pharmacies. Navitus' pharmacy network can be accessed online at [txstarchip.navitus.com/pages/pharmacy-directory.aspx](http://txstarchip.navitus.com/pages/pharmacy-directory.aspx)

Providers may call Navitus at 1-866-333-2757 to inquire about prior authorizations, clinical edits, quantity limits, or to request a peer-to-peer review. Texas Medicaid Formulary drugs requiring prior authorizations, the prior authorization forms, and all Texas Children's Health Plan currently implemented clinical edits can be found at [txstarchip.navitus.com/pages/prior-authorization-forms.aspx](http://txstarchip.navitus.com/pages/prior-authorization-forms.aspx)

The Texas Medicaid Formulary, including the Preferred Drug List and any clinical edits that specify the prior authorization process for non-preferred agents, are defined by the Texas Vendor Drug Program.

### **Quantity Limits**

A quantity limit may reduce the number (or amount) of drugs covered within a certain time period. Quantity limits are designed to limit the use of selected drugs for quality and safety reasons. The quantity limit for each drug is supported by FDA recommended use of the product and per approved dosing instruction in the package insert. This utilization management program encourages appropriate drug use. If a quantity limit is programmed for a medication and the prescription is outside of this predetermined quantity limit, the local pharmacist will review the original request for safety.

### **Step Therapy**

Step therapy is a program that ensures the most effective use of prescription drugs for patients. A step therapy plan starts with the most appropriate drug therapy based on national published guidelines. If those treatments do not work, other alternative treatments are considered. Currently, the Texas Vendor Drug Program PDL is enforced for Texas Children's Health Plan STAR/CHIP Members.

### **Generic Substitution**

The Texas Medicaid Formulary as defined by the Texas Vendor Drug Program has a list of preferred medications on the Preferred Drug List (PDL). A drug that is covered under this PDL may be either brand or generic.

Prescribers are encouraged to reference the Texas Medicaid Formulary and the Preferred Drug List (PDL) when prescribing medication for the most up-to-date, covered medication.

### **Therapeutic Interchange**

Therapeutic interchange involves the dispensing of medications which are chemically different, but therapeutically similar in nature.

Therapeutic interchange helps ensure the most cost-effective treatment and needs the approval of a prescriber. Texas Children's Health Plan does not refuse coverage of any covered product under the Texas Medicaid Formulary and its associated Preferred Drug List in lieu of a similar covered product for cost control reasons. We may, however, contact the Provider to provide education on the Texas Medicaid Formulary and the Preferred Drug List (PDL) which defines all of the covered alternatives available for members. Any changes to medication at any time should only be made under the provider's careful consideration.

### **Formulary Updates and Communications**

Texas Children's Health Plan reviews and modifies necessary rules, limitations, and guidelines periodically throughout the year. This policy is to ensure effective communication to the practitioner and provider community is updated frequently.

At a minimum, practitioners and providers will be updated using a combination of both passive and active means such as newsletters, internet, direct mail, provider manuals, fax alerts, and face-to-face interaction.

## CHIP MEMBER RIGHTS

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan.  
Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copayment depending on your income. Copayments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals, and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.
20. You have the right to make recommendations regarding the organization's member rights and responsibilities policy.



## CHIP MEMBER RESPONSIBILITIES

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
  2. You must become involved in the doctor's decisions about your child's treatments.
  3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
  4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
  5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
  6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
  7. If your child has CHIP, you are responsible for paying your doctor and other providers copayments that you owe them. If your child is getting CHIP Perinatal services, you will not have any copayments for that child.
  8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
  9. You must talk to your provider about your medications that are prescribed.
- I0. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
    - Learn and follow your health plan's rules and Medicaid rules.
    - Choose your health plan and a primary care provider quickly.
    - 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 cannot keep them.
    - Always contact your primary care provider first for non-emergency medical needs.
    - Be sure you have approval from your primary care provider before going to a specialist.
    - Understand when you should and should not go to the emergency room.
  - II. You must share information about your health with your primary care provider and learn 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.
    - Help your providers get your medical records.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services toll-free at **1-800-368-1019**. You also can view information concerning the HHS Office of Civil Rights online at [hhs.gov/ocr](https://www.hhs.gov/ocr).

CHIP Perinatal members get basic medical care that includes:

- Regular check-ups
- Prescription drugs
- Shots
- Coverage for special health needs

## MEDICAID MEMBER RIGHTS

- 1.** You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
  - a.** Be treated fairly and with respect.
  - b.** Know that your medical records and discussions with your providers will be kept private and confidential.
- 2.** You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
  - a.** Be told how to choose and change your health plan and your primary care provider.
  - b.** Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
  - c.** Change your primary care provider.
  - d.** Change your health plan without penalty.
  - e.** Be told how to change your health plan or your primary care provider.
- 3.** You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
  - a.** Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
  - b.** Be told why care or services were denied and not given.
- 4.** You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
  - a.** Work as part of a team with your provider in deciding what health care is best for you.
  - b.** Say yes or no to the care recommended by your provider.
- 5.** You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:
  - a.** Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
  - b.** Get a timely answer to your complaint.
  - c.** Use the plan's appeal process and be told how to use it.
  - d.** Ask for a fair hearing from the state Medicaid program and get information about how that process works.
- 6.** You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
  - a.** Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
  - b.** Get medical care in a timely manner.
  - c.** Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
  - d.** Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
  - e.** Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
- 7.** You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
- 8.** You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
- 9.** You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.



## MEDICAID MEMBER RESPONSIBILITIES

1. You must 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 do not understand your rights.
  - Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
  - Learn and follow your health plan's rules and Medicaid rules.
  - Choose your health plan and a primary care provider quickly.
  - 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 cannot keep them.
  - Always contact your primary care provider first for non-emergency medical needs.
  - Be sure you have approval from your primary care provider before going to a specialist.
  - Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn 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.
  - Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
  - 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 healthy.
  - Treat providers and staff with respect.
  - Talk to your provider about all of your medications.
5. You must follow plans and instructions for care that you have agreed to with your provider.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at **1-800-368-1019**. You also can view information concerning the HHS Office of Civil Rights online at [hhs.gov/ocr](https://www.hhs.gov/ocr).

# AUTHORIZATION FOR HEALTH SERVICES

The primary care provider acts as the coordinator for health care provided to Texas Children's Health Plan members, both within and outside of the primary care provider's office. The primary care provider has the primary responsibility for arranging and coordinating appropriate referrals to other providers/specialists, as well as managing and coordinating the administrative functions related to the delivery of health services in conjunction with Texas Children's Health Plan and case managers as indicated.

The primary care provider or designee may make medically necessary referrals to in-network specialists, ECI, family planning, CPW, Texas Health Steps, and emergency services without authorization from Texas Children's Health Plan.

Current services requiring authorization are listed below, but please check Provider TouCHPoint at [texaschildrenshealthplan.org/for-providers/provider-resources](http://texaschildrenshealthplan.org/for-providers/provider-resources) for updates to this list or with Texas Children's Health Plan Utilization Management at **832-828-1004**, or **1-877-213-5508**, option 3 for updates to this list.

The following services require authorization effective October 1, 2019.

## Medical Authorizations

- Adaptive Aids
- Adult Day Care/Day Activity and Health Services (more than 1 unit per day)
- Augmentative Communication Device and accessories
- Bariatric Surgery
- Case by Case Added Services (Codes not listed in the TMHP Fee Schedule)
- Circumcision (members one year of age and older)
- Clinician Administered Drugs that Require Authorization
- Cosmetic Surgery
- Cranial Molding Orthosis
- DME Repair (K0739) when greater than 35 units
- Employment Assistance
- Emergency Response Services (Community First Choice)
- Flexible Family Support Services
- Financial Management Services
- Gait Trainers and Stenders
- General Anesthesia for Dental Procedures (Facility and Physician) 6 years and under
- Genetic Testing
- Habilitation (Community First Choice)
- Home Health Care
- Home Modifications Maintenance
- Home Telemonitoring Services
- Hospital grade Blood Pressure Monitors for home use
- Hospital Beds and accessories
- Hospital Inpatient care
- Implantable Hearing Device (excluding batteries)
- Magnetoencephalography (MEG)
- Minor Home Modifications
- Miscellaneous DME (E1 399) for billed amount >\$500
- Non-Emergency Ambulance Transport
- Nutritional Supplements for oral nutrition and adults
- Oral Surgery and Medically Necessary Dental Procedures
- Out of Network Services (excluding emergency services, family planning for STAR/STAR Kids only, and well child exams for all plans)
- Personal Care Services
- or Personal Assistance (Community First Choice)
- PET Scans
- Positive Airway Pressure Device (CPAP/BiPAP)
- Prescribed Pediatric Extended Care Centers
- Private Duty Nursing in Home
- Prosthetics
- Respite Care
- Skilled Nursing facility
- Sleep Studies in Children (under 18 years old)
- SPECT Scans
- Supported Employment
- Therapy-Occupational (excluding Early Childhood Intervention (ECI) Programs,
- Reevaluations and Acute Therapy Evaluations with the AT Modifier)
- Therapy-Physical (excluding Early Childhood Intervention (ECI) Programs,
- Reevaluations and Acute Therapy Evaluations with the AT Modifier)
- Therapy-Speech (excluding Early Childhood Intervention (ECI) Programs, Reevaluations)
- Therapeutic and Reconstructive Breast Procedures (including breast prosthesis)

- TMJ diagnosis and treatment
- Transition Assistance Services
- Transplants including Solid Organ and Bone Marrow
- Wheelchairs and accessories

## Behavioral Health Authorizations

- Inpatient Care
- Intensive Outpatient Treatment (Chemical Dependency Treatment Facility)
- Mental Health Rehabilitation Services and Targeted Case Management
- Neuropsychological Testing
- Out of Network Services
- Outpatient Psychotherapy Visits Greater than 30 (Per Calendar Year)
- Partial Hospitalization (Mental Health)
- Psychological Testing (excluding initial evaluation)
- Residential Treatment Facility
- Skills Training and Development
- Substance Use Disorder Treatment (excluding evaluation)

## HOW TO CONTACT UTILIZATION MANAGEMENT

Texas Children's Health Plan Utilization Management (UM) staff is available from 8 a.m. to 6 p.m. Monday through Friday for inbound calls regarding UM issues. Messages left for UM staff after hours by phone are returned the next business day. Inbound messages may be left at any time. Providers may contact Texas Children's Health Plan Utilization Management Services at **832-828-1004** or **1-877-213-5508** option 3.

Texas Children's Health Plan offers TDD.TTY services for deaf, hard of hearing, or speech impaired members and providers. For TDD assistance, please call **1-800-735-2989** or **7-1-1**. Language line assistance is available to UM staff, if needed, in discussion with members or practitioners for any UM issue.

**For STAR Kids Plan Members,** all appeals regarding services that have not been rendered or have already been delivered should be directed to:

**Texas Children's Health Plan  
Attn: Appeals Department**  
P.O. Box 301011, WLS 8390  
Houston, Texas 77230-1011  
1-800-659-5764 or  
832-828-1003  
Fax: 832-825-8796

**For CHIP Plan Members,** all appeals regarding services that have not been rendered or have already been delivered should be directed to:

**Texas Children's Health Plan  
Attn: Appeals Department**  
P.O. Box 301011, WLS 8390  
Houston, Texas 77230-1011  
1-866-959-6555 or  
832-828-1002  
Fax: 832-825-8796

**For STAR Plan Members,** all appeals regarding services that have not been rendered or have already been delivered should be directed to:

**Texas Children's Health Plan  
Attn: Appeals Department**  
P.O. Box 301011, WLS 8390  
Houston, Texas 77230-1011  
1-866-959-2555 or  
832-828-1001  
Fax: 832-825-8796

## AUTHORIZATION AND APPEALS PROCESS

Authorization requests may be submitted to Texas Children's Health Plan by faxing the authorization form and required documentation to **832-825-8760** or toll-free at **1-844-473-6860**, or by calling **832-828-1004**. Behavioral Health authorizations may be faxed toll-free to **1-844-291-7505**. LTSS authorizations may be faxed to **346-232-4757**. When a UM Specialist is unable to approve the requested service based on Texas Children's Health Plan criteria, the Medical Director/Associate Medical Director/Physician Reviewer will review the authorization request and any available clinical information, prior to issuance of any denial based on lack of medical necessity. Before a denial is issued by Texas Children's Health Plan regarding the medical necessity or appropriateness, or the experimental or investigational nature, of a healthcare service, Texas Children's Health Plan provides the requesting provider a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis prior to the adverse determination. A decision to

deny a service authorization based on medical necessity can only be made by a physician.

If a request for services is denied by Texas Children's Health Plan, the ordering provider, rendering provider, and member will receive a letter indicating the reason why services are being denied. The member, member designee, practitioner, or provider has the right to appeal a denial of services. Members may represent themselves or be represented by the health care provider, a friend, a relative, legal counsel, or another spokesperson. Texas Children's Health Plan will make a decision within 30 days of receiving the request for appeal. An expedited appeal may be placed when Texas Children's Health Plan determines or the provider indicates to Texas Children's Health Plan that routine appeal time frames could jeopardize the member's life, health, or ability to recover a function. Texas Children's Health Plan will make a decision within 3 days of receiving the request.

### UTILIZATION MANAGEMENT

Phone: 832-828-1004 or 1-877-213-5508, option 3  
Fax: 832-825-8760 or 1-844-473-6860  
Hours of operation: 8 a.m. to 6 p.m.,  
Monday through Friday

- Prior authorization request
- Concurrent review
- Notification of admissions

## PREVENTIVE HEALTH SERVICE RESPONSIBILITIES

Primary care providers have the responsibility to provide preventive health services in accordance with the STAR/CHIP programs and related medical policies. The preventive health services will include, but are not limited to, the following:

- Annual well checkups for all adult members age 21 and older.
  - Education of members about their right to self-refer to any in-network OB/GYN provider for OB/GYN health-related care.
  - Immunizations, TB screenings, and other measures for the prevention and detection of disease, including instructions in personal health care practices and information on the appropriate use of medical resources.
- Adherence to Texas Health Steps periodicity schedule for STAR and American Academy of Pediatrics (AAP) Guidelines for CHIP.
  - Complying with all prior authorization and certification requirements and admitting patients in need of hospitalization only to in-network facilities or contracted hospitals unless:
    - Prior authorization for admission to an out-of-network facility has been obtained from Texas Children's Health Plan.
    - The condition is emergent and the use of an in-network hospital is not practical for medical reasons.

## AVAILABILITY OF CRITERIA TO PRACTITIONERS

It is the policy of Texas Children's Health Plan to use written criteria based on clinical evidence for appropriate case application in adjunct to a review of individual circumstances and local health system structure when determining medical appropriateness of health care services. Texas Children's Health Plan has developed Utilization Management guidelines that are objective and based on medical evidence to serve as criteria for the determination of medical necessity for services that require

prior authorization. The goal of our UM guidelines is to encourage the highest quality care from the right provider in the right setting.

To access the guidelines providers may log in to the Provider Portal at [texaschildrenshealthplan.org/providers](https://texaschildrenshealthplan.org/providers) or contact Texas Children's Health Plan Provider Network Management department at **832-828-1004** or toll-free at **1-800-731-8527**.

## AFFIRMATIVE STATEMENT

Texas Children's Health Plan UM decision making is based on our Policies, Procedures, and Guidelines. They are based only on appropriateness of care and service and the existence of coverage. Texas Children's Health Plan does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care.

Texas Children's Health Plan does not offer financial incentives for UM decision makers that encourage decisions that result in under-utilization.

Texas Children's Health Plan does not hire, promote, or terminate based on the likelihood that a practitioner will support or tend to support the denial of benefits.

## THSteps CHECKUP DOCUMENTATION – Essential to Medical Records

As a Texas Health Steps (THSteps) provider, you affect the lives of many young Texans. The care you provide helps prevent serious or chronic health care problems and often helps young patients begin to develop positive lifelong health care habits. Being a THSteps provider can be very rewarding. It can also be very challenging, especially when it comes to medical checkup documentation. Independent studies of Texas Health Steps medical checkups indicate that records were most commonly missing documentation of appropriate laboratory tests and immunizations.

THSteps checkups are made up of six primary components, many including individual components. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. Comprehensive health and developmental history which includes nutrition screening, developmental and mental health screening, and TB screening;
2. Comprehensive unclothed physical examination which includes measurements (height or length), weight, front-to-occipital circumference, BMI, blood pressure, and vision and hearing screening;
3. Appropriate immunizations, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV;
4. Appropriate laboratory tests which include newborn screening blood lead level assessment appropriate for age and risk factors, and anemia;
5. Health education (including anticipatory guidance); and
6. Dental referral every 6 months until the parent or caregiver reports a dental home is established.

For you to be reimbursed for THSteps checkups, each of the six components and their individual elements must be completed and documented in the medical record. Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

In support of successful checkup documentation and to assist in documenting each of the components and elements of the checkups, the THSteps program recommends use of the THSteps Child Health Record Forms, which are available for download on the THSteps provider information webpage. Each checkup form is age-specific and can assist you with documenting all required checkup components and elements, including developmental and mental health screenings, laboratory screenings, immunizations, and the dental referral as required until the caregiver reports a dental home is established. The components and elements outlined in the forms can be integrated into electronic health records.

To stay current on THSteps policy and available resources, visit the frequently updated THSteps website for information and policy updates. Information on checkup documentation is also available within THSteps Online Provider Education modules. These modules are free and offer continuing education for healthcare professionals. They are available at [txhealthsteps.com](http://txhealthsteps.com).

Qualified and caring THSteps providers are vital to keeping young Texans healthy. The preventive health care you provide to young Texans is valued. It is important to reflect this care in the completeness of your medical documentation.

## COMPLEX CASE AND DISEASE MANAGEMENT PROGRAM

Services offered to Texas Children's Health Plan providers include case management for chronic, complex conditions and pregnant women. Specific disease management programs designed to assist primary care providers with effective management of asthma, diabetes, and depression are available.

Health Plan care managers enroll members into both disease management and/or case management programs. A referral initiated by the provider is requested to start the services. An assessment and care plan are completed on the patient and referrals are provided to the parent/member. The primary care provider is given a care plan for members enrolled in case/disease management programs. Providers should include the care plans in the patient's medical record. Follow-up calls with phone coaching are done monthly to monitor the patient/parent progress with the plan of care. The care manager collaborates closely with the member's primary care provider to share relevant health information. The objective is to positively impact the member's adherence to the treatment plan.

The goal of the care management team is to partner with families to achieve a better level of care. The provider can contact the care management team for questions regarding emergency room/inpatient visits, number of provider and specialist visits, and medication refill information.

Providers may request these services by calling the Care Management Department at **832-828-1430**. Referral forms are available for download at [texaschildrenshealthplan.org/for-providers](https://texaschildrenshealthplan.org/for-providers).

Once completed, the forms may be faxed to **832-825-8745**.

## QUALITY CARE COORDINATION

Care coordination addresses potential gaps in meeting our members' interrelated medical, social, behavioral, and educational needs to achieve the best health and wellness outcomes.

The goal is to ensure that individualized needs and preferences are recognized, and that high quality and efficient care is delivered for best outcomes. Case managers, social service professionals, and trained health care workers all play a key role in managing care of the individual by providing guidance through the health care system either telephonically or in a face-to-face visit with the member.

Individuals who have multiple ongoing needs—that can't be met by a single practitioner or by a single clinical organization—benefit from care coordination the most.

Care coordination has **3** primary focus areas:

1. Support of self-management through education, advocacy (specialist access, school nurse), shared decision making, and flexibility with individuals and families by connecting members with prevention and wellness services.
2. Coordination of assessment data and health information.
3. Promoting connections to care delivery and transition support from pediatrics into adult care.

Comprehensive care coordination develops a plan of care including clinical (medical and behavioral) and social service needs and wellness goals.

**Comprehensive care coordination:**

1. Establishes a connection to supports and services at home, school, and community, and
2. Provides access to family support services to enhance the success and strength of the family in navigation and advocacy.

Care coordination includes the process of developing an informed and motivated member/family, in partnership with a proactive practice team. Techniques are based on Wagner's Chronic Care Model (informed activated patient with prepared proactive practice team).

You can find a referral form for case management on the Texas Children's Health Plan website. Fax it to **832-825-8745** or call the Care Coordination Department number at **832-828-1430** for more information.



## UNDERSTANDING WASTE, ABUSE AND FRAUD

The Office of Inspector General (OIG) is continuously monitoring the populations served by the HHS enterprise for instances of fraud, abuse and waste. In order to provide a better understanding of the OIG's efforts in detecting, deterring and correcting incidents of fraud, abuse and waste, please refer to their website: [oig.hhsc.texas.gov](http://oig.hhsc.texas.gov). Incidences of fraud, abuse and waste can also be reported through the OIG's website.

If there is a particular topic you would like to have addressed, please contact the OIG at [oig.hhsc.texas.gov/contact](http://oig.hhsc.texas.gov/contact).

To report potential fraud directly to Texas Children's Health Plan:

**The Texas Children's Health Plan Fraud Hotline: 832-828-1320**

**Fax number: 832-825-8722**

**Email: [FraudandAbuse@texaschildrens.org](mailto:FraudandAbuse@texaschildrens.org)**

### Mail:

**Texas Children's Health Plan  
Fraud and Abuse Investigations**  
PO Box 301011, WLS 8302  
Houston, TX 77230-1011

## REPORTING CHANGES TO THE HEALTH PLAN

Providers must notify Texas Children's Health Plan no less than 30 business days prior to the effective date of the changes to the provider data listed below. Changes not received in writing are not valid. If Texas Children's Health Plan is not informed with the timeframe, Texas Children's Health Plan and its designated claims administrator are not responsible for the potential claims processing and payment errors.

Network providers must also notify the Health and Human Services Commission administrative services contractor of any change that involves a provider's address, telephone number, group affiliation, etc.

Providers may update their demographic information on the Texas Children's Health Plan website at [texaschildrenshealthplan.org/for-providers](http://texaschildrenshealthplan.org/for-providers). You can find the forms by clicking on "Downloadable Forms," then "Other Forms." They are also available on the Provider Portal under the Update Provider Information menu. The Provider Information Form should be submitted to add a new provider or a new location to a group. The Provider Information Change Form should be submitted to make demographic changes like address or hours of operation.

The following demographic information must be maintained:

Name	Corporate Number (if applicable)	Permit to Practice	Patient age limitations	Languages spoken by the provider and/or office staff
Address (both physical and billing)	Specialty change	Professional liability insurance coverage	Practice limitations	PCP Providers: Texas Health Steps Provider distinction
Telephone number	Tax ID Number	Change in hospital affiliation	Whether the following is offered with the practice: <ul style="list-style-type: none"><li>• Telehealth</li><li>• Telemedicine</li><li>• Telemonitoring</li></ul>	Other information that may affect current contracting relationship
Office hours	Medicaid Provider Number	Contract status change		
Coverage procedures	National Provider Identifier Number	Open or closure of panel		

\*Hours of operation that practitioners offer to Medicaid members should be no less than those offered to commercial members. Please contact Provider Network Management with reported changes at **832-828-1004** or toll-free at **1-800-731-8527**.

## LEARN MORE INFORMATION ON OUR PROVIDER PORTAL

Texas Children's Health Plan strives to bring users a positive portal experience. We work to continuously improve the features available on the portal for our entire provider network. Our goal is to empower our providers with the tools to access data so that they are able to deliver the best possible care to our members and their families.

Our provider portal is available at: [texaschildrenshealthplan.org/for-providers](https://texaschildrenshealthplan.org/for-providers). Portal features include:

- Improved functionality for the claims, appeals, and messaging center
- Health management tools
- Disease Management programs and resources
- Clinical practice guidelines
- For Primary Care Physicians and OB/GYNs, access to Healthcare Effectiveness Data and Information Set (HEDIS®) data through Inovalon Population management software
- Provider's ability to update demographic information
- Reports, including member rosters with improved descriptions and instructions in the portal training guide
- Ability to check claim status by individual or batch claims
- Claims appeal report
- Claims processing for both batch claims and single claim submission
- Historical claims for the past year have the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) displayed on the provider portal
- Authorization criteria and utilization management guidelines
- Clear Coverage for online authorization requests
- Authorization status available
- Pharmaceutical management procedures and formulary

## TEXAS CHILDREN'S HEALTH PLAN PHONE NUMBERS

### Member Services

STAR members: 832-828-1001 or 1-866-959-2555

CHIP members: 832-828-1002 or 1-866-959-6555

STAR Kids members: 832-828-1003 or 1-800-659-5764

- Information about STAR, CHIP, or STAR Kids
- Eligibility/benefits questions

Telephone TouCHPoint: 832-828-1007

Fax: 832-825-8777

### Utilization Management

Phone: 832-828-1004

Fax: 832-825-8760

Hours of operation: 8 a.m. to 6 p.m.,

Monday through Friday

- Prior authorization request
- Concurrent review
- Notification of admissions

### Provider and Care Coordination

Phone: 832-828-1004

Toll-free: 1-800-731-8527

Fax: 832-825-8750

- Inquiries regarding Texas Children's Health Plan policies and procedures
- Contract clarification
- Fee schedule inquiries
- Change of address/phone number notification
- Requests for provider directories
- Information on provider educational inservices

### Care Management

Phone: 832-828-1430

Fax: 832-825-8745 for members with chronic or complex conditions, pregnant members, and member with a behavioral health condition.

- Questions regarding emergency room/inpatient visits and number of provider/specialist visits
- Medication refill information

### Provider Information Line

Phone: 832-828-1004 or 1-800-731-8527

- Claim status, questions and information
- Questions about how a claim was processed

### Dental Services

- DentaQuest: 1-800-516-0165 (STAR)
- DentaQuest: 1-800-508-6775 (CHIP)
- MCNA Dental: 1-800-494-6262

### Texas Children's Health Plan Nurse Help Line

Phone: 1-800-686-3831

### Electronic Funds Transfer (EFT)

Change Healthcare: 1-800-735-8254

### Pharmacy Hotline

Navitus: 1-877-908-6023

### Behavioral Health Hotline and Referral Line

Phone: 1-800-731-8529 (STAR)

Phone: 1-800-731-8528 (CHIP)

Phone: 1-844-818-0125 (STAR Kids)

