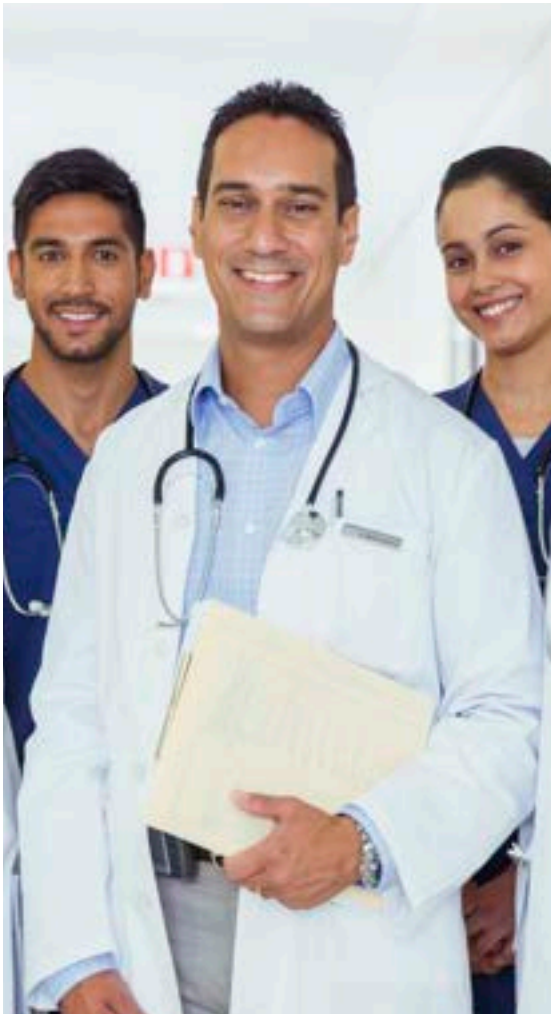
El Paso Health



SEPTEMBER 2024

Provider Manual

CHIP, STAR & STAR+PLUS

1145 Westmoreland Dr.
El Paso, TX 79925
STAR/CHIP Program
1-877-532-3778 Toll Free
www.elpasohealth.com

STAR+PLUS Program
1-833-742-3127 Toll Free

Service Area: El Paso and Hudspeth Counties
(CHIP Programs, STAR Medicaid & STAR+PLUS)

CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS STAR PLUS Your Health Plan ★ Your Choice | TEXAS Health and Human Services

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SECTION 1: OVERVIEW

INTRODUCTION

El Paso Health is pleased to welcome you into our Provider network.

This Provider Manual contains information about El Paso Health policies and procedures and specific "how to" instructions for providers when working with El Paso Health. As changes occur, we will update the Provider Manual and forward new sections for insertion.

It is the intention of El Paso Health, in the development of this Provider Manual, to help you navigate the process of providing and billing for healthcare services to El Paso Health Members. This Manual describes the services covered by El Paso Health, your responsibilities in providing services and how to bill for your services.

While we strive to streamline operational procedures, in many cases our policies and procedures are shaped by our Health and Human Services Commission (HHSC) contract requirements. El Paso Health has contracted with HHSC to provide services to State of Texas Access Reform (STAR), Children's Health Insurance Program (CHIP), CHIP Perinatal Members and STAR+PLUS. If you are interested in obtaining a copy of El Paso Health contract with HHSC, contact Provider Relations at 915-532-3778.

Our goal is to make working with El Paso Health as easy as possible for all providers. We welcome suggestions and comments on our policies and procedures and on the Provider Manual itself. Comments or suggestions can be submitted to:

El Paso Health
ATTN: Provider Relations
1145 Westmoreland Dr.
El Paso, TX 79925
915-532-3778
Email: ProviderRelationsDG@elpasohealth.com

The Provider Relations department is always available to answer any of your questions. Please see the Quick Reference Guide included in this Manual for additional contact information.

BACKGROUND

El Paso Health is a Texas Health Maintenance Organization (HMO) established by the El Paso County Hospital District to enter into contract with HHSC for the purpose of improving access to medical care for STAR, CHIP, CHIP Perinatal and STAR+PLUS recipients. We, at El Paso Health, are pleased that you are a participating Provider and that you share our commitment to improving the health of the El Paso community.

Model for Managed Care

El Paso Health's managed care model has the following components:

- Case management beginning with the primary care physician as the Member's "medical home."
- Preventive care, early intervention, health education and continuity of care in order to improve and maintain Members' health.
- A full range of resources that are available and accessible to Members.
- A comprehensive Quality Improvement/Utilization Management system, tracking key indicators for improved healthcare outcomes and rewarding providers for preventive care.

Building New Partnerships

El Paso Health believes that a successful managed care program is based on an effective partnership with providers, Members and the community.

Providers

El Paso Health is sensitive to the many demands on a Provider's time and resources. Our Provider Relations department offers support and streamlines administrative procedures. El Paso Health pledges to providers that:

- Compensation is fair and timely.
- A Provider Relations line is available to answer questions and help with Member management.
- Provider education and office staff training programs are offered on an ongoing basis.
- The Board of Directors and Quality Improvement Committees (QIC), composed of physicians and other providers, plays an active role in all policy decisions.
- State-of-the-art information systems provide on-line Member profiles, case management data and administrative support.

Members

El Paso Health offers a comprehensive range of health, social, and support services designed to meet the needs of our Members. In addition to standard benefits, El Paso Health pledges to our Members that:

- Each Member is treated with dignity and respect throughout the care process.
- Services are available and accessible.
- A local, bilingual Member Services Line is available to answer questions and ensure connections to services.
- Providers, Case Managers, and other staff are fully responsive to the unique needs of each Member.
- El Paso Health staff facilitates information and links to necessary social and support programs.

Community

El Paso Health is committed to long-term participation and investment in our community. El Paso Health's network builds upon the existing structure of community providers and organizations. El Paso Health expects to draw from and add to the community strengths in program development and implementation.

El Paso Health Departments Overview

El Paso Health has different departments to assist you with your day-to-day operations, questions or problems you may encounter. Listed below are the descriptions of El Paso Health Departments and their functions. Departmental Director's contact information is listed for your convenience.

Provider Relations can assist you with the following:

- Provider Inquiries
- Provider Updates/Demographic changes

Director of Provider Relations, Contracting and Credentialing: Erika Ozuna 915-298-3778 Ext. 1119

Contracting & Credentialing can assist you with the following:

- Credentialing
- Network Participation
- Contract Related Inquiries that include contract reimbursement

Director of Provider Relations, Contracting and Credentialing: Erika Ozuna 915-298-3778 Ext. 1119

C.A.R.E. (Collaborate, Aide, Resolve, and Educate) Solutions is responsible for:

- Member education and outreach
- Collaboration with State agencies and local entities serving Member

C.A.R.E. Solutions Director: Rosalinda Medina 915-532-3778 Ext. 1161

Member Services consist of highly qualified individuals that are fluent in both English and Spanish. Our Member Services staff can:

- Explain what services are covered
- Help Members choose a PCP
- Process PCP changes
- Send new ID cards
- Claim Status
- Answer to claim questions
- Answer to electronic claims submission rejections or questions.

Director of Member Services: Nellie Ontiveros 915-532-3778 Ext. 1112

Claims can assist you with:

- Claims inquiry/processing
- Electronic Billing
- Corrected Claims
- Appeals

Director of Claims: Patricia Diaz 915-532-3778 Ext. 1171

Health Services can assist you with the following:

- Referral to in-network and necessary out-of-network services
- Pre-Authorizations/Pre-certifications
- Disease Management
- Utilization Management
- Case Management

Medical Director: Dr. Jorge Guzman 915-532-3778 Ext. 1221

Director of Health Services: Vianka Navedo-Sanchez 915-532-3778 Ext. 1135

Compliance can assist you with:

- Administering health plan program compliance with HHSC
- Education and training on rules and regulations such as False Claims Act, Deficit Reduction and HIPAA, Waste, Fraud and Abuse
- Information about Special Investigations Unit (SIU)

Chief Compliance Officer: Catherine Gibson 915-532-3778 Ext. 1258

Complaints and Appeals can assist you with:

- Provider Complaints and Appeals, Member Complaints and Appeals.

Complaints and Appeals Manager: Corina Diaz 915-532-3778 Ext. 1092

Quality Improvement can assist you with:

- Access and Availability
- HHSC and El Paso Health Quality Initiatives
- Member Events Review
- Provider Profiling

Director of Quality Improvement: Angelica Chagolla 915-532-3778 ext. 1165

Sub-Contractors for El Paso Health

El Paso Health subcontracts with qualified companies for specialized services to our Members. The subcontracted vendors are listed below and the telephone numbers where each subcontractor can be reached for questions are listed in the Quick Reference Phone List.

QUICK REFERENCE PHONE LIST

The following list of phone numbers is provided for your reference and convenience.

El Paso Health Quick Reference Phone List	Telephone Number
STAR Program Help Line	1-800-964-2777
CHIP Eligibility and Help Line	1-800-647-6558
HHSC Office of the Ombudsman – (Provider Resolution – CHIP and STAR)	1-877-787-8999
HHSC – Office of Inspector General (Medicaid Fraud & Abuse)	800-436-6184
DSHS – El Paso Regional Office	915-834-7675
El Paso Health STAR & CHIP	1-877-532-3778
El Paso Health STAR & CHIP – Member Services	1-877-532-3778
El Paso Health STAR & CHIP – Claims Inquiries/Status	1-877-532-3778
El Paso Health STAR & CHIP – Health Services (Referrals/Authorizations)	1-877-532-3778
El Paso Health STAR & CHIP – Provider Relations	1-877-532-3778
El Paso Health STAR+PLUS	1-833-742-3127
El Paso Health PR Nursing Facility Representative or email EPH_NF@elpasohealth.com	1-915-532-3778 x1244
First Call Medical Advise Infoline (STAR, CHIP & STAR+PLUS)	1-844-549-2826
Non-Emergency Medical Transportation (NEMT) Services (STAR+PLUS) Access2Care	1-855-584-3530
Non-Emergency Medical Transportation (NEMT) Services (STAR) Access2Care	1-844-572-8196
Provider Portal link: EPH Provider Portal	
Behavioral Health Crisis Line Toll Free Number (STAR)	1-877-377-6147
Behavioral Health Crisis Line Toll Free Number (CHIP)	1-877-377-6184
Behavioral Health Crisis Line Toll Free Number (STAR+PLUS)	1-877-377-2950
Vision Services – Provider and Member (STAR, CHIP, STAR+PLUS)	**STAR & CHIP** 1-877-532-3778 **STAR+PLUS** 1-888-310-8037

Dental Services – Provider and Member (STAR, CHIP, STAR+PLUS)	**STAR** DentaQuest 1-800-516-0165 MCNA Dental 1-800-494-6262 UnitedHealthCare 1-877-901-7321 **STAR+PLUS** Liberty Dental 1-866-975-2435 **CHIP** DentaQuest 1-800-508-6775 MCNA Dental 1-800-494-6262 UnitedHealthCare 1-877-901-7321
Pharmacy (Navitus) – Provider (STAR+PLUS) **Pharmacy – Member (STAR+PLUS)**	1-877-908-6023 1-877-742-3127
Pharmacy (Navitus) – Provider (STAR and CHIP) **Pharmacy – Member (STAR and CHIP)**	1-877-908-6023 1-877-532-3778
El Paso Health	1-877-532-3778

PROGRAM OBJECTIVES

STAR Program Overview

The STAR Program was established in 1993 when the Texas Legislature adopted legislation, which authorized the Texas Health and Human Services Commission to undertake a comprehensive restructuring of the Texas Medicaid Program. This restructuring introduced managed care to the Medicaid Program. Eligible Medicaid clients residing in one of the service delivery areas and who receive certain forms of assistance such as Temporary Assistance to Needy Families (TANF) or TANF related benefits are required to participate in a managed care program.

Goals of the STAR Program

The goals and objectives of the STAR program are to use a managed care delivery system to achieve the following:

- Improve access to care for STAR clients.
- Increase quality and continuity of care, and demonstrate the increase.
- Appropriate utilization of services.
- Improve cost effectiveness.
- Improve Member and Provider satisfaction.

CHIP Overview

CHIP is a state-designed program targeted to provide insurance benefits to children ages 18 and under in families between 0 to 200 percent of the Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid, yet cannot afford to buy private insurance. CHIP coverage provides eligible children with coverage for a full range of health services including regular checkups, immunizations, prescription drugs, lab tests, X-rays, hospital visits and more.

CHIP Perinatal Overview

Starting Jan. 1, 2007, CHIP Perinatal coverage began providing prenatal care for the unborn children of low-income women who do not qualify for Medicaid. Once born, the child will receive CHIP benefits for the duration of the 12-month coverage period.

STAR+PLUS Program Overview

STAR+PLUS is a Texas Medicaid program for adults who have disabilities or are age 65 or older. Adults in STAR+PLUS get Medicaid healthcare and long-term services and support through a health plan that they choose. Adults with complex medical needs can choose to live and receive care in a home setting instead of a nursing facility.

Goals of the STAR+PLUS Program are to:

- Promote a system of health care delivery that provides coordinated and improved access to comprehensive health care and enhanced provider and client satisfaction;

- Improve health outcomes by ensuring the quality of health care provided to members and by promoting wellness and prevention;
- Achieve cost effectiveness without compromising access and quality;
- Integrate acute and long-term care services for the STAR+PLUS members;
- Coordinate Medicare services for STAR+PLUS members who have SSI-Medicare and Medicaid; and
- Provide timely claims payment.

Pharmacy Provider Responsibilities

- Adhere to the Formulary and Preferred Drug List (PDL).
- Coordinate with the prescribing physician.
- Ensure Members receive all medications for which they are eligible.
- Coordination of benefits when a Member also receives Medicare Part D services or other insurance benefits.

For more information about El Paso Health's Pharmacy Benefit Manager, Navitus Health Solutions, please refer to the Pharmacy Provider Handbook on our website located at: http://www.elpasohealth.com/pdf/PharmacyProviderManual.pdf

SECTION 2: PROVIDERS

GENERAL PROVIDER RIGHTS AND RESPONSIBILITIES

Provider obligations are spelled out in the Provider Agreement. These obligations specify that Providers agree to:

- Maintain any and all licenses required by the State of Texas that govern a Provider's profession or business
- Notify El Paso Health immediately of any limitation, suspension, or revocation of any license or medical staff Membership
- Maintain a facility that promotes patient safety
- Maintain appropriate professional liability insurance in an amount consistent with the Department of State Health Services (DSHS) requirements
- Meet all credentialing and re-credentialing requirements
- Provider must **never** bill an El Paso Health Member for covered services
- Maintain all medical records for a period of at least seven years from the date of service
- Participate in Provider Orientations and continuing education
- Participate in El Paso Health Quality Assessment and Performance Improvement Program (QIP) Initiatives
- Arrange referrals/authorizations for care and service within El Paso Health network, including facilities and contractors
- Facilitate inpatient and ambulatory services at in-network facilities
- Provider understands that nothing contained in this Manual shall be construed to require any Provider to recommend or withhold any procedure or course of treatment that is not consistent with Provider's best medical judgment. Provider is free to make independent medical recommendations and Members are free to choose to accept or reject any treatment course.
- Not to subcontract for the performance of Contracted Services without the prior written consent of El Paso Health. Any of Provider's subcontractors providing Contracted Services to El Paso Health Members shall be required to comply with the terms in the provider agreement to the same extent as the Provider.
- Comply with all El Paso Health policies, procedures, rules and regulations including those found in the Provider Manual.
- Comply with requests from:
    - Texas Health and Human Services Commission (THHSC)
    - The Texas Attorney General's Medicaid Fraud Control Unit
- Comply with State and Federal laws and administrative regulations concerning nondiscrimination on the grounds of race, color, national origin, age, sex, disability, political beliefs, or religion. These laws and codes include

  - Title VI of the Civil Rights Act of l964 (Public Law 88-352)
  - Section 504 of the Rehabilitation Act of l973 Public Law 93-112)
  - The Americans with Disabilities Act of l990 (Public Law 101-336)
  - Title 40, Chapter 73, of the Texas Administrative Code
  - And all amendments to each and all requirements imposed by the regulations issued about these acts
- Comply with Immigration Reform and Control Act of 1986 (8U.S.C. 1101) and the Immigration Act of 1990 (8 U.S.C.1101)
- Comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191)
- Comply with environment protection laws
  - Pro-children Act of 1994 (20 U.S.C 6081)
  - National Environmental Policy Act of 1969
  - Clean Air Act and Water Pollution Control Act Regulations (Executive Order 11738)
  - State Clean Air Implementation Plan (42 U.S.C. 740)
  - Safe Drinking Water Act of 1974 (21 U.S.C 349)
- Comply with Health and Safety Code 85.113, as described in the Texas Medicaid
- Service Delivery Guide under "HIV/AIDS Model Workplace Guidelines"
- Comply with the U.S. Department of Health and Human Services' Guidance Memorandum (1998) Title VI Prohibition Against National Origin Discrimination-Persons with Limited English Proficiency (LEP)
- Complete Cultural Competency Provider orientation session listed in the Cultural Competency Training – El Paso Health.

PLAN TERMINATION

If a Provider wishes to terminate his/her contract with El Paso Health because of re-location outside Texas, retirement or any other reason, they must submit a letter to the Provider Relations Department stating the effective date of their termination from the network. If the Provider has any Members assigned, El Paso Health needs to re-assign them to another Primary Care Provider, thus, at least a 90-Day notice is preferred. For other provisions regarding Termination, the Provider is encouraged to refer to Section 9 of their Provider Agreement with El Paso Health.

ROLE OF PRIMARY CARE PROVIDER (PCP) FOR STAR, STAR+PLUS, CHIP, AND CHIP PERINATAL NEWBORN MEMBERS

PCP's Medical Home Responsibilities

The PCP is responsible for establishing the "Medical Home" for those Members who have selected them. The "medical home" concept establishes a patient-Provider relationship to ultimately provide better health outcomes. Primary care includes ongoing responsibility for

preventive healthcare, health maintenance, treatment of illness and injuries, and the coordination of access to in-network specialty providers, network Facilities and/or other medically necessary services. Please refer to **ATTACHMENT 1,** List of Services Requiring Prior Authorization for a list of services and procedures requiring a pre-authorizations/pre-certification.

PCP's may provide Behavioral Health related services within the scope if their practice. PCP's must also be available for urgent or emergency care, directly or through on-call arrangement, 24 hours a day, 7 days a week.

Provider types who are eligible to serve as a PCP include:

- Pediatricians
- Family/General Practitioners
- Internal Medicine
- Obstetrician/Gynecologists (OB/GYN)
- Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) (Practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology)
- Certified Nurse-Midwives
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Specialist Physicians (Willing to provide medical homes to Members who have special needs)

Specialists as PCP

Specialty providers may function as PCPs for Members with disabilities, special health care needs, chronic or complex special healthcare needs or a life threatening illness. The specialty Provider must agree to perform all PCP duties required under the contract and the duties must be within the scope of the specialist's license. A request for a specialist to serve as a PCP must include the following information to the Medical Director.

- Specific medical need for Member to utilize the specialist as a PCP.
- Written statement signed by the Specialist accepting responsibility for the coordination of all of the Members healthcare needs.
- Completed "Request for Specialist as a PCP" form included for your convenience as **ATTACHMENT 15** of this manual. Signature of the Member is also a requirement on the form.
- Specialist must also be willing to contract as a PCP as well as meet all of El Paso Health credentialing requirements.
- Specialist must also be willing to accept responsibility for coordination of all of the Members healthcare needs.

The Medical Director will review all documentation submitted to determine the clinical appropriateness of the request. Written notification of a denial to serve as the Members PCP will

be mailed within 30 Days. Denials of such request may be appealed following the process outlined under Adverse Determination Appeal Process, **Section 9;** or under Provider Complaints/Appeals Process, **Section 10** of this manual.

ROLE OF SPECIALTY CARE PROVIDER FOR STAR, STAR+PLUS, CHIP, AND CHIP PERINATAL NEWBORN MEMBERS

A Specialty Care Provider partners with the PCP to deliver specialty care to Members. El Paso Health operates a closed specialty network. This means that PCPs must refer Members to El Paso Health Network specialists and facilities only. A key component of the specialist responsibility is to maintain ongoing communication with the Members PCP. The Members PCP must initiate a referral to the specialty care Provider that outlines the necessary treatment for the Member. If the Member's condition requires urgent care, the specialist should see the Member within 24 hours. For routine care, the specialist should see the Member within two weeks. Specialty care providers and facilities are responsible for ensuring the necessary pre-authorizations/pre-certification has been obtained prior to providing services. Specialty Care Provider responsibilities must adhere to availability and accessibility standards found on p. 27.

Some specialties may include:

- Cardiology
- Dermatology
- Obstetrician/Gynecologists (OB/GYN)
- Orthopaedic Surgery
- Hematology

Referrals are good for a limited number of days as specified by the Member's PCP. If additional treatment is needed, the Specialty Care Provider must coordinate with the Member's PCP.

Note: If a specific specialty, facility or contractor does not appear in the network the PCP should contact the El Paso Health's Utilization Management Department at 915-532-3778 for authorization to refer to an out-of-network Provider.

Members have the right to select and have access to, without a Primary Care Provider referral, a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery.

ROLE OF A CHIP PERINATAL PROVIDER

To provide OB/GYN services to a CHIP Perinatal mother for the duration of the pregnancy in addition to providing all other services covered under CHIP Perinatal for the CHIP Perinatal newborn Member.

ROLE OF A LONG-TERM SERVICES AND SUPPORT (LTSS) PROVIDER

The Long-Term Services and Supports (LTSS) Provider serves certain members participating in the STAR+PLUS program. An LTSS provider assists a member by providing a variety of non-medical services, such as adult day care, adult foster care, home delivered meals, personal attendant services, home modifications, respite services, etc. LTSS services require an authorization.

ROLE OF MAIN DENTAL HOME

Dental plan Members may choose their Main Dental Homes. Dental plans will assign each Member to a Main Dental Home if he/she does not timely choose one. Whether chosen or assigned, each Member who is 6 months or older must have a designated Main Dental Home.

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

How to Help a Member Find Dental Care

The Dental Plan Member ID card lists the name and phone number of a Member's Main Dental Home provider. The Member can contact the dental plan to select a different Main Dental Home provider at any time. If the Member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan's system, and the Member is mailed a new ID card within 5 Business Days.

If a Member does not have a dental plan assigned or is missing a card from a dental plan, the Member can contact the Medicaid/CHIP Enrollment Broker's toll-free telephone number at 1-800-964-2777.

ROLE OF PHARMACY

While responsibilities vary among the different areas of pharmacy practice, the main objective of pharmacists is to help Members get well. Pharmacist responsibilities include a range of care for patients, from dispensing medications to monitoring patient health and progress to maximize their response to the medication. Pharmacists also educate consumers and patients on the use of prescriptions and over-the-counter medications, and advice physicians, nurses, and other health professionals on drug decisions. Pharmacists also provide expertise about the composition of drugs, including their chemical, biological, and physical properties and their manufacture and use. They ensure drug purity and strength and make sure that drugs do not interact in a harmful way. Pharmacists are drug experts ultimately concerned about their patients' health and wellness. (Pharmacy College Application Service retrieved from http://www.pharmcas.org/advisors/roleofpharmacist.htm)

Pharmacy Provider Responsibilities

- Pharmacy Providers participating in the El Paso Health's Provider Network will adhere to the Formulary and Preferred Drug List (PDL) mandated by the Health and Human Services Commission (HHSC).
- Pharmacy Providers will work in coordination with the Member's prescribing physician to ensure that El Paso Health Members receive the correct medications in accordance with will all clinical protocols and administrative policies.
- Pharmacy Providers will ensure that El Paso Health Members receive all medications they are eligible to receive as prescribed by the Members' physician.
- Pharmacy Providers will ensure that the coordination of benefits occurs when a Member also receives Medicare Part D services or other insurance benefits.

El Paso Health Members have the right to obtain medications from any pharmacy participating in the El Paso Health network.

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

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

All Pharmacy Providers must be enrolled with HHSC's Vendor Drug Program and are required to adhere to the Preferred Drug List (PDL). Providers must also have a National Provider Identifier (NPI).

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must follow the process outlined below:

- El Paso Health obtains a Provider Demographic Form and W-9.
- A credentialing and contract packet is prepared for the Provider.
- Provider goes through the credentialing process and contract remains pending until the completion of the Credentialing Peer Review Committee (CPRC) approval process.
- Provider Agreement is executed and becomes effective the 1st day of the following month after the CPRC approves.
- Copy of the original executed agreement is given to the Provider.

The claims process works the same as for other Providers in the network. For more information, please see Section 12. However, the reimbursement is only for DME services unless the Pharmaceutical is included in the Provider Agreement; Provider must be contracted through the Pharmacy Benefit Manager (PBM) for reimbursement of Pharmacy services.

Call 1-877-532-3778 for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

NETWORK LIMITATIONS

El Paso Health (EPH) members must seek services from an EPH contracted provider. Exceptions include when a provider is not accessible within the network, or to ensure continuity of care for a newly enrolled EPH member. All out-of-network services require an authorization.

NETWORK LIMITATIONS FOR CHIP PERINATAL

The CHIP Perinatal Network is limited to the providers listed below:

- OB/GYN
- Family Practitioners
- General Practitioners
- Nurse Practitioners
- Internists
- Nurse Midwives
- Anesthesiologist
- Neonatologists
- Inpatient Hospital

OB/GYN Providers

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

Notification of Pregnant Teen

Providers are required to notify El Paso Health immediately when a pregnant CHIP or Medicaid Member is identified. Providers should call 1-877-532-3778 to notify El Paso Health of the pregnancy. For convenience, Providers can use the Case Management Referral Form which can be found on the El Paso Health website at under Providers Forms. This form may be faxed directly to the Case Management Department at 915-298-7866.

ATTENTION FEMALE MEMBERS

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

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

Due to CHIP program eligibility changes, most pregnant CHIP teenagers and their newborns may qualify for Medicaid. Since the Medicaid program now provides a much more comprehensive scope of services for both a pregnant teen and their newborn, it is in the best interest of the pregnant teen to receive Medicaid coverage as early as possible. El Paso Health **OB Case Management Program** will refer the pregnant teen to the eligibility broker. Pregnant CHIP teens that are eligible for Medicaid will be transferred from CHIP to Medicaid as soon as possible. El Paso Health is not responsible for this process.

FAMILY PLANNING PROGRAMS

El Paso Health must educate providers about the following: Family planning programs including the Texas Women's Health Program and DSHS Family Planning, Primary Health Care, and Expanded Primary Health Care programs.

Healthy Texas Women Program provides family planning services and annual exams at no cost to eligible, low income women. Providers may refer Members who are between the ages of 18 – 44 years old and do not receive full Medicaid, CHIP or Medicare Part A or B benefits. Providers may obtain additional information at www.healthytexaswomen.org.

The DSHS Family Planning program partners with local health departments, medical schools and hospitals across the state to provide quality, comprehensive, low-cost and easily accessible reproductive health care to women and men. Eligible individuals include women who have not had sterilization surgery to prevent pregnancy and men who have not had a vasectomy. Providers may learn more about eligibility requirements and available services at http://www.dshs.state.tx.us/famplan/default.shtm.

The Primary Health Care program through DSHS serves women, children and men whose income is at or below 200% of the Federal Poverty Level and are unable to access healthcare through insurance or other programs. Primary Health Care includes early prevention, early detection, and early intervention of health problems. Please visit the Primary Health Care Program website for more information (Primary Health Care Services Program | Texas Health and Human Services).

DSHS offers primary, preventive and screening services to women age 18 and above whose income is at or below 200% of the Federal Poverty Level through the Expanded Health Care Program. Eligible women receive outreach and direct services through community based clinics

and community health workers. Providers may obtain more information at http://www.dshs.state.tx.us/ephc/Expanded-Primary-Health-Care.aspx.

ANCILLARY PROVIDERS

Ancillary providers participating in the El Paso Health Provider network include:

- Durable Medical Equipment
- Outpatient facilities
- Laboratory
- Hospice Care
- Home Health
- Prosthetics and Orthotics
- Home Health
- Physical Therapy and Rehabilitation
- Radiology
- Audiology
- Dietary

Please refer to **ATTACHMENT 1** for specific services that must be prior authorized.

MONTHLY MEMBER PANEL ROSTER

Each PCP will receive a monthly roster of all assigned patients before the 5th of each month. The roster will identify each Member assigned to that PCP by location. Any patient appearing on this roster will be the responsibility of that PCP for that particular month.

NETWORK CAPACITY AND LIMITATIONS

All PCPs reserve the right to designate the number of patients they are willing to accept into their practice. PCPs have no limitations on the number of patients that can be assigned to his/her practice. Since assignment is based on the Member's choice, El Paso Health does not guarantee that any Provider will receive a set number of Members.

If a PCP does declare a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact El Paso Health's Provider Relations Department.

However, HHSC oversees all Medicaid and CHIP enrolled providers to assure accessibility and quality of care for all Medicaid patients. If HHSC determines that a Medicaid Provider fails to maintain quality and accessible care, the PCP's panel will be frozen to new enrollments by HHSC. This may also include reassignment of current Members to another PCP panel if necessary.

Specialty Care Providers are not assigned a patient panel but can elect to limit their practice to established patients. Specialty Care Providers must contact El Paso Health's Provider Relations Department at 915-532-3778 to make these arrangements.

Coordination of Care

El Paso Health and its Providers partner to identify and manage health care services for all Members to include persons with medical and behavioral disabilities, chronic or complex conditions, and Members with Special Health Care Needs (MSHCN) to ensure these Members have a medical home, a system of care that remains stable, services are consistent and unduplicated. These services include developing a plan of care to meet the needs of the Member, and continually updated when applicable. The plan of care or service plan is based on health needs, specialist(s) recommendations, periodic reassessment of the Member's developmental and functional status and service delivery needs. Members with Special Health Care Needs (MSHCN) are identified by the following groups:

1. ECI program participants
2. Pregnant women identified as high risk, including:
    a. Pregnant Members age 35 and older or 15 and younger:
    b. Pregnant Members diagnosed with pre-eclampsia, high blood pressure, or diabetes;
    c. Pregnant Members with mental health or substance abuse diagnoses;
    d. Pregnant Members with previous pre-term birth, as identified on the perinatal risk report;
3. Members with high-cost catastrophic cases or high service utilization, such as high volume ER or hospital visits;
4. Members with mental illness and co-occurring substance use diagnoses;
5. Members with serious ongoing illness or a chronic complex condition that is anticipated to last for a significant period and requires ongoing therapeutic intervention and evaluation such as:
    a. Members diagnosed with respiratory illness (such as COPD, chronic asthma, or cystic fibrosis), diabetes, heart disease, kidney disease, HIV, or AIDS:
    b. Child Members receiving ongoing therapy services which may include PT, OT, ST (e.g. for longer than six months);
    c. Member receiving CFC, PCS, PDN, or PPECC services
6. Members identified as having behavioral health issues including substance use disorders, or serious emotional disturbance or serious and persistent mental illness, that may affect their physical health or treatment compliance;

El Paso Health provides information, education and health management programs to Members, families, legally authorized representatives (LAR), PCPs, specialty physicians, and training for community agencies about the care and treatment available in the plan of care or service plan, which will include:

- A multidisciplinary team responsible for the delivery of care when determined to be medically necessary for effective treatment to avoid separate and fragmented evaluations and service plans;
- The patient's behavioral health Provider, if applicable in the multidisciplinary team serving the Member's physical and behavioral health needs, to include an exchange of medical records for the patient, as needed;

- Participation in hospital discharge planning;
- Participation in pre-admission hospital planning for non-emergency hospitalizations;
- Developing specialty care and support service recommendations to be incorporated;
- Providing information to the Member, a LAR or the Member's family concerning the specialty care recommendations; and
- Providing necessary laboratory and ancillary medical tests or procedures to monitor disabilities within the Provider's office (if available), or at an El Paso Health contracted Provider's office/facility, which is located at or near the Provider's office.

El Paso Health's Health Services Department is available to assist providers with coordination of care efforts and assist Members by issuing referrals for other needed community services. Contact Health Services at 915-532-3778.

PCPs and Continuity of Care

El Paso Health requires that the Provider assist in the transition of care for the following circumstances:

- El Paso Health must allow pregnant Members with 12 weeks or less remaining before the expected delivery date to remain under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the Provider is Out- of-Network. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.
- El Paso Health's obligation to reimburse the Member's existing out-of-network providers for on-going care does not extend to the following:
    1. More than 90 Days after a Member enrolls in the HMO's Program, or
    2. For more than nine (9) months in the case of a Member who, at the time of enrollment in the HMO, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the HMO.
- An out-of-network Provider treating a new El Paso Health Member must comply with El Paso Health's Utilization Management Program and accept standard managed care rates. The out-of-network Provider must transfer the patient's records to the in- network Provider.
- El Paso Health will continue to facilitate services for Members who move out of the Service Area until such time that Member is removed from El Paso Health's eligibility.
- Pre-existing conditions are not imposed.

MEDICAL RECORD STANDARDS

El Paso Health promotes maintenance of medical records in a legible, current and comprehensive manner that permits effective patient care and quality review. Each Provider must maintain and make available medical records in accordance with the applicable Provider agreement. Medical records must reflect all aspects of patient care, including ancillary services. The use of electronic

medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.

As stated in the Provider agreement, section 7.1, the Provider agrees to maintain with respect to each Member a medical record in such form, containing such information, and preserved for such time as is required by reasonable medical practice standards by State and Federal law and applicable licensing and accreditation agencies. Provider also agrees to maintain in accordance with generally-accepted accounting principles, books and records relating to the services rendered to Members and the payment therefore.

El Paso Health requires all providers to have an organized record keeping system with office standards for medical record availability. There are also requirements regarding what information should be kept on the medical record.

El Paso Health has strict internal standards regarding the confidentiality of medical records. No information should be released from the Members' records without the written consent of the individual Member.

AVAILABILITY AND ACCESSIBILITY

Primary Care Providers are required to have at least one of the following arrangements in place to provide 24-hour, 7-day a week access for managed care clients:

- An office phone answered after-hours by a medical exchange or a professional answering service. If an answering service is used, the following must be met:
    - The answering exchange or service must be able to contact the PCP or designated back-up Provider for immediate assistance
    - The PCP, or designated back-up Provider, must be notified of all calls
    - All calls must be returned in a timely manner by the PCP or designated back-up Provider, no more than 30 minutes after the call
    - The answering service must meet the language requirements of the major population groups in the PCP's area
- An office phone answered after office hours by an answering machine that instructs the client (in the language of the major population groups) to do one of the following:
    - Call the name and phone number of a medical facility where the client can request to speak with a medical professional to determine whether emergency treatment is appropriate
    - Call another number where the PCP can be reached
    - Call the name and phone number of a medical professional serving as designated back-up. In this situation, the client must be able to speak with the back-up Provider or a clinician who can offer immediate assistance
- An office phone transferred after hours to another location where someone will answer and be able to contact the PCP or designated back-up Provider who can return the call within 30 minutes

PCP's and Specialty care providers must have adequate office hours to accommodate appointments for Members and arrange for coverage with another El Paso Health Provider during scheduled and unscheduled time off.

Appointment Availability

PCP's and Specialist must have adequate office hours to accommodate appointments for Members.

The standards listed below are consistent with HHSC requirements for STAR and CHIP.

1. Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;
2. Urgent care, including urgent specialty care and behavioral health services, must be provided within 24 hours of request; treatment for behavioral health services may be provided by a licensed behavioral health clinician.
3. Primary Routine Care must be provided within 14 Days of request;
4. Specialty Routine Care must be provided within 21 Days of request;
5. Initial outpatient behavioral health visits must be provided within 14 Days of request;
6. Referrals for routine specialty care must be provided within 5 Days of request;
7. Pre-natal care must be provided within 14 Days of request, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within 5 Days, or immediately, if an emergency exists;
8. Preventive health services for adults (21 years and older) must be offered within 90 Days of request; and
9. Preventive Health Services for children less than 6 months of age must be provided within 14 Days of request. For children 6 months to 20 years of age, services must be provided within 60 Days of request. CHIP Members should receive preventive care in accordance with the American Academy of pediatrics (AAP) periodicity schedule. Medicaid Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule. MCOs must encourage new Members 20 years of age or younger to receive a Texas Health Steps checkup within 90 Days of enrollment. For purposes of this requirement, the terms "New Member" is defined in Chapter 12.4 of the UMCM.
10. Community-based LTSS must be initiated by the state date on the ISP or Service Plan; or in the case of a Change of Condition within 7 days of the ISP or Service Plan effective date, unless otherwise stated and documented by the referring Provider or Member.
11. Specialty Therapy (PT/OT/ST) evaluations must be provided within 21 calendar days of submission of signed referral.
12. Case Management for Children and Pregnant Women services must be provided within 14 calendar days of request.

Updates to Contact Information

Network Providers must inform both El Paso Health and HHSC's administrative services contractor of any changes to the Provider's address, telephone number, group affiliation, etc.

Member Right to a Second Opinion

El Paso Health requires that each Member have access to a second opinion regarding the use of any healthcare service. A Member must be allowed access to a second opinion from a network or out-of-network Provider if a network Provider is not available, at no additional cost to the Member.

Advanced Directives

Federal and state law require providers to maintain written policies and procedures for informing and providing written information to all adult Members 18 years of age and older about their rights under state and federal law, in advance of their receiving care (Social Security Act §§1902[a][57] and 1903[m][1][A]). The written policies and procedures must contain procedures for providing written information regarding the Member's right to refuse, withhold, or withdraw medical treatment advance directives. These policies and procedures must comply with provisions contained in 42 CFR §§434.28 and 489, Subpart I, relating to the following state laws and rules:

- A Member's right to self-determination in making healthcare decisions
    - The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
    - A Member's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition
    - A Member's right to make written and non-written Out-of- Hospital Do-Not-Resuscitate Orders
    - A Member's right to execute a Medical Power of Attorney to appoint an agent to make healthcare decisions on the Member's behalf if the Member becomes incompetent
- These policies can include a clear and precise statement of limitation if a participating Provider cannot or will not implement a Member's advance 24 Last Revision: 01-13-12 directive. A statement of limitation on implementing a Member's advance directive should include at least the following information:
    - A clarification of the Provider's conscience objections
    - Identification of the state legal authority permitting a Provider's conscience objections to carrying out an advance directive
    - A description of the range of medical conditions or procedures affected by the conscience objection
- A Provider cannot require a Member to execute or issue an advance directive as a condition for receiving healthcare services. A Provider cannot discriminate against a

Member based on whether or not the Member has executed or issued an advance directive.

A Provider's policies and procedures must require the Provider to comply with the requirements of state and federal law relating to advance directives.

TELECOMMUNICATION SERVICES

What are these Services?

Telecommunication services are virtual health-care visits with a provider through a mobile app, online video or telephone. Most Providers in El Paso Health s network can offer these services for certain health-care needs and are identified in the provider directory and searches.

Telemedicine: Telemedicine services are health care services delivered by a physician licensed in the state of Texas, or a health professional acting under the delegation and supervision of a physician licensed in Texas and acting within the scope of the physician s or health professional s license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Telehealth: Telehealth services are defined as health-care services, other than telemedicine medical services or a teledentistry service, delivered by a health professional licensed, certified or otherwise entitled to practice in Texas and acting within the scope of the health professional s license, certification or entitlement to a patient at a different physical location other than the health professional using telecommunications or information technology.

Telemonitoring: Home telemonitoring is a health service that requires scheduled remote monitoring of data related to a client s health, and transmission of the data from the client s home to a licensed home health agency or a hospital. The data transmission must comply with standards set by HIPAA.

Providers delivering telemedicine, telemonitoring and telehealth services to eligible El Paso Health members should reference the Texas Medicaid Provider Procedures Manual, for billing guidance and applicable modifiers.

El Paso Health will not deny, limit, or reduce reimbursement for a covered health-care service or procedure based on the provider s choice of telecommunications platform to provide the service or procedure using telemedicine or telehealth. Through telemedicine or telehealth services members can access doctors/providers as needed by phone and/or video for non-emergency medical issues. Members can receive medical advice, a diagnosis and a prescription when appropriate. El Paso Health treats telehealth/telemedicine services with in-network providers in the same way as face-to-face visits with in-network providers. A telehealth/telemedicine visit with an in-network provider does not require prior authorization and there is no cost for a telehealth/telemedicine visit with an in-network EPH provider for Members.

REPORTING ABUSE, NEGLECT, OR EXPLOITATION (ANE)

MEDICAID MANAGED CARE

Report suspected Abuse, Neglect, and Exploitation:

MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to the HHS (Health and Human Services) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and HHS;
- Adult Day Care centers; or
- Licensed adult foster care providers

The toll-free number to contact is 1-800-458-9858.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
    - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to HHS;
    - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
    - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
    - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
    - a managed care organization;
    - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option

  Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

The Provider must provide El Paso Health with a copy of the abuse, neglect, and exploitation report findings within one (1) Business Day of receipt of the findings from the Department of Family and Protective Services (DFPS).

MARKETING GUIDELINES FOR PROVIDERS

E Paso Health providers must adhere to marketing guidelines as outlined by HHSC and in your El Paso Health contract for the STAR Medicaid and CHIP programs. Those guidelines include the following:

Providers must:

- Inform patients of all health plans in which they participate when a patient is making an enrollment decision.
- Market and communicate based on the continuance of the patient/Provider relationship.

Providers (or their office staff) may:

- Display in their offices state approved marketing materials provided it is done equally for all Plans in which they participate.
- Inform the patients of particular hospital services, specialists, or specialty care available in all Plans in which they participate.
- Assist a patient contacting a Plan (or Plans) to determine if a particular specialist or service is available.
- Provide the necessary information for the patient to contact a particular Plan (*but cannot promote any Plan over another*).

- Inform Medicaid recipients they can enroll by calling the STAR Program Help Line at 1-800-964-2777 *(Cannot assist in placing the phone call.)*.
- Inform potential CHIP Members they can enroll by calling CHIP at 1-800-647-6558 *(can assist in placing the phone call.)*.
- Only directly contact potential Members with whom they have an established relationship *(Relationship is defined as one where services have been provided within -the previous 12 months.)*.

Providers (or their office staff) cannot:

- Influence a patient to choose one health plan over another.
- Influence patients based upon reimbursement rates or methodology used by a particular Plan.
- Enroll patients in a Plan.
- Stock, reproduce or assist in filling out or otherwise handle the enrollment form.
- Perform direct marketing efforts for one or more health plans.

CREDENTIALING

El Paso Health Credentialing Department follows Utilization Review Accreditation Commission (URAC), National Committee for Quality Assurance (NCQA) guidelines in addition to relevant and federal regulations for initial and re-credentialing standards. El Paso Health requires Providers to be credentialed prior to joining the network with the exception of Hospital Based Providers. Providers are required to be re-credentialed every three years. El Paso Health uses Aperture, the states Credentialing Verification Organization (CVO) vendor for primary source verification. Credentialing applications can be submitted by using Availity's web-based portal at www.availity.com, or Council for Affordable Quality Healthcare, Inc (CAQH). Providers can Contact the Contracting and Credentialing Department at Contracting_Dept@elpasohealth.com for any questions.

COMMUNITY FIRST CHOICE

Program Provider Responsibilities

- The CFC services must be delivered in accordance with the Member's service plan.
- The program provider must have current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable)
- The HCS or TxHmL program provider must ensure that the rights of the Members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and

characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member's health, safety, and welfare. The program provider must maintain documentation of this training in the Member's record.

- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline. (1-800-647-7418).
- The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the MCO financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a Member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a Member, including unauthorized disclosure of information related to a Member's finances and the purchase of goods that a Member cannot use with the Member's funds.

SECTION 3: COVERED SERVICES

STAR COVERED SERVICES

El Paso Health STAR plan Members are entitled to all medically necessary services covered under the Texas Medicaid Program. Please refer to the current Texas Medicaid Provider Procedures Manual, weekly Texas Medicaid Banner Messages and the bi-monthly Texas Medicaid Bulletin for a more inclusive listing of limitations and exclusions. These services include, but may not be limited to:

- Ambulance services
- Applied Behavior Analysis (ABA)
- Audiology services, including hearing aids, for adults (audiology services and hearing aids for children are a non-capitated service)
- (These services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service Medicaid coverage. The services may be subject to the HMO's non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.) Behavioral Health Services, including:
    - Acute Inpatient psychiatric benefits for adults
    - Inpatient mental health services for Children (under age 21)
    - Outpatient mental health services
    - Psychiatry services
    - Counseling services for adults (21 years of age and over)
    - Outpatient substance use disorder treatment services including:
        - Assessment
        - Detoxification services
        - Counseling treatment
        - Medication assisted therapy
    - Residential substance use disorder treatment services including:
    - Detoxification services
    - Substance use disorder treatment (including room and board)
- Birthing services provided by a physician or Advanced Practice Nurse in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment 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
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
    - inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    - all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
    - surgery and reconstruction on the other breast to produce symmetrical appearance;
    - treatment of physical complications from the mastectomy and treatment of lymphedemas; and
    - prophylactic mastectomy to prevent the development of breast cancer.
    - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
- Medical checkups and Comprehensive Care Program (CCP) Services for children (under age 21) through the Texas Health Steps Program
- Non-Emergency Medical Transportation (NEMT) services
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
- Podiatry
- Prenatal care
- Primary care services
- Preventive services including an annual adult well check for patients 21 years of age and over
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction, which cannot be accomplished by glasses.)

Attention Deficit Hyperactivity Disorder (ADHD)

Providers will be reimbursed for the treatment of ADHD in children who are Members and providers may conduct follow-up visits with children for whom they have prescribed ADHD medications.

For training materials, please reference the clinical practice guidelines found here Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder.

El Paso Health (EPH) encourages Providers during quarterly Provider Orientation, trainings and on-site visits to utilize evidence-based guidelines for the effective diagnosis and treatment of ADHD and other behavioral health conditions by promoting mental health screening for Members from birth to age 20. EPH supports delivery of services to include the following assessments that will assist Providers in determining the best course of action for our Members:

Assessments	
Health and Behavior Assessment (HBAI)	To identify the psychological, behavioral, emotional, cognitive and social factors important to prevention, treatment or management of physical health symptoms.
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Early intervention and treatment services for Members who are 10 years of age and older and who have alcohol or substance use disorders or are at risk of developing such disorders.

APPLIED BEHAVIOR ANALYSIS (ABA)

Starting February 1, 2022, the Texas Health and Human Services (HHS) is adding a new STAR Medicaid benefit for Applied Behavior Analysis (ABA) services for members 20 years of age or younger with Autism Spectrum Disorder (ASD). This new benefit provides for coordination of the service array in interdisciplinary team meetings.

Autism Spectrum Disorder (ASD) is a condition characterized by restricted, repetitive patterns of behavior, interests, or activities and deficits in social communication and social interaction, with onset of symptoms occurring in early childhood.

Applied Behavior Analysis (ABA) is the scientific study of the principles of learning and behavior, specifically about how behavior affects, and is affected by, past and current environmental events in conjunction with biological variables.

These services might require prior authorization before services are rendered.

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A Member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services, and must be coordinated to prevent duplication. A Member may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the Member's medical condition or the authorized hours are not commensurate with the Member's medical needs. Per 1 Tex. Admin. Code §363.209 (c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.

Vision

El Paso Health has contracted with Envolve Benefit Options (formerly OptiCare/AECC Total Vision Health Plan of Texas, Inc.) to provide our Members' eye care benefits.

Envolve has been providing comprehensive and affordable eye care services for over 25 years. Envolve has an extensive local Provider network of Optometrists and Ophthalmologists. For more information please use the Envolve website https://visionbenefits.envolvehealth.com/ or call (888) 310-8037.

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES

What are NEMT services?

As of June 1, 2021 Access2Care provides Non-Emergency Medical Transportation (NEMT) services to El Paso Health STAR and STAR+PLUS members. NEMT services provide transportation to covered health care services for members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and any other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips.

What do NEMT services include?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services which is curb-to-curb service transportation in private buses, vehicles, or sedans, including wheelchair accessible vans, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered healthcare service. The ITP can be the member, the member's family member, friend, or neighbor.
- Members 20 years old or younger may be eligible to receive the cost of meals associates with a long-distance trip to obtain covered health care services. The daily rate for meals is $25 per day for the member, and $25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care services. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room services, or laundry service.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a member needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the cost of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other adult or have consent from a parent or guardian or other authorized adult on file to travel alone. Parental consent is not required if the covered health care service is confidential in nature.

If you have a member you think would benefit from receiving NEMT services, please refer STAR Members to call 1-844-572-8196 and STAR+PLUS Members to call 1-855-584-3530 for more information.

Call Access2Care at 1-844-572-8196 for STAR and STAR+PLUS Members at least (5) Business Days before you need to travel to set up this type of help. This call is toll free.

ADDITIONAL TRANSPORTATION BENEFITS

El Paso Health also offers additional transportation services for medical appointments, when NEMT is not an option or is unavailable. STAR and CHIP Members or their advocates may call the Member Services Department at 915-532-3778 to request transportation services offered through El Paso Health Value Added Services. For STAR+PLUS Members and or their advocates they may call the Member Services Department at 1-833-742-3127. Transportation requests should be requested at least 48-hours before the scheduled appointment. The following Member information must be provided to the intake operator at the time of the call:

- Medicaid ID number
- Name, address, and telephone number
- Name, address, and telephone number of the healthcare Provider
- Purpose of the trip
- Affirmation that no other means of transportation are available
- Special needs, wheelchair lift, or attendant need

Transportation Limitations

Members and their attendants are not eligible to receive medical transportation services under the following circumstances:

- Transportation for children who are younger than 18 years of age and not accompanied by a parent or legal guardian, unless one of the following conditions exists:
- The Member is between15 through 17 years of age and presents the parent's or legal guardian's signed, written consent for the transportation services
- Transportation to or from a day activity health services facility, personal care home, state institution, nursing facility (unless the Member requires dialysis treatment), or facility participating in another Title XIX program for which the reimbursement rate structure includes transportation funds
- Transportation when the Member or another person or entity providing care for the Member receives direct payment of worker's compensation benefits, U.S. Department

of Veterans Affairs benefits, or other third-party resources for transportation to healthcare services on the Member's behalf

- Transportation when the Member is an inpatient in a healthcare facility
- Transportation of deceased Members

Self-Referred Services

Members enrolled in El Paso Health STAR plan may self-refer to any Medicaid participating Provider for the following services:

- Emergency Services – In case of a true medical emergency, Members may seek emergency medical services from the nearest facility. The emergency facility is required to contact the Member's PCP within 24 hours or close of the next business day after providing service. PCPs or designee must be available to respond to an ER call promptly. If the emergency visit results in an admission, the facility must also notify El Paso Health within 10 Days of admission.
- Family Planning Services – Include preventive health, medical counseling, and educational services that assist individuals to control their fertility and achieve optimal reproductive and general health. Members are free to select any Texas Medicaid family planning Provider to access family planning services. PCPs are encouraged to provide these services if requested by a Member. Members are not required to obtain Family Planning services from their PCP.
- Early Childhood Intervention (ECI) – Case Management for Early Childhood Intervention.
- Case Management for Children and Pregnant Women (CPW) – provides services to children with a health condition/health risk, birth through 20 years of age and to high-risk pregnant women of all ages, in order to help them gain access to medical, social, educational and other health-related services.
- School Health and Related Services (SHARS) – Members may select any qualified Provider to access medically necessary and reasonable services to ensure that Medicaid-eligible children with disabilities receive the benefits mandated by Federal and state legislation that guarantees a free and appropriate public education.
- School-Based Clinic Services – Members may receive services from school-based clinics without a referral from their PCP.
- Routine Vision Services – Members may self-refer themselves to any participating Provider in the Opti-Care Provider network without a referral from their PCP.
- Behavioral Health Services –Members may go to any participating behavioral health Provider in the Provider network without a referral from their PCP.

El Paso Health will require an authorization for subsequent visits. Authorization of services may be obtained by submitting a prior authorization form to the Health Services Department via fax, telephonically or electronically. Providers should submit prior authorization requests utilizing the Pre-certification Fax Form for OUTPATIENT /INPATIENT Behavioral Health included as **ATTACHMENT 2** of this manual.

OUTPATIENT
Fax: (915) 298-7866
Toll Free Fax: 1-844-298-7866
Phone: (915) 532-3778
Toll Free: 1-877-532-3778

INPATIENT
Fax: (915) 298-5278
Toll Free Fax: 1-844-200-5278
Phone: (915) 532-3778
Toll Free: 1-877-532-3778

- Dental Services – Members may self-refer themselves to any Medicaid participating dentist. Children under the age of 21 can receive dental care. This care includes: fillings, getting teeth pulled, crowns, root canals, and teeth cleaning every 6 months and getting wisdom teeth pulled. If Member are 21 or older, Medicaid will cover Members' dental care only if it is an emergency that puts Members' life in danger.

Additional STAR Benefits

- Unlimited Prescriptions for Adults – the three prescriptions per month limit has been eliminated. Under the STAR program, El Paso Health Members are entitled to all medically necessary prescriptions. El Paso Health is responsible for administering the prescription program. A Medicaid formulary listing is included on the Vendor Drug Programs Website, at: http://www.hhsc.state.tx.us/HCF/vdp/vdpstart.html
- Unlimited Medically Necessary Inpatient Days – The 30-Day spell of illness limitation has been removed for STAR program and El Paso Health Members over age of 21 who require inpatient hospital care
- Spell-of-illness limitation does not apply for STAR Members.
- $200,000 annual limit on inpatient services does not apply for STAR and STAR+PLUS Members.

Additional CHIP and CHIP Perinatal Benefits

There is no spell-of-illness limitation for CHIP Members and CHIP Perinatal Newborn Members.

VALUE ADDED SERVICES FOR STAR MEMBERS

El Paso Health is pleased to offer additional services to our Members. We believe these services will help promote wellness by teaching children how to manage a chronic condition. Through a combination of Case Management and Health Education, El Paso Health staff will use a variety of sources to develop training and educational programs for Members. For more information, please call an El Paso Health Case Manager for more information at 915-532-3778. The following is a list of the value added services:

El Paso Health STAR Members:

Value-Added Service	STAR Members	Limitations or restrictions apply
24-Hour Nurse Line	Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual Medical Advice Infoline staffed by nurses, pharmacists, and a Medical Director on call.	None
Extra Help with Getting a Ride	A free ride service to help you get to medical appointments, health education classes or Member Advisory Group meetings that are not covered under the Non-Emergency Medical Transportation (NEMT) benefit.	Only available to help Members get to health education classes, appointments, or Member Advisory Group meetings not covered by the Non-Emergency Medical Transportation (NEMT) benefit.
Dental Services	Pregnant Members 21 or older can receive up to $500 each year for dental checkups, x-rays, routine cleaning, fillings, and extractions.	Members will be eligible to receive dental service by scheduling an appointment at the Project Vida or Centro San Vicente Dental Clinics. Only available for Pregnant Members over 21 years of age, once every 12 months.
Extra Vision Services	• For contact lenses and glasses (lenses and frames), Members 20 and younger receive up to $125 above the Medicaid benefit. • For contact lenses and glasses (lenses and frames), members 21 and older receive up to $150 above the Medicaid benefit once every 24 months.	Only available for Members 20 and younger. Only available for Members 21 and older.
Discount Pharmacy / Over-the-Counter Benefits	$25 gift packet which includes a first aid kit and a $25 Walmart gift card for health-related items, for new members who complete the request form and send by return mail within 30 days of enrollment.	Members are eligible to receive this packet every 12 months.

Help for Members with Asthma	One allergy-free pillow case is given to members who are enrolled in the Asthma Disease Management Program.	Once a year, Members will be eligible to receive one allergy-free pillow case when enrolled in the Asthma Disease Management Program at El Paso Health.
Extra Help for Pregnant Women	Pregnant members can receive: • A free convertible car seat after attending a baby shower at El Paso Health.	STAR Pregnant Members must complete one baby shower (pregnancy class) at El Paso Health to receive a free convertible car seat. Limited to one free convertible car seat per pregnancy.
	• Gift cards for completing prenatal visits and after confirmation of those visits for: —$25 – Prenatal visit in the first trimester or within 42 days of enrollment, —$25 – 3rd prenatal visit, —$25 – 6th prenatal visit, —$25 – 9th prenatal visit, —$25 – flu shot during pregnancy, —$25 – a timely postpartum visit within 7-84 days of delivery.	Pregnant members can receive gift cards for completing prenatal visits, following confirmation of the visits. For the 1st, 3rd, 6th, and 9th prenatal visit, members must notify us that they are pregnant prior to having the baby by calling us or submitting a completed Notification of Pregnancy (NOP) form. Prenatal visit count begins after we are notified of the pregnancy. To earn the reward for the first visit, the visit must be completed within 42

		days of enrollment in El Paso First Health Plans. The postpartum doctor visit must be completed between 7-84 days after delivery. For the annual flu vaccine, it is limited to one per flu season from September to April.
	• A First-Steps Baby Shower including a diaper bag, a starter supply of diapers, and other items for the baby.	STAR pregnant Members must complete one pregnancy class (baby shower) at El Paso Health to receive a diaper bag, starter supply of diapers and other items, such as baby lotion and baby wipes. The diaper bag, starter supply of diapers and other items are limited per pregnancy.
	• Pregnant STAR Members age 21 or older must receive four additional nutritional counseling/meal planning services to receive a $25 Walmart gift card for healthy food related items.	**Available to STAR members age 21 and older.**
	• In-home breastfeeding counseling support visits for postpartum members with high-risk pregnancies that require specialized intervention.	Post-Partum members identified with high risk pregnancies that require specialized intervention.

Home Visits/Virtual Visits	"Virtual Connect by El Paso Health" is a service that provides face-to-face virtual home visits for members with social determinants of health or complex conditions such as high-risk pregnancies, behavioral, or medical conditions that require specialized intervention.	Available to members with social determinants of health or complex conditions to include high-risk pregnancies, behavioral, or medical conditions that require specialized intervention.
Health and Wellness Services	• Members age 20 or younger can receive four additional nutritional/obesity counseling and meal planning services above the Medicaid Benefit. • A $25 "EPH Food from the Heart" food basket for new members after completing a new member orientation with El Paso Health.	Only available for Members age 20 and younger. The new member orientation class must be completed within 90 days of enrollment to be eligible to receive a $25 EPH Food from the Heart food basket. Every 12 months Members are eligible to receive one EPH Food from the Heart food basket per household.
Inpatient Follow-up Incentive Program	A $25 Walmart gift card is offered to members 20 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay.	For members 20 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay. Members can receive one Walmart gift card per year.

Gift Programs	• A free "EPH Stay Safe kit" that includes 2 reusable cloth masks, 4 disposable masks, gloves, hand sanitizers, thermometer, healthy tips on hand washing, and sanitizing wipes.	EPH high-risk Members must complete a wellness class within 90 days of enrollment to be eligible to receive an EPH Stay Safe kit. Every 12 months Members are eligible to receive one kit per household.
	• A Calming Kit that includes calming strips, pop-it fidgets, clickers, and fidget spinners is offered to members age 6 through 12 years with a prescription dispensed for ADHD medication and who complete a follow-up visit with a practitioner with prescribing authority within 30 days. Members can receive one Calming Kit per year.	For members ages 6 through 12 years of age with a prescription dispensed for ADHA medication who complete a follow up visit with a practitioner with prescribing authority within 30 days.
	• A $15 gift card is offered to Members age 20 and younger who complete a Texas Health Steps check up on time.	Members age 20 and younger must complete a timely Texas Health Steps checkup as references in their medical checkups periodicity schedule.
	• A $20 gift card is offered to members ages 21 and older who get an annual preventative wellness exam.	Only available for Members ages 21 and older.
Sports and School Physicals	Members between the ages of 4 through 18 can get free physical for sports each year.	Members between the ages of 4 through 18 can get a free physical for sports each year.

Books from the EPH Literacy Program	Two free books from the EPH Literacy Program for members in speech therapy.	Must be in speech therapy to be eligible to receive the two books. Available every 12 months.
Sport, Swim or Camp Registration Fee Discount	Up to $35 discount for any sport, swim, or camp registration fee at participating YMCA's; once every 12 months.	The sport, swim or camp registration activity fee is applicable once every 12 months.

Member Handbook

All Members receive a Member handbook when enrolled with El Paso Health. This handbook includes information about El Paso Health that the Member needs to know, including benefits. A copy of the El Paso Health Member handbook can be obtained by contacting Member Services at 915-532-3778.

Network Hospitals

A network hospital is one that is contracted to provide services to El Paso Health Members. Individual reimbursement arrangements are negotiated between El Paso Health and the hospital. The following hospitals are considered to be in network.

- University Medical Center of El Paso
- THOP Providence Memorial, THOP Sierra East, THOP Sierra, THOP Transmountain, THOP Northeast, THOP Horizon City, THOP Montwood
- Las Palmas/Del Sol
- El Paso Children's Hospital
- Peak Behavioral Health
- Rio Vista Behavioral Health
- University Behavioral Health

Out-of-Network Hospitals

An out-of-network hospital is one that is not contracted to provide services to El Paso Health Members. Reimbursement for out-of-network hospitals will be as follows:

- Out-of-network hospitals are reimbursed only for inpatient services provided to El Paso Health Members as the result of an emergency admission.
- Reimbursement for emergency treatment will be made at the current Medicaid rates.
- Hospitals that are not contracted with El Paso Health are reimbursed according to Texas Medicaid fee-for-service rates.

Coordination with Non-Medicaid Managed Care Covered Services

The State of Texas has chosen to provide certain services to clients under individual contracts with those providers. El Paso Health staff will work closely with providers and vendors to assure that Members receive all medically appropriate and necessary services. A PCP is the coordinator of health services for his/her Members, whether services are delivered within or outside their office. They are responsible for arranging and coordinating appropriate referrals to other providers and specialists and for managing, monitoring, and documenting the services of other providers. Providers may call the Case Manager for assistance in accessing these services and scheduling of appointments.

PCPs are responsible for the appropriate coordination and referral of El Paso Health Members for the following non-Medicaid Managed Care Covered Services (Non-Capitated Services), as identified in the Texas Medicaid Provider Procedures Manual:

- Texas Health Steps Dental (including orthodontia)
- Texas Health Steps Environmental Lead Investigation (ELI)
- Early Childhood Intervention (ECI) Case Management/Service Coordination
- Early Childhood Intervention Specialized Skills Training
- Department of State Health Services (DSHS) Targeted Case Management (w/Modifier HZ)
- DSHS Mental health rehabilitation (w/Modifier HZ)
- Mental Health Targeted Case Management
- Texas Health Steps Medical Case Management (STAR)
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Texas Commission for the Blind (TCB) Case Management
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Women, Infants and Children nutrition program (WIC)
- Case Management for Children and Pregnant Women
- Health and Human Services (HHS) hospice services
- Admissions to inpatient mental health facilities as a condition of probation
- For STAR, Texas Health Steps Personal Care Services for Members birth through age 20
- HHS contracted providers of long-term services and supports (LTSS) for individuals who have intellectual or developmental disabilities.
- HHS contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities.

- Essential Public Health Services
- STAR+PLUS – Nursing Facility Services (non-capitated until February 28, 2015)
- STAR+PLUS, PASRR screenings, evaluations, and specialized services
- HHSC contracted providers of long-term services and supports (LTSS) for individuals who have intellectual or developmental disabilities.
- HHSC contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities.

El Paso Health contracts with the City/County Health Department to ensure its Members have the availability of all public health services. Should a Provider require assistance with referring a Member to the City/County Health Department, the Provider may call a Case Manager for assistance.

El Paso Health and providers must coordinate services with the Texas Department of Family and Protective Services (DFPS) (formerly the Department of Protective and Regulatory Services) for those children who are receiving services from or are placed in conservatorship with DFPS. These services cannot be denied, reduced, or converted for any reason without court approval. A Member or the parent or guardian whose rights are subject to an Order or Service Plan cannot use El Paso Health's Complaint or Appeal processes, or the HHSC Fair Hearing process to Appeal the necessity of the Covered Services.

Providers are required to cooperate with TDFPS by providing medical records when requested, scheduling medical and behavioral health appointments within 14 Days unless requested earlier by TDFPS and recognizing and referring abuse and neglect as appropriate. El Paso Health will continue to provide all Covered Services to a Member receiving services from, or in the protective custody of, TDFPS until the Member has been: (1) disenrolled due to loss of Medicaid managed care eligibility; or (2) enrolled in HHSC's managed care program for children in foster care.

CHIP COVERED SERVICES

Benefits

- Inpatient General Acute and Inpatient Rehabilitation Hospital Services
- Transplants
- Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including Health Center) and Ambulatory Health Care Center
- Physician/Physician Extender Professional Services
- Home and Community Health Services
- Rehabilitation Services
- Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services
- Chiropractic Services
- Tobacco Cessation Programs

A copy of the Evidence of Coverage (EOC) is included as **ATTACHMENT 11** of this manual. The CHIP Schedule of Benefits is as follows:

Covered Benefit	Limitations	Co-payments*
Inpatient General Acute and Inpatient Rehabilitation Hospital Services Services include: ▪ Hospital-provided Physician or Provider services ▪ Semi-private room and board (or private if medically necessary as certified by attending) ▪ General nursing care ▪ Special duty nursing when medically necessary ▪ ICU and services ▪ Patient meals and special diets ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) ▪ Surgical dressings, trays, casts, splints ▪ Drugs, medications and biologicals ▪ Blood or blood products that are not provided free-of-charge to the patient and their administration ▪ X-rays, imaging and other radiological tests (facility technical component) ▪ Laboratory and pathology services (facility technical component) ▪ Machine diagnostic tests (EEGs, EKGs, etc.) ▪ Oxygen services and inhalation therapy ▪ Radiation and chemotherapy	▪ Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition. ▪ Requires authorization for in- network or out-of-network facility and Physician services for a mother and her newborn(s) for up to 48 hours following an uncomplicated vaginal delivery and after 96 hours following	Applicable level of inpatient co-payment per admission.

Covered Benefit	Limitations	Co-payments*
▪ Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care ▪ In-network or out-of-network facility and Physician services for a mother and her newborn(s) up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care. ▪ Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate Provider-administered medications; - ultrasounds; and - histological examination of tissue samples. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. ▪ Surgical implants ▪ Other artificial aids including surgical implants ▪ Inpatient services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12 month period limit	an uncomplicated delivery by caesarian section.	
Skilled Nursing Facilities **(Includes Rehabilitation Hospitals)** Services include, but are not limited to, the following:	▪ Requires authorization	Co-payment

Covered Benefit	Limitations	Co-payments*
▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility	and physician prescription. ▪ 60 Days per 12-month period limit.	does not apply.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility services ▪ Drugs, medications and biologicals ▪ Casts, splints, dressings ▪ Preventive health services ▪ Physical, occupational and speech therapy ▪ Renal dialysis ▪ Respiratory services ▪ Radiation and chemotherapy ▪ Blood or blood products that are not provided free-of-charge to the patient and the administration of these products ▪ Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. ▪ Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate Provider-administered medications; - ultrasounds; and - histological examination of tissue samples. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined	▪ May require prior authorization and physician prescription.	Applicable level of co-payment applies to prescription drug services Co-payment does not apply for preventive services.

Covered Benefit	Limitations	Co-payments*
treatment plan to treat: - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. ▪ Surgical implants ▪ Other artificial aids including surgical implants ▪ Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12 month period limit		
Physician/Physician Extender Professional Services Services include, but are not limited to the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) ▪ Physician office visits, in-patient and outpatient services ▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation ▪ Medications, biologicals and materials administered in Physician's office ▪ Allergy testing, serum and injections ▪ Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions	May require authorization for specialty services.	Co-pays do not apply to preventive visits or to prenatal visits after the first visit.

Covered Benefit	Limitations	Co-payments*
- Same-Day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations ▪ Hospital-based Physician services (including Physician-performed technical and interpretive components) ▪ Physician and professional services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ In-network and out-of-network Physician services for a mother and her newborn(s) for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation. ▪ Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate Provider-administered medications; - ultrasounds; and - histological examination of tissue samples. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.		

Covered Benefit	Limitations	Co-payments*
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery)	None.
Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center.	None.
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to: ▪ Orthotic braces and orthotics ▪ Dental Devices ▪ Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses ▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease ▪ Other artificial aids including surgical implants ▪ Hearing aids ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. ▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.	▪ May require prior authorization and physician prescription. ▪ $20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap).	None.
Home and Community Health Services Services that are provided in the home and community, including, but not limited to:	▪ Requires prior authorization	None.

Covered Benefit	Limitations	Co-payments*
▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and occupational therapies.	and physician prescription. ▪ Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker. ▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. ▪ Services are not intended to replace 24-hour inpatient or skilled nursing facility services	
Inpatient Mental Health Services **Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state operated facilities, including but not limited to:** ▪ Neuropsychological and psychological testing.	▪ Requires prior authorization for non-emergency services. ▪ Does not require PCP referral. ▪ When inpatient psychiatric services are ordered by a	Applicable level of inpatient co-payment.

Covered Benefit	Limitations	Co-payments*
	court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility ▪ Neuropsychological and psychological testing. ▪ Medication management ▪ Rehabilitative day treatments	▪ May require prior authorization. ▪ Does not require PCP referral. ▪ When outpatient psychiatric	Applicable level of co-payment applies to office visits.

Covered Benefit	Limitations	Co-payments*
▪ Residential treatment services ▪ Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development)	services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. ▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part	

Covered Benefit	Limitations	Co-payments*
	I, Chapter 412, Subchapter G, Division 1), §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	

Covered Benefit	Limitations	Co-payments*
Inpatient Substance Abuse Treatment Services Inpatient substance abuse treatment services include, but are not limited to: ▪ Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.	▪ Requires prior authorization for non-emergency services. ▪ Does not require PCP referral.	Applicable level of co-payment applies to office visits.
Outpatient Substance Abuse Treatment Services **Outpatient substance abuse treatment services include, but are not limited to, the following:** ▪ Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. ▪ Intensive outpatient services ▪ Partial hospitalization ▪ Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. ▪ Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.	▪ Requires prior authorization. ▪ Does not require PCP referral.	Applicable level of co-payment applies to office visits.
Rehabilitation Services Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: ▪ Physical, occupational and speech therapy ▪ Developmental assessment	▪ Requires prior authorization and physician prescription.	None.
Hospice Care Services Services include, but are not limited to: ▪ Palliative care, including medical and support services, for those children who have six months or	▪ Requires authorization and physician prescription.	None

Covered Benefit	Limitations	Co-payments*
less to live, to keep patients comfortable during the last weeks and months before death ▪ Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.	▪ Services apply to the hospice diagnosis. ▪ Up to a maximum of 120 Days with a 6 month life expectancy. ▪ Patients electing hospice services may cancel this election at any time.	
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include: ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers ▪ Medical screening examination ▪ Stabilization services ▪ Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services ▪ Emergency ground, air and water transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	▪ Does not require authorization for post-stabilization services.	Co-payment applies to emergency room visit (ER. Facility only)
Transplants Covered services include: ▪ Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	▪ Requires authorization.	None

Covered Benefit	Limitations	Co-payments*
Vision Benefit Covered services include: ▪ One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization ▪ One pair of non-prosthetic eyewear per 12-month period	▪ El Paso Health plan may reasonably limit the cost of the frames/lenses. ▪ May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	Applicable level of co-payment applies to office visits billed for refractive exam.
Chiropractic Services Covered services do not require physician prescription and are limited to spinal subluxation	▪ Requires authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit). ▪ [Requires][May require][Does not require] authorization for additional visits.	Applicable level of co-payment applies to chiropractic office.
Tobacco Cessation Program Covered up to $100 for a 12- month period limit for a plan- approved program	▪ May require authorization. ▪ Health Plan defines plan-approved program.	None.

Covered Benefit	Limitations	Co-payments*
	▪ May be subject to formulary requirements.	

El Paso Health CHIP Members:

Value-Added Service	CHIP Members	Limitations or restrictions apply
24-Hour Nurse Line	Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual Medical Advice Infoline staffed by nurses, pharmacists, and a Medical Director on call.	None
Extra Help with Getting a Ride	A free transportation service that helps members be able to attend their doctor visits or health education classes.	None
Extra Vision Services	For contact lenses and glasses (lenses and frames), members receive up to $125 above the CHIP benefit.	Must use vision providers in the El Paso Health network.
Discount Pharmacy / Over-the-Counter Benefits	$25 gift packet which includes a first aid kit and a $25 Walmart gift card for health-related items, for new members who complete the request form and send by return mail within 30 days of enrollment.	Members are eligible to receive this packet every 12 months.
Sports and School Physicals	Members between the ages of 4 through 18 can get free physical for sports each year.	Members between the ages of 4 through 18 can get a free physical for sports each year.
Help for Members with Asthma	One allergy-free pillow case is given to members who are enrolled in the Asthma Disease Management Program.	Once a year, Members will be eligible to receive one allergy-free pillow case when enrolled in the Asthma Disease Management Program at El Paso Health.

Home Visits/Virtual Visits	"Virtual Connect by El Paso Health" is a service that provides face-to-face virtual home visits for members with social determinants of health or complex conditions such as high-risk pregnancies, behavioral, or medical conditions that require specialized intervention.	Available to members with social determinants of health or complex conditions to include high-risk pregnancies, behavioral, or medical conditions that require specialized intervention.
Health and Wellness Services	• Members age 18 or younger can receive four additional nutritional/obesity counseling and meal planning services above the CHIP Benefit. • A $25 "EPH Food from the Heart" food basket for new members after completing a new member orientation with El Paso Health.	Only available for Members age 18 and younger. The new member orientation class must be completed within 90 days of enrollment to be eligible to receive a $25 EPH Food from the Heart food basket. Every 12 months Members are eligible to receive one EPH Food from the Heart food basket per household.
Gift Programs	• A free "EPH Stay Safe kit" that includes 2 reusable cloth masks, 4 disposable masks, gloves, hand sanitizers, thermometer, healthy tips on hand washing, and sanitizing wipes. • A Calming Kit that includes calming strips, pop-it fidgets, clickers, and fidget spinners is	EPH high-risk Members must complete a wellness class within 90 days of enrollment to be eligible to receive an EPH Stay Safe kit. Every 12 months Members are eligible to receive one kit per household. For members ages 6 through 12 years of

	offered to members age 6 through 12 years with a prescription dispensed for ADHD medication and who complete a follow-up visit with a practitioner with prescribing authority within 30 days. Members can receive one Calming Kit per year.	age with a prescription dispensed for ADHA medication who complete a follow up visit with a practitioner with prescribing authority within 30 days.
	• A $25 gift card is offered to members 18 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay. Members can receive one gift card per year.	A $25 gift card is offered to members 18 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay. Members can receive one gift card per year.
	• A $15 gift card is offered to members ages 3-19 who get a check-up when due and on time.	For El Paso Health CHIP members only. CHIP Perinate members are not eligible for this VAS.
Sport, Swim, or Camp Registration Discount	Up to $35 discount for any sport, swim, or camp registration fee at participating YMCA's; once every 12 months.	The sport, swim, or camp registration activity fee is applicable once every 12 months.
Books from the EPH Literacy Program	Two free books from the EPH Literacy Program for members in speech therapy.	Must be in speech therapy to be eligible to receive the two books. Available every 12 months.

EXCLUSIONS

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system

- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, "External Review by Independent Review Organization").
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Dental devices solely for cosmetic purposes
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Routine foot care such as hygienic care (routine foot care does not include treatment injury or complications of diabetes).
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes

- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse that do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

DME SUPPLIES

DME SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to

DME SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			provide care for a covered diagnosis as outlined in a treatment care plan
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X		For covered DME items
Batteries-replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes
Colostomy Bags		.	. See Ostomy Supplies
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X	.	Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X	.	Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.

DME SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.

NOTIFICATION OF PREGNANT CHIP MEMBER

The Provider will be required to notify El Paso Health in the event that a CHIP Member becomes pregnant. Teens will be directed to enroll in Medicaid when a pregnancy has been diagnosed. A Member who is potentially eligible for Medicaid must apply for Medicaid. A Member who is determined to be Medicaid eligible will no longer be eligible for CHIP. Please call 1-877-532-3778 to notify El Paso Health of the pregnancy. For convenience of our providers the Case Management Referral Form which can be found on the El Paso Health website at under Provider Forms – El Paso Health. This form may be faxed directly to the Case Management Department at 915-298-7866 for any Member with a high-risk condition.

CHIP MEMBER PRESCRIPTIONS

CHIP Members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-Day supply of the drug.

VISION

El Paso Health has contracted with Envolve Benefit Options (formerly OptiCare/AECC Total Vision Health Plan of Texas, Inc.) to provide our Members' eye care benefits.

Envolve has been providing comprehensive and affordable eye care services for over 25 years. Envolve has an extensive local Provider network of Optometrists and Ophthalmologists. For more information please use the Envolve website https://visionbenefits.envolvehealth.com/ or call (888) 310-8037.

CHIP VACCINE PROGRAM

The Texas Department of State Health Services (DSHS) will use the Centers for Disease Control and Prevention federal contracts to purchase vaccines for provision to providers enrolled in the CHIP. The vaccines purchased will be based on the most current recommended childhood immunization schedule of the Advisory Committee on Immunization Practices (ACIP). DSHS will purchase, store, and distribute vaccines purchased using the vaccine delivery system operated by DSHS.

DSHS and the Texas Health and Human Services Commission (HHSC) will provide information and training, as necessary, to providers, healthcare plans, and parents of CHIP-eligible children regarding the CHIP vaccine program. CHIP providers must complete and submit the vaccine accounting documents to DSHS. The documentation required tracks the requirements for the Texas Vaccines for Children Program (TVFC) with forms designated as "CHIP".

Please feel free to contact the nearest health service regional office or a TVFC Consultant at 512-458-7284, or toll-free at 1-800-252-9152 as the vaccines are available through the Texas Vaccines for Children Program, El Paso Health will reimburse providers an administration fee only.

CHIP CO-PAYMENTS

The following table lists the CHIP co-payment schedule according to family income. Co-payments for medical services or prescription drugs are to be collected by the healthcare Provider at the time of service. There are no co-payments for preventive care such as well-child or well-baby visits or immunizations.

Each child's health plan ID card lists the co-payments that apply to that family situation. The member's ID card must be presented when they receive an office visit, emergency services, or have a prescription filled. The table below lists the various co-payments.

Federal Poverty Levels	Office Visit	None-Emergency ER	Prescription Generic Drugs	Prescription Brand Name Drugs	Facility Co-pay Inpatient (per admission)	Annual Co-pay Maximum
Native Americans	$0	$0	$0	$0	$0	None
At or below 151%	$5	$5	$0	$5	$35	5% of family's income
Above 151% up to and including 186%	$20	$75	$10	$35	$75	5% of family's income
Above $186% up to and including 201%	$25	$75	$10	$35	$125	5% of family's income

COORDINATION WITH NON-CHIP COVERED SERVICES

The services listed in the following are accessed outside of the El Paso Health network, and are not part of the CHIP managed care programs.

- Texas Agency Administered Programs and Case Management Services
- Essential Public Health Services

All El Paso Health providers are encouraged to refer to and coordinate services with the above agencies. If more information or assistance is required, contact El Paso Health's Member Services at (915)532-3778.

CHIP PERINATAL COVERED SERVICES

CHIP COVERED SERVICES FOR CHIP PERINATAL (Pregnant Mother)

CHIP Perinatal Evidence of Coverage is included as **ATTACHMENT 12** of this manual. The schedule of benefits is as follows:

Covered Benefit	Limitations	Co-payments
Inpatient General Acute Services include: Covered medically necessary Hospital-provided services • Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) ▪ Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). ▪ Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ▪ dilation and curettage (D&C) procedures, ▪ appropriate Provider-administered medications, ▪ ultrasounds, and ▪ histological examination of tissue samples.	For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with incomes above 185% up to and including 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth	None.
Comprehensive Outpatient Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:	▪ May require prior authorization and physician prescription	None.

Covered Benefit	Limitations	Co-payments
▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Drugs, medications and biologicals that are medically necessary prescription and injection drugs ▪ Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ▪ dilation and curettage (D&C) procedures, ▪ appropriate Provider-administered medications, ▪ ultrasounds, and ▪ histological examination of tissue samples.	Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth. Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation, or miscarriage or non-viable pregnancy. Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits of the CHIP Perinatal Program with an appropriate diagnosis. Laboratory tests for the CHIP Perinatal Program are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV)	

Covered Benefit	Limitations	Co-payments
	antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.	
Physician/Physician Extender Professional Services Services include, but are not limited to the following: ▪ Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. ▪ Physician office visits, in-patient and out-patient services ▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation ▪ Medically necessary medications, biologicals and materials administered in Physician's office ▪ Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. - Administration of anesthesia by Physician (other than surgeon) or CRNA	Requires authorization for specialty services Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation. Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT.	None.

Covered Benefit	Limitations	Co-payments
- Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. - Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). ▪ Hospital-based Physician services (including Physician-performed technical and interpretive components) ▪ Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures, appropriate Provider-administered medications, ultrasounds, and histological examination of tissue samples.		
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) Applies only to CHIP Perinate Members (unborn child) with incomes at 186% FPL to 200% FPL.	None.
Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: (1) One (1) visit every four (4) weeks for the first 28 weeks or pregnancy;	None.

Covered Benefit	Limitations	Co-payments
	(2) one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and (3) one (1) visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 Days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. Visits after the initial visit must include: ▪ interim history (problems, marital status, fetal status); ▪ physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and ▪ laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and	

Covered Benefit	Limitations	Co-payments
	other lab tests as indicated by medical condition of client).	
Prenatal care and family services and supplies Covered services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: One visit every four weeks for the first 28 weeks or pregnancy; one visit every two to three weeks from 28 to 36 weeks of pregnancy; and one visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary.	May require prior authorization**.** Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 Days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: interim history (problems, maternal status, fetal status), physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).	None.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services El Paso Health cannot require authorization as a condition for payment for emergency conditions related to labor and delivery. Covered services are limited to those emergency services that are directly	Post-delivery services or complications resulting in the need	None.

Covered Benefit	Limitations	Co-payments
related to the delivery of the covered unborn child until birth. ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. ▪ Stabilization services related to the labor and delivery of the covered unborn child. ▪ Emergency ground, air and water transportation for labor and threatened labor is a covered benefit. ▪ Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.)	for emergency services for the mother of the CHIP Perinate are not a covered benefit.	
Case Management Services Case management services are a covered benefit for the Unborn Child.	These covered services include outreach informing, case management, care coordination and community referral.	None.
Care Coordination Services Care coordination services are a covered benefit for the Unborn Child.		None.
Drug Benefits Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and Provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.	Services must be medically necessary for the unborn child.	None.

El Paso Health CHIP Perinatal Members:

Value-Added Service	CHIP Perinatal Members	Limitations or restrictions apply
Extra Help with Getting a Ride	A free transportation service that helps members be able to attend their doctor visits or health education classes.	None
24-Hour Nurse Line	Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual Medical Advice Infoline staffed by nurses, pharmacists, and a Medical Director on call.	None
Dental Services	Pregnant Members 21 or older can receive up to $500 each year for dental checkups, x-rays, routine cleaning, fillings, and extractions.	Members will be eligible to receive dental service by scheduling an appointment at the Project Vida or Centro San Vicente Dental Clinics. Only available for Pregnant Members over 21 years of age, once every 12 months.
Discount Pharmacy / Over-the-Counter Benefits	$25 gift packet which includes a first aid kit and a $25 Walmart gift card for health-related items, for new members who complete the request form and send by return mail within 30 days of enrollment.	Members are eligible to receive this packet every 12 months.
Extra Help for Pregnant Women	Pregnant members can receive: • A free convertible car seat after attending a baby shower at El Paso Health.	CHIP Perinate Members must complete one baby shower (pregnancy class) at El Paso Health to receive a free convertible car seat. Limited to one free convertible car seat per pregnancy.
	• Gift cards for completing prenatal visits and after confirmation of those visits for: — $25 – Prenatal visit in the first trimester or within 42 days of enrollment, — $25 – 3rd prenatal visit,	CHIP Perinate Pregnant members can receive gift cards for completing prenatal visits,

	— $25 – 6th prenatal visit, — $25 – 9th prenatal visit, — $25 – flu shot during pregnancy, — $25 – a timely postpartum visit within 7-84 days of delivery.	following confirmation of the visits. For the 1st, 3rd, 6th, and 9th prenatal visit, members must notify us that they are pregnant prior to having the baby by calling us or submitting a completed Notification of Pregnancy (NOP) form. Prenatal visit count begins after we are notified of the pregnancy. To earn the reward for the first visit, the visit must be completed within 42 days of enrollment in El Paso Health. The postpartum doctor visit must complete between 7-84 days after delivery. For the annual flu vaccine, it is limited to one per flu season from September to April.
	• A First-Steps Baby Shower including a diaper bag, a starter supply of diapers, and other items for the baby.	CHIP Perinate pregnant Members must complete one pregnancy class (baby shower) at El Paso Health to receive a diaper bag, starter supply of diapers and other items, such as baby lotion and baby wipes. The diaper bag, starter supply of

		diapers and other items are limited per pregnancy.
	• Pregnant CHIP Perinate Members age 19 or older must receive four additional nutritional counseling/meal planning services to receive a $25 Walmart gift card for healthy food related items.	Available to CHIP Perinate members age 19 and older.
	• In-home breastfeeding counseling support visits for postpartum members with high-risk pregnancies that require specialized intervention.	Post-Partum members identified with high risk pregnancies that require specialized intervention.
Home Visits/Virtual Visits	"Virtual Connect by El Paso Health" is a service that provides face-to-face virtual home visits for members with social determinants of health or complex conditions such as high-risk pregnancies, behavioral, or medical conditions that require specialized intervention.	Available to members with social determinants of health or complex conditions to include high-risk pregnancies, behavioral, or medical conditions that require specialized intervention.
Gift Programs	• A free "EPH Stay Safe kit" that includes 2 reusable cloth masks, 4 disposable masks, gloves, hand sanitizers, thermometer, healthy tips on hand washing, and sanitizing wipes.	EPH high-risk Members must complete a wellness class within 90 days of enrollment to be eligible to receive an EPH Stay Safe kit. Every 12 months Members are eligible to receive one kit per household.
	• A $25 "EPH Food from the Heart" food basket for new members after completing a new member orientation with El Paso Health.	The new member orientation class must be completed within 90 days of enrollment to be eligible to receive a

		$25 EPH Food from the Heart food basket. Every 12 months Members are eligible to receive one EPH Food from the Heart food basket per household.

CHIP PERINATAL EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES (PREGNANT MEMBER)

- For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. “Initial Perinatal Newborn admission” means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth. Services related to preterm, false or other labor not resulting in delivery are excluded services.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.

- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment related to labor and delivery or post-partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, "External Review by Independent Review Organization").
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor and delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care (routine foot care does not include treatment of injury or complications of diabetes).
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes

- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse that do not require the skill and training of a nurse.
- Vision training, vision therapy, or vision services.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services is not covered.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

CHIP COVERED SERVICES FOR CHIP PERINATAL (NEWBORN MEMBERS)

CHIP Perinatal Newborn Evidence of Coverage is included as **ATTACHMENT 13** of this manual. The schedule of benefits is as follows:

Covered Benefit	Limitations	Co-payments
Inpatient General Acute and Inpatient Rehabilitation Hospital Services Services include: ▪ Hospital-provided Physician or Provider services ▪ Semi-private room and board (or private if medically necessary as certified by attending) ▪ General nursing care ▪ Special duty nursing when medically necessary ▪ ICU and services ▪ Patient meals and special diets ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) ▪ Surgical dressings, trays, casts, splints ▪ Drugs, medications and biologicals	▪ Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition. ▪ Requires authorization for in-network or out-of-network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section.	None

Covered Benefit	Limitations	Co-payments
▪ Blood or blood products that are not provided free-of-charge to the patient and their administration ▪ X-rays, imaging and other radiological tests (facility technical component) ▪ Laboratory and pathology services (facility technical component) ▪ Machine diagnostic tests (EEGs, EKGs, etc.) ▪ Oxygen services and inhalation therapy ▪ Radiation and chemotherapy ▪ Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care ▪ In-network or out-of-network facility and Physician services for a mother and her newborn(s) for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care. ▪ Surgical implants. ▪ Other artificial aids including surgical implants ▪ Inpatient services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or		

Covered Benefit	Limitations	Co-payments
- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.		
Skilled Nursing Facilities (Includes Rehabilitation Hospitals) Services include, but are not limited to, the following: ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility	▪ Requires authorization and physician prescription ▪ 60 Days per 12-month period limit.	None
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include but are not limited to the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility services ▪ Drugs, medications and biologicals ▪ Casts, splints, dressings ▪ Preventive health services ▪ Physical, occupational and speech therapy ▪ Renal dialysis ▪ Respiratory services ▪ Radiation and chemotherapy ▪ Blood or blood products that are not provided free-of-charge to the patient and the administration of these products ▪ Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility, ▪ Surgical implants. ▪ Other artificial aids including surgical implants ▪ Outpatient services provided at an outpatient	▪ May require prior authorization and physician prescription	None.

Covered Benefit	Limitations	Co-payments
hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.		
Physician/Physician Extender Professional Services Services include, but are not limited to the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) ▪ Physician office visits, in-patient and out-patient services ▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation ▪ Medications, biologicals and materials administered in Physician's office ▪ Allergy testing, serum and injections ▪ Professional component (in/outpatient) of surgical services, including:	May require authorization for specialty services.	None

Covered Benefit	Limitations	Co-payments
- Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions - Same-Day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations ▪ Hospital-based Physician services (including Physician-performed technical and interpretive components) ▪ Physician and professional services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ In-network and out-of-network Physician services for a mother and her newborn(s) for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic, skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.		

Covered Benefit	Limitations	Co-payments
Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.	Covers services rendered to a newborn immediately following delivery.	None
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to: ▪ Orthotic braces and orthotics ▪ Dental devices ▪ Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses ▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease ▪ Hearing aids ▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.	May require prior authorization and physician prescription ▪ $20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap).	None
Home and Community Health Services Services that are provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and occupational therapies.	▪ Requires prior authorization and physician prescription ▪ Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker. ▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24- hour skilled nursing services. ▪ Services are not intended to replace 24-hour inpatient or skilled nursing facility services.	None
Inpatient Mental Health Services Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care	▪ Requires prior authorization for non-emergency services	None

Covered Benefit	Limitations	Co-payments
hospitals and state-operated facilities, including, but not limited to: ▪ Neuropsychological and psychological testing.	▪ Does not require PCP referral. ▪ When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, include , but are not limited to: ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. ▪ Neuropsychological and psychological testing ▪ Medication management ▪ Rehabilitative day treatments ▪ Residential treatment services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development	▪ Requires prior authorization. ▪ Does not require PCP referral. ▪ When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the	None

Covered Benefit	Limitations	Co-payments
	court with jurisdiction over the matter for determination. ▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412 Subchapter G, Division 1, §412.303(31). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	
Inpatient Substance Abuse Treatment Services Services include, but are not limited to: ▪ Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.	▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral.	None
Outpatient Substance Abuse Treatment Services Services include, but are not limited to: ▪ Prevention and intervention services that are provided by physician and non-physician	▪ Requires prior authorization. ▪ Does not require PCP referral.	None

Covered Benefit	Limitations	Co-payments
providers, such as screening, assessment and referral for chemical dependency disorders. ▪ Intensive outpatient services ▪ Partial hospitalization ▪ Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. ▪ Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.		
Rehabilitation Services Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: ▪ Physical, occupational and speech therapy ▪ Developmental assessment	▪ Requires prior authorization and physician prescription	None
Hospice Care Services Services include, but are not limited to: ▪ Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death ▪ Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services.	▪ Requires authorization and physician prescription ▪ Services apply to the hospice diagnosis. ▪ Up to a maximum of 120 Days with a 6 month life expectancy. ▪ Patients electing hospice services may cancel this election at anytime.	None
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include but are not limited to the following: ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Hospital emergency department room and ancillary services and physician services 24	▪ May require authorization for post-stabilization services	None

Covered Benefit	Limitations	Co-payments
hours a day, 7 days a week, both by in-network and out-of-network providers ▪ Medical screening examination ▪ Stabilization services ▪ Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services ▪ Emergency ground, air and water transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.		
Transplants Services include but are not limited to the following: ▪ Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	▪ Requires authorization	None
Vision Benefit Services include: ▪ One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization ▪ One pair of non-prosthetic eyewear per 12-month period	El Paso Health may reasonably limit the cost of the frames/lenses. ▪ May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	None
Chiropractic Services Covered services do not require physician prescription and are limited to spinal subluxation	▪ Requires authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit) ▪ Requires authorization for additional visits.	None
Tobacco Cessation Program Covered up to $100 for a 12- month period limit for a plan- approved program	▪ May require authorization ▪ El Paso Health Plan defines plan-approved program.	None

Covered Benefit	Limitations	Co-payments
	▪ May be subject to formulary requirements.	
Case Management and Care Coordination Servic	▪ These services include outreach, informing, case management, care coordination and community referral.	None

CHIP PERINATAL EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATE NEWBORNS

All the following exclusions match those found in the CHIP program.

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning).
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, “External Review by Independent Review Organization”).
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan.
- Medications prescribed for weight loss or gain
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.

- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care (routine foot care does not include treatment injury or complications of diabetes).
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice.
- Housekeeping.
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse that does not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

CHIP PERINATE DME/SUPPLIES

Note: DME/SUPPLIES are not a covered benefit for CHIP Perinate Members but are a benefit for CHIP Perinate Newborns.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X		For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for treatment

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			of craniofacial anomalies requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Enteral Nutrition Supplies	**X**		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the
			structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	**X**		Covered for patients with amblyopia.
Formula		**X**	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 Days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For Members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding in pudding form (except for clients with documented

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake
			from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parentally
Gloves		**X**	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		**X**	Over-the-counter supply.
Hygiene Items		**X**	
Incontinent Pads	**X**		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	**X**		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	**X**		Eligible for coverage when used during covered home care for wound care.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Irrigation Sets, Urinary	**X**		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	**X**		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy
K-Y Jelly		**X**	Over-the-counter supply.
Lancet Device	**X**		Limited to one device only.
Lancets	**X**		Eligible for individuals with diabetes.
Med Ejector	**X**		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	**X**		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	**X**		
Ostomy Supplies	**X**		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	**X**		Necessary supplies (e.g., tubing, filters, connectors,

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	**X**		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	**X**		
Stump Socks	**X**		
Suction Catheters	**X**		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheotomy Supplies	**X**		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	**X**		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		**X**	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	**X**		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	**X**		Cover supplies needed for intermittent or straight catherization.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Urine Test Kit	**X**		When determined to be medically necessary.

BREAST PUMP COVERAGE IN MEDICAID AND CHIP

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

Coverage in Prenatal Period	Coverage at Delivery	Coverage for Newborn	Breast Pump Coverage & Billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee- for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	
STAR Health	STAR Health	STAR Health	

Coverage in Prenatal Period	Coverage at Delivery	Coverage for Newborn	Breast Pump Coverage & Billing
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

*CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30 Days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

**These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.

STAR+PLUS COVERED SERVICES

Medicaid members participating in the STAR+PLUS program receive all the benefits of the traditional Texas Medicaid program.

EPH will provide functionally-necessary community LTSS services to all STAR+PLUS members beginning on the members' date of enrollment regardless of pre-existing condition, prior diagnosis and/or receipt of any prior health care services. EPH will not impose any pre-existing condition limitations or exclusions, or require evidence of insurability to provide coverage to any members enrolled in the STAR+PLUS program.

All adult members in STAR+PLUS who are not covered by Medicare, or are dual eligible and receiving STAR+PLUS Waiver services receive unlimited medically necessary prescription drugs. Dual eligible STAR+PLUS members will continue to receive pharmacy benefits from their Medicare Part D pharmacy plan. Please refer to the current Texas Medicaid Provider Procedures Manual, weekly Texas Medicaid Banner Messages and the bi-monthly Texas Medicaid Bulletin for a more inclusive listing of limitations and exclusions.

Long-Term Services and Supports (LTSS)

LTSS includes both Long-Term Care (LTC) and Home and Community Based Services (HCBS). Long-Term Care programs are when an individual is living in a facility-based care setting (such as a nursing home or intermediate care facility). Home and community-based services programs provide alternatives to living in facility-based care settings. These programs empower consumers to take an active role in their health care and to remain in the community. The programs serve people who are older adults, people with intellectual and/or developmental disabilities, or people with disabilities. EPH understands the importance of working with our providers and Community Based Organizations (CBO's) in our area to ensure our members receive LTSS services that maintain their independence and ability to remain in the community.

EPH's LTSS provider network is a critical component to ensuring our members receive the right care, in the right place, at the right time. The following information has been included to help support our LTSS provider network and achieve a successful partnership in serving those in need.

LTSS Services and EPH Long-Term Care and Support Services (LTSS) are benefits that help members stay safe and independent in their home or community. Members can receive LTSS services if they need help with daily healthcare and living needs and meet the level of care eligibility standards. Members who are eligible to receive LTSS services can receive:

Personal Assistant Services (PAS)

Provides in-home assistance to individuals as authorized on their Individual Service Plan (ISP) with the performance of activities of daily living, household chores and delegated nursing tasks that have been delegated by a registered nurse (RN). PAS are subject to Electronic Visit Verification (EVV). See EVV Section for more details on EVV. The Provider must be licensed by the State as a HCSSA. The level of licensure required depends on the type of service delivered. An agency may have only the PAS level of licensure.

Day Activity and Health Services (DAHS)

Services include nursing and personal care services, nutrition services, transportation services, social and recreational activities and other supportive services. These services are provided at adult day care facilities licensed by the Department of State Health Services (DSHS) and certified by HHS. The Provider must be licensed by HHSC regulatory services and to deliver DAHS, the Provider must provide the range of services required for DAHS.

Community First Choice (CFC) is a Medicaid benefit that provides services for people with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities. The services available under CFC are:

- **Personal Assistance Services (PAS):** Help with daily living activities and health-related tasks.
- **Habilitation:** Services to help members learn new skills and care for themselves.
- **Emergency Response Services (ERS):** Help members who live alone or are alone for most of the day.
- **Support Management:** Training to help members learn how to select, manage and dismiss attendants.

The Provider must be licensed as HCSSA or certified as a Home and Community-Based Services (HCS) or TxHmL agency. The level of licensure required depends on the type of service delivered. For Members using the CDS option, providers include individuals hired by the Member or LAR who meets provider qualifications and qualified FMSAs.

For PAS-CFC: the agency may have only the PAS level of licensure.

Cognitive Rehabilitation Therapy (CRT) is a benefit and service under the STAR+PLUS Waiver (SPW) program. CRT is a service that assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. CRT is provided in accordance with the developed plan of care and includes reinforcing, strengthening, or re-establishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. This service can be associated with individuals with Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI) CRT is a service that is based on Medical Necessity (MN) through an assessment conducted by a licensed Psychologist, Occupational Therapist (OT) or Speech and Language Pathologist (SLP). Psychologist must be licensed under Tex. Occ. Code ch. 501. Speech and language pathologists must be licensed under Tex. Occ. Code ch. 401. Occupational therapist must be licensed under Tex. Occ. Code ch. 454.

STAR+PLUS members can receive additional long-term care services based on their medical need. These are called **STAR+PLUS Waiver Services.** They include:

Adaptive Aids and Medical Supplies: Includes devices, controls or medically necessary supplies that enable individuals with functional impairments to perform activities of daily living or control the environment in which they live. No licensure or certification requirements.

Adult Foster Care (AFC): Provides a 24-hour living arrangement in an HHS-contracted foster home for persons who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, minimal help with personal care, nursing tasks, supervision, companion services, help with activities of daily living and provision of or arrangement for transportation. The unit of service is one day. AFC homes including the Member's home must either have been determined qualified based on the standards or licensed by HHSC under 26 Tex. Admin. Code ch. 553, for homes serving four or more residents. The MCO must demonstrate the ability to recruit, train, and certify AFC Providers based on standards referenced above either in-house or through an AFC-agency Provider.

Assisted Living Facility (ALF): Provides 24-hour living arrangement for persons who, because of physical or mental limitations, are unable to continue independent functioning in their own home. Services are provided in personal care facilities licensed by HHS. Participants are responsible for their room and board costs and, if applicable, copayments for ALF services. The Provider must be licensed by HHSC's Long Term Care Regulatory Division in accordance with 26 Tex. Admin. Code ch. 553. The type of licensure determines what services may be provided.

Consumer-Directed Services: In the consumer-directed model, the member or the member's legally authorized representative is the employer of record and retains control over the hiring, management and termination of an individual providing PAS. The member is responsible for assuring that the employee meets the requirements for PAS, including the criminal history check. Member uses a Financial Management Services Agency (FMSA) to handle the employer-related administrative functions such as payroll, substitute (back-up) attendant in place and filing tax-related reports of PAS. To participate as a EPH FMSA providing services under the consumer-directed model, a FMSA must be specifically identified to provide consumer direct services by HHS. For Members using the CDS option, providers include individuals hired by the Member or LAR who meets provider qualifications and qualified FMSAs.

Dental Services: Services provided by a licensed dentist such as dentures, routine cleaning, emergency procedures, preventive care and treatment of injuries. The Provider must be licensed by the Texas State Board of Dental Examiners as a Dentist under 22 Tex. Admin. Code ch. 101.

Emergency Response Services (ERS): Provided through an electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in the community. In an emergency, the individual can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven days a week monitoring capability, helps insure that the appropriate person or service agency responds to an alarm call from the individual. The Provider must meet HHSC's qualifications described in 26 Tex. Admin. Code § 279.51.

Employment Assistance: Provides identification of member's preferences, skills and work setting/condition needs, locating available jobs that match the member's criteria/needs and negotiating the member's potential employment with the employer. Please note, Employment

Assistance is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

The Provider must meet all of the criteria in one of these three options.

Option 1:

1. A bachelor's degree in rehabilitation, business, marketing, or a related human services field; and
2. Six months of documented experience providing services to people with Disabilities in a professional or personal setting.

Option 2:

1. An associate's degree in rehabilitation, business, marketing, or a related human services field; and
2. One year of documented experience providing services to people with Disabilities in a professional or personal setting.

Option 3:

1. A high school diploma or GED; and
2. Two years of documented experience providing services to people with Disabilities in a professional or personal setting.

Financial Management Services: Services provided by Certified Financial Management Services Agencies (FMSA) to support members who hire their own service providers under the Consumer Directed Services (CDS) option. The Provider must complete initial and ongoing HHSC-required training and receive a certificate of completion of training. FMSAs must be eligible to contract with HHSC to contract with an MCO.

Home Delivered Meals: Meal services provide hot, nutritious meals delivered to an individual's home. The benefit limitation is one meal per Day, and the need for a home delivered meal must be part of the individual service plan. Home delivered meals will be provided to individuals who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet individual requirements. Menu plans will be reviewed and approved by a registered dietician licensed by the Texas State Board of Examiners of Dietitians or has a baccalaureate degree with major studies in food and nutrition, dietetics or food service management. Any agency providing home delivered meals must comply with all state and local health laws and ordinances concerning preparation, handling and serving of food. Home Delivered Meal Providers must report any member illnesses, potential threats to the member's safety or observable changes in the member's condition to the MCO, orally within one Business Day and in writing within five Business Days. The Provider must comply with requirements for providing home delivered meal services in accordance with 40 Tex. Admin. Code ch. 55.

In-Home Skilled Nursing Care: Direct delivery of skilled tasks/procedures by a registered or practical nurse based on an assessment of the member's health care needs, guidance by professional practice standards and physician order if required. Texas Board of Nurse Examiners allows delegation of nursing tasks to unlicensed persons following the development of a care plan and education on proper health maintenance. The Provider must be a licensed RN by the Texas Board of Nursing under 22 Tex. Admin. Code ch. 217.

Mental Health Rehabilitative Services: Services are defined as age-appropriate services determined by HHS and federally-approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness for adults, or serious emotional, behavioral, or mental disorders for children, and to restore the member to their best possible functioning level in the community.

Mental Health Targeted Case Management: Assist members with gaining access to needed medical, social, educational and other services and supports. Members are eligible to receive these if they have been assessed and diagnosed with a severe and persistent mental illness (SPMI) or a severe emotional disturbance (SED) and they are authorized to receive Mental Health Rehabilitative Services.

Minor Home Modifications: Includes services that assess the need for, arrange for and provide home modifications and/or improvements to an individual's residence to enable them to reside in the community and to ensure safety, security and accessibility within their home. There are no licensure or certification requirements.

Personal Assistant Services (PAS): Provides in-home assistance to individuals as authorized on their Individual Service Plan (ISP) with the performance of activities of daily living, household chores and nursing tasks that have been delegated by a registered nurse (RN). PAS is subject to Electronic Visit Verification (EVV). See EVV Section for more details.

Respite Care Services: Available on an emergency or short-term basis to relieve those persons normally providing unpaid care for a STAR+PLUS waiver member unable to care for themselves. In-home respite care services are subject to EVV. See EVV Section for details on EVV. The Provider must be licensed by HHSC as a HCSSA under 26 Tex. Admin. Code ch. 558; licensed as a NF Provider under 26 Tex. Admin. Code ch. 554; licensed by HHSC as an Assisted Living provider under 26 Tex. Admin. Code ch. 553; or AFC provider licensed by HHSC under 26 Tex. Admin. Code ch. 553. Unlicensed AFC providers must meet the qualifications described in Exhibit E. AFC homes serving four or more participants must be licensed by HHSC under 26 Tex. Admin. Code ch. 553.

Supported Employment: Service available to members who earn at least minimum wage, that provides employment adaptations, supervision and additional training to sustain employment.

Support Consultation: Support Consultation services are available to members participating in the CDS option. It is an optional service. A member's service planning team may recommend the service when the employer (the individual or legally authorized representative (LAR)) or the designated representative (DR) would benefit from additional support with employer responsibilities. Support consultation services must not duplicate or replace services to be delivered through a case manager, a service coordinator, the financial management services

agency (FMSA) or other sources. A support advisor provides skills-specific training, assistance and supports to the employer or the employer's designated representative (DR) to meet responsibilities of the CDS option.

Examples of services a support advisor may provide include training related to recruiting and screening applicants for employment and verifying employment eligibility, assistance with developing job descriptions, coaching on problem solving and coordinating employee management activities, training on developing and implementing service backup and corrective action plans, and coaching on handling other employer responsibilities. The Provider must complete HHSC required training and receive a certificate of completion from HHSC.

Therapy (Occupational, Physical, Speech): Includes the evaluation, examination and treatment of physical, functional, speech and hearing disorders and/or limitations. A full range of services are provided in the member's home or a rehabilitative center by a licensed therapist or an assistant under the direction of a licensed therapist. The full range of activities provided by an occupational or physical therapist, speech or language pathologist, or a licensed occupational or physical therapy assistant under the direction of a licensed occupational or physical therapist, within the scope of his/her state licensure are covered LTSS services.

Transitional Assistance Services (TAS): Assists individuals who are discharging from a nursing facility to the community and set up their household. A maximum of $2,500 is available on a one-time basis to help offset the costs associated with setting up their household. Some examples of what TAS money provides payment for are security deposits, moving expenses, essential furnishings and set-up fees for utilities. The Provider must comply with the requirements for delivery of TAS. TAS Providers must demonstrate knowledge of, and experience in, successfully serving Members who require home and Community-Based Services.

Supplemental Transition Services (STS): Service offered through Medicaid MCOs to assist members who are transitioning from a Nursing Facility (NF) into the community, along with the support of a home and community-based services program authorized by a 1915(c) or 1115 waiver. Form H1746-A NF resident discharged from the facility into a home and community-based services program is eligible to receive up to $2,500 in STS for assistance with moving and setting up a household. STS is available on a one-time only basis and only after TAS has been exhausted.

Long Term Services & Support Provider Responsibilities

Long term services and support providers are responsible for:

- Verifying member eligibility prior to performing services;
- Adhering to the El Paso Health's authorization policies;
- Medicaid/Medicare coordination;
- Determining if members have medical benefits through other insurance coverage, including Dual eligibles;
- Ensuring that there is ongoing continuity of care between the member's El Paso Health's Healthcare coordinator and the PCP; and

- Notifying the plan whenever there is change in the member's physical or mental condition and/or a change in their eligibility;
- Community First Choice services
- Employment Assistance services; provider must develop and update quarterly plan for delivering employment assistance services
- Supported Employment Responsibilities; providers must develop and update quarterly a plan for delivering supported employment services.
- Provide a copy to EPH of the abuse neglect and exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services (DFPS).

Employment Assistance Services

Employment Assistance (EA) services provide assistance to the member, as authorized on Form H1700-1, Member Service Plan – SPW (Pg. 1), to help a member locate competitive employment or self-employment.

Competitive employment is work:

- in the competitive labor market, in which anyone may compete for employment, that is performed on a full-time or part-time basis in an integrated setting; and
- for which a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by members without disabilities.

An integrated setting is a setting typically found in the community in which applicants or eligible members interact with people without disabilities, other than service providers, to the same extent that people without disabilities in comparable positions interact with other people without disabilities. An integrated setting does not include a setting in which:

- groups of people with disabilities work in an area that is not part of the general workplace where people without disabilities work; or
- a mobile crew of people with disabilities work in the community.

Self-employment is work in which the member:

- Solely owns, manages, and operates a business;
- Is not an employee of another person or entity, business; and
- Actively markets a service or product to potential customers.

Description of Employment Assistance Services

- EA services include, but are not limited to, the following:
    - identifying a member's employment preferences, job skills, and requirements for a work setting and work conditions;

  - locating prospective employers offering employment compatible with a member's identified preferences, skills, and requirements; and
  - contacting a prospective employer on behalf of a member and negotiating the member's employment.
- The managed care organization (MCO) must ensure provision of EA as identified through use of Job Interest Assessment, to participants of the SPW if the services are not available through DARS or the local school district for members under age 22.
- EA may be provided through the SPW if documentation is maintained in the member's record that the service is not available to the member under a program funded under 110 of the Rehabilitation Act of 1973 or, for members under age 22, under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.)

Employment Assistance Activities

EA activities consist of developing and implementing strategies for achieving the member's desired employment outcome:

- exploring options related to wages and employment outcomes (including self-employment outcomes);
- exploring the member's interests, capabilities, preferences, and ongoing support needs;
- exploring the extended services and supports required at and away from the job site that will be necessary for employment success;
- observing the member's work skills and behaviors at home and in the community and touring current or potential work environments with the member;
- assisting the member to understand the impact of work activity on their services and financial supports;
- assisting the member to utilize work incentives;
- collecting personal and employer reference information;
- assessing the member's learning style and needs for adaptive technology, accommodations, and on-site supports;
- assessing the member's strengths, challenges, and transferable skills from previous job placements;
- identifying the member's assets, strengths and abilities;
- identifying negotiable and non-negotiable employment conditions;
- identifying targeted job tasks the member can perform or potentially perform;
- identifying potential business ideas or employers;
- writing résumés and proposals to assist in placement;
- contacting employers and developing member jobs;
- performing a job analysis;
- reviewing job match information;
- assisting the member with job applications, pre-employment forms, practice interviews, and pre-employment testing or physicals;

- accompanying the member to interviews and company visits;
- negotiating aspects of the member's employment with prospective employers;
- assisting the employer with the Work Opportunity Tax Credit and other employer benefits;
- developing the member's transportation plan;
- training the member on how to travel to and from a job;
- securing transportation for or transporting a member as necessary to assist the member to obtain a job;
- participating in service planning meetings; and
- assisting to help a member find more suitable employment.

VALUE ADDED SERVICES FOR STAR+PLUS MEMBERS

- ✓ Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual medical advice infoline staffed by nurses, pharmacists, and a Medical Director on call.
- ✓ A free ride service to help you get to appointments, health education classes, non-medical drivers of health locations, or Member Advisory Group meetings that are not covered under the NEMT benefit.
- ✓ Up to $2,000 each year for Dental check-ups, x- rays, cleanings, fillings and simple tooth extractions for members 21 and older for STAR+PLUS non-HCBS waiver members.
- ✓ Medicaid only members get $150 allowance every two years to be used on one pair of eyeglasses (lenses and frames) or contact lenses and get one routine eye exam every two years. Dual eligible members receive a $300 yearly allowance and get one routine eye exam per year.
- ✓ Dual coverage members receive 12 additional routine foot doctor (podiatry) visits per year (including members who reside in a nursing facility); Members with only Medicaid who reside in a nursing facility can receive 4 additional podiatry visits per year.
- ✓ Up to $140 once a year: $35 gift card every three months for over-the-counter medicines and other medical or health-related supplies not covered by Medicaid, upon request.
- ✓ El Paso Health Members ages 18 years and older eligible for the Federal Lifeline Program and Affordable Connectivity Program are offered at no cost to the member the exclusive El Paso Health Unlimited Plan.
- ✓ Emergency response services for STAR+PLUS non-HCBS waiver members age 21 and older.
- ✓ Up to an extra 40 hours respite services for STAR+PLUS non-HCBS waiver members age 21 and older.
- ✓ Dual coverage members (including those who reside in a nursing facility) can receive a hearing aid allowance limited to $2,000 every year.
- ✓ Diabetic STAR+PLUS Non-HCBS waiver members can participate in the Healthy Eats Program and receive a $50 gift card each quarter to obtain nutritious food.

- ✓ Receive up to 14 healthy meals delivered to their home after being discharged from a hospital or nursing facility for STAR+PLUS non-HCBS waiver members 21 and older.
- ✓ Four additional nutritional counseling/meal planning services for diabetic STAR+PLUS non-HCBS waiver members 21 and older.
- ✓ STAR+PLUS Non-HCBS waiver members have a choice of the El Paso Health Get Fit Program at the YMCA or a home fitness kit, or both (for members with dual coverage only).
- ✓ $25 gift card for members after completing an annual wellness exam each year.
- ✓ $25 gift card for members that get an annual flu shot and COVID-19 vaccine.
- ✓ $25 gift card for members who have a follow-up doctor visit within 30 days of getting out of the hospital once a year.
- ✓ $25 gift card for members after completing an HbA1c blood test each year.
- ✓ $25 gift card for members after completing a diabetic eye exam each year.
- ✓ $25 gift card for female members ages 21-64 who get a recommended cervical cancer screening once every three years.
- ✓ $25 gift card for members that complete a doctor follow-up visit within 30 days of hospital discharge for a mental illness condition. Limit one gift card every 30 days.
- ✓ Receive a free personal blanket, skid proof socks, an accessory tote bag, and a large print digital clock.

Restrictions and limitations may apply.

SECTION 4: MEMBER INFORMATION

STAR AND STAR+PLUS MEMBER IDENTIFICATION

Your Texas Benefits Medicaid Card. Medicaid recipients received a plastic credit card-type ID. This new plastic card will take the place of the paper Medicaid ID letter (Form3087). Information on the new Medicaid ID card is included as **ATTACHMENT 14** of this manual. If Members lose the Your Texas Benefits Medicaid Card, they will be issued a temporary ID form 1027-A that they can present as proof of eligibility at Provider offices.

STAR MEMBER ELIGIBILITY

HHSC has identified the TANF, TANF related and those individuals receiving blind and disabled benefits living in the community as participants in the STAR Program. TANF and TANF related clients are primarily women and their dependent children under the age of 21. The following clients are NOT eligible for participation in STAR:

- Those with Medicare eligibility
- Those residing in a nursing home, intermediate care facility or MR facility
- Clients enrolled in the Medically Needy Program
- Live in an area excluded from the Texas STAR Program area
- Refugees

VERIFYING MEMBER MEDICAID ELIGIBILITY

Providers should verify Member eligibility prior to delivering services at each visit.

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's eligibility for the date of service prior to services being rendered. There are two ways to do this:

- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Call Provider Services at the patient's medical or dental plan.

Important: Members can request a new card by calling 1-800-252-8263. Members also can go online to order new cards or print temporary cards at www.YourTexasBenefits.com and see their benefit and case information, view Texas Health Steps Alerts, and more.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients. A copy is required during the appeal process if the client's eligibility becomes an issue.

El Paso Health Members are also issued an identification card that includes their date of birth and identifies their Primary Care Provider. Specialists must ensure that they have a referral from the Primary Care Provider whose name appears on the ID card. An example of an El Paso Health Membership ID card is included as **ATTACHMENT 7** of this manual.

All providers must verify eligibility before medical care is provided, except in cases of emergency. In an emergency situation, eligibility should be determined as soon as possible.

Providers can verify eligibility based on the effective date on the Members ID card, contacting El Paso Health Member Services at 915-532-3778 or accessing El Paso Health's Provider Portal at www.elpasohealth.com.

Disenrollment from El Paso Health

Member's disenrollment request from managed care will require medical documentation from Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment.

El Paso Health can request that a Member be terminated from the Plan only under certain conditions. HHSC will make the final decision on these requests.

El Paso Health has a limited right to request a Member be disenrolled from the plan without the Member's consent. HHSC must approve requests for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances (This list is not all inclusive):

- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow HMO to treat the underlying medical condition).
- Member is disruptive, unruly, threatening or uncooperative to the extent that Member's Membership seriously impairs HMO's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.

Providers cannot take retaliatory action against a Member.

Removal from Provider Panel

Providers may request that a Member be removed from his/her panel for the following reasons:

- The Member loans/gives their Membership identification card to another person for the purpose of obtaining services.
- The Member continually disregards the advice of his/her PCP.
- The Member repeatedly uses the emergency room in an inappropriate fashion.

The request to remove a Member from the panel must be in writing and sent to the El Paso Health Provider Relations Department. Before the Member is removed from the panel, there will

be an attempt at educating the Member to change his/her behavior. The Member has the right to appeal this attempt to remove him/her from the panel.

Neither the Provider nor El Paso Health can request a Member be removed based on a change in the Member's health or the utilization of services that are medically necessary for the treatment of the Member's condition.

If a Member loses Medicaid eligibility and then regains eligibility within six months, the Member is automatically reassigned to his or her previous plan and PCP.

Enrollment Broker Roles and Responsibilities

The Texas Department of Health and Human Services (HHSC) provides **MAXIMUS** updated information on the status of Medicaid, CHIP and CHIP Perinatal recipients who are eligible to participate in the STAR and CHIP programs. **MAXIMUS** is responsible for:

- Issuing enrollment packets in order to educate and enroll the recipients.
- The enrollment broker assists these clients in selecting a health plan.
- The management of information to HHSC and other state agencies using interface files.
- Providing updated changes and new Member enrollment information for rosters.
- Updating the Primary Care Provider (PCP) and Specialist lists for the HMOs based on the data submitted by El Paso Health.

Note: The date a Medicaid client becomes eligible for Medicaid and the effective date of enrollment in the health plan are not the same.

***Members can change health plans by calling the Texas STAR Program Hotline at 1-800-964-2777.** The Member has 30 Days to choose a health plan or one will be chosen for them by **MAXIMUS**. Benefits with the health plan usually begin on the first day of the next month following the selection of a plan and a PCP. A Member **cannot** change from one health plan to another health plan during an inpatient hospital stay.

If a Member calls to change health plans on or before the 15th of the month, the change will take place on the first day of the next month. If they call after the 15th 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 1st.
- If a request for plan change is made after April 15, the change will take place on June 1st.

The Texas Health and Human Services Commission (HHSC) is responsible for determining Medicaid, CHIP and CHIP Perinatal eligibility. Contact El Paso Health Member Services if you need information about or location of HHSC eligibility offices. The State's Enrollment Broker, **MAXIMUS**, is responsible for enrolling individuals into the STAR and CHIP programs. **MAXIMUS** can be contacted through the Texas STAR Program Hotline at 1-800-964-2777 or the CHIP Helpline at 1-800-647-6558. El Paso Health is not financially responsible for services until the actual date of enrollment.

Automatic Re-Enrollment

Members who are disenrolled because of temporary ineligibility will be automatically re-enrolled in the same health plan when they regain eligibility. Temporary loss of eligibility is defined as a period of six months or less. Members may also choose to enroll with another Medicaid managed care plan in their service area at that time if they so desire. Providers should use special caution to verify eligibility to determine if a plan change has occurred.

STAR+PLUS MEMBER ELIGIBILITY

STAR+PLUS Program

The STAR+PLUS program is designed to assist Medicaid recipients with chronic and complex conditions who require more than acute care services. STAR+PLUS integrates the delivery of acute care services and long-term services and supports (LTSS) to aged, blind and disabled Medicaid recipients through a managed care system. The STAR+PLUS program operates under the federal Medicaid waiver Home and Community-Based Services in order to mandate participation and to provide Home and Community-Based Services. HHS is the oversight agency for the STAR+PLUS program.

Mandatory Members

The following Medicaid-eligible individuals MUST enroll in the STAR+PLUS program:

- Supplemental Security Income (SSI) eligible 21 and over.
- Individuals 21 and over who are Medicaid eligible because they are in a Social Security exclusion program. These individuals are considered Medical Assistance Only (MAO) for purposes of HCBS STAR+PLUS (c) waiver eligibility.
- Dual eligible individuals who are 21 and over covered by both Medicare and Medicaid.
- Individuals 21 and over who reside in a nursing facility.
- Individuals age 18 to 64 and qualify for Medicaid for Breast and Cervical Cancer.

Voluntary Members

The following Medicaid-eligible individuals may opt to enroll in the STAR+PLUS program:

- Nursing facility resident, age 21 and over, who is federally recognized as a tribal member.
- Nursing facility resident, age 21 and over, who receives services through the Program of All-Inclusive Care for the Elderly (PACE).

Excluded Individuals

The following Medicaid-eligible individuals are excluded from participation in the STAR+PLUS program:

- Nursing facility residents who reside in the Truman W. Smith Children's Care Center or reside in a state Veterans home.
- Residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).
- Residents of institutions of mental disease or state hospitals.
- Children in the conservatorship of the Texas Department of Family and Protective Services (DFPS).
- Dual eligible (individuals who have both Medicare and Medicaid) who are residents of Intermediate Care Facilities for Persons with IID (ICF/IID) Community Living Assistance and Support Services.
- Persons enrolled in a waiver program other than the HCBS STAR+PLUS(c) nursing facility waiver program.
- Individuals not eligible for full Medicaid benefits (e.g., frail elderly program, Qualified Medicare Beneficiary [QMB], Service Limited Medicare Beneficiary [SLMB], Qualified Disabled Working Individual [QDWI], undocumented immigrants).
- Individuals receiving long-term care services through non-Medicaid funded programs.

To find additional information on Medicaid programs available to your patients, please visit: https://www.hhs.texas.gov/services/health/medicaid-chip.

Dual Eligible Members

Dual eligible are members that have both Medicare and Medicaid health insurance coverage. Medicare or the member's Medicare Health Maintenance Organization (HMO) is the primary payer and will reimburse all Medicare-covered services. The state Medicaid program serves as a secondary payer and will continue to reimburse Medicare co-insurance and deductibles for dual eligible members unless enrolled in El Paso Health's Medicare Advantage Special Needs Plans (SNP). El Paso Health will reimburse Long-Term Services and Supports (LTSS) covered under the STAR+PLUS program. El Paso Health STAR+PLUS benefits will not change or reduce any Medicare benefits for which a member is eligible. Members with traditional Medicare coverage may choose to use their existing Primary Care Providers (PCP), and may access specialty services without prior approval from El Paso Health. Dual eligible members do not have to select a separate PCP through El Paso Health for their LTSS services. The Service Coordinator will communicate and coordinate services with the member's Medicare PCP to ensure continuity of care.

Dual eligible members should notify their service coordinators that they have Medicare coverage, and will provide the name of their chosen PCP. Dual eligible members have identification cards that indicate Long-Term Care (LTC) services only, and must show their ID cards each time they receive El Paso Health STAR+PLUS covered services. Dual eligible members do not receive the unlimited prescription drug benefit because the delivery of primary and acute care services are beyond the scope of the Medicaid managed care program.

For dual eligible members, claims will process according to the member's Medicare insurance, and as per CMS guidance on processing Medicare Part D and/or Part B pharmacy claims. Medicare (part B or D) covered drugs and/or products must be billed to Medicare and/or commercial insurance (if there is commercial insurance on file) prior to billing Medicaid. For medications which are exclusions to CMS Medicare coverage, if the medications are included under the Medicaid formulary they will be adjudicated under the Medicaid benefit as a "wrap-around" drug. "Wrap-around" drugs/products include non-prescription (over-the-counter medications), some products used in symptomatic relief of cough and colds, limited home health supplies (LHHS) and some prescription vitamins and mineral products, which are identified on the HHS Drug Exception file. However, these wrap-around drugs/products must also follow Medicaid (Texas VDP) formulary. Please note:

- A member with a Medicare Advantage plan will not affect the coverage of wrap benefits.
- Over-the-counter "wrap-around" drugs require a prescription for Medicaid payment (these drugs will not be covered by Medicaid without a prescription).

Note: If a STAR+PLUS dual member has Medicare, Medicare is responsible for most primary, acute and behavioral health services. Therefore, the PCP's name, address and telephone number are not listed on the member's ID card.

CHIP PROGRAM MEMBER ELIGIBILITY

The State's Administrative Services contractor is responsible to provide El Paso Health with new Member and Member change information within five (5) Days of the beginning of the month, for that month's eligibility information. However, HHSC makes the final decision of enrollment for all CHIP Members.

Once enrolled with El Paso Health, a CHIP Member is enrolled for a period of twelve (12) months from the date the Member is first covered by the Plan. There is no retroactive enrollment in the CHIP program.

A CHIP Perinate (unborn child) who is born to a family with an income at or below 185% of the FPL will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker.

A CHIP Perinate mother in a family with an income at or below 185% of the FPL may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under 185% of the FPL will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the Doctor at the time of birth and returned to HHSC's enrollment broker.

A CHIP Perinate will continue to receive coverage through CHIP Perinatal as a "CHIP Perinate Newborn" if born to a family with an income above 185% to 200% FPL and the birth is reported to HHSC's enrollment broker.

A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus

11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

El Paso Health Members will be provided an ID card that serves as initial evidence that a patient is an El Paso Health Member. Please see **ATTACHMENT 8** for **CHIP**, **ATTACHMENT 9** for **CHIP Perinatal Mother** and **ATTACHMENT 10** for **CHIP Perinatal Newborn** for examples of Membership cards. The Member ID card is not a guarantee of enrollment or payment.

CHIP Cost Sharing Schedule

Co-payments for medical services or prescription drugs are paid to the health care provider at the time of service. CHIP Perinatal members and CHIP members who are Native American or Alaskan Native are exempt from all cost-sharing obligations, including enrollment fees and co-pays. Additionally, for all CHIP Members there is no cost-sharing on benefits for well-baby and well-child services, preventive services, or pregnancy-related assistance.

The El Paso Health ID card lists the co-payments that apply to the member's family situation. The member's ID card must be presented when they receive an office visit, emergency services, or have a prescription filled.

Federal Poverty Levels	Office Visit	None-Emergency ER	Prescription Generic Drugs	Prescription Brand Name Drugs	Facility Co-pay Inpatient (per admission)	Annual Co-pay Maximum
Native Americans	$0	$0	$0	$0	$0	None
At or below 151%	$5	$5	$0	$5	$35	5% of family's income
Above 151% up to and including 186%	$20	$75	$10	$35	$75	5% of family's income
Above $186% up to and including 201%	$25	$75	$10	$35	$125	5% of family's income

It is important that members keep track of their CHIP related expenses. This will help them know when they have reached their cap. When members reach their annual cap, they can contact HHSC. HHSC will contact El Paso Health and the health plan will issue a new ID card. This new card will show that no co-payments are due when the child receives services.

The member may also have to pay a premium, unless they are Native American or are at or below the 100% Federal Poverty Level. If the member needs to pay a premium, they will receive a bill from HHSC with the amount they need to send. If members have any questions regarding their premium, contact HHSC at **1-800-647-6558.**

If the member gets a bill from the child's doctor, they should call El Paso Health at **915-532-3778** or **1-877-532-3778.** A Member Services Representative will be happy to help. The member needs to have their El Paso Health ID card and the bill ready.

Determination by the Administrative Services Contractor Section

In the 10th month of coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated and will include CHIP Perinate Newborn's and CHIP Program Members currently receiving CHIP benefits.

El Paso Health Members are issued an identification card that includes their date of birth and identifies their PCP. Specialists must ensure that they have a referral from the PCP whose name appears on the ID card. The appropriate co-pays are noted on the card. An example of a CHIP Program Member ID Card is included as **ATTACHMENT 8** of this manual.

Providers can verify eligibility by verifying the effective date on the Members ID card by contacting Member Services line at 915-532-3778 or 1-877-532-3778 by accessing El Paso Health's Provider Portal at www.elpasohealth.com.

Plan Changes

Members are allowed to make health plan changes under the following circumstances:

- for any reason within 90 Days of enrollment in CHIP;
- for cause at any time;
- if the client moves to a different service delivery area; and,
- during the annual re-enrollment period.

HHSC will make final decision.

Disenrollment

The State's Administrative Services contractor is responsible to provide El Paso Health with new Member and Member change information within five (5) Days of the beginning of the month, for that month's eligibility information. However, HHSC makes the final decision of enrollment for all CHIP Members.

Disenrollment occurs due to loss of eligibility, including, but not limited to the following events:

- when a child turns nineteen
- failure to re-enroll at the conclusion of the twelve month eligibility period
- change in health insurance status, such as a child enrolling in an employer- sponsored insurance plan
- permanent move out of the state

- enrollment in Medicaid
- death of a child

Retaliation Prohibited

Providers cannot take retaliatory action against a Member.

El Paso Health will not take any retaliatory action, including refusal to renew coverage, against a CHIP Member because the Member or person acting on behalf of the Member has filed a complaint against El Paso Health or appealed a decision made by El Paso Health.

El Paso Health shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a physician or Perinatal Provider because the physician or Perinatal Provider has, on behalf of a Member, reasonably filed a complaint against El Paso Health or has appealed a decision made by El Paso Health**.**

CHIP PERINATAL MEMBER ELIGIBILITY

Enrollment

- 12-month eligibility for CHIP and CHIP Perinatal Members.
- The mother of the CHIP Perinatal has 15 Calendar Days from the time the enrollment packet is sent by the Enrollment Broker to enroll in a Managed Care Organization.

Newborn Process

When a Member of a household enrolls in CHIP Perinatal all traditional CHIP Members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Member's health plan if those health plans are different. All Members of the household must remain in the same health plan until the later of: (1) the end of the CHIP Perinatal Member's enrollment period, or (2) the end of the traditional CHIP Members' enrollment period. Co-payments, cost-sharing, and enrollment fees still apply to children enrolled in the CHIP Program.

In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Members' information. Once the child's CHIP Perinatal coverage expires, the child will be added to his or her siblings' existing CHIP case.

Plan Changes

A CHIP Perinate (unborn child) who lives in a family with an income at or below Medicaid Eligibility Threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker.

A CHIP Perinate mother in a family with an income at or below Medicaid Eligibility Threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under Medicaid Eligibility Threshold will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the Doctor at the time of birth and returned to HHSC's enrollment broker.

A CHIP Perinate will continue to receive coverage through the CHIP Program as a "CHIP Perinate Newborn" if born to a family with an income above Medicaid Eligibility Threshold and the birth is reported to HHSC's enrollment broker.

A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

CHIP Perinate mothers must select an MCO within 15 Days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 Days to select another MCO.

When a Member of a household enrolls in CHIP Perinatal, all traditional CHIP Members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Member's health plan if the plan is different. All Members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal Member's enrollment period, (2) the end of the traditional CHIP Members' enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Members' information. Once the child's CHIP Perinatal coverage expires, the child will be added to his or her siblings' existing CHIP program case.

CHIP Perinatal Members may request to change health plans under the following circumstances:

- for any reason within 90 Days of enrollment in CHIP Perinatal;
- if the Member moves into a different service delivery area; and,
- for cause at any time.

Disenrollment

The State's Administrative Services contractor is responsible to provide El Paso Health with new Member and Member change information within five (5) Days of the beginning of the month, for that month's eligibility information. However, HHSC makes the final decision of enrollment for all CHIP Members.

Disenrollment occurs due to loss of eligibility, including, but not limited to the following events:

- failure to re-enroll at the conclusion of the twelve-month eligibility period

- change in health insurance status, such as a child enrolling in an employer- sponsored insurance plan
- permanent move out of the state
- enrollment in Medicaid

Note:
The switch of the CHIP Members from their Managed Care Organization to the Managed Care Organization providing CHIP Perinatal coverage does not count as their one Managed Care Organization plan change per year.

- Members may request to change Managed Care Organizations for exceptional reasons or good cause.

Retaliation Prohibited

Providers cannot take retaliatory action against a Member.

El Paso Health will not take any retaliatory action, including refusal to renew coverage, against an UNBORN CHILD or CHIP Member because the UNBORN CHILD/Member or person acting on behalf of the UNBORN CHILD/Member has filed a complaint against El Paso Health or appealed a decision made by El Paso Health.

El Paso Health shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a physician or Perinatal Provider, because the physician or Perinatal Provider has, on behalf of an UNBORN CHILD, reasonably filed a complaint against El Paso Health or has appealed a decision made by El Paso Health**.**

Verify Eligibility for Service

El Paso Health Members are issued an identification card that includes their date of birth and identifies their PCP. Specialists must ensure that they have a referral from the PCP whose name appears on the ID card. A copy of the CHIP Perinatal (Newborn) ID card is included as **ATTACHMENT 10** and Perinatal (Mother) ID card as **ATTACHMENT 9.**

NOTE: CHIP Perinatal newborns are not responsible for co-pays during the 12 month enrollment period.

Pharmacy Providers can verify eligibility electronically for example through NCPDP E1 Transaction.

Providers can verify eligibility by verifying the effective date on the Members ID card, contacting Member Service at 915-532-3778 or 1-877-532-3778 accessing El Paso Health's Provider Portal at www.elpasohealth.com

Member Portal and Mobile App

El Paso Health Members can now stay connected with El Paso Health's Member Portal and Mobile App!

El Paso Health's member portal and mobile app are convenient and secure tools to help them manage their health care. By downloading the app and/or accessing the member portal website; they can create a free account, that will allow them to:

- View and print a temporary ID
- View eligibility coverage information
- Find a Provider or request a PCP change
- View authorizations
- View claims

Members can access the Member Portal on our website at www.elpasohealth.com, by clicking on the Member Portal Login. Members can also access the mobile app by downlaoding the free app to their mobile devices through the Apple App Store or Google Play.

If you have questions or concerns about the El Paso Health's member portal or mobile app, call Member Services at 1-877-532-3778.

SECTION 5: ROUTINE, URGENT AND EMERGENCY SERVICES

Based on the following definitions, Members of El Paso Health may seek care from any Provider in an office, clinic, or emergency room. Treatment of emergency conditions does not require pre-certification or a referral from the Member's PCP. Emergency Room (ER) staff is requested to call the PCP or El Paso Health if a Member presents with a non-emergent condition at 915-532-3778 ext. 1500.

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

An ***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 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

An ***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:

1. Place the patient's health in serious jeopardy;
2. Result in serious impairment to bodily functions;
3. Result in serious dysfunction of a bodily organ or part;
4. Result in serious disfigurement; or
5. For a pregnant woman result in serious jeopardy to the health of the fetus.

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. Renders Members incapable of controlling, knowing or understanding the consequences of their actions.

A Member may select any Provider or hospital for true emergency care.

El Paso Health will pay for professional, facility, and ancillary services provided in a hospital emergency department that are medically necessary to perform the medical screening examination and stabilization of a Member presenting with an Emergency Medical Condition or an Emergency Behavioral Health Condition, whether rendered by Network Providers or Out-of-Network providers.

Emergency care obtained out-of-network and out of El Paso Health's service area will be reviewed as soon as notification is received.

El Paso Health will not require prior authorization as a condition for payment for an Emergency Medical Condition, an Emergency Behavioral Health Condition, or labor and delivery. El Paso Health will not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. El Paso Health will not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP or El Paso Health of the Member's screening and treatment within ten (10) Calendar Days of presentation for Emergency Services.

El Paso Health will pay for post-stabilization care services obtained within or outside the Network that are not pre-approved by a Provider or other El Paso Health representative, but administered to maintain, improve, or resolve the Member's stabilized condition if:

- El Paso Health does not respond to a request for pre-approval within one (1) hour;
- El Paso Health cannot be contacted; or
- El Paso Health representative and the treating physician cannot reach an agreement concerning the Member's care and a Network physician is not available for consultation. In this situation, El Paso Health will give the treating physician the opportunity to consult with a Network physician and the treating physician may continue with care of the patient until a Network physician is reached. El Paso Health's financial responsibility ends as follows:
- the Network physician with privileges at the treating Hospital assumes responsibility for the Member's care;
- the Network physician assumes responsibility for the Member's care through transfer;
- El Paso Health's representative and the treating physician reach an agreement concerning the Member's care; or
- the Member is discharged.

APPOINTMENT ACCESSIBILITY

Providers must assure that Members have access to routine, urgent, and emergent services within the following time frames:
(in this section, days refers to calendar days)

1. Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;
2. Urgent care, including urgent specialty care and behavioral health services, must be provided within 24 hours of request; treatment for behavioral health services may be provided by a licensed behavioral health clinician.
3. Primary Routine Care must be provided within 14 Days of request;
4. Specialty Routine Care must be provided within 21 Days;
5. Initial outpatient behavioral health visits must be provided within 14 Days of request;

6. Specialty Therapy evaluations must be provided within 21 Days of submission of a signed referral. If an additional evaluation or assessment is required (e.g. audiology testing) as a condition for authorization of therapy evaluation services, the additional required evaluation or assessment should be scheduled to allow the Specialty Therapy evaluation to occur within 21 Days from date of submission of a signed referral;
7. Referrals for routine specialty care must be provided within 5 Days of request;
8. Pre-natal care must be provided within 14 Days of request, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within 5 Days, or immediately, if an emergency exists;
9. Preventive health services for adults (21 years and older) must be offered within 90 Days of request; and
10. Preventive Health Services for children less than 6 months of age must be provided within 14 Days of request. For children 6 months to 20 years of age, services must be provided within 60 Days of request. CHIP Members should receive preventive care in accordance with the American Academy of pediatrics (AAP) periodicity schedule. Medicaid Members should receive preventive care in accordance with the Texas Health Steps periodicity schedule. MCOs must encourage new Members 20 years of age or younger to receive a Texas Health Steps checkup within 90 Days of enrollment. For purposes of this requirement, the terms "New Member" is defined in Chapter 12.4 of the UMCM.
11. Community-based LTSS must be initiated by the state date on the ISP or Service Plan; or in the case of a Change of Condition within 7 days of the ISP or Service Plan effective date, unless request otherwise stated and documented by the referring Provider or Member.
12. Case Management for Children and Pregnant Women services must be provided within 14 calendar days of.

NEMT TRANSPORTATION SERVICES

El Paso Health is committed to providing accessibility to all healthcare needs of Members by facilitating transportation to obtain covered services, supplies, or equipment.

Non-emergency transportation

Members requesting help in finding transportation to a non-emergency appointment with a network Provider must be:

- Over age 18 years (unless accompanied by their parent or legal guardian), or emancipated due to pregnancy.
- Eligible for services on the scheduled appointment date.
- Have no other means of transportation to his/her healthcare Provider.

Members may call the Member Services Department at 915-532-3778 to request transportation services. Transportation should be requested at least 48 hours before the scheduled appointment. The following Member information must be provided to the intake operator at the time of the call:

- Medicaid ID number.

- Name, address, and telephone number.
- Name, address, and telephone number of the healthcare Provider.
- Purpose of the trip.
- Confirmation that no other means of transportation are available.
- Special needs, wheelchair lift, or attendant need.

Transportation Limitations

Members and their attendants are **not** eligible to receive medical transportation services under the following circumstances:

- Transportation to or from a day activity health services facility, personal care home, state institution, nursing facility (unless the Member requires dialysis treatment), or facility participating in another Title XIX program for which the reimbursement rate structure includes transportation funds
- Transportation when the Member or another person or entity providing care for the Member receives direct payment of worker's compensation benefits, U.S. Department of Veterans Affairs benefits, or other third-party resources for transportation to healthcare services on the Member's behalf
- Transportation when the Member is an inpatient in a healthcare facility
- Transportation of deceased Members

Emergency Transportation

Emergency transport is a service provided by an ambulance Provider for a Member whose condition meets the definition of an emergency medical condition. Conditions requiring cardio pulmonary resuscitation (CPR) in transit or the use of routine restraints for the safety of the Member or crew are also considered emergencies.

Emergencies include medical conditions for which the absence of immediate medical attention could reasonably be expected to result in serious impairment, dysfunction, or failure of one or more organs or body parts, and the required emergency treatment is not available at the first facility. Claims for such transports must document the aforementioned criteria. Emergency transports do not require prior authorization.

Examples of conditions considered for emergency transports include, but are not limited to:

- Acute and severe illnesses
- Untreated fractures
- Loss of consciousness
- Semi-consciousness
- Seizures
- Necessity for CPR
- Injuries from auto accidents
- Extensive burns

Non-Emergency Ambulance Transportation

Effective April 1, 2016 all medically necessary non-emergency ambulance transports (service provided to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the Member's home after discharge when the Member has a medical condition such that the use of an ambulance is the only appropriate means of transportation) provided for a Medicaid member will require the authorization to **be obtained by a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party** (other responsible parties include staff working with a health care service provider submitting prior authorization on behalf of the provider or facility).

An ambulance provider may not request a prior authorization for non-emergent ambulance transports. The ambulance provider is responsible for ensuring that a prior authorization has been obtained prior to transport; non-payment may result for services provided without a prior authorization or when the authorization request is denied.

ROLE OF MAIN DENTAL HOME

Dental Services

Dental plan Members may choose their Main Dental Homes. Dental plans will assign each Member to a Main Dental Home if he/she does not timely choose one. Whether chosen or assigned, each Member who is six (6) months or older must have a designated Main Dental Home.

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

Medicaid Emergency Dental Services

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

- treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- treatment of oral abscess of tooth or gum origin

CHIP Emergency Dental Services

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

- treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- treatment of oral abscess of tooth or gum origin

Medicaid Non-Emergency Dental Services

El Paso Health is **not responsible** for paying for routine dental services provided to Medicaid Members. These services are paid through Dental Managed Care Organizations.

El Paso Health is **responsible** for paying for treatment and devices for craniofacial anomalies, and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members age 6 months through 35 months.

The intermediate oral evaluation with fluoride varnish application must be billed on the same date of service as a medical checkup or an exception to the periodicity visit (procedure code S-99381, S-99382, S-99391, or S-99392) and is limited to 6 services per lifetime by any Provider. Procedure code 99429 must be billed with modifier U5 and diagnosis code V202. Federally qualified health centers (FQHCs) must submit modifier EP in addition to modifier U5 when billing procedure code S-99429).

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

- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist Members with establishing a Main Dental Home.

CHIP Non-Emergency Dental Services

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

El Paso Health is **responsible** for paying for treatment and devices for craniofacial anomalies**.**

How to Help a Member Find Dental Care

The Dental Plan Member I.D. card lists the name and phone number of the Member's Main Dental Home Provider. The Member can contact the Dental Plan to select a different Main Dental Home Provider at any time. If the Member selects a different Main Dental Home Provider, the change is reflected immediately in the dental plan's system and the Member is mailed a new I.D. card within five (5) Business Days.

If a Member does not have a dental plan assigned or is missing a card from a dental plan, the Member can contact the Medicaid/CHIP enrollment broker's toll free telephone number at 1-800-964-2777.

EMERGENCY PRESCRIPTION SUPPLY

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the Member's medical condition. If the prescribing Provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- "8" in "Prior Authorization Type Code" (Field 461-EU).
- "8Ø1" in "Prior Authorization Number Submitted" (Field 462-EV).
- "3" in "Days' Supply" (Field 4Ø5-D5, in the Claim segment of the billing transaction)
- The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed, e.g. an inhaler, it is still permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispense.

Call Navitus, El Paso Health's Pharmacy Benefit Manager, toll-free at 1-877-908-6023 for more information about the 72-hour emergency prescription supply policy.

72-hour Emergency Prescription Rejection Message

The following message will be returned to pharmacies on all electronically-submitted claims that the PBM rejects because the prior authorization criteria have not been met:

"Prior Authorization Required. Prescriber call 877-908-6023 or RPH should submit 72HR Emergency fill if Dr. not available."

CHIP Member Prescriptions

CHIP Members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-Day supply of a drug.

For additional information about the 72-hour emergency prescription supply, call Navitus, El Paso Health's Pharmacy Benefit Manager, at 1-877-908-6023.

SECTION 6: TEXAS HEALTH STEPS

TEXAS HEALTH STEPS OVERVIEW

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is Medicaid's comprehensive preventive child health service for children, adolescents and young adults birth through 20 years of age. In Texas, EPSDT is known as Texas Health Steps. EPSDT was defined by federal law as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 and includes periodic screening, vision, hearing, and dental preventive and treatment services. These additional services are available through the Comprehensive Care Program (CCP). For information regarding Texas Health Steps please refer to the most current issue of the Texas Medicaid Provider Procedures Manual.

STATUTORY REQUIREMENTS

Several specific legislative requirements affect the Texas Health Steps Program and the providers participating in the program. Please refer to the current Texas Medicaid Provider Procedures Manual for information regarding Texas Health Steps and Comprehensive Care Program services, including private duty nursing, prescribed pediatric extended care centers, and therapies. Some of the requirements include, but are not limited to, the following:

- The *Health and Safety Code* (HSC), Chapter 33, Section §33.011, implemented by the rules found at 25 TAC, Part 1, Chapter 37, Subchapter D, requires testing of all newborns for phenylketonuria (PKU), other heritable diseases, or hypothyroidism. A current list of 27 disorders is found at www.dshs.state.tx.us/newborn/quickreference.shtm
- Parental Accompaniment, as outlined in Appendix K of the Texas Health Steps Statutory Requirements, "Parental Accompaniment" HRC §§32.024(s)-(s-1) requires, as a condition for Provider reimbursement, a child 14 years of age or younger be accompanied by the child's parent, guardian, or other authorized adult during medical and dental checkups and dental treatment. DSHS implemented this requirement through rules found in 25 TAC §33.2 (Definitions) and 25 TAC §33.6 (THSteps Provider Responsibilities).
- Professionals, as defined in TFC §261.101 (b), are required to report abuse or neglect no later than the 48th hour after the hour in which the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.
- ECI is a coordinated system of services available in every Texas County for children who are birth through 36 months of age with disabilities or delays. ECI is federally and state funded through the Title 20 *Individuals with Disabilities Education Act* (IDEA), Chapter 33, and *Texas Human Resources Code* (HRC), Chapter 73. ECI provides support to families to help their children reach their potential through developmental services.
- Reports of Childhood Lead Poisoning, Chapter 88, Health & Safety Code, and Title 25 Texas Administrative Code (TAC), Chapter 37. The Texas Childhood Lead Poisoning Prevention Program (TXCLPPP) maintains a surveillance system of blood lead results on

children younger than 15 years of age. Texas law requires reporting of blood lead tests, **elevated** and **non-elevated**, for children younger than 15 years of age. Physicians, laboratories, hospitals, clinics, and other healthcare facilities must report all blood lead tests to the Texas Child Lead Registry.

- Teen Confidentiality Issues. The Department of State Health Services has developed the *Adolescent Health Guide*, designed for health care providers, social workers, counselors, teachers and other professionals who provide services, information, and support to young people. It offers guidelines on health and health-related legal issues pertinent to the adolescent years.

Texas Health Steps is the Medicaid healthcare program for children, teens and young adults, birth through age 20, covering comprehensive medical checkups and treatment services. Texas Health Steps medical checkups are important and should be set up within 60 Days of becoming an El Paso Health Member. Even if a child looks and feels good, he or she may still have a health problem that needs to be treated. Effective July 1, 2009 as per the *Frew v. Suehs'* Corrective Action Order: Healthcare Provider Training, HHSC must recognize Medicaid enrolled health care providers who complete training on *Frew* and/or Texas Health Steps related topics. HHSC and DSHS recognize providers on a quarterly basis on the HHSC website. The *Frew* Provider training recognition requirement also requires that providers will be given an opt-out option if they choose not to be recognized by HHSC for completing the required training. El Paso Health encourages their health care providers to take the training modules available through the DSHS Online Provider Education located on the DSHS website at http://www.txhealthsteps.com. All Texas Health Steps Providers who have their own practice or belong to a group are required to complete the Online Modules. Additional information may be found on the website. You can also access this link at the El Paso Health website by clicking at: http://www.elpasohealth.com/providers/texas-health-steps-information-for-providers/ and selecting ***Texas Health Steps Online Provider Education***.

DOCUMENTATION OF COMPLETED TEXAS HEALTH STEPS COMPONENTS AND ELEMENTS

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

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

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

1. **Comprehensive health and developmental history** which includes nutrition screening, developmental and mental health screening and TB screening
    - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
2. **Comprehensive unclothed physical examination** which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening
    - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.
3. **Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
    - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule-United States," unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
    - The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
    - Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
    - Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit https://www.dshs.texas.gov/immunize/tvfc/.
4. **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia
    - Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
    - Anemia screening at 12 months.
    - Dyslipidemia Screening at 9 to 12 years of age and again 18-20 years of age
    - HIV screening at 16-18 years

- Risk-based screenings include:
    - dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.

5. **Health education** (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.
6. **Dental referral** every 6 months until the parent or caregiver reports a dental home is established.
    - Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

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

Exceptions to the Periodicity Schedule

On occasion, a child may require a Texas Health Steps checkup that is outside of the recommended schedule. Such reasons for an exception to periodicity include:

- Medical necessity (developmental delay, suspected abuse).
- Environmental high-risk (for example, sibling of child with elevated lead blood level).
- Required to meet state or federal exam requirements for Head Start, day care, foster care or pre-adoption.
- Required for dental services Provider under general anesthesia.

Exceptions to periodicity must be billed on the CMS 1500 and should comply with the standard billing requirements as discussed in the Section entitled “Filing Encounters and Claims”.

If a Provider other than the PCP performs the Exception to Periodicity medical checkup, the PCP must be provided with medical record information. In addition, all necessary follow-up care and treatment must be referred to the PCP.

Newborn Screening

Inpatient newborn examinations billed with newborn procedure codes 99460, 99461, or 99463 are counted as Texas Health Steps medical checkups and should not be billed with modifier 52. The descriptions of these newborn exam codes reflect the completion of all the Texas Health Steps checkup components. Newborn screening must include, at a minimum, the components listed below:

- Family and neonatal history

- Physical Exam (including height, weight and head circumference)
- Vision and Hearing Screening
- Health Education/Anticipatory Guidance
- State-required newborn hereditary / metabolic test
- Hepatitis B immunizations
- Newborn screening for critical congenital heart disease (CCHD) performed in the birth facility in accordance with Health and Safety Code (HSC), Chapter 33, §§ 33.011, and the Texas Administrative Code (TAC), Title 25, Part 1, Chapter 37, Subchapter E, §§ 37.75 – 37.79.

Newborn Testing

Any Provider attending the birth of a baby must require newborn hereditary/metabolic testing on all newborns as required by Texas law. All infants must be tested a second time at 3 to 5 Days of age.

These tests must be submitted to the DSHS Laboratory Services Section. For complete information, instructions and newborn screening forms contact:

DSHS Laboratory Services Section
1100 West 49th Street
Austin, Texas 78756-3199
512-458-7318
www.dshs.state.tx.us/lab/default.shtm

Texas Health Steps and Laboratory Testing

Laboratory specimen collection testing materials, and necessary forms and supplies are made available free of charge to all Texas Health Steps providers. For forms and supplies providers should contact:

DSHS Laboratory Services Section
1100 West 49th Street
Austin, Texas 78756-3199
512-458-7318
www.dshs.state.tx.us/lab/default.shtm

Providers may not bill for supplies and services provided by the DSHS laboratory.

Tests for hemoglobin/hematocrit, Chlamydia, gonorrhea, and lead must be sent to the DSHS lab, with the exception of point-of-care testing in the Provider's office for the initial lead specimen. All other tests may be sent to the lab of the Provider's choice.

TEXAS VACCINES FOR CHILDREN PROGRAM

The Texas Vaccines for Children (TVFC) Program is a federally funded, state-operated vaccine distribution program. It provides vaccines free of charge to enrolled providers for administration to individuals birth through 18 years of age.

Qualified Medicaid and CHIP Providers can enroll in the TVFC Program by completing the TVFC Provider Enrollment Application form from the DSHS TVFC web page http://www.dshs.state.tx.us/immunize/tvfc/default.shtm

El Paso Health will pay for TVFC Program Provider's private stock of vaccines, but only when the TVFC posts a message on its website that no stock is available. In that case, providers should submit claims for vaccines with the "U1" modifier, which indicates private stock. Providers should only submit claims for private stock until the vaccine is available from TVFC again. El Paso Health will no longer reimburse providers for private stock when the TVFC stock is replenished.

DSHS Region 9 & 10 – El Paso
401 E. Franklin
El Paso, Texas 79901
915-834-7675

TEXAS HEALTH STEPS DENTAL CHECKUPS

Patients should be encouraged to visit a Texas Health Steps dental Provider for routine dental exams.

Dental exams are required once every six months from the last date of dental service for Medicaid clients age 6 months through 20 years.

If dental exams result in treatment requiring a facility or anesthesia charge, the dentist must contact El Paso Health for prior approval.

Starting March 1, 2012, Members will need to go to the dentist they picked. All children and young adults age 20 and younger with Medicaid need to pick a dental plan.

Individuals who are receiving Medicaid and who meet the conditions listed below will continue to receive dental services through their existing service delivery models and not through Medicaid and CHIP Dental Managed Care:

- Medicaid clients who are 21 years of age and older.

  91 Last Revision: 01-13-12
- All Medicaid clients, regardless of age, who reside in Medicaid-paid facilities such as nursing homes, state supported living centers or intermediate care facilities for mentally retarded persons (ICF/MR).
- STAR Health Program clients (foster care).

With a dental plan, children will get the same Medicaid dental services they do now:

- Regular dental checkups starting at 6 months of age.
- Services to keep teeth healthy like cleanings, exams, and tips for good health.
- Services like fillings, crowns, and root canals when needed.
- Emergency dental services.

Each dental plan also gives these benefits:

- A main dentist who takes care of a child's basic dental needs.
- A list of dental specialists.
- Extra services not covered by Medicaid. These extra services are called value-added services.

If a Member wants to change their dental plan, they must call 1-800-964-2777 (toll-free) or TTY 1-800-267- 5008. You can call Monday to Friday, 8 a.m. to 8 p.m. Central Time.

CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

This is another Texas Health Steps service available to children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and have health problems or are at risk for getting health problems.

A case manager will visit with them:

- Find out what services they need.
- Find services near where they live.
- Teach them how to find and get other services.
- Make sure they are getting the services they need.

Case managers can help them:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

Providers or Members can call Texas Health Steps Case Management for Children and Pregnant Women by calling 1-877-847-8377 (toll-free), Monday to Friday, 8 a.m. to 8 p.m. To learn more, go to: www.dshs.state.tx.us/caseman

Members will still have access to an El Paso Health STAR+PLUS case manager for all other case management services. For additional benefit details and requirements, refer to the Texas

Medicaid Provider Procedures Manual Behavioral Health and Case Management Services Handbook at https://www.tmhp.com/resources/provider-manuals/tmppm

SERVICE COORDINATION

Role of the El Paso Health Service Coordinator

Service coordination means specialized care management services performed by a licensed, certified and/or experienced person called a service coordinator. This includes but is not limited to:

- Identifying a member's needs through an assessment.
- Documenting how to meet the member's needs in a care plan.
- Arranging for delivery of the needed services.
- Establishing a relationship with the member and acting as an advocate for the member in coordinating care.
- Coordinating different types of services.
- Making sure the member has a PCP.

A service coordinator works as a team with the member and the PCP to arrange all services the member needs to receive, including services from specialists and behavioral health providers (if needed). A service coordinator helps ensure that all of the member's health care needs are met.

The EPH Service Coordinator will coordinate and collaborate with providers to ensure members have access to medical, social, and education services related to their health condition, health risk, or high-risk (pregnancy) condition.

EPH Service Coordinators are available to assist with coordination of services such as, but not limited to:

- Referrals to medical/mental/behavioral services
- Referrals to covered benefits and services such as WIC, ECI, OT, PT, ST,
- Access to educational services related to the Member's health condition,
- Dental services for pregnant members
- SSI referrals

To reach an El Paso Health Service Coordinator you may contact 915-532-3778 or toll free at 1-877-532-3778 for STAR, and toll free at 1-833-742-3127 for STAR+PLUS.

Discharge Planning

El Paso Health will promptly assess the needs of a member discharged from a hospital, nursing facility, or other care or treatment facility. A service coordinator will work with the member's PCP, the hospital or nursing facility discharge planner, the attending physician, the member, and the member's family to assess and plan for the member's discharge. When long-term services

and supports are needed, we will ensure the member's discharge plan includes arrangements for receiving community-based care whenever possible. The service coordinator will provide information to the member, the member's family and the member's PCP regarding all service options available to meet the member's needs in the community.

Transition Plan for New El Paso Health STAR+PLUS Members

El Paso Health will provide a transition plan for a member newly enrolled with El Paso Health STAR+PLUS who is already receiving long-term services and supports, including nursing facility services. HHSC, or the previous STAR+PLUS MCO, will give us information such as detailed care plans and names of current providers. We will ensure that current providers are paid for medically necessary and functionally necessary covered services that are delivered in accordance with the member's existing care plan beginning with the member's date of enrollment with El Paso Health's STAR+PLUS program until the transition plan is developed and implemented.

Role of the STAR+PLUS Service Coordinator

Service Coordination is a special program offered by El Paso Health to help members manage their health, long-term and behavioral health care needs. EPH will furnish a Service Coordinator to all STAR+PLUS Members in the Nursing Facility. EPH will ensure that each STAR+PLUS Member has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, serves as a central point of integration and coordination of Covered Services, including primary, Acute Care, Long-term Services and Supports, and Behavioral Health Services. The Service Coordinator will work as a team with the PCP to coordinate all STAR+PLUS Covered Services and any applicable Non-capitated Services. All Care coordinator staff members can assist with basic inquires. If additional follow up is needed, the assigned Service Coordinator will contact the provider or member within 24 hours. We provide a single identified person as a service coordinator to all El Paso Health STAR+PLUS members, not limited to level 1, 2, and 3. The member will be notified by letter of the name and direct telephone number of their assigned personal service coordinator.

COMPREHENSIVE CARE PROGRAM (CCP) COORDINATION

CCP is an expansion of the Texas Health Steps program. CCP services are designed to treat and improve specific physical and mental health problems of STAR and STAR+PLUS children, adolescents and young adults discovered during the Texas Health Steps checkup.

Providers should follow the Referral and Prior Authorization procedures as outlined in Section 9, for all services.

CHILDREN OF MIGRANT FARMWORKERS

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup.

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

TEXAS HEALTH STEPS PROVIDER

A Provider must be an enrolled **Texas Health Steps Provider** in order to conduct and be reimbursed for Texas Health Steps medical and dental checkups. The Texas Medicaid Healthcare Partnership (TMHP) is responsible for Medicaid Provider enrollment in Texas and a link to the Provider application can be found at www.tmhp.com

Remember that a child may go to any Medicaid ***Texas Health Steps Provider*** for Texas Health Steps medical checkups but they must go to the dentist they picked when they picked their dental plan. Most of the El Paso Health PCPs who work with children are also able to offer Texas Health Steps services. Members are issued an El Paso Health Premier Plan ID card and Your Texas Medicaid Benefits ID card as proof of eligibility. Providers are responsible for verifying the Member's eligibility for a Texas Health Steps checkup. Providers may refer to the Texas Medicaid Provider Procedures Manual for more Texas Health Steps information.

El Paso Service Area Texas Health Steps Regional Office

The Department of State Health Services regional office for Culberson, El Paso and Hudspeth Counties is located in El Paso. DSHS regional staff for the El Paso Service Area are available at:

401 E. Franklin #210
El Paso, Texas 79901
915-834-7675
Fax: 915-834-7799

If you need assistance or have questions regarding the Texas Health Steps Program you can contact the Department of State and Human Services Provider Relations staff regarding how to enroll as a Texas Health Steps Provider or how to obtain supplies from the state as well as if you need an overview on the Program's components and history. However, if you have questions regarding Texas Health Steps claims status or need to know your progress regarding Texas Health Steps checkup completion for your Membership with El Paso Health please contact Rosalinda Medina, C.A.R.E. Unit Manager at 915-532-3778 Ext. 1161. We can also provide training for your staff on the Program components and additional services part of Texas Health Steps as well as El Paso Health initiatives to increase Member compliance.

SECTION 7: QUALITY IMPROVEMENT PROGRAM

El Paso Health's Quality Assessment and Performance Improvement Program (QAPI) is designed to evaluate and measure the degree of quality healthcare our Members receive and the quality of services we offer to our Members and to you our Provider. The aim of the QAPI is to assure that the healthcare Members receive is optimal and consistent with the mission of El Paso Health. Our commitment is to improve the health status of the Members we serve through an integrated Quality Improvement (QI) approach to health and social services. El Paso Health's QAPI is actively involved in the following aspects:

- Accessibility & Availability Surveys
- Clinical Practice Guidelines
- Inter-Rater Reliability Audit
- Medical Record Review
- Member Events Review
- Member Complaints
- Process Improvement
- Provider Profiling
- Studies & UM Reporting
- Quality Improvement Committees

Your partnership is paramount in the success in any of our QI initiatives and in fulfilling the requirements mandated by Texas Health and Human Services Commission (HHSC) and Texas Department of Insurance (TDI). For this reason, we highly encourage your participation in our quality improvement endeavors to continuously improve the delivery of healthcare services that are coordinated to meet Member needs in a timely, safe, efficient, effective and caring manner.

ACCESSIBILITY & AVAILABILITY SURVEYS

El Paso Health's QI Department monitors our Primary Care Providers (PCP), OB, Specialist, LTSS, and Behavioral Health Providers on an annual basis for appointment accessibility compliance. In addition, PCPs are assessed for 24 hour availability. El Paso Health's QI Department will coordinate annual Office Accessibility & 24 hour Availability Surveys. Here's an in depth look at how this process works.

El Paso Health's QI personnel will conduct a random sampling of the Provider network every quarter. Based on compliance with El Paso Health's A & A standards our Providers may be surveyed more than once a year.

El Paso Health Members must be able to schedule an appointment for covered services within the time frames mandated by TDI and HHSC.

The standards for Providers are as follows:
(in this section, days refers to calendar days)

1. **Emergency Services** must be provided upon member presentation at the service delivery site, including at non-network and out-of-area facilities.
2. **Urgent Care** including specialty urgent care and behavioral health services must be provided within 24 hours of request.
3. **Routine Primary Care** must be provided within 14 Days of request.
4. **Specialty Routine Care** must be provided within 21 Days of request.
5. **Initial Outpatient Behavioral Health** visits must be provided within 14 Days of request.
6. **Specialty Therapy** evaluations must be provided within 21 Days of submission of a signed referral. If an additional evaluation or assessment is required (e.g. audiology testing) as a condition for authorization of therapy evaluation services, the additional required evaluation or assessment should be scheduled to allow the Specialty Therapy evaluation to occur within 21 Days from date of submission of a signed referral;
7. **Routine Specialty Care** referrals must be provided within 5 Days of request.
8. **Pre-natal Care** must be provided within 14 Days of request, except for high-risk pregnancies or new members in the third trimester, for whom an appointment must be offered within 5 Days, or immediately, if an emergency exists.
9. **Preventive Health Services** for adults (21 years and older) must be provided within 90 Days of request.
10. **Preventive Health Services** for children less than 6 months of age must be provided within 14 Days of request. For children 6 months to 20 years of age, services must be provided within 60 Days of request.
11. **Community-based LTSS** must be initiated by the state date on the ISP or Service Plan; or in the case of a Change of Condition within 7 days of the ISP or Service Plan effective date, unless otherwise stated and documented by the referring Provider or Member.
12. **Case Management for Children and Pregnant Women** services must be provided within 14 calendar days of request.

TDI and HHSC have also established that a member wait at the office should not be longer than 15 minutes to be taken to the exam room.

As mandated by TDI and HHSC all PCPs must be available 24 hours, 7 days a week. If the Provider delegates this duty, the covering Provider must also be available 24 hours, 7 days a week.

The standards for 24-hour availability are as follows:

1. Answering service meets language requirements of that for major population groups. Answering service must be able to contact the Provider or other designated medical practitioner.

2. Recording meets language requirements. Directs patient to call another phone number to reach the Provider or designated medical practitioner. Other phone number provided must be answered by someone at the time of call.
3. Call is transferred to an on-call person. Call meets language requirements. Person on-call must be able to reach the Provider or designated medical practitioner to return call to patient.

Once the Provider is paged, he/she or the designated medical practitioner must return call within 30 minutes.

The following is considered ***non-acceptable*** criteria:

1. Office telephone is only answered during office hours.
2. Office telephone is answered by a recording that tells patients to leave message.
3. Office telephone is answered by a recording that tells patient to go to an Emergency Room for services needed.
4. Returning after-hours calls past 30 minutes.
5. Member is informed of a fee for after hour calls.

The results of the Provider Accessibility and Availability surveys will be recorded on the QI Credentialing Report as well as any Provider Profiling reports conducted by El Paso Health. Results are also shared with the Credentialing and Peer Review Committee (CPRC) and the Quality Improvement Committee (QIC).

CLINICAL PRACTICE GUIDELINES

El Paso Health defines clinical practice guidelines as practice parameters, recommendations, or an agreed upon set of principles for the delivery of a certain type or aspect of health care. El Paso Health's Quality Improvement Committee (QIC) has adopted guidelines that are developed primarily to address Members' physical, behavioral health, social needs and specific identified opportunities for improvement, such as high risk or problem/prone diagnoses and conditions. Our Practice Guidelines are designed to address the needs of our Members.

You can obtain a copy of our Practice Guidelines in one of the following methods:

- Contacting the Quality Improvement Department at 915-532-3778 or toll free at 1-877-532-3778.
- El Paso Health website at http://www.elpasohealth.com/ under the Providers section tab, Quality Improvement Program link.

INTER-RATER RELIABILITY AUDIT

El Paso Health's QI Department monitors authorization process within the Health Services Department. El Paso Health's QI personnel conduct regular Inter-Rater Reliability (IRR) audits on the Prior Authorization, Behavioral Health and Utilization Review Units to ensure there is a

consistent application of review criteria and uniform decision-making. The audit determines if authorizations maintain consistency and accuracy based on clinical criteria and/or the Medical Director review. An effective authorization process is beneficial to our organization, Members and you, the Provider. Please contact our Health Services Department at ***915-532-3778 or toll-free 877-532-3778*** if you would like to have a copy of the clinical guidelines our medical staff utilizes when making Utilization Management and Prior-Authorization determinations.

MEDICAL RECORD REVIEW

In accordance with the standards set forth by HHSC and TDI, El Paso Health Providers are expected to maintain medical records in a current, detailed, and comprehensive manner that conform to good, professional medical practices. El Paso Health employs the American Medical Association (AMA) and National Committee for Quality Assurance (NCQA) medical record standards such as documentation legibility, medical record organization and medical record content. Medical record reviews include auditing the requirement documentation for Texas Health Steps periodic exams, HEDIS hybrid measures, and other special projects related to QI initiatives. Providers must make the El Paso Health Member medical records available to El Paso Health's Quality staff and approved external reviewers including HHSC and the Institute for Child Health Policy (ICHP). Please feel free to contact our QI Department at ***915-532-3778 or toll-free 877-532-3778*** if you have any questions.

MEMBER EVENTS REVIEW

El Paso Health's QI Department has established a process by which any possible quality issue is referred for investigation. El Paso Health is committed to investigating and correcting any issues, which interfere with the quality of health care delivered to our Members. In accordance with *The National Quality Forum* report on serious reportable events in healthcare and *The Joint Commission*, El Paso Health's QI Department monitors possible triggers for Member events to include, but are not limited to:

- Post-operative complications/unplanned return to surgery.
- Nosocomial infection.
- Trauma suffered in the hospital.
- Mortality that is not a direct result of a terminal condition.
- Hospital readmissions within 30 Days of discharge.

The QI Department systematically evaluates the process of care that may have led to an adverse event. Member events that are determined to have had a significant adverse effect on the Member will be referred to the Quality Improvement Committee (QIC) for an appropriate course of action. El Paso Health therefore urges that any possible quality issues be reported. To report a quality issue, please contact our QI Department at ***915-532-3778 or toll-free 877-532-3778.***

MEMBER COMPLAINTS

It is inevitable that Providers will encounter a patient that is displeased with the quality of service or care that is provided at one time or another. However, when this does occur, and the patient/Member files a complaint, El Paso Health must acknowledge their concern and attempt to achieve the best resolution. A complaint is defined by HHSC as an expression of dissatisfaction expressed by a complainant, orally or in writing to El Paso Health. Possible triggers for complaints include, but are not limited to, the quality of care or services provided, and aspects of interpersonal interactions such as rudeness of a Provider or office staff, or failure to value the Member's rights.

It is the intent of El Paso Health to resolve Member complaints informally and to the mutual satisfaction of our Members and providers. El Paso Health must exercise due diligence by confirming all facts in any quality of care or service complaint we receive. How do we safeguard our Members' satisfaction? The following measures are employed to ensure that we keep our Members content with the quality of health care or service they receive:

Acknowledgement

When we receive a verbal or written complaint from a Member about the quality of service or quality of care they received during their visit to a Provider office, the Member will receive an acknowledgement letter within five (5) Days of receipt of their complaint. The purpose of the acknowledgement letter is to recognize the time and effort our Member has invested in informing us of their concerns.

Examine

As part of our commitment to quality we must examine all facts in the complaint filed in order to achieve satisfactory and fair resolution. El Paso Health's QI Department will contact the Member directly and ask for a detailed account of the situation that triggered the complaint. El Paso Health will also contact the Provider to explain the complaint received and obtain the Provider's account of the situation. Collaboratively with the Provider we determine the best resolution to the Member's complaint. As mandated by our regulators, El Paso Health has thirty (30) Calendar Days to provide a written resolution to our Member's complaint from the date of receipt.

Resolution

Once we have identified the problem and determined a course of action to obtain resolution, we communicate the resolution to the Member via written correspondence. Our main objective for issuing a resolution to our Member is to ensure their satisfaction with the outcome. If our Members are not satisfied with the complaint resolution, he/she has the right to file a complaint with the Texas Health and Human Services Commission (HHSC) or Texas Department of Insurance (TDI).

PROCESS IMPROVEMENT

El Paso Health's QAPI stresses as its utmost priority the need to continually improve the quality of care provided and service we offer. El Paso Health accomplishes this ongoing process through data collection and multidisciplinary analysis of data, identifying opportunities to improve

processes, and implementing improvement. El Paso Health develops performance thresholds and benchmarks for all of our QI indicators incorporating the following elements:

- Assessment of Expectations. El Paso Health recognizes that no matter how much work we put into our QI process, if we do not get our Providers and Member's input, achieving a successful process can be hindered. For that reason, El Paso Health identifies what our Providers and Members are seeking through our annual satisfaction survey that assesses on a continuous basis whether or not we are achieving those expectations.
- Identification of Opportunities. El Paso Health approaches the QI process as the opportunity to assess the quality and appropriateness of service provision to improve performance.
- Setting Goals. El Paso Health translates expectations into measurable goals which are attainable. El Paso Health actively and continuously seeks to assess, understand and respond to identified needs and expectations with the intention of meeting or exceeding the goals set.
- Assessment of Outcome. El Paso Health analyzes the results of QI initiatives to determine if it brought a positive outcome and identify any barriers faced. These results are used toward improving the quality of care and service delivery for the next cycle of improvement.

PROVIDER PROFILING

Provider profiling allows El Paso Health to compare individual and aggregate Provider performance to other Providers at the specialty, Health Plan, state and national levels. Indicators may include HEDIS results; Emergency Department usage; hospital days/1000; cost; average length of stay; outpatient encounters; THSteps rates; information from QI activities such as adverse events and access and availability; and member satisfaction. Provider profiles are used to identify outlier providers for under-utilization and over-utilization and to evaluate Health Plan performance. El Paso Health encourages our Provider's input on what information would be pertinent to your practice patterns, please feel free to contact our *QI Department* at ***915-532-3778 or toll-free 877-532- 3778.***

FOCUS STUDIES AND UM REPORTING

El Paso Health recognizes the importance of conducting focus studies around health problems or services that are particularly important or prevalent to our Member population. Our focus studies are objective retrospective medical reviews designed to evaluate a specific topic. The aim of a focused study is to provide objective data necessary for problem identification; implementation of corrective action, assessment of corrective action, and problem resolution. El Paso Health's QI Department may require the assistance of our Provider network when collecting precise data for a focus study. For that reason, your collaboration and consideration is imperative to our QI endeavors that assist in delivery of quality of care and service.

Additionally, El Paso Health monitors inpatient admissions, emergency room utilization, ancillary, out of area, and acute care services as part of the Utilization Management Program. All utilization patterns and trends are reviewed quarterly at the Utilization Management Committee

(UMC) and subsequently reviewed by the Quality Improvement Committee (QIC). Ultimately all utilization trends and patterns are reported to the BOD on a monthly and quarterly basis.

QAPI COMMITTEES

It would be both a privilege and pleasure to have you join in on our Quality Improvement journey. El Paso Health's QAPI has physician driven committees as we value your input. All physician committees are peer protected and the various meetings are held monthly, quarterly or as needed. El Paso Health has the following physician committees:

- Quality Improvement Committee (QIC)
- Credentialing and Peer Review Committee (CPRC)
- Utilization Management Committee (UMC)

If you are interested in joining any of our committees, please feel free to contact our *Medical Director* at ***915-532-3778 or toll-free 1- 877-532-3778.***

SECTION 8: BEHAVIORAL HEALTH SERVICES FOR STAR, STAR+PLUS, CHIP AND CHIP PERINATAL

DEFINITION OF BEHAVIORAL HEALTH

Behavioral Health Services – Covered Services for the treatment of mental, emotional, or chemical dependency disorders.

Severe and Persistent Mental Illness (SPMI) – means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by:

- Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or
- Impaired emotional or behavioral functioning that interferes substantially with the Member's capacity to remain in the community without supportive treatment or services.

Severe Emotional Disturbance (SED) – means psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.

Behavioral Health Covered Services

STAR Medicaid Covered Services, STAR+PLUS Covered Services, CHIP Covered Services and CHIP Perinatal Covered Services.

Coordination between behavioral health and physical health services

El Paso Health (EPH) is committed to promote integrated medical and behavioral health care. Currently, PCPs are responsible for coordinating the Member's physical and behavioral health which includes making referrals to behavioral health providers when necessary, however, a referral is not required to access services.

The PCP is required to obtain consent for disclosure of information from the Member to permit the exchange of clinical information between the behavioral health Provider and the Member's PCP. If the Member refuses to release the information, they will sign the consent for disclosure of information that indicates their refusal to release the information. The Provider will document the reason(s) for declination in the medical record. El Paso Health monitors the Provider's compliance with the completion of a release of information to promote the integrated communication between the behavioral health Provider and the PCP via summary reports of the Member's behavioral health status.

Screening tools available to PCPs are the Health and Behavior Assessment (HBAI) and Screening, Brief Intervention, and Referral to Treatment (SBIRT). PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.

EPH notifies in-network PCPs on available resources to screen for and identify behavioral health disorders, EPH's referral process for Behavioral Health Services, and clinical coordination requirements for such services. EPH must include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.

Behavioral Health Service Providers are aware that they must refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical Health Care Services if they are licensed to do so. EPH behavioral health Providers are encouraged to send initial and quarterly, or more frequently if clinically indicated, summary reports of a Members' behavioral health status to the PCP and other subspecialty Providers with the Member's or the Member's legal guardian's consent.

STAR AND STAR+PLUS COVERED BENEFITS

Behavioral Health Services*, including:

- Inpatient mental health services for Children (birth through age 20)
- Acute inpatient mental health services for Adults
- Outpatient mental health services
- Psychiatry services
- Mental Health Rehabilitative Services
- Counseling services for adults (21 years of age and over)
- Collaborative Care Model services
- Outpatient Substance Use Disorder treatment services including:
    - Assessment
    - Detoxification services
    - Counseling treatment
    - Medication assisted therapy
- Residential Substance Use Disorder treatment services including:
    - Detoxification services
    - Substance use disorder treatment (including room and board)

*These services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service Medicaid coverage. The services may be subject to El Paso Health's non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.

Hospital services, including inpatient and outpatient:

- El Paso Health may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.

- El Paso Health may provide substance use disorder treatment services in a chemical dependency treatment **facility in lieu of an acute care inpatient hospital setting.**

Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM) Services for Medicaid Members

Mental Health Rehabilitative (MHR) Services are those age-appropriate services determined by HHSC and federally approved protocol as medically necessary to 1) reduce a member's disability resulting from severe mental illness for adults or serious emotional, behavioral, or mental disorders for children and 2) to restore the member to their best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a member achieve a rehabilitation goal as defined in the member's rehabilitation plan.

MHR services include training and services that help the member maintain independence in the home and community such as the following:

- Medication training and support: curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of their mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community
- Psychosocial rehabilitative services: social, educational, vocational, behavioral, or cognitive interventions to improve the member's potential for social relationships, occupational or educational achievement, and living skills development
- Skills training and development: skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers
- Crisis intervention: intensive community-based one-to-one service provided to members who require services in order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting
- Day program for acute needs: short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting

Mental Health Targeted Case Management (TCM) means services designed to assist members with gaining access to needed medical, social, educational, and other services and supports. TCM services include:

- Case management for members who have SED (children 3 to 17 years of age), which includes routine and intensive case management services.
- Case management for members who have SPMI (adults 18 years of age or older).

Provider Requirements

- Training and certification to administer Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) assessment tools.
- Providers can reference the Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG) for these services.
- Attestation from Provider entity to El Paso Health that organization has the ability to provide, either directly or through sub-contract the Members with the full array of MHR and TCM services as outlined in the RRUMG.
- HHSC-established qualifications and supervisory protocols.

Providers can contact the Provider Relations Department for further information.

CHIP COVERED BENEFITS

Outpatient Mental Health Services

- Attention Deficit Hyperactivity Disorder (ADHD)
- Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:
    - The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility
    - Neuropsychological and psychological testing
    - Medication management
    - Rehabilitative day treatments
    - Residential treatment services
    - Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment)
    - Skills training (psycho-educational skill development)
    - When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determinatio
- A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of

interventions such as day treatment and in-home services), patient and family education, and crisis services.

- Does not require PCP referral.

INPATIENT SUBSTANCE USE TREATMENT SERVICES

Services include, but are not limited to:

- Inpatient and residential substance use treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.
- Does not require PCP referral.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES

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

- Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.
- Intensive outpatient services.
- Partial hospitalization.
- Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day.
- Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.
- Does not require PCP referral.

INPATIENT MENTAL HEALTH SERVICES

Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to:

- Neuropsychological and psychological testing.
- When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination
- Does not require PCP referral.

NON-COVERED BEHAVIORAL HEALTH SERVICES

Members may access local community resources for behavioral health services that are not covered. Services may be sought through the local office of the Texas Department of State Health Services (DSHS) or located through the Texas 211 website: www.211texas.org.

Members may also receive services through the local mental health authority (LMHA). The LMHA accepts patients with chronic mental health disorders (i.e. schizophrenia, bi-polar disorder, severe major depression). In the event that an El Paso Health Member will need to access services through the LMHA, the El Paso Health case management staff will assist the Member through the LMHA system of care.

MEMBER ACCESS TO BEHAVIORAL HEALTH CARE

Members may access services through:

- A self-referral to any Network behavioral health Provider
- A referral from the PCP
- El Paso Health case management 915-532-3778

NOTE: A referral from a PCP is **NOT** required to access behavioral health services.

Members may receive behavioral health services from licensed professionals including:

- Child and Adult Psychiatrists (MD)
- Psychologists (PhD)
- Licensed Professional Counselors (LPC)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Masters Social Worker – Advanced Clinical Practitioner (LMSW-ACP)

El Paso Health provides a Behavioral Health crisis hotline staffed by trained personnel 24 hours a day, seven (7) days a week at (877) 377-6184 for CHIP Members; (877) 377-6147 for STAR Members; and 1-877-377-2950 for STAR+PLUS Members.

PRIOR AUTHORIZATION

El Paso Health engages in a utilization review process to ensure services are reasonable and necessary for the diagnosis and treatment of a mental health or chemical dependency disorder. There is no lifetime maximum on the benefits; however, annual limitations do apply to certain services and are regulated by HHSC. Providers should submit prior authorization requests utilizing the Pre-certification Fax Form for OUTPATIENT/INPATIENT Behavioral Health included as **ATTACHMENT 2** of this manual. For Mental Health Rehabilitation or Targeted Case Management services use the *Texas Standard Prior Authorization Request Form for Health Care Services* only.

OUTPATIENT	INPATIENT
Fax: (915) 298-7866	Fax: (915) 298-5278
Toll Free Fax: 1-844-298-7866	Toll Free Fax: 1-844-200-5278
Phone: (915) 532-3778	Phone: (915) 532-3778
Toll Free: 1-877-532-3778	Toll Free: 1-877-532-3778

For Prior Authorizations for STAR+PLUS Members call Toll Free at 1-833-742-3127.

Please refer to previous sections regarding benefit limitations and prior authorization requirements for CHIP, CHIP Perinate, STAR, and STAR+PLUS.

El Paso Health is responsible for authorized inpatient Hospital services. This includes services provided in Freestanding Psychiatric Facilities for children in STAR and STAR+PLUS, and for adults in STAR+PLUS.

El Paso Health does not require prior authorization as a condition for payment for an Emergency Medical Condition or Emergency Behavioral Health Condition.

Emergency inpatient admissions must be faxed to El Paso Health by 5 p.m. of the next business day following admission to determine authorized inpatient hospital services.

The Pre-certification Fax Form for OUTPATIENT/INPATIENT Behavioral Health should be submitted for notification of inpatient psychiatric admissions.

Prior authorization is <u>not</u> required for the initial outpatient assessment.
Providers are responsible for using appropriate coding for the reimbursement of the initial assessment.

All subsequent visits after the initial assessment or evaluation require prior authorization.

- A prior authorization request form must be completed and faxed to the El Paso Health Utilization Management Department.
- Prior authorization is required for the following behavioral health services:
    - Outpatient services (i.e. intensive outpatient program services, and partial hospitalization program services, and residential treatment services).

PRIOR AUTHORIZATION PROCESS

Providers may contact the Behavioral Health Unit for questions regarding prior authorization. The Behavioral Health Unit can be reached at 915-532-3778 or 1-877-532-3778.

- Authorization request determinations are communicated to the Provider within 3 Business Days.
- Authorizations will not be retroactive at any time for any reason.
- Authorizations are approved by the El Paso Health Medical Director and are based on medical necessity.
- Failure to request authorization for services requiring authorization may result in payment denials.

El Paso Health Behavioral Health Network Providers agree to:

- Refer Members with known or suspected physical health problems or disorders to the PCP for examination and treatment.
- Refer Members for needed lab and ancillary services at a convenient location if not available in the Provider's office.
- Provide medical services if they are licensed to do so.
- Ensure their patients are knowledgeable about their rights to execute Behavioral Health Advance Directives.
- Schedule Medicaid/CHIP Members that receive inpatient psychiatric services for outpatient follow up and/or continuing treatment within 7 Days from the date of discharge.
- Contact Members who have missed appointments within 24 hours to reschedule.
- Send initial and quarterly (or more frequently if clinically indicated) summary reports of Member's behavioral health status to the PCP and other subspecialty Providers.

PRIMARY CARE PROVIDERS (PCP) AND BEHAVIORAL HEALTH

PCPs are responsible for coordinating the Member's physical and behavioral healthcare, including making referrals to behavioral health providers when necessary. The PCP is required to obtain consent for disclosure of information from the Member to permit the exchange of clinical information between the behavioral health Provider and the Member's PCP. If the Member refuses to release the information, they will sign the consent for disclosure of information that

indicates their refusal to release the information. The Provider will document the reason(s) for declination in the medical record. El Paso Health monitors the Provider's compliance with the completion of a release of information to promote the integrated communication between the behavioral health Provider and the PCP via summary reports of the Member's behavioral health status.

PCP's may provide behavioral health related services within the scope of their practice. PCP's must adhere to screening and evaluation procedures for the detection and treatment of, or referral for any known or suspected behavioral health problems or disorders. Providers should follow generally accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies, such as the National Institute of Health or the Texas Medicaid Manual. El Paso Health requires, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

DSM Diagnostic Codes and Behavioral Health Claims

Behavioral health claims should be filed using the appropriate and current DSM diagnostic code to define the patient's condition.

DSM Diagnostic Codes and Medical Records and Referrals

Medical records and referrals documentation are required to use the most current DSM classification to define the patient's condition.

BEHAVIORAL HEALTH QUALITY INITIATIVES

El Paso Health assures quality behavioral health services are provided to all El Paso Health Members. This assurance is monitored through the following quality efforts:

- Quality Improvement committees
- Focus studies
- Education and assistance to providers regarding the appropriate exchange of medical information.
- Behavioral health inpatient and outpatient utilization reports
- Benchmarks for performance
- Behavioral health assessment instruments for use by PCPs which are made available through Clinical Practice Guidelines for behavioral health published on the El Paso Health website.

COURT ORDERED COMMITMENTS

El Paso Health provides inpatient psychiatric services to Members birth through age 20, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under Texas Health and Safety Code Chapters 573 and 574, relating to Court-Ordered

Commitments to inpatient mental health facilities. El Paso Health is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code. These placements are Non-capitated services.

El Paso Health cannot deny, reduce, or controvert the Medical Necessity of inpatient mental health services provided pursuant to a Court-ordered Commitment for Members birth through age 20. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

A Member who has been ordered to receive treatment under Texas Health and Safety Code Chapter 573 or 574 can only Appeal the commitment through the court system.

El Paso Health coordinates with the Local Mental Health Authority (LMHA) and state psychiatric facility regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric facility.

EARLY CHILDHOOD INTERVENTION

El Paso Health ensures Network Providers are educated regarding the federal laws on child find and referral procedures. Providers should refer any child who is 35 months of age and younger (i.e. before their third birthday) who have a disability or developmental delay as defined by Early Childhood Intervention (ECI) criteria for screening and assessment as soon as possible, but no longer than seven (7) Calendar Days after identifying a disability or suspected delay in development. Referrals can be based on professional judgment or a family's concern. El Paso Health does not require a medical diagnosis or a confirmed developmental delay for referrals. To refer families for services, providers can call an El Paso Health Case Manager at 915-532-3778 or toll free at 1-877-532-3778 for assistance; or contact the Department of Assistive and Rehabilitative Services (DARS) Inquiry Line at 1-800-628-5115.

For additional ECI information, providers can visit the DARS website at www.dars.state.tx.us/ecis. Persons who are hearing-impaired can call the TDD/TTY line at 1-866-581-9328.

ECI Providers must submit claims for all physical, occupational, speech, and language therapy to El Paso Health.

El Paso Health permits Members to self-refer to local ECI Service Providers without requiring a referral from the Member's PCP.

SECTION 9: UTILIZATION MANAGEMENT

DEFINITIONS

Adverse Benefit Determination means:

1. the denial or limited authorization of a Member or Provider requested services, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. the reduction, suspension, or termination of a previously authorized service;
3. the denial in whole or in part of payment for service *(Please refer to Section 10)*;
4. the failure to provide services in a timely manner as determined by the State;
5. the failure of El Paso Health to act within the timeframes set forth in the Contract and 42 C.F.R. §438.408(b) *(Please refer to Section 10)*; or
6. for a resident of a rural area with only one health plan, the denial of a Medicaid Members' request to obtain services outside of the Network *(Please refer to Section 10)*; or,
7. the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

Administrative Appeal means the formal process by which a Provider requests a review of any of the below actions **that do not require a medical review**:

- The failure of El Paso Health to act within the described timeframes
- The denial in whole or in part of payment for a service not related to medical necessity
- Dispute of a claim denial for a non-covered benefit
- Reimbursement dispute
- Claims Coding dispute

Administrative Denial is not a determination of the medical necessity or appropriateness of health care services furnished or proposed to be furnished to a Member.

Adverse Determination (CHIP). A determination by a URA made on behalf of any payor that the health care services provided or proposed to be provided to an enrollee are not medically necessary or appropriate or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

Adverse Determination (STAR) means a determination by an MCO or Utilization Review agent that the Health Care Services furnished, or proposed to be furnished to a Member, are not Medically Necessary or not appropriate.

Adverse Determination Appeal means the formal process by which a Provider, a Member or their legal representative requests a review of any of actions requiring medical interpretation such as:

- 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
- Denial of a request to obtain services outside of the network
- A determination that a service is not medically necessary, experimental, or investigational in nature

Business Day means any day other than a Saturday, Sunday, or a state or federal holiday on which HHSC's offices are closed, unless the context clearly indicates otherwise.

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

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

Emergency Services means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-stabilization Care Services.

Expedited MCO Internal Appeal means an appeal to the MCO in which the decision is required quickly based on the Member's health status, and the amount of time necessary to participate in a standard appeal could jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

Health Care Provider means a person, corporation, facility, or institution that is:

- licensed by a state to provide or is otherwise lawfully providing health care services; and
- eligible for independent reimbursement for those health care services.

Life-threatening means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Physician means a licensed doctor of medicine or a doctor of osteopathy.

Provider of Record means the physician or other health care provider with primary responsibility for the care, treatment, and services provided to an enrollee. The term includes a health care facility if treatment is provided on an inpatient or outpatient basis.

Utilization Review includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

Utilization Review Agent (URA) means an entity that conducts utilization review for:

- an employer with employees in this state who are covered under a health benefit plan or health insurance policy;
- a payor; or
- an administrator holding a certificate of authority under Chapter 4151.

UTILIZATION REVIEW

El Paso Health is accountable to its Members for the effective utilization of resources in the provision of healthcare and the quality of care and services provided by its participating providers.

El Paso Health will have a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

El Paso Health is committed to having a Utilization Review Process (UR Process) that adheres to standards for conducting utilization review which is in compliance with the Texas Department of Insurance (TDI) and Health and Human Services Commission (HHSC) rules and regulations.

El Paso Health has appropriate trained, qualified and licensed staff available to perform utilization review.

Utilization Management staff are reasonably available by telephone at (915) 532-3778, or toll-free at (877) 532-3778 to discuss patient care during normal business hours between 9:00 a.m. – 6:00 p.m. Central Standard Time (CST) and 8:00 a.m. – 5:00 p.m. Mountain Standard Time (MST), Monday through Friday on each day that is not a legal holiday. An answering system is in place to accept inquiries Monday through Friday outside of these hours, weekends, and legal holidays. Calls will be transferred to the Medical Director or designee. The Medical Director or designee will acknowledge calls as soon as possible, but no later than 24 hours after receipt of the call.

For Utilization Management for STAR+PLUS Members call (833) 742-3127.

El Paso Health will make medical necessary determinations based on written screening criteria established and periodically updated. Under no circumstances will the term Medical Necessity emphasize cost/resource issues above clinical effectiveness.

El Paso Health utilizes the list of procedures identified by Centers for Medicare and Medicaid Services (CMS) for services being performed in an ambulatory surgical setting. Milliman Care Guidelines and Interqual Inc., criteria are used in issuing utilization management and pre-certification determinations. Providers can access guidelines adopted by El Paso Health at http://www.elpasohealth.com or request a copy by submitting a written request to the Utilization Management Unit at 1145 Westmoreland Drive, El Paso, TX 79925.

The screening criteria used for the determination will be objective, clinically valid, compatible with established principles of health care; and flexible enough to allow a deviation from the norm on a case by case basis. Screening criteria is established, periodically evaluated, and updated by El Paso Health's Utilization Management Committee (UMC).

Screening Criteria will be used to determine whether to approve the prospective, concurrent or retrospective review for medical necessity and appropriateness of the health care services; and prospective, concurrent, or retrospective review of the experimental or investigative nature of the health care services.

Authorization requests are accepted via fax, telephonically, or electronically.

Faxed Requests:

Outpatient and Scheduled Inpatient procedures
Fax No: 915-298-7866
Toll free: 844-298-7866.

The Fax Server is in operation twenty-four (24) hours a day, seven (7) days a week.

Inpatient notifications
Fax No: 915-298-5278
Toll free at 844-298-5278;

Electronic Requests: Provider Portal www.elpasohealth.com

Telephonic Requests: 915-532-3778 (toll free at 1-877-532-3778);
For STAR+PLUS Members call 833-742-3127.

El Paso Health will request all relevant and updated information and medical records to complete a review. The information needed for a review may include, but is not limited to:

- identifying information about the Member;
- the benefit plan or claim;
- the treating physician, doctor, or other health care provider;
- the facility rendering the care;
- clinical and diagnostic testing information regarding the diagnoses of the Members
- Member's medical history relevant to the diagnoses;

- Member's prognosis; and
- the plan of treatment prescribed by the provider of record, along with the provider of record's justification for the plan of treatment.

From time to time, a Member, physician, or other healthcare Provider will not be in agreement with the medical necessity or appropriateness of the requested services. In any instance in which El Paso Health questions the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, prior to the issuance of an adverse determination, El Paso Health will afford the provider of record a reasonable opportunity to discuss the plan of treatment for the Member with the Medical Director or Associate Medical Director. A denial in whole or in part of requested treatment will be made by the Medical Director, designated physician, dentist, or other health care Provider. The notice will include the professional specialty of the physician who made the determination.

El Paso Health will notify Members of any action or intended action in regards to their request for services. If a denial is based on lack of supporting documentation from the Provider, El Paso Health will describe the supporting documentation that needs to be submitted.

The notice of action or intended action will include the date the action will take effect along with an explanation on how the requested service does not meet one or more of the criteria for medical necessity.

El Paso Health will send written notice of determination to the Member, or an individual acting on behalf of the Member, and the Member's provider of record, including the health care provider who rendered the service, of a determination made in a utilization review.

PRIOR AUTHORIZATIONS

Authorization is required for all inpatient admissions, outpatient procedures, all out- of-area and out-of-network services and other services as defined by El Paso Health, with the exception of family planning services. For a list of procedures requiring authorization please refer to the ***Listing of Services Requiring Prior Authorization*** included as **ATTACHMENT 1** of this manual. Refer to the *Current Procedural Terminology* (CPT) manual for specific codes to use when requesting services.

To ensure El Paso Health has all it needs to initiate a prior authorization request you will need to submit the Texas Standard Prior Authorization Request Form for Health Care Services included as **ATTACHMENT 5** of this manual, or for behavioral health the Behavioral Health Prior Authorization Form included as **ATTACHMENT 2** of this manual.

The form must include the following essential information:

- Member name
- Member number
- Member date of birth
- Requesting Provider name

- Requesting Provider's National Provider Identifier (NPI)
- Rendering Provider's Name
- Rendering Provider's NPI
- Rendering Provider's Tax Identification Number
- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- Service requested start and end dates
- Quantity of service units requested based on the CPT, or HCPCS requested

If El Paso Health receives a request for prior authorization with information that is incomplete, missing, incorrect, or illegible El Paso Health will not enter the request in our system and will not approve or deny the request. El Paso Health will return the request and provide an explanation by fax of why it is unable to be processed. You will need to resubmit the rejected prior authorization request with completed information.

Please note, if any prior authorization form is returned with the language "PA Not Required" (Prior Authorization not Required) the requesting provider should verify if the service is a covered benefit and requires authorization using the prior authorization tool located on the El Paso Health website at: https://www.elpasohealth.com/providers/prior-authorization/.
If you have an urgent request that requires immediate attention after normal business hours, or on the weekend, please contact the FIRSTCALL Medical Advice InfoLine at 1-844-549-2826.

Notification of a service not requiring authorization does not constitute approval of that service.

Medicaid Members have the right to choose any Medicaid-enrolled family planning provider whether the provider is in-Network or out-of-network. Family planning services include medically approved methods of contraception that are made available to the Member, whether directly or by referral to a subcontractor. Access to family planning services is confidential.

El Paso Health does not process authorization requests beyond 30 Days in advance to ensure the most updated clinical possible is provided.

Inpatient Admissions

Inpatient notifications and supporting documentation should be submitted to the Utilization Management Unit by fax at **915-298-5278, telephonically at 915-532-3778 (toll free at 877-532-3778), or electronically** through the El Paso Health Provider Portal at http://www.elpasohealth.com. El Paso Health requests that Providers submit the hospital's face sheet for notification of inpatient admissions and the NICU Notification Form for all NICU notifications. Inpatient notifications should be submitted as follows:

- Two face sheets for all deliveries (one for the mother and one for the infant);
- The mother's face sheet should include the type of delivery (vaginal or c-section);
- The baby's face sheet should include the baby's gender and indicate well or sick; and

- If baby was a sick baby transferred to NICU, the ***NICU Notification Form*** included as **ATTACHMENT 4** of this manual should be submitted; and
- A separate face sheet for Med/Surg notifications
- A face sheet for observation stays converted to inpatient status to include the physicians' orders
- Authorization is required for in-network or out-of-network facility and Physician services for a mother and/or newborn remaining inpatient after 48 hours following an uncomplicated vaginal delivery, or after 96 hours following an uncomplicated delivery by caesarian section

When submitting additional clinical information pertaining to a continued stay, Providers should reference the authorization issued for the current inpatient stay.

Inpatient notifications should also include applicable clinical information such as diagnosis, lab values, diagnostic test results, plan of care, and discharge planning necessary to:

- Evaluate medical appropriateness/medical necessity of care
- Substantiate level of care
- Assess and identify quality issues
- Identify case management opportunities

The facility's' utilization management/case management department is responsible for providing notice of a determination to El Paso Health members during the course of stay.

Concurrent Review and Discharge Planning

All inpatient admissions are monitored for compliance with the certified length of stay. Admissions which are continued beyond the expected length of stay, are reviewed to determine the medical necessity for the continued stay, and to identify the expected discharge date of the patient. El Paso Health's Utilization Management staff will work collaboratively with the facility when a patient can appropriately be transferred to an alternative care setting; or when a patient is discharged from an acute care setting to an alternative care setting such as home health care.

Please refer to Section 7 of this manual for inpatient notification process of behavioral health services.

Outpatient/Scheduled Procedures

All outpatient requests or requests for scheduled procedures should be submitted to the Utilization Management Unit by fax at **915-298-7866, telephonically at 915-532-3778 (toll free at 877-532-3778), STAR+PLUS Members at 833-742-3127;** by completing the ***Texas Standard Prior Authorization Request Form*** included as **ATTACHMENT 5** of this manual; **or electronically** through the El Paso Health Web Portal at http://www.elpasohealth.com**.**

CHIP Providers submitting authorization requests will be notified if additional information is needed to determine medical necessity. If not submitted the same day, determination will be based on the information at hand.

When it is determined that the clinical information submitted with the initial authorization request does not support medical necessity, STAR Providers will be faxed a request within 3 Business Days from the date El Paso Health receives the PA requesting the specific information needed and extend the time period for determination up to 14 Business Days. If the information is not received by the 7th Business Day after the PA receipt date, the Medical Director will make a final decision with the information at hand, this may take up to 3 Business Days.

Determination for authorization requests submitted by CHIP Providers will be made based on the information submitted with the original requests.

Please refer to Section 7 of this Manual for outpatient authorization request process of behavioral health services.

Out-of-Area

All inpatient requests should be submitted to the Utilization Management Unit at **915-298-5278 (toll free 844-298-5278), STAR+PLUS Members at 833-742-3127; or electronically** by completing the ***Texas Standard Prior Authorization Request Form for Health Care Services*** included as **ATTACHMENT 6** of this manual.

Time frames for Precertification

Time frames for precertification are as follows:

- Three (3) Days prior to elective admissions;
- 24-hour notification is required for conversion from Observation Status to Inpatient Status;
- Urgent admissions can be faxed the day of, but prior to admitting the patient;
- Emergency admissions must be faxed by 5 p.m. on the next business day following the admission;
- All emergent and non-emergent out-of-network transfer notifications should be made PRIOR to patient transfer for coordination and approval by the Medical Director;
- Notification of detained babies should be made prior to the mother's discharge;
- Services deemed necessary for discharge may require prior authorization and should be submitted during discharge planning.

It is the Provider's responsibility to verify eligibility or authorization of services.

REFERRALS

Referrals are an integral component of El Paso Health. Referrals ensure that Members gain access to all necessary and appropriate covered services and that care is delivered in the most clinically suitable and cost-effective setting. El Paso Health operates a closed specialty network which means that Primary Care Physicians (PCP) should refer Members to El Paso Health network specialists only.

The PCP functions as the medical home for assigned Members. PCPs are responsible for arranging and coordinating appropriate referrals to other providers and specialists, and for managing, monitoring, and documenting the services of other providers.

PCPs are required to maintain documentation of communication with the specialist in the Member's medical record and must supply the specialist with his/her El Paso Health Provider number for inclusion on the specialist's claim.

Out-of-Network Referrals

El Paso Health recognizes that there may be instances when an out-of-network referral is justified. The Health Services staff will work with our Medical Director and the PCP to determine the medical necessity of the out-of-network referral. Out-of-network referrals will be authorized on a limited basis. Providers are responsible for providing a justification to El Paso Health regarding Out-of-Network referrals, including partners not contracted with El Paso Health. El Paso Health may be contacted at 915-532-3778 or toll free at 877-532-3778 for questions regarding non-network providers. For STAR+PLUS Members call 833-742-3127.

Member's Right to Designate an Obstetrics/Gynecology (OB/GYN)

El Paso Health allows the Member to pick an OB/GYN, but this doctor must be in the same network as the Member's Primary Care Provider.

Attention Female Members

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

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

Specialist to Specialist Referrals

El Paso Health does not allow specialty providers to refer directly to another specialist. This request must be coordinated through the PCP. Once a PCP has referred a Member to a specialist, the specialist can order diagnostic tests and/or refer to an additional specialist with an authorization; this does not require PCP involvement.

For Members with disabilities, special healthcare needs, Chronic or Complex conditions, there may be instances where the specialist is acting as the PCP for a Member. In these situations, Members are allowed direct access to the specialist-PCP, and the specialist may refer to other specialists with prior authorization, or admit the Member to the hospital.

MEMBER RIGHT TO A SECOND OPINION

El Paso Health requires that each Member have access to a second opinion regarding the use of any healthcare service. A Member must be allowed access to a second opinion from a network or out-of-network Provider if a network Provider is not available, at no additional cost to the Member.

OUT-OF-NETWORK HOSPITALS

An out-of-network hospital is one that is not contracted to provide services to El Paso Health Members:

- Out-of-network hospitals are reimbursed only for inpatient services provided to El Paso Health Members as the result of an emergency admission. Other inpatient/outpatient services are reimbursed at the rate paid by the Traditional Medicaid Program, if authorized reimbursement for emergency treatment will be made at the current Medicaid rates.
- All out-of-network hospital services require prior authorization for non-emergency services.

AUTHORIZATION REQUEST DETERMINATIONS

Administrative Denials

*Please refer to **Section 10** for Administrative Denial Complaint and Appeal process.*

Administrative Denials are issued for services not related to a determination of medical necessity. An Administrative Denial is issued for health care service requests related to, but not limited to the following:

CHIP Administrative Denials Only

• Lack of notification for emergent services within one (1) business day	• Lack of authorization prior to rendering non-emergent elective or scheduled services
• Failure to notify of transfer to out-of-area or out-of-network facility in advance (except when emergent)	• Non-compliance of provider with EPH's UM process
• Lack of notification when Observation status is changed to Inpatient	• Non-covered benefits using the current CHIP, CHIP Perinate scope of benefits

• Duplicate request (already an authorization on file from the same provider for the same DOS, CPT/Units, and same POS)	• Lack of Information (no clinical information provided to be able to make a determination)

STAR Administrative Denials Only

• Requesting Provider is not a Medical Provider	• Duplicate request (already an authorization on file from the same provider, for the same DOS, CPT/Units, and same POS)

ADVERSE DETERMINATIONS

CHIP and CHIP Perinatal

An Adverse Determination is issued when it is determined that a health care service requested is not medically necessary, and only after the provider has been given the opportunity to discuss with a physician the patient's treatment plan and clinical basis of the request. An adverse determination of requested treatment will be made by the Medical Director, Associate Medical Director or appropriate physician, dentist, or other health care provider.

El Paso Health does not issue adverse determinations based on initial clinical review. Screening criteria will be used to determine whether to approve the prospective, concurrent or retrospective review for medical necessity and appropriateness of the health care services; and prospective, concurrent, or retrospective review of the experimental or investigative nature of the health care services.

The screening criteria used for the determination will be objective, clinically valid, compatible with established principles of health care; and flexible enough to allow a deviation from the norm on a case by case basis. The notice will include the professional specialty of the physician who made the determination on the requested service.

What can I do if El Paso Health denies or limits my Member's request for a covered benefit?

El Paso Health will include a description of the procedure for the appeals, including the notice to the Member, the Member's representative, the provider of record, health care provider rendering services if different from the provider of record, the right to appeal an adverse determination to an Independent Review Organization (IRO), and of the procedures to obtain that review along with the notice of adverse determination.

For Members who have a life-threatening condition or urgent care situation, the notice will include a description of the Member's right to an immediate review by an IRO and the steps to take in order to obtain the immediate review by the IRO.

El Paso Health does not discriminate or take punitive action against a Member or their authorized representative for submitting an appeal.

Timeframe for Notice of Adverse Determination

- With respect to a patient who is hospitalized at the time of the adverse determination, notification will be made within one (1) Business Day by telephone or by electronic transmission to the provider of record, followed by a letter within three (3) Business Days notifying the patient, or an individual acting on behalf of the patient, including the health care provider who rendered the service of the adverse determination;

- With respect to a patient who is not hospitalized at the time of the adverse determination, notification will be made within three (3) Business Days in writing to the provider of record, the patient or an individual acting on behalf of the patient, and the healthcare provider who rendered the service;

- Within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, that notice will be sent not later than one (1) hour after the time of the request; and

- Within a reasonable period for retrospective utilization review in writing to the provider of record and the patient, but not later than thirty (30) Days after the date on which the request for a utilization review is received. This timeframe may be extended once by El Paso Health for a period not to exceed fifteen (15) Days if El Paso Health determines that an extension is necessary due to matters beyond their control. In this circumstance, El Paso Health will notify the provider of record and the Member prior to the expiration of the initial 30-Day period. The notification will include the date in which a determination is expected.

How will I find out if services are denied?

El Paso Health will send written notification to the Member or an individual acting on the Member's behalf and the Member's Provider of Record, including the health care provider who rendered the service, of a determination made in a utilization review.

Requirements for Notice of an Adverse Determination

In all instances of a prospective, concurrent, or retrospective utilization written notification of the adverse determination will include:

- The principal reasons and clinical basis for the adverse determination.
- The screening criteria utilized in making the determination.
- The professional specialty of the physician that made the adverse determination.
- A description of the procedure for the complaint and appeals process.

- The right to request an IRO and instructions on how to obtain the IRO.
- A copy of the request for review by an IRO form, (also available at www.tdi.texas.gov/forms).

CHIP MEMBER APPEAL PROCESS

When does a Member have the right to request an Appeal?

A member has a right to request an appeal for services that have been denied in whole or in part. Appeals need to be filed within sixty (60) Days of the notice of the adverse determination.

A member or an individual acting on behalf of the Member and the Member's provider of record, including the health care provider who rendered the service, of a determination made in a utilization review may appeal an Adverse Determination. A physician who has not previously reviewed the case will review the appeal. This includes an Expedited Appeal for emergency care or life-threatening situations.

Appeals can be made orally or in writing to:
El Paso Health
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925
Fax No: 915-298-7872 (Toll Free – 844-298-7872)
Phone: 915-532-3778 (Toll Free – 877-532-3778)
Online: www.elpasohealth.com

If your appeal was made over the phone (orally), a one-page appeal form will be included with the letter of acknowledgement. The appeal form does not have to be returned. El Paso Health will still review your appeal. We do encourage that requested information be provided to help resolve the appeal.

Can someone from El Paso Health help me file an Appeal?

El Paso Health has a Member Advocate available to assist Members or the Member's representative with the appeal process at 915-532-3778 or 877-532-3778..

Types of Appeals

Standard Appeal: An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization.

Expedited Appeal: An expedited appeal is available for emergency care, life-threatening conditions, and hospitalized enrollees. An expedited appeal is also available for failure to provide services in a timely manner.

Timeframe for an Expedited Appeal: One working day from the date we receive all information necessary to complete the appeal. We may provide the determination by telephone or electronic transmission, but will provide a written determination within three (3) Business Days of the initial telephonic or electronic notification.

What can I do if El Paso Health denies or limits my Member's request for a Covered Service?

If the member does not agree with El Paso Health's decision to deny or limit their services, an appeal can be requested.

How will I find out if the Appeal is denied?

If El Paso Health denies the appeal, the member will receive a denial letter.

What Happens if El Paso Health Denies the Request for an Expedited Appeal?

If a request for an Emergency Appeal is denied, El Paso Health will transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member a prompt oral notice of the denial, following up within two (2) Calendar Days with a written notice regarding the denial of the Emergency Appeal and inform the enrollee of the right to file a grievance if he or she disagree with that decision.

Who can help with filing an Expedited Appeal?

El Paso Health has a Member Advocate available to assist Members or the Member's representative with the Expedited Appeal.

Adverse Determination Appeal Timeframe

Standard Appeal: 30 Calendar Days of receipt of the appeal.

Expedited Appeal: One working day from the date we receive all information necessary to complete the appeal. We may provide the determination by telephone or electronic transmission, but will provide a written determination within three (3) Business Days of the initial telephonic or electronic notification.

Appeal Acknowledgment

Within five (5) Business Days of receipt of the appeal, we will send the appealing party a letter acknowledging the date that we received the appeal and a list of documents that we may need for the appeal. If the appeal is oral, we will send the appealing party a one-page appeal form. The appealing party does not have to return the appeal form but we encourage its return because the form will help us resolve the appeal.

Providers are encouraged to contact El Paso Health should they not receive a letter of acknowledgement within five (5) Business Days.

All appeal documentation and telephone discussions will be logged, documented, scanned and attached to the authorization in El Paso Health's management information system.

Review of Appeal

Upon review of the appeal and it is determined that the health care service requested is not medically necessary, the provider will be provided with an opportunity to discuss the clinical peer reviewer's determination prior to issuing an adverse determination.

What if El Paso Health Denies the Appeal?

The Provider may request a Specialty Review. The requesting Provider has ten (10) Business Days from the day an appeal is denied to send a written request for Specialty review. The request must be in writing and state a good cause for having a particular type of specialty Provider review the case. El Paso Health will identify a physician of the same or similar specialty as typically manages the medical, dental or specialty condition, procedure, or treatment under review.

Timeframe for Resolution of the Specialty Review

The Specialty review will be completed within fifteen (15) Business Days of the date the health care Provider requested the Specialty review. Notification of the determination will be provided in writing by letter to the Member, the person acting on behalf of the Member, the Provider of record, and health care Provider rendering services if different from the Provider of record.

- A statement of the dental, medical, contractual reasons for resolution;
- The clinical or contractual basis for the decision;
- The description of or the source of the screening criteria that were utilized in making the determination;
- The professional specialty of the physician who made the determination.

REQUESTING AN EXTERNAL REVIEW BY AN IRO

What is an external review by an IRO?

It is a request to have an independent third party, not affiliated with El Paso Health, review the medical necessity and appropriateness of health care services denied by El Paso Health. The Member or their representative has the right to request the external review at no cost to the Member.

How do I request a review by an IRO?

To request a standard IRO review, the Member must complete and sign the **HHS Federal External Review Process Appointment of Representative Form** to name someone to be the Member's representative. See **ATTACHMENT 17**.

What should I do to request the IRO?

You will need to complete ***HHS Federal External Review Request Form***, **ATTACHMENT 17**, once the Member names you as their representative on the HHS Federal External Review Process Appointment of Representative Form.

You may ask for a standard external review by fax, mail, or online at:

Fax:	1-888-866-6190
Mail:	MAXIMUS Federal Services State Appeals East 3750 Monroe Avenue, Suite 705 Pittsford, NY 14534
Online Portal:	https://www.externalappeal.com/ferpportal

If you need to send more information to include with your review, you can send it using the *HHS Federal External Review Request Form*.

What happens after I send the request for IRO?

MAXIMUS will decide if the request is eligible for external appeal. If not eligible MAXIMUS will notify the Member and El Paso Health.

If the request is eligible for external review, MAXIMUS will request the case information from El Paso Health for review. El Paso Health will have five (5) Business Days to send the information to MAXIMUS. If you send MAXIMUS more information they will share it with us. We may change our decision when MAXIMUS informs us of the IRO. If not, the IRO will continue the review and notify you when they make their decision.

How long will it take for the IRO to complete the review?

MAXIMAUS will notify you 45 Days from when the request for an IRO.

What happens if MAXIMUS decides to approve the services?

El Paso Health will provide coverage or payment for the health care item or service upon receiving notification from MAXIMUS.

Who do I call if I have questions on the IRO?

If you have questions about the about the IRO, call 1-888-866-6205.
Maximus will keep record for up to six years.

What if the Member needs an Immediate Review by IRO?

El Paso Health will not require exhaustion of El Paso Health's internal appeals process prior to requesting an external review by IRO if El Paso Health fails to meet internal appeal process timelines, or if the Member has a life-threatening condition or urgent care situation.

How do I request the Immediate Review by the IRO?

You can ask for an immediate IRO by calling 1-888-866-6205 to begin the process. You may also request the immediate review in writing to the following:

Fax: 1-888-866-6190
E-mail: FERP@maximus.com
Online Portal: https://www.externalappeal.com/ferpportal

How do I know that my Immediate Review Request has been received?

MAXIMUS will notify El Paso Health within one business day to request case documentation for review.

How do I send additional information for the Immediate Review by the IRO?

To send information to include in the review, you may use the *HHS Federal External Review Request Form* and send it to the following:

Fax: 1-888-866-6190
Mail: MAXIMUS Federal Services
State Appeals East
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
E-mail: FERP@maximus.com
Online Portal: https://www.externalappeal.com/ferpportal

What happens after I send the request for Immediate Review by the IRO?

MAXIMUS will notify El Paso Health immediately upon receipt to request case information for review. MAXIMUS may request more information if needed.

MAXIMUS will decide if the request is eligible for immediate external appeal. If not eligible MAXIMUS will notify the Member and El Paso Health.

How long will it take for the Immediate Review by the IRO?

MAXIMUS will notify Member or the Member's representative as soon as possible but no later than 72 hours. The notice can be orally and will be followed in writing within 48 hours of the oral notification.

What happens if MAXIMUS decides to approve the services?

El Paso Health will provide coverage or payment for the health care item or service upon receiving notification from MAXIMUS.

Maximus will keep record for up to six years.

MEDICAID MEMBER APPEAL PROCESS

An Adverse Determination is issued when it is determined that a health care service furnished, or proposed to be furnished to a Member are not medically necessary or appropriate. An adverse determination of requested treatment will be made by the Medical Director, Associate Medical Director or appropriate physician, dentist, or other health care provider.

Medical Necessity applies to, but is not limited to the following:

- For Medicaid Members birth through 20, the following Texas Health Steps services:
  - Screening, vision, and hearing services; and
  - Other health care services, including behavioral health services necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition
- For Medicaid Members over age 20, non-behavioral health related health care services that are reasonable and necessary to prevent illnesses or medical conditions, or provide early screening , interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity, or endanger a life, or could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered;
- Services that are not experimental or investigative; and
- Are not primarily for the convenience of the Member or Provider.

El Paso Health does not issue adverse determinations based on initial clinical review. Screening criteria will be used to determine whether to approve the prospective, concurrent or retrospective review for medical necessity and appropriateness of the health care services; and prospective, concurrent, or retrospective review of the experimental or investigative nature of the health care services.

The screening criteria used for the determination will be objective, clinically valid, compatible with established principles of health care; and flexible enough to allow a deviation from the norm on a case by case basis. The notice will include the professional specialty of the physician who made the determination.

What can I do if El Paso Health denies or limits my Member's request for a Covered Service?

If the member does not agree with El Paso Health's decision to deny or limit their services, an appeal can be requested.

If El Paso Health denies the appeal, the member has the option to request an External Medical Review and State Fair Hearing no later than 120 Days after El Paso Health mails the appeal decision notice.

Member's also have the option to request only a State Fair Hearing, no later than 120 days after El Paso Health mails the appeal decision notice.

How will I find out if the Appeal is denied?

If El Paso Health denies the appeal, the member will receive a denial letter.

How will I find out if services are denied?

If services are denied, El Paso Health will send the Member a denial letter explaining why services were not approved.

ADVERSE DETERMINATION APPEAL PROCESS

When does a Member have the right to request an Appeal?

A member has a right to request an appeal for denial of payment for services in whole or in part. Appeals need to be filed within sixty (60) Days of the notice of the adverse determination.

A member or their authorized representative may appeal an Adverse Determination. A physician who has not previously reviewed the case will review the appeal. This includes an Expedited Appeal for emergency care or life-threatening situations.

Appeals can be made orally or in writing to:

El Paso Health
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925
Fax No: 915-298-7872
Phone: 915-532-3778 (Toll Free 1-877-532-3778) STAR
Phone: 1-833-742-3127 (Toll-Free) STAR+PLUS
Online: www.elpasohealth.com

In order to ensure continuity of current authorized services, the Member must file the Appeal on or before the later of: 10 Days following El Paso Health's mailing of the notice of the Action, or the intended effective date of the proposed Action.

Note: The Member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the Member.

Appeals must be accepted orally or in writing. Oral appeals must be signed by the Member or his or her representative, unless the Member or his or her representative requests an expedited resolution. The date of the oral request should be treated as the filing date of the request.

El Paso Health requires the following information for the appeal:

- a cover letter requesting an appeal that includes the Member's name, Member's I.D. number, El Paso Health's reference number and the date of service;

- a copy of the medical record if not previously submitted; and
- any new or additional information

In order to ensure continuity of current authorized services, the Member must file the Appeal on or before the later of: 10 Days following El Paso Health's mailing of the notice of the Action, or the intended effective date of the proposed Action.

Note: The Member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the Member.

El Paso Health will continue benefits currently being received by the Member if the following criterion is met:

- The Member or their representative files the Appeal timely;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Provider;
- The original period covered by the original authorization has not expired; and
- The Member requests an extension of the benefits.
- If, at the Member's request, El Paso Health continues or reinstates the Member's benefits while the appeal is pending, the benefits will be continued until one of the following occurs:
    - The Member withdraws the appeal within ten (10) Days from the date El Paso Health mails the notice resolving the appeal;
    - the Member, within the 10-Day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision can be reached;
    - a State Fair Hearing officer issues a decision adverse to the Member; or
    - the time period or service limits of a previously authorized service has been met.

Can someone from El Paso Health help me file an Appeal?

A Member Services Representative or a Member Advocate can help in filing an appeal.
A member can call El Paso Health at 915-532-3778 or toll free at 1-877-532-3778 for STAR and toll free at 1-833-742-3127 for STAR+PLUS.

Timeframes for the Appeals Process:

El Paso Health must complete the entire standard appeal process within 30 days after receipt of the initial written or oral request for Appeal. This deadline may be extended for up to 14 Days at the request of a Member; or the MCO shows that there is a need for additional information and how the delay is in the Member's interest. If El Paso Health needs to extend, Member must receive written notice of the reason for delay.

Member has the option to request an External Medical Review and State Fair Hearing no later than 120 Days after El Paso health mails the appeal decision notice. Member has the option to

request only a State Fair Hearing, no later than 120 days after El Paso Health mails the appeal decision notice.

Types of Appeals

Standard Appeal: An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization.

Expedited Appeal: An Expedited (Emergency) Appeal is when the health plan has to decide quickly based on the condition of the member's health, and taking the time for a standard appeal could jeopardize their life or health.

How to request an Emergency Appeal
Expedited Appeals can be made orally or in writing to:

El Paso Health
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925
Fax No: 915-298-7872
Phone: 915-532-3778
Toll Free 1-877-532-3778 STAR
Phone: Toll Free 1-833-742-3127 STAR+PLUS
Online: www.elpasohealth.com

Timeframes for an Emergency Appeal: The Member will be notified of the outcome within 72 hours. For Expedited Appeals relating to an ongoing emergency or denial of continued hospitalization, El Paso Health will complete the investigation and resolution no later than (1) one Business Day after receiving the Member's request.

What Happens if El Paso Health Denies the Request for an Emergency Appeal?

If El Paso Health determines that the emergency appeal request does not meet the emergency criteria, El Paso Health will notify the member immediately and will process the appeal as Standard and provide the member a response within thirty (30) Calendar days and inform the enrollee of the right to file a grievance if he or she disagree with that decision.

Who can help with filing an Emergency Appeal?

El Paso Health's, Health Services Representatives are available to assist Members or the Member's representative with the Emergency Appeal.

State Fair Hearing: A State Fair Hearing is when the Texas Health and Human Services Commission (HHSC) directly reviews El Paso Health's decisions with your medical care.

Expedited State Fair Hearing: The Member may request an expedited Fair Hearing. The Member must first exhaust El Paso Health's expedited appeal process before a request for an expedited fair hearing can be made. The resolution of the expedited appeal will include the

procedure for requesting the expedited fair hearing. El Paso Health will be responsible for providing documentation of the expedited appeal to HHSC if an expedited fair hearing request is made.

Adverse Determination Appeal Timeframe

Standard Appeal: El Paso Health must complete the entire standard appeal process within 30 days after receipt of the initial written or oral request for Appeal, including the option to extend up to 14 Days if Member requests an extension; or El Paso Health shows that there is a need for additional information and how the delay is in the Member's interest. If El Paso health needs to extend, Member must receive written notice of the reason for delay.

Emergency Appeal: One working day from the date El Paso Health receives all information necessary to complete the appeal. El Paso Health may provide the determination by telephone or electronic transmission, but will provide a written determination within three (3) Business Days of the initial telephonic or electronic notification.

Expedited Fair Hearing: Resolution of an expedited State Fair Hearing appeal will be based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution to the appeal does not exceed one (1) Business Day from the date all the information necessary to complete the appeal is received. If a request for an expedited State Fair Hearing is denied, El Paso Health will transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the Member a prompt oral notice of the denial, following up within two (2) Calendar Days with a written notice regarding the denial of the Expedited Appeal.

Appeal Acknowledgment

Within five (5) Business Days of receipt of the appeal, we will send the appealing party a letter acknowledging the date that we received the appeal.

Providers are encouraged to contact El Paso Health should they not receive a letter of acknowledgement within five (5) Business Days.

All appeal documentation and telephone discussions will be logged, documented, scanned and attached to the authorization in El Paso Health’s management information system.

Requests for Additional Information for the Appeal

During the appeal process, El Paso Health will provide for a reasonable opportunity to present any additional information in person as well as in writing. El Paso Health will inform the Member of the time available for providing this information and that, in the case of an expedited resolution, limited time will be available. El Paso Health will also provide the Member or their representative with an opportunity, before and during the appeal process, the opportunity to examine the Member’s case file, including medical records and any other documents considered during the appeal process.

The appeal resolution letter will include:

- The specific dental, medical, contractual reasons for resolution;
- Clinical basis for decision;
- The description of or the source of the screening criteria used in making the determination;
- The professional specialty of the physician who made the determination;
- The notice of the appealing party's right to request a State Fair Hearing and External Medical Review or State Fair Hearing.
- A copy of the State Fair Hearing and External Medical Review Request Form.
- Procedures for filing a complaint to the Health and Human Services Commission (HHSC).

El Paso Health Services Representatives are available to assist the Member or Member's representative file any type of appeal to include an Expedited Appeal at 915-532-3778 or toll free at 1-877-532-3778.

El Paso Health does not discriminate or take punitive action against a Member or their representative for submitting an appeal.

STATE FAIR HEARING INFORMATION

Can a Member ask for a State Fair Hearing?

If a Member, as a member of El Paso Health, disagrees with the El Paso Health's decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling El Paso Health the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the Member does not ask for the State Fair Hearing within 120 days, the Member may lose his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member's representative should either send a letter to El Paso Health, Attention: Complaints and Appeals Department, 1145 Westmoreland Drive, El Paso Texas 79925 or call 915-532-3778 or toll free 1-877-532-3778 for STAR and toll free 1-833-742-3127 for STAR+PLUS.

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

If the Member asks for a State Fair Hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most State Fair Hearings are held

by telephone. At that time, the Member or the Member's representative can tell why the Member needs the service the health plan denied.

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

EXTERNAL MEDICAL REVIEW INFORMATION

Can a Member ask for an External Medical Review?

If a Member, as a member of El Paso Health, disagrees with the internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to El Paso Health telling El Paso Health the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of El Paso Health Internal Appeal Decision letter and mail or fax it to El Paso Health by using the address or fax number at the top of the form;
- Call El Paso Health at 915-532-3778 or toll free at 1-877-532-3778 for STAR and toll free at 1-833-742-3127 for STAR+PLUS;
- Email El Paso Health at Complaints&AppealsTeam@elpasohealth.com

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service the health plan denied, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, the State Fair Hearing decision is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling El Paso Health. To qualify for an emergency External Medical Review and emergency State Fair Hearing the Member must first complete El Paso Health's internal appeals process.

What is the Process after a determination is made by the Hearing Officer?

If the final determination of the appeal is adverse to the Member and is *upheld*, the Member may be required to pay the services furnished while the appeal was pending.

If the final determination of the appeal is to *reverse* a decision to deny, limit, or delay services that were not furnished while the appeal was pending, El Paso Health will authorize or provide the disputed services promptly and as expeditiously as the Member’s health condition requires.

If El Paso Health reverses a decision to deny authorization of services and the Member received the disputed services while the appeal was pending, El Paso Health will be responsible for the payment of services.

The Member may qualify for free or low cost legal services by contacting the Texas Rio Grande Legal Aide located at 1331 Texas Avenue, El Paso, TX 79901, at phone number 915-585-5100, toll free at 800-369-2792, or fax at 915-544-3789. You can also contact El Paso Health at 915-532-3778 or toll free at 1-877-532-3778 for assistance.

SECTION 10: PROVIDER COMPLAINTS/APPEALS PROCESS

DEFINITIONS

Complainant means a Member or a physician, Provider or other person designated to act on behalf of a Member, who files a complaint.

Complaint (CHIP Program only) means any dissatisfaction, expressed by a Complainant, orally or in writing to El Paso Health, with any aspect of El Paso Health operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or Appeal of an Adverse Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

Complaint (Medicaid only) means an expression of dissatisfaction expressed by a Complainant, orally or in writing to El Paso Health, about any matter related to El Paso Health other than an Action. As provided by 42 C.F.R. §438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights.

Action (Medicaid only) means:

1. the denial or limited authorization of a requested Medicaid service, including the type or level of service;
2. the reduction, suspension, or termination of a previously authorized service;
3. the denial in whole or in part of payment for service;
4. the failure to provide services in a timely manner;
5. the failure of El Paso Health to act within the timeframes set forth in the Contract and 42 C.F.R. §438.408(b); or
6. for a resident of a rural area with only one health plan, the denial of a Medicaid Members' request to obtain services outside of the Network.

An Adverse Determination is one type of Action.

Appeal (Medicaid only) means the formal process by which a Member or his or her representative request a review of the MCO's Action, as defined above.

PROVIDER COMPLAINTS

Disputes Involving Administrative Matters

Disputes involving administrative matters are those which arise from non-clinical or administrative issues from or with contracted Providers. The process described herein applies to all contracted Providers, delegated and non-delegated. The contract Provider under a delegated service (e.g., behavioral health) may also have additional specifically related processes.

In the event that El Paso Health takes an action to terminate, suspend or limit a Provider's participation status with El Paso Health, El Paso Health's Credentialing Unit will provide a dispute resolution process as delineated:

- Investigation
- Appeal
- Reapplication Subsequent to Adverse Action

Disputes Concerning Professional Competence or Conduct

All professional review actions based on reasons related to professional competence or professional conduct that affects or could affect adversely the health or welfare of a patient or patients and that adversely affect a Provider's privilege for a period of longer than thirty (30) Days must be reported, in accordance with Public Law 99-6660 and the Healthcare Quality Improvement Act of 1986. See, 45CFR 60.9.

The process described herein applies to all contracted Providers, delegated and non-delegated. The contracted Provider under a delegated service (e.g., behavioral health) may also have additional specifically related processes. In compliance with state and federal regulations, URAC standards, and El Paso Health standards, El Paso Health must report to appropriate monitoring agencies, e.g., the Texas Board of Medical Examiners, Health Integrity Data Bank, and/or the National Practitioner Data Bank (NPDB), quality-of-care issues resulting in termination or suspension of a Provider's privileges of participation or denial of acceptance to El Paso Health's Provider network. Other types of disputes may include not inviting a Provider to participate in the El Paso Health network and immediate termination due to imminent harm and adverse determinations. El Paso Health's various appeals policies are available upon request.

In the event that El Paso Health takes an action to terminate, suspend or limit a Provider's participation status with El Paso Health, El Paso Health will provide a dispute resolution process as delineated:

- Investigation
- Appeal Hearing (Appeals)
    - Level 1
    - Level 2
- Reapplication Subsequent to Adverse Action

PROVIDER COMPLAINTS

Medicaid Provider Complaints

El Paso Health wants all Providers to be satisfied. If at any time you are not satisfied, you may call 915-532-3778 and toll free at 1-877-532-3778 for STAR and toll free 1-833-742-3127 for STAR+PLUS if outside the service area for *claims related inquires.*

Providers have the right to file a complaint with El Paso Health.

Submit your complaint in writing to:

El Paso Health
Attn: Complaints and Appeals Department
1145 Westmoreland Dr.
El Paso, TX 79925

Complaints may be submitted by fax at: (915) 298-7872

Complaints may be submitted electronically through our WebPortal at:
http://www.elpasohealth.com

When a complaint is received, no later than the fifth (5th) Business Day, El Paso Health will send the complainant an acknowledgement letter including the complaint procedures and time frames.

El Paso Health records, tracks, maintains, and date stamps all written, faxed, and electronic complaints received. Complaint information including fax cover pages, emails to and from El Paso Health, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management system. Complaints will be resolved no later than thirty (30) Calendar Days after the date El Paso Health receives the complaint.

Complaint information including fax cover pages, emails, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management system.

Please note: A written appeal is not necessary for corrected claims; they may be submitted to the El Paso Health claims address.

MEDICAID PROVIDER APPEALS

El Paso Health recognizes two levels of appeals: 1st level and the 2nd level appeal.

An appeal is a request for reconsideration of a previously dispositioned claim.

Appeals of denied claims and requests for adjustments on paid claims must be in writing and must be received by El Paso Health within one hundred twenty (120) Days from the date of the

Remittance Advice (RA) on which that claim appears. If the one hundred twenty (120) Day appeal deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

Medicaid Provider 1st Level Claims Appeal Process

If the Provider is not satisfied with the disposition of the claim, the Provider has the right file an appeal. El Paso Health will recognize this appeal as a 1st level appeal. A Provider may appeal the claim by completing the following steps:

- Submit an appeal letter for each member specifying the reason for appealing the claim
- Letter MUST include:
    - Date
    - Contact Names (First and Last Name)
    - Mailing Address
    - Phone Number
    - Provider Name and NPI #
    - Member Name, Date of Birth, and ID number
    - Date of Service
    - Claim #
    - Reason for Appeal (be detailed)
- Support information:
    - Copy of Remittance Advice
    - Medical Records (if necessary)
    - Proof of Timely Filing
    - Any pertinent information for review

The appeal must be submitted in writing to:

El Paso Health
Attn: Complaint and Appeal Department
1145 Westmoreland Dr.
El Paso, TX 79925

Appeals may be submitted via fax at: Fax (915) 298-7872.

Appeals may be submitted electronically through our WebPortal at: www.elpasohealth.com

Upon receipt of the appeal, the appeal will be date stamped, logged and tracked by the Complaints and Appeals Department. The Appeal will be acknowledged within five (5) Business Days from receipt. El Paso Health will send the Provider a letter acknowledging the date of receipt and a description of El Paso Health appeal procedures and time frames. The Appeal will be resolved within thirty (30) Calendar Days of receipt. El Paso Health records,

tracks, maintains, and date stamps all telephonic, written, faxed and electronic appeals received. Complaint information including fax cover pages, emails, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management system.

If the Provider is not satisfied with the resolution of the appeal, and the Provider has additional information and/or documentation regarding the case that has not been previously considered, the Provider has the right to file a request for a 2nd level appeal. The request for a 2nd level appeal must be filed within one hundred twenty (120) Days of the resolution of the 1st level appeal or from the last Provider Remittance Advice Notification received in regards to the claim in question.

Medicaid Provider 2nd Level Claims Appeal Process

Upon receipt of the 2nd level appeal, the appeal will be date stamped, logged and tracked by the Complaints and Appeals Department. The Appeal will be acknowledged within five (5) Business Days from receipt. El Paso Health will send the Provider a letter acknowledging the date of receipt and a description of El Paso Health appeal procedures and time frames. The 2nd level appeal will be resolved within thirty (30) Calendar Days of receipt. El Paso Health records, tracks, maintains, and date stamps all telephonic, written, faxed and electronic appeals received. Complaint information including fax cover pages, emails, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management system.

Following the conclusion of the 2nd Level Claims Appeal Process, the Provider has exhausted the El Paso Health appeal process. If the Provider is not satisfied with the resolution of the 2nd level appeal and believes that they have not been given full due process the Provider may file a complaint to Health and Human Services Commission (HHSC) after they have exhausted El Paso Health's process.

Medicaid Provider Complaints to HHSC

The complaint can be submitted in writing or via email to the Health and Human Services Commission. The letter should be sent to the following address:

Texas Health and Human Services Commission
MCCO Research and Resolution
P.O. Box 149030, MC:0210
Austin, TX 78714-9030
Attn: Resolution Services
or
HPM_Complaints@hhsc.state.tx.us

PROVIDER APPEAL PROCESS TO HHSC

(related to claim recoupment due to Member disenrollment)

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

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- **The Explanation of Benefits (EOB) showing the original payment.** Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- **The EOB showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- **Completed clean claim.** All paper claims must include the valid NPI number and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

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

CHIP Provider Complaints and Appeals Process

CHIP Provider Complaints

El Paso Health wants all Providers to be satisfied. If at any time you are not satisfied, you may call (915) 532-3778 or 1(877) 532-3778 if outside the service area for *claims related inquires*.

Providers have the right to file a complaint with El Paso Health. Complaints may be submitted in writing to:

El Paso Health
Attn: Complaints and Appeals Department
1145 Westmoreland Dr.
El Paso, TX 79925
Complaints may be submitted by fax at: (915) 298-7872

Complaints may be submitted electronically through our WebPortal at:

http://www.elpasohealth.com

When a complaint is received, no later than the fifth (5th) Business Day, El Paso Health will send the complainant an acknowledgement letter including the complaint procedures and time frames.

El Paso Health records, tracks, maintains, and date stamps all written, faxed, and electronic complaints received. Complaint information including fax cover pages, emails, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management system. Complaints will be resolved no later than thirty (30) Calendar Days after the date El Paso Health receives the complaint.

Please note: A written appeal is not necessary for corrected claims; they may be submitted to the El Paso Health claims address.

CHIP PROVIDER APPEALS

El Paso Health recognizes two levels of appeals: 1st level and the 2nd level appeal.

An appeal is a request for reconsideration of a previously dispositioned claim.

Appeals of denied claims and requests for adjustments on paid claims must be in writing and must be received by El Paso Health within one hundred twenty (120) Days from the date of the Remittance Advice (RA) on which that claim appears. If the one hundred twenty (120) Day appeal deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

CHIP Provider 1st Level Claims Appeal Process

If the Provider is not satisfied with the disposition of the claim, the Provider has the right file an appeal. El Paso Health will recognize this appeal as a 1st level appeal. A Provider may appeal the claim by completing the following steps:

- Submit an Appeal letter for each Member specifying the reason for appealing the claim
- Letter MUST include:
    - Date
    - Contact Names (First and Last Name)
    - Mailing Address
    - Phone Number
    - Provider Name and NPI #
    - Member Name, Date of Birth, and ID number
    - Date of Service
    - Claim #
    - Reason for Appeal (be detailed)
- Support information:
    - Copy of Remittance Advice

- Medical Records (if necessary)
- Proof of Timely Filing
- Any pertinent information for review

The appeal must be submitted in writing to:

El Paso Health
Attn: Complaint and Appeal Department
1145 Westmoreland Dr.
El Paso, TX 79925

Appeals may be submitted via fax at: (915) 298-7872
Appeals may be submitted electronically through our WebPortal at:
http://www.elpasohealth.com

Upon receipt of the appeal, the appeal will be date stamped, logged and tracked by the Complaints and Appeals Department. The Appeal will be acknowledged within five (5) Business Days from receipt. El Paso Health will send the Provider a letter acknowledging the date of receipt and a description of El Paso Health appeal procedures and time frames. The Appeal will be resolved within thirty (30) Calendar Days of receipt. El Paso Health records, tracks, maintains, and date stamps all telephonic, written, faxed and electronic appeals received. Complaint information including fax cover pages, emails, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management system.

If the Provider is not satisfied with the resolution of the appeal, and the Provider has additional information and/or documentation regarding the case that has not been previously considered, the Provider has the right to file a request for a 2nd level appeal. The request for a 2nd level appeal must be filed within one hundred twenty (120) Days of the resolution of the 1st level appeal or from the last Provider Remittance Advice Notification received in regards to the claim in question.

CHIP Provider 2nd Level Claims Appeal Process

Upon receipt of the 2nd level appeal, the appeal will be date stamped, logged and tracked by the Complaints and Appeals Department. The Appeal will be acknowledged within five (5) Business Days from receipt. El Paso Health will send the Provider a letter acknowledging the date of receipt and a description of El Paso Health appeal procedures and time frames. The 2nd level appeal will be resolved within thirty (30) Calendar Days of receipt. El Paso Health records, tracks, maintains, and date stamps all telephonic, written, faxed and electronic appeals received.

Complaint information including fax cover pages, emails, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management system.

Following the conclusion of the 2nd Level Claims Appeal Process, the Provider has exhausted the El Paso Health appeal process. If the Provider is not satisfied with the resolution of the 2nd

level appeal and believes that they have not been given full due process the Provider may file a complaint to the Texas Department of Insurance (TDI). The Provider can file a complaint with TDI at any time.

CHIP Provider Complaints to TDI

The complaint must be submitted in writing to the Texas Department of Insurance. The letter should be sent to the following address:

Texas Department of Insurance
Consumer Protection
P.O. Box 149091
Austin, TX 78714-9091
Call Toll Free: 1-800-252-3439
or
https://www.tdi.texas.gov/consumer/complfrm.html

GENERAL PROVIDER COMPLAINTS

Providers have the right to file a complaint with El Paso Health.
Complaints may be submitted to:

El Paso Health
Attn: Complaints and Appeals Department
1145 Westmoreland Dr.
El Paso, TX 79925

Complaints may be submitted by fax at: (915) 298-7872
Complaints may be submitted electronically through our WebPortal at:
http://www.elpasohealth.com

El Paso Health will send the complainant an acknowledgement letter within 5 business days of receiving the complaint and a resolution letter within 30 calendar days. El Paso Health records, tracks, maintains, and date stamps all written, faxed, and electronic complaints received. Complaint information including fax cover pages, emails, and telephone records become part of the case and are maintained in hard copy and/or electronic copy within the information management.

SPAN OF COVERAGE (HOSPITAL)

Responsibility during a Continuous Inpatient Stay [1]

Payment responsibility for Medicaid enrollment changes that occur during Continuous Inpatient Stay in a Hospital, as of the Member's Effective Date of Coverage with the receiving (New) MCO.

	Scenario	Hospital Facility Charge
1	Client moves from FFS to STAR+PLUS Plan	FFS
2	Client moves from FFS to STAR+PLUS Plan but is transferred with no other break in service	FFS (original coverage at initial admit prior to transfer)
3	Client moves from STAR+PLUS Plan to FFS	STAR+PLUS
4	Client moves from STAR+PLUS Plan to FFS but is transferred with no other break in service	STAR+PLUS Plan (original coverage at initial admit prior to transfer)
5	Client moves from STAR+PLUS Plan to a new STAR+PLUS Plan	Former STAR+PLUS Plan
6	Client moves from STAR+PLUS Plan to a new STAR+PLUS Plan but is transferred with no other break in service	Former STAR+PLUS Plan (original coverage at initial admit prior to transfer)
7	Client moves from STAR+PLUS to a STAR HEALTH Plan	STAR+PLUS Plan
8	Client moves from STAR+PLUS to a STAR HEALTH Plan but is transferred with no other break in service	STAR+PLUS Plan (original coverage at initial admit prior to transfer)
9	Client moves from STAR HEALTH to a STAR+PLUS Plan	STAR HEALTH
10	Client moves from STAR HEALTH to a STAR+PLUS Plan but is transferred with no other break in service	STAR HEALTH (original coverage at initial admit prior to transfer)
11	Client moves from FFS to STAR HEALTH	FFS
12	Client moves from FFS to STAR HEALTH but is transferred with no other break in service	FFS (original coverage at initial admit prior to transfer)
13	Client moves from STAR HEALTH to FFS	STAR HEALTH
14	Client moves from STAR HEALTH to FFS but is transferred with no other break in service	STAR HEALTH (original coverage at initial admit prior to transfer)
15	Client is retroactively enrolled in STAR or STAR+PLUS	New MCO

[1] This document is not intended to supercede any HHSC Contract. This is a reference tool determining the span of coverage limitation. For up to date references, please see the following: Uniform Managed Care Contract for Medicaid and CHIP, STAR+PLUS Expansion Contract, STAR Health Managed Care Contract, and STAR+PLUS Medicaid Rural Services Area (MRSA) Contract.

http://www.hhsc.state.tx.us/medicaid/managed-care/forms.shtml

SECTION 11: MEMBER COMPLAINT PROCES

What should I do if I have a complaint?

Members may file complaints to El Paso Health verbally or in writing. It is El Paso Health's goal to resolve all complaints in a timely manner. When a complaint is received, a written acknowledgement is sent within five (5) Business Days.

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

El Paso Health has thirty (30) Calendar Days to resolve any complaint received.

Can someone from El Paso Health help me file a complaint?

Yes. El Paso Health's Member Services Representative or one of our Member Advocates can assist Members with the process of filing a complaint.

Who do I call?

A member can call Member Services at the numbers below:

- STAR and CHIP toll-free 1-877-532-3778 Local (915)532-3778
- STAR+PLUS toll-free 1-833-742-3127 Local (915)742-3127
- STAR, CHIP, and STAR+PLUS TTY Line: 711

Members can also complete a complaint form provided by a Member Services Representative or mail a complaint letter to:

El Paso Health
Member Services Department
1145 Westmoreland Dr.
El Paso, TX 79925

For Medicaid Members – If I am not satisfied with the outcome, who else can I call?

Once you have gone through El Paso Health's complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services
Commission Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247

If you can get on the Internet, you can send your complaint at:
hhs.texas.gov/managed-care-help

For CHIP Members – If I am not satisfied with the outcome, who else can I call?

A copy of the CHIP Member Complaint form is included as **ATTACHMENT 19** in this Manual. The Member has the right to request a second review of the resolution of the complaint if he/she is not satisfied with the resolution.

At any time, a CHIP Member can complain to the Texas Department of Insurance by calling toll-free 1-800-252-3439 or complaints may be sent to the following address:

Texas Department of Insurance
Consumer Protection
P.O. Box 149104
Austin, TX 78714-9104
Phone Number: 1-800-252-3439
http://www.tdi.texas.gov/consumer/complfrm.html

SECTION 12: CLAIMS PROCESSING GUIDELINES

This chapter establishes the Claims Processing requirements and timelines that must be used by providers. These requirements are based on the authorities noted below.

El Paso Health follows Texas Department of Insurance (TDI), Health and Human Services Commission (HHSC), Health Insurance Portability and Accountability Act of 1996 (HIPAA), National Standard Correct Coding Initiative (NSCCI) and Centers for Medicare and Medicaid Services (CMS) guidelines.

Statutory and Regulatory Authority

- 42 USC §1396a (a) (37) [§1902(a)(37) of the Social Security Act]
- 42 U.S.C. §1396u-2(f) [§ 1932(f) of the Social Security Act]
- Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191
- 42 CFR §438.242
- 42 CFR §447.45
- 42 CFR §447.46
- 45 CFR §160 - §164
- Texas Insurance Code §§ 843.349 (e) and (f)
- 1 TAC, Part 15, Chapter 353, Subchapter A, §353.4

Informational Resources

- 28 TAC Chapter 21, Subchapter T, “Submission of Clean Claims”
- Texas Insurance Code Chapter 843, “Subchapter J, Payment of Claims to Physicians and Providers”
- 28 TAC §21.2826 waives the application of certain statutes and rules regarding prompt payment of claims.

Information Reference

El Paso Health references Texas Department of Insurance (TDI), Health and Human Service Commission (HHSC), Health Insurance Portability and Accountability Act of 1996 (HIPAA), National Standard Correct Coding Initiative (NSCCI), American Medical Association coding books (CPT, ICD-9, ICD-10, and Coding with Modifiers), and Centers for Medicare and Medicaid Services (CMS) guidelines.

PROMPT PAYMENT REQUIREMENTS

El Paso Health will adjudicate both paper and electronic clean claims:

1. by Claim Type,
2. by Program, and
3. by Service Area.

The statutory payment period by which a clean claim must be paid begins to run upon the receipt date of a clean claim, including a corrected clean claim. Clean claims received by El Paso Health are adjudicated in adherence to the following performance requirements and timeframes set by HHSC:

1. 98% of all Clean Claims within 30 Days of receipt (whether paper or electronic)
2. 99% of all Clean Claims within 90 Days of receipt.
3. 98% of all Appealed Claims within 30 Days of receipt.
4. 100% of all claims, including Appealed Claims, within 24 months from Date of Service (DOS).

CLAIMS DEFINITIONS

1. Adjudication: The process of determining if a claim should be paid based on the services rendered, the patient's covered benefits, and the provider's authority to render the services. Claims for which the adjudication process has been temporarily put on hold (e.g., awaiting additional information, correction) are considered "suspended" and, therefore, are not "fully adjudicated.
2. Adjudicate: to deny or pay a Clean Claim, where an MCO has reviewed and either approved or denied, either all or in part, for payment. Of a Claim that has gone through the Adjudication process.
3. Adverse Benefit Determination: The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service. 42 CFR §438.400(b)(3).
4. Approved Claim: A Clean Claim having completed the Adjudication process for reimbursement.
5. Claim: A bill for services, a line item of service, or all services for one beneficiary with a bill. 42 CFR § 447.45(??).
6. Claims Processing: The action(s) taken on a Claim by the Claims Examiner.
7. Clean Claim: A claim submitted by a provider for medical care or services rendered to an enrolled member that contains the necessary data elements to be processed or adjudicated.
8. Date Adjudicated: The date a Clean Claim completes the Adjudication process.
9. Date Paid: The date payment is made by check or electronic funds transfer to a Provider for an approved claim.

10. Deficient Claim: A Claim that is not a Clean Claim.
11. Recoupment: The recovery of funds paid to a provider or individual to which the provider or individual was not entitled.
12. Received Date of Claim:
    a. The Received Date of Claim is the date that the claim was received by the MCO or its subcontracted claims processor, except for claims forwarded to the MCO from the HHSC Administrative Services Contractor;
    b. For claims forwarded to the MCO from the HHSC Administrative Services Contractor, the creation date of the claim, located in the ISAO9 field of the claim, is the Received Date of the claim.

Timeframes are based on calendar days and are subject to change due to updates in HHSC requirements, federal and state laws, rules, or regulations.

Payment of a clean claim is considered to have been paid on the date of:

1. Date of issue of a check for payment and its corresponding Remittance Advice to the Provider.
2. Electronic transmission, if claim paid electronically.
3. Delivery of the claim payment, if payment is made through a commercial carrier, such as UPS or Federal Express.
4. Receipt by the Provider, if payment is made other than steps one through three.

El Paso Health is not required to pay any claims to providers who:

1. Are excluded or suspended from the Medicare, Medicaid, CHIP or CHIP Perinatal Programs for fraud, waste, and abuse, or
2. Are on payment hold under the authority of HHSC or its authorized agents or have pending accounts receivable with HHSC.

Payment of clean claims to providers who render Medically Necessary Covered Services to Members, for whom a capitation has been paid to El Paso Health, shall be done in an accurate and timely manner, as per our contract.

If you have questions related to services included in the monthly capitation, please contact the Provider Relations Department at 915-532-3778.

El Paso Health is subject to remedies, including liquid damages and reasonable attorney fees and taxes, if it fails to process and finalize clean claims or a portion of a clean claim within the statutory 30 Day timeframe and performance requirements. This interest rate is calculated at an annual 18% rate, accrued daily, for the period of time the clean claim remains unadjudicated. If the Provider agreement specifies a contracted penalty rate, then that provision controls and the Provider must be paid the contracted penalty rate.

If due to a catastrophic event, El Paso Health is unable to meet the statutory timeframes for claim processing and adjudication, the deadlines may be extended. However, El Paso Health must notify TDI and HHSC within five (5) Days of the catastrophic event. Within ten (10) Days after

returning to normal business operations, El Paso Health must send a certification of the catastrophic event to TDI in order to be in compliance. A valid certification of occurrence will toll the applicable deadlines for the number of days identified as the date of the catastrophic event.

OUT OF NETWORK PROVIDER

Providers that have not signed a contract to provide care for El Paso Health members are considered out-of-network. In such cases where an out-of-network provider provides care to an El Paso Health member, El Paso Health will reimburse the out-of-network, in-area service provider the Medicaid Fee-For-Service (FFS) rate whereby El Paso Health will pay for services rendered, less five percent per rules found in 1 Texas Administrative Code (TAC) § 353.4

REQUIREMENTS

Under the National Uniform Insurance Industry and CMS, El Paso Health will only accept paper claims submitted on **CMS 1500 or CMS 1450 UB-04** claim forms. **It is important to note that the National Uniform Claim Committee (NUCC) has approved a revised version of the CMS 1500 claim form** effective 04-01-2014.

Under the HIPAA provisions, El Paso Health will only accept 5010 ANSI X12N electronic files. El Paso Health requires all electronic files to contain Taxonomy Codes. The Provider Taxonomy code set is an external non-medical data code set designed for use in an electronic environment, specifically within the ANSI ASC X12N healthcare transaction. These codes may be obtained from X12.

The implementation guides may be obtained from:

X12, PMB 161,
5284 Randolph Road
Rockville, MD, 20852-2116
Telephone (301) 949-9740
Fax (301) 949-9742 https://x12.org/products

Under HIPAA guidelines, El Paso Health will only accept HCPCS, CPT-4, ICD-10, and ICD-9 codes approved by CMS for claims reimbursement.

Under CMS guidelines, El Paso Health will accept place-of-service codes approved by CMS. El Paso Health adheres to the following 28 TAC Chapter 21, Subchapter T, "Submission of Clean Claims" amendments to §§21.2802, 21.2807, 21.2815, and 21.2821.

These amendments:

1. ensure that carriers are aware of the responsibility to process a clean claim submitted together with deficient claims;
2. ensure that penalties are calculated consistently and in accordance with statutory requirements; and

3. provide consistency in reporting dates and clarify the reporting period for the required verification data report.

Documentation Requirements

Providers must include the following required documentation with the claim submission:

National Provider Identifier (NPI) Requirements

The National Provider Identifier (NPI) final rule, Federal Register 45, *Code of Federal Regulations* (CFR) Part 162, established the NPI as the standard unique identifier for health-care providers and requires covered health-care providers, clearinghouses, and health plans to use this identifier in *Health Insurance Portability and Accountability Act* (HIPAA)-covered transactions. An NPI is a 10-digit number assigned randomly by the National Plan and Provider Enumeration System (NPPES). Providers must verify the NPI number associated with their Provider name and specialty before beginning the online attestation process. Provider must ensure to attest all NPI numbers for the practice name and individual name *Taxonomy Code Requirements*.

Taxonomy Code

The Health Care Provider Taxonomy Code Set is an external, non-medical collection of alphanumeric codes designed to classify health-care providers by Provider type and specialty. Providers may have more than one taxonomy code. (Taxonomy codes can be obtained from the X12 website at https://x12.org/products). Providers must verify the taxonomy code associated with their Provider type and specialty before beginning the online attestation process.

Diagnosis Codes (ICD-10-CM/PCS)

El Paso Health requires the International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM/PCS).

This coding system is published by the U.S. Department of Health and Human Services, and is available from:

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

Diagnosis Codes (ICD-10)

The ICD-10 classification system was developed by the National Center for Health Statics (NCHS) as a clinical modification to the ICD-10 system developed by the World Health Organization (WHO). The ICD-10 draft and crosswalk between ICD-9 and ICD-10 are available on the CMS website. Compliance with ICD-10 CM and ICD-10 PCS as a replacement for ICD-9 was implemented on 10/01/2015.

CPT-Code

El Paso Health requires that providers use the Current Procedural Terminology (CPT), which contains a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

These codes are used for the following services:

- Evaluation and Management
- Texas Health Steps
- Anesthesia
- Surgery
- Pathology and Laboratory
- Radiology (Including Nuclear medicine, diagnosis ultrasound)
- Medicine

Modifier Requirements

A Current Procedural Terminology (CPT) code set modifier is a two-digit code reported in addition to the CPT services or procedure code that indicates the service or procedure was modified in some way. Modifiers are essential tools in the coding process. The American Medical Association (AMA) developed modifiers to be used with its CPT codes set to explain various aspects of coding. Modifiers are used to enhance a code narrative to describe the circumstances of each procedure or service and how it individually applies to the patient and payers. A modifier provides the means by which a rendering physician may indicate that a service or procedure has been performed, or has been altered by some specific circumstances, but not changed in its definition or code. The lack of modifiers or the improper use of modifiers can result in claims delays or denials from El Paso Health. Most procedure codes do not require a modifier, but are required for some services submitted on professional claims and outpatient hospital claims.

Modifiers are used as a method to report:

- A service or procedure that has been modified but not changed in its identification or definition
- Special circumstances or conditions of patient care
- Repeat or multiple procedures
- Cause for higher or lower costs while protecting charges history data
- Assistant surgeon services
- Anesthesia service
- Interpretation service
- Technical component service
- Professional component for a procedure or service

- Service or procedure performed bilaterally
- Multiple services performed
- Reduction or elimination of a procedure by the same Provider
- Service performed by more than one physician

PRACTICE SPECIALTY CLAIM SUBMISSION REQUIREMENTS

Anesthesia

Anesthesiologists must identify the following information on their claims:

- Procedure performed (CPT anesthesia code in Block 24 of the CMS-1500 claim form).
- Providers are expected to bill using the current ICD-10, HCPCS, CPT and applicable modifiers codes. Payment will be denied for use of invalid coding.
- Providers are expected to use the appropriate American Society of Anesthesiologist (ASA) codes when billing for anesthesia. Physical status modifiers are ASA codes ranking the patients physical status.
- The number of anesthesia minutes should be reported on each claim.
- Modifiers must be used to designate the Provider type
- Providers must include the following required documentation with the claim submission:
- Radiology Reports–When the services are repeated on the same day or during the postoperative period.
- Pathology Readings–When a second test using the same CPT performed on the same day for the same site. Failure to do so may result in denial of the claim. El Paso Health reserves the right to request additional documentation of the claim.

In-Patient Hospital Claims

Present on Admission (POA) reporting is required for all inpatient hospital claims. No hospital is exempt from this requirement. All hospital providers are required to submit a POA value for each diagnosis on the claim form. POA is defined as a condition present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient visit, including emergency department, observation, or outpatient surgery, are also considered POA. POA information helps to determine whether a claim will be considered for payment. No payment will be made for claims containing POA indicators “N” or “U” when a Hospital Acquired Condition (HAC) is present.

Claims submitted without a POA value will be denied unless the diagnosis code is exempt from POA reporting. The following table shows the POA values.

POA Value	Description
Y	Diagnosis was present at time of admission
N	Diagnosis was not present at the time of admission
U	Documentation was insufficient
W	Clinically undetermined
Blank	Exempt from POA reporting

Special Billing for Newborn Claims

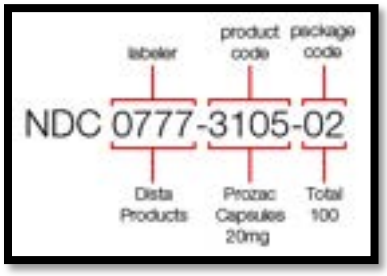
A temporary "proxy" identification (ID) number will be assigned to infants born to Medicaid members if the newborn's state issued ID number has not been received by the health plan. El Paso Health will process and adjudicate claims using the proxy number issued by the Member Services Department until the state issued Medicaid ID number is received.

NATIONAL DRUG CODE (NDC) CLAIMS FILING

All claims must have, if applicable, a national drug code (NDC) and a HCPCS procedure code for Provider administered drugs. Claims that do not have this information shall be rejected and returned to the Provider for correction. The unit of measure and unit quantity must also be included in the claim. It is important to note that codes in the A Code Series do not require an NDC.

An NDC is composed of three sets of numbers:

- The first set is assigned by the Food and Drug Administration (FDA) and identifies the labeler, that is, the manufacturer, repackager, or distributer of the drug.
- The second is the product code. It identifies the specific strength, dosage form, i.e. capsule, tablet, liquid, etc., and the formulation of a drug for a specific manufacturer.
- The third set is the package code, which identifies package sizes and types.



According to the TMPPM, an N4 prefix must precede the NDC on claims. Units of measurement codes and unit quantities must also be submitted. The codes to be used for all claim forms are:

- F2 – International unit
- GR – Gram
- ML – Milliliter
- UN – Unit

Each NDC must be reported as an 11-digit code unique to the manufacturer of the specific drug or product administered to the beneficiary, using a 5-4-2 format *(i.e.*, 5 digits, followed by 4 digits, followed by 2 digits [99999999999]).

Some NDCs may be in a 10-digit format. The chart below illustrates how to convert the NDC code into an 11-digit format by the addition of a zero (0).

Hyphens in the example below are for illustration only.

10-Digit Format on Package	10-Digit Format Example	11-Digit Format	11-Digit Format Example
4-4-2	9999-9999-99	5-4-2	**0**9999-9999-99
5-3-2	99999-999-99	5-4-2	99999-**0**999-99
5-4-1	99999-9999-9	5-4-2	99999-9999-**0**9

The following tables indicate how providers must submit NDC information on paper claims.

Block No.	Description	Guidelines
24A	Dates of service	In the shaded area, enter the: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). ***Example:*** *N400409231231*
24D	Procedures, services, or supplies	In the shaded area, enter the NDC quantity of units administered (up to 12 digits, including the decimal point.). A decimal point must be used for fractions of a unit (e.g., 0.025).
24G	Days or units	In the shaded area, enter the NDC unit of measurement code. There are 5 allowed values: F2, GR, ML, UN, or ME.

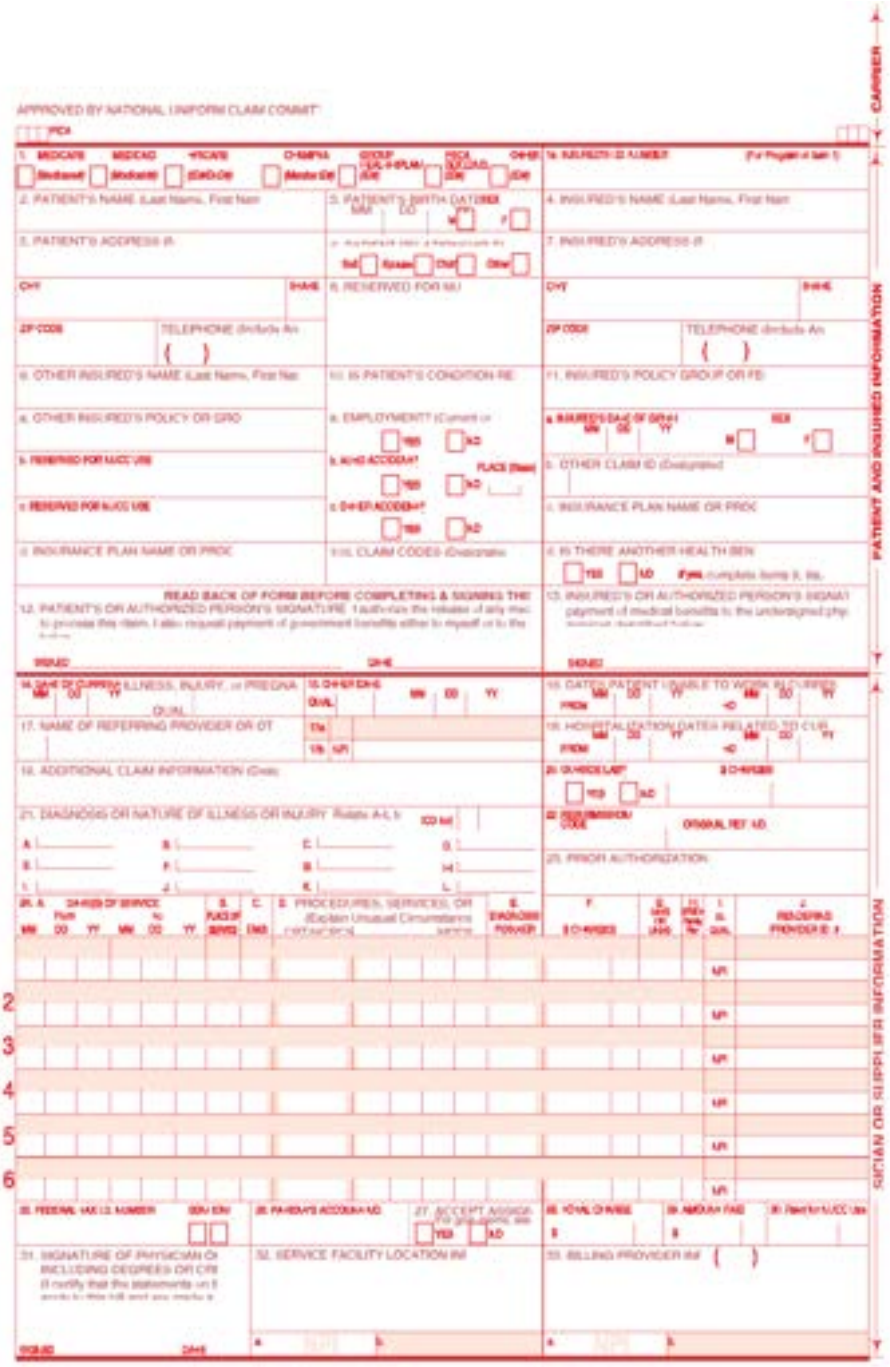
Block No.	Description	Guidelines
42-43	Revenue codes and description	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. **NDC** This block should include the following elements in the following order: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). • The unit of measurement code. There are 5 allowed values: F2, GR, ML, UN, or ME (e.g., GR). • The unit quantity with a floating decimal for fractional units (limited to 3 digits, e.g., 0.025). ***Example:*** *N400409231231GR0.025* ***Refer to:*** Subsection 6.3.4, "National Drug Code (NDC)" in this section.

Claim Submission Timelines

For Professional Provider claims, the Date of Service (DOS) drives submission timelines. In order to be considered timely, a claim for medical services must be presented for processing within 95 Days of the DOS. In the case of Institutional Providers, the Date of Discharge (DOD) is the driving element. Institutional claims for medical services must be presented within 95 Days from the DOD. In the cases of prolonged in-patient stays, Institutional Providers may submit interim billing.

At no time will El Paso Health charge a Provider or a Member a fee for claim adjudication.

Example: HCFA CMS 1500 Form



The instructions describe what information must be entered in each of the block numbers of the CMS-1500 paper claim form. Block numbers *not* referenced in the table may be left blank. They are *not* required for claim processing by TMHP.

CMS 1500(08-05) FORM FOR PROFESSIONAL CLAIMS

Block No.	Description	Guidelines
1a	Insured's ID No. (include all letters)	Enter the client's nine-digit patient number from Medicaid ID form.
2	Patient's Name	Enter the patient's last and first names, and middle initial as printed on Medicaid ID form. If patient uses a last name suffix (Ex: Jr, Sr) enter it after the last name and before the first name.
3	Patient's Date of Birth Patient's Sex	Enter numerically the month, day, and year (MM/DD/YYYY) the patient was born. Indicate gender by checking the appropriate box. (Only one box can be marked.)
5	Patient's Address	Enter the patient's complete address: street, city, state, and ZIP code.
9	Other Insured's Name	For special situations, use this space to provide additional info such as: If client is deceased, enter "DOD" in block 9 and time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.
10a 10b 10c	If patient's condition is related to: a. Employment (current or previous) b. Auto accident c. Other accident	Check appropriate box. If other insurance is available, enter appropriate info in blocks 11, 11a, and 11b.
11 11a 11b	Other Health Insurance Coverage	If another insurance resource has made payment or denied a claim, enter the name of the insurance company. The other insurance EOB or denial letter must be attached to the claim form. • If the client is enrolled in Medicare attach a copy of the MRAN to the claim form. • For Workers Compensation and other property and casualty claims: (Required if known) Enter Workers' Compensation or property and casualty claim number assigned by the payer.
11c	Insurance Plan or Program Name	Enter the benefit code, if applicable, for the billing or performing Provider.

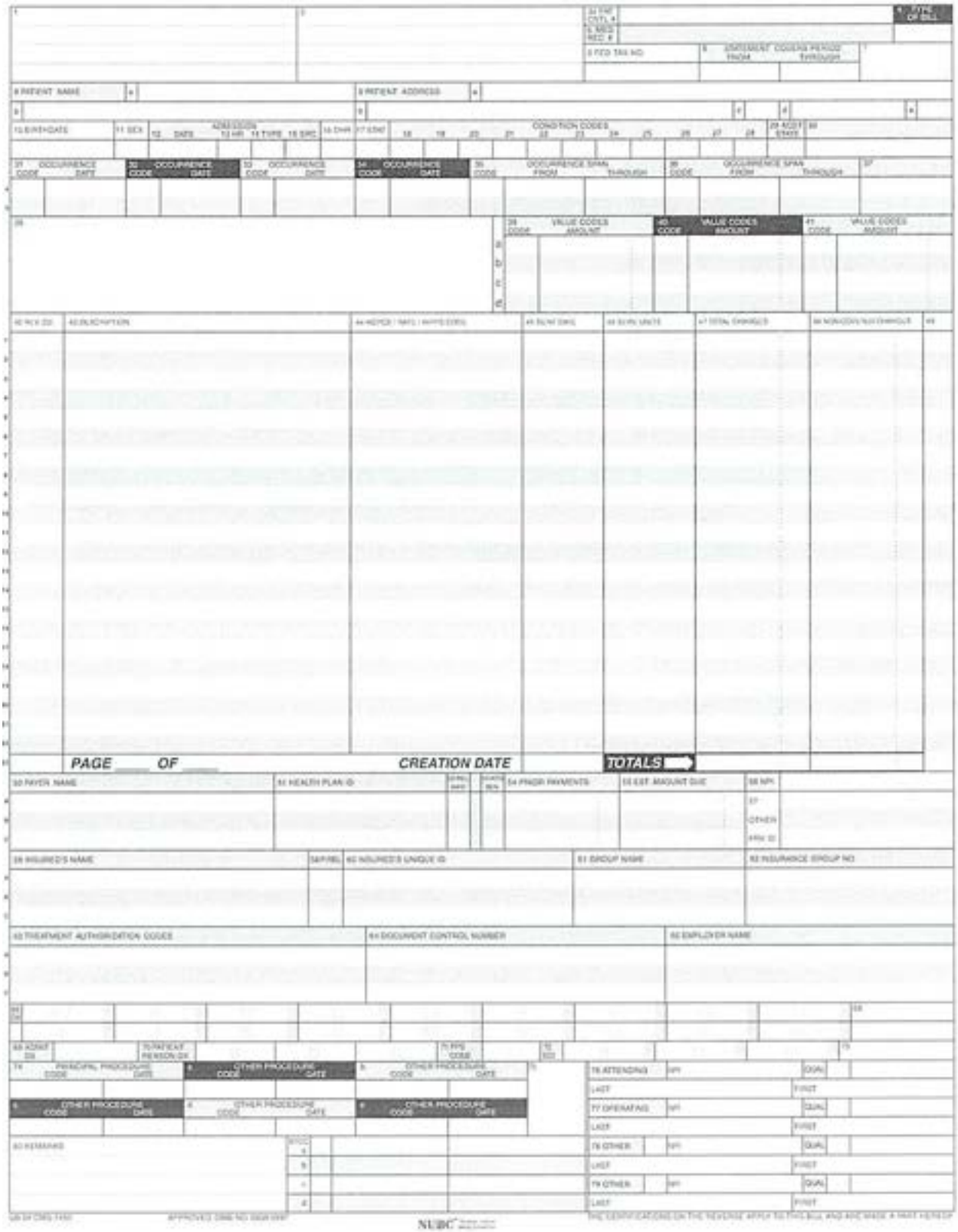
Block No.	Description	Guidelines
12	Patient's or Authorized Person's Signature	Enter "Signature on File," "SOF," or legal signature. El Paso Health will process claim without patient's signature.
13	Date of Current	Enter first date (MM/DD/YYYY) of present illness or injury. For pregnancy, enter date of the last menstrual period. If the client has chronic renal disease, enter date of onset of dialysis treatments. Indicate date of treatments for PT and OT.
17 17b	Name of referring physician or other source	Enter the complete name (block 17) and the NPI (block 17b) of the attending, referring, ordering, designated, or performing (freestanding ASCs only) Provider. Refer to specific TMPPM sections for requirements.
19	Reserved for local use	**Transfers of multiple clients** If the claim is part of a multiple transfer, indicate other client's complete name and Medicaid number. **Ambulance Hospital-to-Hospital Transfers** Indicate the services required from second facility and unavailable at first facility.
20	Outside Laboratory	Check the appropriate box. (Info may be requested for retrospective review.) If "yes," enter the Provider identifier of the facility that performed the service in block 32.
21	Diagnosis or Nature of Illness or Injury	Enter up to four ICD-10-CM diagnosis codes to the highest level of specificity available.
22	Medicaid Resubmission Code	When Resubmitting a Claim, enter the appropriate bill frequency code left justified in the left hand side of the field: Code: 7 = Replacement of prior claim Code: 8 = Void/cancel of prior claim List the original reference number for resubmitted claim in the Original Reference No. section.
23	Prior Authorization Number (PAN)	Enter the PAN issued by El Paso Health. This is required when prior authorization, referral, concurrent review, or voluntary certification was received.

Block No.	Description	Guidelines
24	Various	**General notes for 24a through 24j:** • Unless otherwise specified, all required info should be entered in unshaded portion. • If more than six line items are billed for entire claim, a Provider must attach additional claim forms with no more than 28-line items for the entire claim. • For multi-page claim forms, indicate the page number of the attachment (for example, page 2 of 3) on the top right-hand corner of claim form.
24a	Date(s) of Service (DOS)	For each procedure provided, enter DOS in a MM/DD/YYYY format. If more than one DOS for a single procedure, each DOS must be given on a separate line. **NDC:** In shaded area, enter NDC qualifier of N4 and the 11-digit NDC number (number on package or container from which med was administered). Do not enter hyphens or spaces. Example**:** N400409231231
24b	Place of Service (POS)	Select the appropriate POS code for each service from the table under TMPPM subsection 6.3.1.1, "Place of Service (POS) Coding."
24c	EMG (THSteps medical checkup condition indicator)	Enter the appropriate condition indicator for THSteps medical checkups. Refer to TMPPM Subsection 5.3.6, "THSteps Medical Checkups" in *Children's Services Handbook*
24d	Fully describe procedures, medical services, or supplies furnished for each date given	Enter appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description. **NDC:** In shaded area, enter a 1 through 12-digit NDC quantity of unit. Must use a decimal point for fractions of a unit. Refer to TMPPM Subsection 6.3.4, "National Drug Code (NDC)."

Block No.	Description	Guidelines
24e	Diagnosis Pointer	Enter the line item reference (1, 2, 3, or 4) of each diagnosis code identified in block 21. Indicate the primary diagnosis only. Do not enter more than one diagnosis code reference per procedure. This can result in denial of the service.
24f	Charges	Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.
24g	Days or Units	If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). ***Note:*** The maximum number of units per detail is 9,999. **NDC:** In shaded area, enter the NDC unit of measurement code. Refer to TMPPM Subsection 6.3.4, "National Drug Code (NDC)".
24j	Rendering Provider ID (performing)	Enter Provider ID of individual rendering the services unless otherwise indicated in the TMPPM. Enter the NPI in the unshaded area of the field.
26	Patient's Account Number	**Optional:** Enter the patient id number if different than the subscriber/insured's id number. Used by Provider's office to identify internal client account number.
27	Accept Assignment	**Required:** All providers of Texas Medicaid must accept assignment to receive payment by checking **Yes**.
28	Total Charge	Enter the total charges. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim. **Note:** Indicate the page number of the attachment (for ex: page 2 of 3) on the top right-hand corner of the form.

Block No.	Description	Guidelines
29	Amount Paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If client makes a payment, the reason for payment must be indicated in block 11.
30	Balance Due	If appropriate, subtract block 29 from block 28 and enter the balance.
31	Signature of Physician or Supplier	The physician, supplier, or an authorized representative must sign and date the claim. Billing services may print "Signature on File" along with the printed Provider's name in place of the Provider's signature if the billing service obtains and retains on file a letter signed by the Provider authorizing this practice. Refer to TMPPM Subsection 6.4.2.1, "Provider Signature on Claims."
32	Service facility location information	Enter the name, address, and ZIP code of the facility where the service was provided.
32A	NPI	Enter the NPI of the service facility location.
33	Billing Provider info & PH #	Enter billing Provider's name, street, city, state, ZIP+4 code, and phone number.
33A	NPI	Enter the NPI of the billing Provider.
33B	Other ID #	Enter the taxonomy code of the billing Provider.

Example: UB-04 Claim Form



UB-04 Form Guidelines

The instructions describe what information must be entered in each of the block numbers of the UB-04 CMS-1450 paper claim form. Block numbers not referenced in the table may be left blank. They are not required for claim processing by TMHP.

UB–O4 CMS-1450 FORM FOR INSTITUTIONAL PROVIDERS

Block	Description	Guidelines
1	Unlabeled	Enter hospital name, street, city, state, ZIP+4 Code, and phone number.
3	Patient Control Number	**Optional:** Any alphanumeric character (limit 16) entered in this block is referenced on the R&S Report.
3B	Medical Record Number	Enter patient's medical record number (limit ten digits) assigned by the hospital.
4	Type of Bill (TOB)	Enter a TOB code. First Digit—Type of Facility Second Digit—Bill Classification Third Digit—Frequency **First Digit—Type of Facility:** 1 Hospital 2 Skilled nursing 3 Home health agency 7 Clinic (RHC,FQHC, and RDC) 8 Special facility **Second Digit—Bill Classification (except clinics and special facilities):** 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, Ex: labs and X-rays) 7 Intermediate care **Second Digit—Bill Classification (clinics only):** 1 Rural health 2 Hospital-based or independent renal dialysis center 3 Free standing 5 CORFs **Third Digit—Frequency:** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim-first claim 3 Interim-continuing claim 4 Interim-last claim

Block	Description	Guidelines
		5 Late charges-only claim 6 Adjustment of prior claim 7 Replacement of prior claim
6	Statement covers period	Enter the beginning and ending dates of service billed.
8a	Patient Identifier	**Optional:** Enter the patient id number if different than the subscriber/insured's ID number. Used by Provider's office to identify internal patient account number.
8b	Patient Name	Enter patient's last and first names, and middle initial as printed on the Medicaid ID form.
9a–9b	Patient Address	Starting in 9a, enter patient's complete address: street, city, state, and ZIP+4 Code.
10	Birth Date	Enter patient's date of birth: MM/DD/YYYY
11	Sex	Indicate patient's gender by entering an "M" or "F."
12	Admission Date	Enter numerical date (MM/DD/YYYY) of admission for inpatient claims; DOS for outpatient claims; or start of care (SOC) for home health claims. Providers that receive a transfer patient from another hospital must enter actual dates patient was admitted into each facility.
13	Admission Hour	Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.
14	Type of Admission	Enter appropriate admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 15.) 5 Trauma center
15	Source of Admission	Enter the appropriate source of admission code for inpatient claims. **For type of admission 1, 2, 3, or 5:** 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from skilled nursing facility (SNF) 6 Transfer from another health-care facility 7 Emergency room

Block	Description	Guidelines
		8 Court/law enforcement 9 Information not available **For type of admission 4 (Newborn):** 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available
16	Discharge Hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank.
17	Patient Status	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Patient Discharge Status Codes.
18-28	Condition Codes	Enter the two-digit condition code "05" to indicate that a legal claim was filed for recovery of funds potentially due to a patient.
29	ACDT State	**Optional:** Accident state.
31-34	Occurrence Codes and Dates	Providers can refer to the National Uniform Billing Code website at www.nubc.org for the current list of Occurrence Codes.
35-36	Occurrence Span Codes and dates	For inpatient claims, enter code "71" if this hospital admission is a readmission within seven (7) Days of a previous stay. Enter the dates of the previous stay.
39-41	Value Codes	**Accident hour** – For inpatient claims, if patient admitted as result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if time is unknown. **Inpatient Claims** – enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. **In All Circumstances** – the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. **Sum of Blocks 39–41** must equal the total days billed as reflected in Block 6.

Block	Description	Guidelines
42-43	Revenue Codes and Description	For inpatient hospital services, enter description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. The space to the right of the dotted line is used for the accommodation rate. List ancillaries in ascending order. **NDC** Enter N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to 3 digits) must be submitted. Do not enter hyphens or spaces within this number. **Example:** N400409231231GR0.025 Refer to TMPPM Subsection 6.3.4, "National Drug Code (NDC)."
44	HCPCS/Rates	**Inpatient:** Enter accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. Multiple dates of service may not be combined on outpatient claims. **Home Health Services** Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. **Outpatient:** Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code.

Block	Description	Guidelines
		Note Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement. The UB-04 CMS-1450 paper claim form is limited to 28 items per outpatient claim. This includes surgical procedures from Blocks 74 and 74a-e. If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service.
45	Service Date	Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.
45 (line 23)	Creation Date	Enter the date the bill was submitted.
46	Service Units	Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation.
47	Total Charges	Enter the total charges for each service provided.
47 (line 23)	Totals	Enter the total charges for the entire claim. **Note:** For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim and the page number of the attachment (Ex: page 2 of 3) on the top right-hand corner of the form.
48	Noncovered Charges	If any of the total charges are non-covered, enter this amount.
50	Payer Name	Enter the health plan name.
51	Health Plan ID	Enter the health plan id number.
54	Prior payments	Enter amounts paid by any TPR and complete Blocks 32, 61, 62, and 80 as required.
56	NPI	Enter the NPI of the billing Provider.

Block	Description	Guidelines
57	Code code (CC)	Optional: Area to capture additional information necessary to adjudicate the claims. Required when, in the judgement of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere on the claim data set.
58	Insured's Name	If other health insurance is involved, enter the insured's name.
60	Medicaid ID Number	Enter the patient's nine-digit Medicaid ID number.
61	Insured Group Name	Enter the name and address of the other health insurance.
62	Insurance Group Number	Enter the policy number or group number of the other health insurance.
63	Treatment Authorization Code	Enter prior authorization number if one was issued.
65	Employer Name	Enter name of the patient's employer if health care might be provided.
66	Diagnosis/Procedure Code Qualifier	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM
67	Principal Diagnosis Code	Enter ICD-10-CM diagnosis code for the principal diagnosis to the highest level of specificity available.
67A-67Q	Secondary DX codes and POA indicator	Enter ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only. A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB "141"). **Exception:** A diagnosis is required when billing for estrogen receptor assays, plasmapheresis, and cancer antigen CA 125, immunofluorescent studies, surgical pathology, and alphafetoprotein. **Note:** ICD-10-CM diagnosis codes entered in 67K–67Q are not required for systematic claims processing. **Required:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. Refer to: TMPPM Subsection 6.4.2.8.3, "Inpatient Hospital Claims".

Block	Description	Guidelines
69	Admit DX code	Enter the ICD-10-CM diagnosis code indicating the cause of admission or include a narrative. **Note:** Admitting diagnosis is for inpatient claims only.
70a-70c	Patient's reason DX	**Optional:** New block indicating the patient's reason for visit on unscheduled outpatient claims.
71	Prospective Payment System (PPS) code	**Optional:** The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72a-72c	External cause of injury (ECI) and POA indication	**Optional:** Enter the or ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. **Required:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims. **Refer to:** TMPPM Subsection 6.4.2.8.3, "Inpatient Hospital Claims"
74	Principal procedure code and date	Enter the ICD-10-PCS procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
74a-74e	Other procedure codes and dates	Enter the or ICD-10-PCS procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
76	Attending Provider	Enter the attending Provider name and identifiers, along with NPI number of the attending Provider. Services that require an attending Provider are defined as those listed in the ICD-10-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures.
77	Operating Provider	Enter operating Provider's name (last and first names) and NPI.
78-79	Other Provider	Other Provider's name (last and first names) and NPI. Other operating physician—An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. Rendering Provider—The health-care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure.

Block	Description	Guidelines
		Important: *Qualifier 82 is required to identify the rendering provider for acute care inpatient and outpatient institutional services.* **Note:** If the referring physician is a resident, Blocks 76 through 79 must identify the physician who is supervising the resident.
80	Remarks	This block is used to explain special situations such as the following: • The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. • If patient stays beyond dismissal time, indicate the medical reason if additional charge is made. • If billing for a private room, the medical necessity must be indicated, signed, and dated by the physician. • If services are the result of an accident, cause and location of the accident must be entered in this block. The time must be entered in Block 39. • If laboratory work is sent out, name and address or facility's Provider identifier where the work was forwarded must be entered in this block. • If the patient is deceased, enter date of death and indicate "DOD". If services were rendered on the date of death, enter the time of death. • If services resulted from a family planning Provider's referral, write "family planning referral." • If services were provided at another facility, indicate the name and address where those services were rendered. • Request for 110-Day rule for a third party insurance.
81A-81D	Code code (CC)	**Optional:** Area to capture additional information necessary to adjudicate the claims. Required when, in the judgment of the Provider, the information is needed to substantiate the medical treatment and is not supported elsewhere on the claim data set.

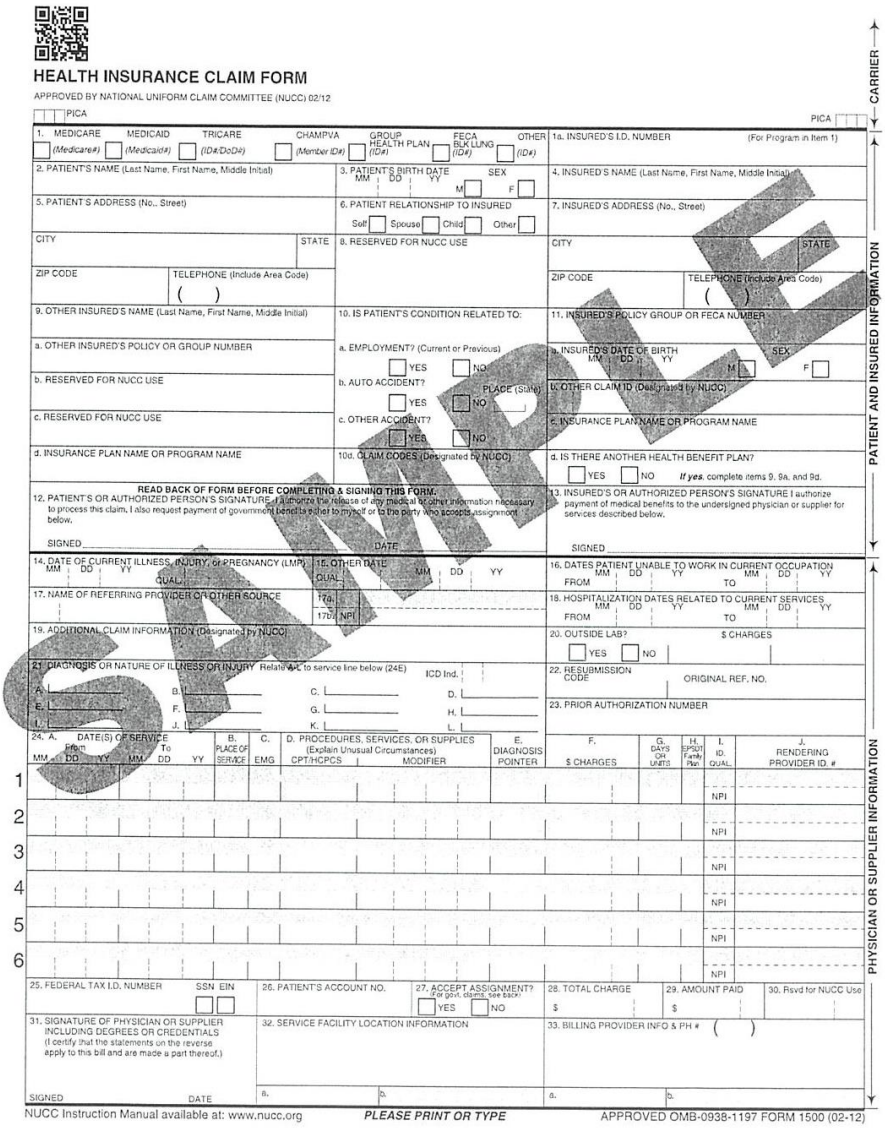
ELECTRONIC CLAIM SUBMISSION 837P OR 8371	
Provider Type	**Submission Type**
Professional	837P
Institutional	837I

Revised CMS 1500 (02/12)

It is important to note that the National Uniform Claim Committee (NUCC) has approved a revised version of the CMS 1500 claim form. This version shall be CMS (02/12). CMS has announced the following tentative datelines:

- January 6, 2014: Payers will begin to receive and process paper claims submitted on the revised 1500 Claim Form.
- January 6 through March 31, 2014: Dual use period during which payers continue to receive and process paper claims on the old 1500 Claim Form (version 08/05) along with paper claims on the new form.
- **April 1, 2014: Payers receive and process paper claims submitted only on the revised 1500 Claim Form (version 02/12).**

Example: CMS 1500 (02/12)



Of the revised claim form's various changes, the most notable are the following functionalities:

- Indicators for differentiating between ICD-9-CM and ICD-10-CM diagnosis codes.
- Expansion of the number of possible diagnosis codes to 12.
- Qualifiers to identify the following Provider roles (on Box 17):
    - Ordering
    - Referring
    - Supervising

The following is a list of changes between the 1500 Claim Form (08/05) and the CMS 1500 Claim Form (02/12).

Location	Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code).
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12."
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed " (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#) under "GROUP HEALTH PLAN."
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER."
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "RESERVED FOR NUCC USE."
Item Number 9b	Deleted "OTHER INSURED'S DATE OF BIRTH, SEX." Changed title to "RESERVED FOR NUCC USE."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "RESERVED FOR NUCC USE."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)."
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "OTHER CLAIM ID (Designated by NUCC)." Added dotted line in the left-hand side of the field to accommodate a 2-byte qualifier.
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d."

Location	Change
Item Number 14	Changed title to “DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP).” Removed the arrow and text in the right-hand side of the field. Added “QUAL.” with a dotted line to accommodate a 3-byte qualifier.
Item Number 15	Changed title from “IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE” to “OTHER DATE.” Added “QUAL.” with two dotted lines to accommodate a 3-byte qualifier.
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier.
Item Number 19	Changed title from “RESERVED FOR LOCAL USE” to “ADDITIONAL CLAIM INFORMATION (Designated by NUCC).”
Item Number 21	Changed instruction after title from “(Relate Items 1, 2, 3 or 4 to Item 24E by Line)” to “Relate A-L to service line below (24E).”
Item Number 21	Removed arrow pointing to 24E.
Item Number 21	Added “ICD Ind.” and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator.
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly spaced the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A – L).
Item Number 21	Removed the period within the diagnosis code lines.
Item Number 22	Changed title from “MEDICAID RESUBMISSION” to “RESUBMISSION.”
Item Number 30	Deleted “BALANCE DUE.” Changed title to “Rsvd for NUCC Use.”
Footer	Changed “APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)” to “APPROVED OMB-0938-1197 FORM 1500 (02/12).”
Back	Updates to the language.

The following is a crosswalk of the 02/12 version 1500 Health Care Claim Form (1500 Claim Form) to the X12 837 Health Care Claim: Professional Version 5010/5010A1 electronic transaction.

1500 Form Locator		837P		Notes
Item Number	**Title**	**Loop ID**	**Segment/Data Element**	
N/A	Carrier Block	2010BB	NM103 N301 N302 N401 N402 N403	
1	Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other	2000B	SBR09	Titled Claim Filing Indicator Code in the 837P.
1a	Insured's ID Number	2010BA	NM109	Titled Subscriber Primary Identifier in the 837P.
2	Patient's Name	2010CA or 2010BA	NM103 NM104 NM105 NM107	
3	Patient's Birth Date, Sex	2010CA or 2010BA	DMG02 DMG03	Sex is titled Gender in the 837P.
4	Insured's Name	2010BA	NM103 NM104 NM105 NM107	Titled Subscriber in the 837P.
5	Patient's Address	2010CA	N302 N401 N402 N403	
6	Patient Relationship to Insured	2000B 2000C	SBR02 PAT01	Titled Individual Relationship Code in the 837P.
7	Insured's Address	2010BA	N301 N302 N401	Titled Subscriber Address in the 837P.

1500 Form Locator		837P		Notes
Item Number	**Title**	**Loop ID**	**Segment/Data Element**	
8	Reserved for NUCC Use (previously Patient Status)	N/A	N/A	Patient Status was removed. Patient Status does not exist in the 837P.
9	Other Insured's Name	2330A	NM103 NM104 NM105 NM107	Titled Other Subscriber Name in the 837P.
9a	Other Insured's Policy or Group Number	2320	SBR03	Titled Insured Group or Policy Number in the 837P.
9b	Reserved for NUCC Use (previously Other Insured's Date of Birth, Sex)	N/A	N/A	Other Insured's Date of Birth, Sex was removed. Other Insured's Date of Birth and Sex do not exist in the 837P.
9c	Reserved for NUCC Use (previously Employer's Name or School Name)	N/A	N/A	Employer's Name or School Name was removed. Employer's Name and School Name do not exist in the 837P.
9d	Insurance Plan Name or Program Name	2320	SBR04	Titled Other Insured Group Name in the 837P.
10a	Is Patient's Condition Related to: Employment	2300	CLM11	Titled Related Causes Code in the 837P.
10b	Is Patient's Condition Related to: Auto Accident	2300	CLM11	Titled Related Causes Code in the 837P.
10c	Is Patient's Condition Related to: Other Accident	2300	CLM11	Titled Related Causes Code in the 837P.
10d	Claim Codes (previously Reserved for Local Use)	2300	K3	This is specific for reporting Workers' Compensation Condition Codes.

1500 Form Locator		837P		Notes
Item Number	**Title**	**Loop ID**	**Segment/Data Element**	
11	Insured's Policy, Group, or FECA Number	2000B	SBR03	Titled Subscriber Group or Policy Number in the 837P.
11a	Insured's Date of Birth, Sex	2010BA	DMG02 DMG03	Titled Subscriber Birth Date and Subscriber Gender Code in the 837P.
11b	Other Claim ID (previously Insured's Employer Name or School Name)	2010BA	REF01 REF02	Changed to Other Claim ID. Insured's Employer Name or School Name does not exist in 837P.
11c	Insurance Plan Name or Program Name	2000B	SBR04	Titled Subscriber Group Name in the 837P.
11d	Is there another Health Benefit Plan?	2320		Presence of Loop 2320 indicates Y (yes) to the question.
12	Patient's or Authorized Person's Signature	2300	CLM09	Titled Release of Information Code in the 837P.
13	Insured's or Authorized Persons Signature	2300	CLM08	Titled Benefits Assignment Certification Indicator in the 37P.
14	Date of Current Illness, Injury, Pregnancy (LMP)	2300	DTP01 DTP03	Titled in the 837P: Date – Onset of Current Illness or Symptom Date – Last Menstrual Period

1500 Form Locator		837P		Notes
Item Number	**Title**	**Loop ID**	**Segment/Data Element**	
15	Other Date (previously If Patient Has Had Same or Similar Illness)	2300	DTP01 DTP03	Titled in the 837P: Date – Initial Treatment Date Date – Last Seen Date Date – Acute Manifestation Date – Accident Date – Last X-ray Date Date – Hearing and Vision Prescription Date Date – Assumed and Relinquished Care Dates Date – Property and Casualty Date of First Contact If Patient Has Had Same or Similar Illness does not exist in 837P.
16	Dates Patient Unable to Work in Current Occupation	2300	DTP03	Titled Disability From Date and Work Return Date in the 837P.
17	Name of Referring Provider or Other Source	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM101 NM103 NM104 NM105 NM107	
17a	Other ID#	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	REF01 REF02	Titled Referring Provider Secondary Identifier, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier in the 837P.
17b	NPI #	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM109	Titled Referring Provider Identifier, Supervising Provider Identifier, and Ordering Provider Identifier in the 837P.

1500 Form Locator		837P		Notes
Item Number	**Title**	**Loop ID**	**Segment/Data Element**	
18	Hospitalization Dates Related to Current Services	2300	DTP03	Titled Related Hospitalization Admission Date and Related Hospitalization Discharge
19	Additional Claim Information (previously Reserved for Local Use)	2300	NTE PWK	
20	Outside Lab Charges	2400	PS102	Titled Purchased Service Charge Amount in the 837P.
21	Diagnosis or Nature of Illness or Injury	2300	HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2	
22	Resubmission and/or Original Reference Number	2300	CLM05-3	Titled Claim Frequency Code in the 837P.
		2300	REF02	Titled Payer Claim Control Number in the 837P.
23	Prior Authorization Number	2300	REF02	Titled Prior Authorization Number in the 837P.
		2300	REF02	Titled Referral Number in the 837P.
		2300	REF02	Titled Clinical Laboratory Improvement Amendment Number in the 837P.
		2300	REF02	Titled Mammography Certification Number in the 837P.
24A	Date(s) of Service	2400	DTP03	Titled Service Date in the 837P.
24B	Place of Service	2300	CLM05-1	Titled Facility Code Value in the 837P.
		2400	SV105	Titled Place of Service Code in the 837P.

1500 Form Locator		837P		Notes
Item Number	**Title**	**Loop ID**	**Segment/Data Element**	
24C	EMG	2400	SV109	Titled Emergency Indicator in the837P.
24D	Procedures, Services, or Supplies	2400 2400	SV101 (2-6)	Titled Product/Service ID and Procedure Modifier in the 837P.
30	Rsvd for NUCC Use (previously Balance Due)	N/A	N/A	Balance Due was removed. Balance Due does not exist in the 837P.
31	Signature of Physician or Supplier Including Degrees or Credentials	2300	CLM06	Titled Provider or Supplier Signature Indicator in the 837P.
32	Service Facility Location Information	2310C	NM103 N301 N401 N402 N403	
32a	NPI #	2310C	NM109	Titled Laboratory or Facility Primary Identifier in the 837P.
32b	Other ID #	2310C	REF01 REF02	Titled Reference Identification Qualifier and Laboratory or Facility
33	Billing Provider Info & Ph #	2010AA	NM103 NM104 NM105 NM107 N301 N401 N402 N403 PER04	
33a	NPI #	2010AA	NM109	Titled Billing Provider Identifier in the 837P.

1500 Form Locator		837P		Notes
Item Number	Title	Loop ID	Segment/Data Element	
33b	Other ID #	2000A 2010AA	PRV03 REF01 REF02	Titled Provider Taxonomy Code in the 837P. Titled Reference Identification Qualifier and Billing Provider Additional Identifier in the 837P.

Billing Using the Electronic Claim Format

The following data elements should be used to submit the NDC information in the HIPAA- standard ASC X12N 837 electronic claims format:

Loop 2400

- SV101 CPT/HCPCS code
- SV104 CPT/HCPCS units
- Loop 2410
- LIN03 NDC (11-digit format)
- CTP04 NDC Quantity
- CTP05-1 NDC Unit or Basis for Measurement Code

Loop	Segment	Value
2400	SV101	90680
	SV104	1
2410	LIN03	00006404741
	CPT04	2
	CPT05-1	ML

Example:

RotaTeq Rotavirus Vaccine

CPT Code - 90680

CPT DUTS - 1

NDC - 00006404741

NDC Drug Quantity - 2

NDC UOM - ML

The complete 837 instructions are available in the *HIPAA Implementation Guide*, on the X12 website at https://x12.org/products.

NOTE: If the NDC is not submitted in the correct format, the claim will be denied.

EARLY CHILDHOOD INTERVENTION (ECI) PROVIDERS

Early Childhood Intervention (ECI) providers must submit claims for all physical (PT), occupational (OT), speech (ST), and language therapy to El Paso Health for services to covered Members birth through 35 months of age who have been determined eligible for ECI services.

- ECI providers are not required to file claims with private insurance before billing Medicaid for Targeted Case management services and Specialized Skills Training (SST).

Services for PT, OT, and ST procedure codes may be billed in multiple quantities (i.e. 15 minutes each) and are limited to two hours (eight units) per day per individual, groups, or a combination of individual and group therapy. Services must be billed per therapy type (two hrs. of OT and two hrs. of PT).

Example: (22 minutes) divided by (15 minutes) = One unit

UNIT CONVERSION GRID	
UNITS	**NUMBER OF MINUTES**
0 Units	**0 Minutes through 7 minutes**
1 Units	**8 Minutes through 22 minutes**
2 Units	**23 Minutes through 37 minutes**
3 Units	**38 Minutes through 52 minutes**
4 Units	**53 Minutes through 67 minutes**
5 Units	**68 Minutes through 82 minutes**
6 Units	**83 Minutes through 97 minutes**
7 Units	**98 Minutes through 112 minutes**
8 Units	**113 Minutes through 127 minutes**

AUTHORIZATION REQUIREMENTS

El Paso Health cannot issue a prior authorization for service requests for Members not enrolled with El Paso Health. To determine Member eligibility, the Provider must contact the Member Services Department for verification of eligibility status.

To determine whether a service requires authorization, the Provider should refer to the Precertification Flyer located on the El Paso Health website at www.elpasohealth.com under Provider Forms. The Provider may also contact El Paso Health's Intake Unit at 915-532-3778 for questions about services requiring prior authorization.

Newborn Members who need Neonatal Critical Care (NICU) will be assigned an authorization under the mother's identification number until the child has obtained an identification number.

Retroactive authorizations will not be issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. For these services, providers have 95 Days from the add date of the client's retroactive eligibility in TMHP's system to obtain authorization for services that have already been performed.

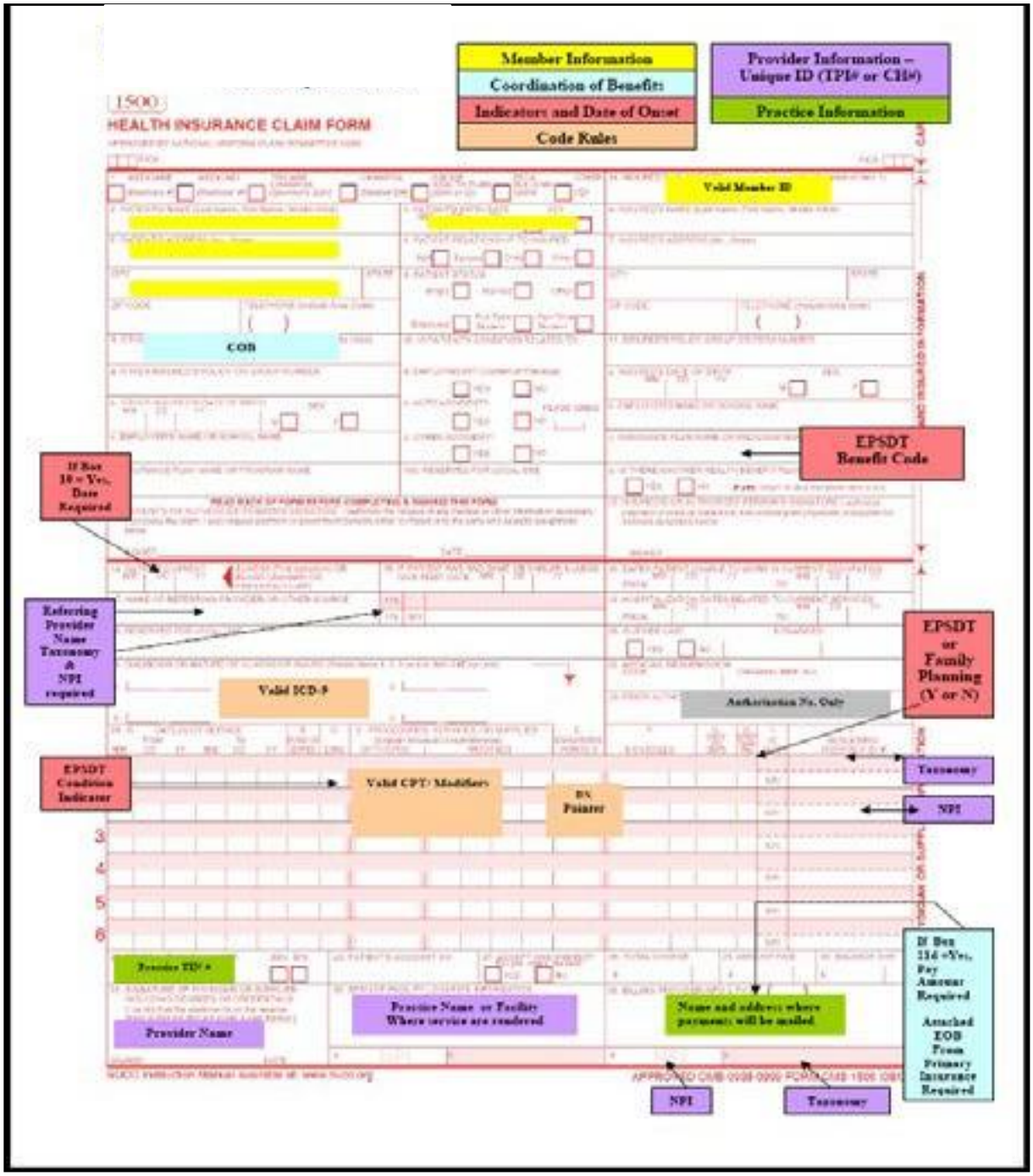
For Coordination of Benefits (COB), El Paso Health pre-certification requirements will apply.

All claims for services that require authorization must be submitted with the correct and complete authorization number in the appropriate field of the claim or the Provider may risk a claim denial.

HOW TO FILE A CLAIM

CMS 1500 Claim Form

The CMS 1500 claim form is used to bill professional services, freestanding and ambulatory surgical centers, ambulance, independent laboratories and durable medical equipment.



***Form guide may be obtained on the El Paso Health Website at www.elpasohealth.com.**

Newborn Claim Submission Requirements

Provider must submit claims according to the following: 'Newborn Claims Hints'.

- If the mother's name is "Jane Jones", use "Boy Jane Jones" for a male child and
- "Girl Jane Jones" for a female child.
- Enter "Boy Jane" or "Girl Jane" in the first name field and "Jones" in the last name field. **Always** use "boy" or "girl" first then followed by the mother's full name. An exact match must be submitted for the claims to process.
- Do not use "NBM" for newborn male or "NBF" for newborn female.
- El Paso Health will adjudicate claims using the proxy number unless the State issued Medicaid ID number has been received.

NEMT Services Claim Submission Instructions

For Non-Emergency Medical Transportation (NEMT) services please bill:

Access2Care
Attn: Claims Submission
6363 S. Fiddlers Green Circle, Suite 1400
Greenwood Village, CO 80111

For any Non-Emergency Medical Transportation (NEMT) claims related questions, please contact Access2Care 1-844-572-8196.

Provider Signature on Claim= [Box 31 of the CMS 1500]

The Provider's full name and credential must be populated in Box 31 of the CMS 1500. Example: John Doe, MD along with a signature. Claims prepared by computers billing services or office based computers may populate "Signature on File" in the signature along with the Provider's full name in the CMS1500 (box 31). If the claim is prepared by a billing service, the billing service must retain a letter on file from the Provider authorizing that the billing service may submit claims for the providers. For further information please refer to the Texas Medicaid Provider Procedures Manual.

Claims with Attachments

To expedite claims processing, providers must supply all information on the claim form itself and limit attachments to the documentation needed to adjudicate the claims. Example:

- Providers filing for coinsurance, deductible, or both must attach the primary carrier explanation of benefits along with denial remarks

Multipage Claim Forms

If a claim is split the Provider must ensure that the claim is split at a logical break and all pages must contain the required information. For example, the Provider may submit the surgery

charges in one claim and the subsequent recovery days in the next claim. Hospitals are required to submit all charges including HCPCS codes when required with the Revenue Codes.

The CMS-1500 Paper claim form is designed to list six line items in Box 24. If more than six line items are billed on a paper claim, a Provider may attach additional forms (pages). All the claims must contain all the required billing information. On subsequent pages of a multipage claim, the Provider should indicate "continued" in Block 28 and the combined total charges for all pages should be listed on the last page in Block 28. In addition the Provider should indicate the number of pages of the multipage claim on the top right hand corner of the form for example, (page 2 of 3).

The paper UB-04 CMS-1450 is designed to list 22 lines in Box 42. If services exceed the 22-line limitation, the Provider may attach additional claim forms. Each of the claim forms must contain all the required billing information. All subsequent pages of the multipage claim should indicate the page numbers in Box 23 and "continued" in line 23 Box 47. The combined total charges for all pages should be listed on the last page in line 23 of Box 47.

Note: It is strongly recommended that providers who submit paper claims keep a copy of the documentation they send for processing. It is also recommended that paper claims be sent by certified mail with a return receipt requested and a detailed listing of the claims enclosed. This is important to demonstrate the claims were received by El Paso Health and that the 95-Day claims filing deadline has been met.

Electronic Claim Submission and Response Reports

El Paso Health has the capability to receive ANSI X12N 837I and 837P health claims. To enroll, contact El Paso Health to obtain a companion guide at:

El Paso Health Provider Relations Department
915-532-3778 or 1-877-532-3778 ext. 1504
Or via e-mail at: Helpdesk@elpasohealth.com

A clearinghouse is an electronic claims and information network available to all providers and their billing agents in the El Paso health care community that enables physicians' hospitals and ancillary providers to file patient claims electronically to El Paso Health. Filing electronic claims directly to a clearinghouse will allow for the reduction in administrative costs, accelerate claims payment, increase accuracy, and simplify daily administration.

Note: All clearinghouse entities provide their individual Payer Identification numbers. For more information or to obtain the Payer Identification numbers, log onto the El Paso Health website (www.elpasohealth.com**) for a Companion Guide.**

The Companion Guide assists trading partners in clarifying El Paso Health's specified values in order to facilitate implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HIPAA directed the Secretary to adopt standards for each transaction. These standards enable health information to be exchanged electronically and adopt specifications for implementing each transaction. HIPAA Implementation Guides were published for this purpose and should be used by all affected legal entities.

Recommendations for a clean testing process:

- It is important to make sure the four payer ID's have been entered into your computer system. A list of available Payer IDs can be located in the companion manual.
- It is important to provide a "good, clean" 837(I or P) 4010A1 test file which meets all HIPAA specifications.
- It is important to provide a unique NPI number for all 837 submissions at the corresponding Provider and facility loops that are submitted within the transaction.
- It is recommended that the Provider's social security number or Federal Tax Id Number (TIN) is included as a secondary identifier in REF02 loop 2010AA for validation purposes.
- It is required to address all grey areas in the El Paso Health 837P Companion Guide. All grey areas have an attachment note that provides additional formatting information.
- It is required to provide the proper Taxonomy codes per specialty. To accommodate our providers, we are only requiring the Header Taxonomy number to be reported. A list of all header taxonomy numbers can be obtained in our Electronic Claims Submission companion manual or at:

  X12

  Publishes X12 Implementation Guides and offers training on EDI standards, etc.
  https://x12.org/products

Note: Our contracted clearinghouse will reject any claims that do not contain proper Rendering Provider Taxonomy Numbers and/or Rendering Providers Unique Identifiers.

Once the testing process is complete, El Paso Health will notify your office of the exact date electronic claims processing may begin. If you have any questions, feel free to contact EDI Development Department / Provider Relations at 915-532-3778 or 877-532-3778.

CMS 1500 Professional Claims

The HIPAA Electronic claims format is designed to list 50 line items. The total number of details allowed for electronic claims by the El Paso Health claims processing system is 28. If the services provided exceed 28 line items on an approved electronic claims format, or the Provider must submit another claim for the additional line items.

UB-04 CMS-1450 Institutional Claims

The HIPAA Electronic claims format is designed to list 61 line items. The total number of details allowed for electronic claims by the El Paso Health claims processing system is 28. If the services provided exceed 28 line items on an approved electronic claims format the Provider must submit another claim for the additional line items. It is recommended that the Provider merge like revenue codes together to reduce the lines to 28 or less or payment may be delayed.

CLAIM FILING DEADLINES

Claims must be received by El Paso Health within 95-Days from each date of service (DOS). A clean claim will be processed within 30 Days. The Provider should allow 30-Days before rebilling any claim to avoid duplication of claims.

Once a Clean Claim is received, El Paso Health is required, within the 30-Day claim payment period and 18-Day clean claim payment for electronic pharmacy claim submission, to: (1) pay the total amount of the claim, or part of the claim, in accordance with the contract, (2) deny the entire claim, or part of the claim, and notify the Provider why the claim will not be paid.

Payment is considered to have been paid on the date of: (1) the date of issue of a check for payment and its corresponding EOB to the Provider by El Paso Health, or (2) electronic transmission, if payment is made electronically.

If a claim was denied due to a billing error, the corrected claim must be resubmitted within 120 Days from the disposition date on the EOB.

If the claim was denied due to a request for medical documentation, please include a copy of the claim, a copy of the EOB and the requested documentation with the resubmission. Providers must adhere to the claim filing timelines and claims received after the filing deadline will be denied for failure to meet timely filing.

When a service is billed to another insurance resource, the filing deadline is 95 Days from the date of disposition by the other insurance carrier. When a service is billed to a third party and no response has been received, the Provider must allow 110 Days to elapse before submitting a claim to El Paso Health however, the federal 365 Day filing requirement must still be met.

Note: It is strongly recommended that providers who submit paper claims keep a copy of the documentation they send. It is also recommended that paper claims be sent by certified mail with a return receipt requested and a detailed listing of the claims enclosed. This is important to demonstrate that the claims were received by El Paso Health and that the 95-Day claims filing deadline has been met.

OUTPATIENT PHARMACY PRESCRIPTIONS

Navitus Health Solutions (Navitus) is the Pharmacy Benefit Manager (PBM) contracted by El Paso Health to manage the outpatient pharmacy benefit for Members. Navitus operates on a payment cycle which allows all payments for clean electronic claims to be made within 18-Days. Claims received non-electronically are adjudicated no later than 21 Days after receipt. Pharmacy payment cycles occur twice per month.

Compounded Prescriptions

A compound consists of two or more ingredients, one of which must be a formulary Federal Legend Drug that is weighed, measured, prepared, or mixed according to the prescription order. For Navitus to cover a compound medication, one active ingredient must be covered on the patient's formulary. In general, drugs used in a compound follow the Member's formulary as if each drug components were being dispensed individually. Compound drugs must be included as a covered benefit for the Member for Navitus to allow reimbursement. The pharmacist is responsible for compounding approved ingredients of acceptable strength, quality, and purity, with appropriate packaging and labeling in accordance with good compounding practices. Any compounded prescription ingredient that is not approved by the FDA (e.g. Estriol) is considered a non-covered product and will not be eligible for reimbursement.

Processing Compound Prescriptions

Navitus uses a combination of the claims, compound, and DUR segment to fully adjudicate a compound prescription.

- Use the Compound Code of 02 (NCPDP field 406-D6 located in Claim Segment on payer sheet) when submitting compound claims.
- The claim must include an NDC for each ingredient within the compound prescription with a minimum of 2 NDCs and a maximum of 25 NDCs (NCDPD field 447-EC located in Compound Segment).
- The claim must include a qualifier of "03" (NDC) to be populate in NCPDP field 448-RE followed by NCPDP field 489-TE (NDC's).

If an NDC for a non-covered drug is submitted, the claim will be denied.

If the pharmacy will accept non-payment for the ingredient, submit an "8" in the Clarification Code Field (420-DK located on the D.0 Claim Segment Field).

If a compound includes a drug that requires prior authorization, the prior authorization must be approved before the compound is submitted. Prior authorization forms are available at https://www.navitus.com/texas-medicaid-star-chip/prior-authorization-forms.aspx

The minutes spent compounding the prescription must be submitted for reimbursement. The minutes listed are to be populated within NCPDP D.0 Field 474-8E (level of effort- DUR segment).

How to find a list of covered drugs
The HHSC formulary is available for our Providers to view on-line at www.elpasohealth.com or through the Vendor Drug Program at http://www.txvendordrug.com/formulary/formulary-search.asp.

How to find a list of preferred drugs
The HHSC Preferred Drug List is available for our Providers to view on-line through the Vendor Drug Program at https://www.txvendordrug.com/formulary/formulary-search

Process for requesting a prior authorization (PA) for Pharmacy
Navitus processes pharmacy prior authorization requests. The formulary, the Preferred Drug List and the prior authorization criteria are determined by HHSC. Information regarding the formulary and the specific prior authorization criteria can be found on the Vendor Drug Program's website www.txvendordrug.com

Prescribers can access prior authorization forms online via www.navitus.com under the "Prescribers – Texas Medicaid STAR/CHIP" section or have them faxed by Navitus Customer Care to their office.

Completed prior authorization forms can be faxed 24/7 to Navitus at 920-735-5312 or toll-free at 855-668-8553.

Prescribers can also call Navitus Customer Care toll-free at 877-908-6023. Providers can select the prescriber option and speak with the Prior Authorization department between 8 am-5 pm Monday-Friday to submit a PA request over the phone. Decisions regarding prior authorizations will be made within 24 hours from the time Navitus receives the PA request. The Provider will be notified by fax regarding the outcome or verbally if an approval can be established during a phone request.

Pharmacies will submit pharmacy claims to Navitus. Medications that require prior authorization will undergo an automated review to determine if the necessary criteria are met. If all the criteria are met, the claim is approved and paid, and the pharmacy continues with the dispensing process. If the automated review determines that all the criteria are not met, the claim will be rejected and the pharmacy will receive a message indicating that the drug requires prior authorization. At that point, the pharmacy should notify the prescriber and the process identified previously should be followed.

72 Hour Override Emergency Prescription Supply
A 72 hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and the prior authorization (PA) is not available. The 72 hour emergency supply applies to all drugs requiring PA either because they are non-preferred on the Preferred Drug List or are subject to clinical edits. If the prescribing Provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription. The 72 hour emergency supply is also applicable any time a PA cannot be resolved within 24 hours for a medication on the HHSC formulary that is appropriate for the Member's condition. This procedure should not be used for routine and continuous overrides, but can be used more than once if the Provider remains unavailable. If a pharmacy is not complying with the 72-hour

emergency fill requirement, they can be reported to the HHSC Office of Inspector General and the Navitus Network department at 608-729-1577 for review.

Submitting Corrected Claims

Providers that receive an EDI rejection may resubmit an electronic claim within 95 Days of the DOS. Submit a copy of an Electronic Claims Report that includes the following information:

- Batch submission ID and date
- Individual claim that is being appealed
- El Paso Health -assigned batch ID number

Note: Office notes indicating claims were submitted on time or personal screen prints of claim submissions are not considered proof of timely filing.

Only zero Paid Denied claims may be sent electronically within a 95 Day timely filing. Claims with partial payments should be submitted on paper.

All corrected paper claims must be submitted within 120 Days of the EOB to meet the filing deadline of a corrected claim timeline. Each corrected claim must include: a corrected CMS 1500 or UB04 claim **ATTACHMENT 22**, a copy of the EOB and any other attachments needed.

The following are examples of forms attached to returned claims explaining the reason(s) for the return.

CMS

UB 04

DELIVERY OF PAPER CLAIMS

- Claims must be submitted on CMS approved forms such as CMS 1500 or UB04.
- Please refer to the official CMS website for most current format. www.cms.hhs.gov
- It is recommended paper claims be sent by certified mail with a return receipt requested and a detailed log listing of the claims enclosed.

El Paso Health will not accept copies of claims or faxed claims on first time submissions. Please mail all new or corrected claims to:

El Paso Health
P.O. Box 971370
El Paso, TX 79997-1370

APPEAL OF DENIAL DECISION

Providers may request a reconsideration of a claim denial by resubmitting the claim with the appropriate documentation and /or necessary corrections or by calling El Paso Health. If you have attempted to resolve your claim issues with El Paso Health but are still dissatisfied with the outcome, you may file a formal complaint with El Paso Health Complaints and Appeals Department.

The complaint must be a formal written letter addressed to the attention of the Complaints and Appeals Department. The Provider must provide the certified mail receipt and a log that includes the Medicaid ID number, billed amount, and a signed claim copy:

El Paso Health
Attn: Complaints and Appeals Department
P.O. BOX 971100, El Paso, Texas 79997-1370

Note: All appeals of denied claims and requests for adjustments on paid / denied claims must be received by El Paso Health within 120 Days from the date of the Remittance Advice on which the claim appears.

COORDINATION OF BENEFITS (COB)

El Paso Health does not process as a primary carrier if the services qualify for COB benefits unless the services have not been allowed or were denied by the primary carrier. The remittance advice on the primary carrier should reflect the denial.

Example: Member not enrolled.

Deductibles: El Paso Health will consider deductibles for reimbursement when the primary carrier applied the payment amount directly to the Member's deductible. The explanation of benefits must reflect the applicable payment by the primary carrier and a completed, signed copy of the claim must be submitted to El Paso Health for consideration.

El Paso Health STAR *as Primary*

If it is determined that El Paso Health STAR is the primary insurance plan, or COB status guidelines do not coordinate, claims are processed as though there is no other coverage following standard processing guidelines. If the services do not qualify for Coordination of Benefits, claims are processed as though there is no other coverage following standard processing guidelines.

El Paso Health will take into account any other coverage to include any group insurance, prepaid health plans, or any other insured or uninsured arrangement of group coverage.

- Where permitted by state law, any automobile insurance contract, pursuant to any federal or state law, which mandates indemnification for medical services to persons suffering bodily injury from motor vehicle accidents, but only if:
    a. Covered Services are eligible for payment under the provisions of such policy; and,
    b. The policy does not, under its rules, determine its benefits after the benefits of any group health insurance.

El Paso Health STAR *as Secondary*

If the amount paid by a third party health insurer is less that the amount payable for the services by El Paso Health, providers may bill El Paso Health for the difference between the amount paid by the third party carrier and the El Paso Health allowable amount. The claim must be filed timely and in accordance with all the filing guidelines.

Note: If it is determined that El Paso Health is the secondary (or tertiary) payer, El Paso Health will reimburse per COB Processing Guidelines. We will calculate the difference between El Paso Health's Maximum Allowed Amount and the primary carrier's payment, paying the lesser of the two.

For Example: We processed the claim to pay the patient responsibility which is less than the Medicaid allowable.

- Primary Carrier Allowed Amount: $248.00
- Primary Carrier Paid: $100.00
- Primary Carrier Patient Resp/Deductible: $148.00
- Medicaid Allowable: $162.00
- EP First STAR Paid: $62.00

Medicare/Medicaid Coverage: (Qualified Medicare Beneficiaries - QMB)

Medicare/Medicaid Eligible Status: The payable period for Medicare /Medicaid eligible recipient claims filed on paper is 24 months from the date listed on the Medicare Remittance Advice**. El Paso Health is only required to pay for coinsurance and/or deductibles for QMBs.**

Providers must submit Medicare-paid claims to El Paso Health for payment for the coinsurance and/or deductible. Providers must send the Medicare Remittance Advice Notice (MRAN) with the client information circled in black ink. All claims denied by Medicare for administrative reasons must be appealed to Medicare before they are sent to El Paso Health. An assigned claim that was denied by Medicare because the client does not have Part B benefits or because the transport destination is not allowed can be submitted to El Paso Health for consideration.

CHIP coverage is secondary when coordinating benefits with all other insurance coverage. Coverage provided under CHIP will pay benefits for Covered Services that remain unpaid after all other insurance coverage has been paid up to the agreed rates.

For Out-of-Network providers without a written reimbursement arrangement, El Paso Health will pay the unpaid balance for Covered Services in accordance with TDI's rules regarding usual and customary payment.

The COB process for Medicaid claims will be applied to CHIP and CHIP Perinatal Members that have a Primary Insurance in addition to their CHIP coverage as secondary.

After CHIP eligibility has been established, CHIP Members remain eligible until the end of their 12 months certification period even if a third party payer has been reported.

If a claim with Primary Insurance for a CHIP Member is submitted **without** an EOB from primary carrier the claims should be ***denied***.

If a claim with Primary Insurance for a CHIP Member is submitted **with** an EOB from primary carrier indicating payment from the primary carrier, ***we will coordinate benefits for the remaining balance***. The COB process will mirror the Medicaid COB claims process.

El Paso Health **will be responsible for the remainder of the claim if a third party does not cover the full 100% of the Medicaid allowable amount billed.**

Note: If it is determined that El Paso Health is the secondary (or tertiary) payer, El Paso Health will reimburse per COB Processing Guidelines. We will calculate the difference between El Paso Health's Maximum Allowed Amount and the primary carrier's payment, paying the lesser of the two.

For Example: We processed the claim to pay the patient responsibility which is less than the CHIP fee schedule allowable.

- Primary Carrier Allowed Amount: $248.00
- Primary Carrier Paid: $100.00
- Primary Carrier Patient Resp/Deductible: $148.00
- CHIP fee schedule Allowable: $162.00
- EP First CHIP Paid: $62.00

STAR / CHIP Emergency Service Claims

El Paso Health will pay both In-Network and Out-of-Network (OON) providers for emergency, stabilization and post-stabilization services. This includes professional, facility, and ancillary services provided in a Hospital emergency department. Emergency services are available to enrolled members at all times without regard to prior authorization or a provider's contractual relationship.

CHIP Exception to Secondary Coverage: Third Party Liability

If a claim comes in indicating a possible school accident and the Member has school insurance, the initial claim will be automatically processed as COB coverage.

- These claims will be sent to the Third Party Recovery (TPR) Department for primary carrier verification and system setup.
- If the TPR Department does not receive the proper verification, the claims will be denied with Denial Reason:
    - D09- Paid by other Insurance
    - No Coordination of benefits will be followed

CHIP Perinatal Emergency Services Claims

Emergency Medical Services for CHIP Perinatal Members are limited to those services directly related to the delivery of the unborn child until birth. Post delivery services or complications resulting in the need for emergency services for the mother of the CHIP unborn child are not covered benefits. In case of a medical emergency, the Member may seek emergency medical services from the nearest facility. To ensure continuity of care, the emergency facility is asked to contact El Paso Health within 24 hours or the next business day after providing the services. If the emergency visit results in an admission, the facility must also notify El Paso Health prior to claims submission. Out of network emergency services are covered as long as the emergency visit is an emergency as defined in this section.

CHIP Perinatal Hospital Claims

** All CHIP Perinatal hospital claims submitted for Members above 185% FPL (Rate Code 310 on El Paso Health ID card) should be submitted to El Paso Health.

** All CHIP Perinatal hospital claims submitted for Members at or below 185% FPL (Rate Code 309 on El Paso Health ID card) should be submitted to the Texas Medicaid Claims Administrator.

Cost Sharing Schedule: For CHIP Perinatal there is no cost sharing schedule that is applicable.

No co-payments exist for STAR Members, CHIP Perinate Members, CHIP Perinate Newborn Members, and CHIP Members who are Native Americans or Alaskan Natives.

Additionally, for CHIP Members there is no cost-sharing on benefits for well-baby and well-child services, preventive services, or pregnancy-related assistance.

El Paso Health does not process claims under capitation rates. All claims are paid through fee for service rates using the Medicaid fee schedule.

BILLING MEMBERS

Co-payment
Provider understands and agrees that Provider is responsible for collecting at the time of the service any applicable co-payments, given the limitations on those co-payments. Co-payments are the only amounts that a Provider may collect from Members.

Non-Covered Services
Providers must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed acknowledgement statement from the Member.

Balance Billing
Providers agree to accept payment made by El Paso Health as payment in full. The Member cannot be held liable for any balance related to covered services.

Member Acknowledgement Statement
A Provider may only bill a Member when the Member has signed the Member Acknowledgement Statement and the following conditions are met:

- A claim is denied as not being medically necessary
- A claim is denied as part of a non-covered service,
- The service is provided at the request of the client

PRIVATE PAY

If the Provider accepts the Member as a private pay patient and informs the Member at the time of service that the Member will be responsible for paying for all services, the Provider may bill the Member. In this situation, it is recommended that the Provider use a Private Pay Form. Without written, signed documentation that the Member has been properly notified of their private pay status, the Provider cannot ask for payment from a Member. The Private Pay Form can be found as **ATTACHMENT 23** of this manual.

RESOURCES FOR CLAIMS STATUS

Member Services Department

Member Services Department can assist providers with claims inquiries. Member Services Department can be reached at 915-532-3778 or 1-877-532-3778. When calling, you will reach a Call Center Representative (CCR) who can assist you with:

- Claim status
- Answers to claim questions
- Answers to electronic claims submission rejections or questions
- Resolving claims
- Special billing for newborn claims, value added services (for compounded medications please contact NAVITUS)

Please note you have the right to appeal any disposition of a claim through a written formal appeal. Written request must be mailed to:

El Paso Health
Attn: Complaints and Appeals Department
P O BOX 971100, El Paso, Texas 79997-1370
Within 120 Days from the date of your Provider Remittance Advice

WEB PORTAL ACCESS (PROVIDER PORTAL)

El Paso Health offers a number of claims processing functionalities and benefits:

- Available to all Providers at no cost
- Available twenty-four (24) hours per day, seven (7) days per week
- Ability to add attachments to claims (Portal and clearinghouse submissions)
- Ability to submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim
- Online Batch Claims Processing
- Request Prior Authorizations

You can register online at www.elpasohealth.com. By taking advantage of El Paso Health services, you can easily reduce your administrative costs and improve the accuracy of claim submissions.

HEALTHX

The Health X Fax System is an automated fax system created to provide status inquiries pertaining to Member eligibility, claims and pre-authorizations status. Providers can dial 915-225-5463 or 866-283-2792 and follow the automated instructions. Confirmation can be provided by fax or voice play back. A flow chart has been included as **ATTACHMENT 24** of this manual.

SECTION 13: ELECTRONIC VISIT VERIFICATION

GENERAL INFORMATION ABOUT EVV

1. What is EVV?

EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV System documents the following:

- Type of service provided (Service Authorization Data);
- Name of the Member to whom the service is provided (Member Data);
- Date and times the visit began and ended;
- Service delivery location;
- Name of the Service Provider or CDS Employee who provided the service (Service Provider Data); and
- Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.

2. Is there a law that requires the use of EVV?

Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Section 531.024172, requires HHSC to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To comply with these statutes, HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. HHSC plans to require the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2023.

3. Which services must a Service Provider or CDS Employee electronically document and verify using EVV?

The EVV required services that must be electronically documented and verified through EVV are listed on the HHSC EVV website. Refer to the Programs, Services and Service Delivery Options Required to Use Electronic Visit Verification.

Check the EVV Service Bill Codes Table on the HHSC EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services.

HHSC EVV website for the EVV Service Bill Codes Table

4. Who must use EVV?

The following must use EVV:

- Provider: An entity that contracts with an MCO to provide an EVV service.
- Service Provider: A person who provides an EVV required service and who is employed or contracted by a Provider or a CDS Employer.
- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
- Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employer as described in Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, 41.103(25), Consumer Directed Services Option.
- CDS Employer: A Member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a service provider who delivers a service.

EVV SYSTEMS

5. Do Providers and FMSAs have a choice of EVV Systems?

Yes. A Provider or FMSA must select one of the following two EVV Systems:

- EVV vendor system. An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV proprietary system.

https://www.tmhp.com/topics/evv

- EVV proprietary system. An EVV proprietary system is an HHSC-approved EVV System that a Provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
  - Is purchased or developed by a Provider or an FMSA.
  - Is used to exchange EVV information with HHSC or an MCO; and
  - Complies with the requirements of Texas Government Code Section 531.024172 or its successors.

https://www.tmhp.com/topics/evv/evv-proprietary-systems

6. Does a CDS Employer have a choice of EVV Systems?

No. A CDS Employer must use the EVV System selected by the CDS Employer s FMSA.

7. What is the process for a Provider or FMSA to select an EVV System?

- To select an EVV vendor from the state vendor pool, a Provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV vendor's website.

https://www.tmhp.com/topics/evv/evv-vendors

- To use an EVV proprietary system, a Provider or FMSA, signature authority, and the agency's appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV PSO Onboarding process and HHSC EVV Proprietary System approval process.

https://www.tmhp.com/topics/evv/evv-proprietary-systems

8. What requirements must a Provider or FMSA meet before using the selected EVV System?

Before using a selected EVV System:

- The Provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor.

https://www.tmhp.com/topics/evv/evv-proprietary-systems

- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
  - An EVV Proprietary System Request Form
  - EVV PSO Detailed Questionnaire (DQ)
  - TMHP Interface Access Request
- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV proprietary system to comply with HHSC EVV requirements.
- If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
  - Complete all required EVV training as described in the answer to Question #18; and
  - Complete the EVV System onboarding activities:
    - Manually enter or electronically import identification data;
    - Enter or verify Member service authorizations;
    - Setup member schedules (if required); and
    - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

9. Does a Provider or FMSA pay to use the selected EVV System?

- If a Provider or FMSA selects an EVV vendor system, the Provider or FMSA uses the system free of charge.
- If a Provider or FMSA elects to use an EVV proprietary system, the Provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

10. Can a Provider or FMSA change EVV Systems?

Yes. A Provider or FMSA may:

- Transfer from an EVV vendor to another EVV vendor within the state vendor pool;
- Transfer from an EVV vendor to an EVV Proprietary System;
- Transfer from an EVV Proprietary System to an EVV vendor; or
- Transfer from one EVV Proprietary system to another EVV Proprietary system.

11. What is the process to change from one EVV System to another EVV System?

To change EVV Systems, a Provider or FMSA must request a transfer as follows:

- To request a transfer to an EVV vendor, a Provider or FMSA must submit an EVV Provider Onboarding Form to the new EVV vendor.
- To request a transfer to an EVV proprietary system, a Provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A Provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 Days before the desired effective date of the transfer.
- If a Provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the Provider or FMSA and the newly selected EVV vendor agree on an earlier date.
- If a Provider or FMSA is transferring to an EVV proprietary system, the Provider or FMSA, TMHP, and HHSC will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.
- An FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
- A Provider or FMSA must complete all required EVV System training before using the new EVV System.
- A Provider or FMSA who transfers to a new EVV vendor or proprietary system:
    - Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement; and
    - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.

- After a Provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

12. Are the EVV Systems accessible for people with disabilities?

The EVV vendors provide accessible systems, but if a CDS Employer, service provider or CDS Employee needs an accommodation to use the EVV System, the vendor will determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.

If the Provider or FMSA is using a proprietary system, the Service Provider, CDS Employer or CDS Employee must contact the Provider or FMSA to determine accessibility features of the system and if an accommodation can be provided.

EVV SERVICE AUTHORIZATIONS

13. What responsibilities do Providers and FMSAs have regarding service authorizations issued by an MCO for an EVV required service?

A Provider and FMSA must do the following regarding service authorizations issued by an MCO for an EVV-required service:

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:
  - Name of the MCO;
  - Name of the Provider or FMSA;
  - Provider or FMSA Tax Identification Number;
  - National Provider Identifier (NPI) or Atypical Provider Identifier (API);
  - Member Medicaid ID;
  - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s);
  - Authorization start date; and
  - Authorization end date.
- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System; and
- Manually enter service authorization changes and updates into the EVV System as necessary.

EVV CLOCK IN AND CLOCK OUT METHODS

14. What are the approved methods a Service Provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?

A Service Provider or CDS Employee must use one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to end service delivery when providing services to a member in the home or in the community. A Service Provider or CDS Employee may use one method to clock in and a different method to clock out.

(1) Mobile method

- A Service Provider must use one of the following mobile devices to clock in and clock out:
  - the Service Provider's personal smart phone or tablet; or
  - a smart phone or tablet issued by the Provider.
- A Service Provider must not use a Member's smart phone or tablet to clock in and clock out.
- A CDS Employee must use one of the following mobile devices to clock in and clock out:
  - the CDS Employee's personal smart phone or tablet;
  - A smart phone or tablet issued by the FMSA; or
  - the CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.
- To use a mobile method, a Service Provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the Service Provider or CDS Employee has downloaded to the smart phone or tablet.
- The mobile method is the only method that a Service Provider or CDS Employee may use to clock in and clock out when providing services in the community.

(2) Home phone landline

- A Service Provider or CDS Employee may use the Member's home phone landline, if the Member agrees, to clock in and clock out of the EVV System.
- To use a home phone landline, a Service Provider or CDS Employee must call a toll-free number provided by the EVV vendor or the PSO to clock in and clock out.
- If a Member does not agree to a Service Provider's or CDS Employee's use of the home phone landline or if the Member's home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another approved clock in and clock out method.

The Provider or FMSA must enter the Member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.

(3) Alternative device

- A Service Provider or CDS Employee may use an HHSC-approved alternative device to clock in and clock out when providing services in the Member's home.
- An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
- An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
- The alternative device codes are active for only seven days after the date of service and must be entered into the EVV system before the code expires.
- The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit.

An alternative device must always remain in the Member's home even during an evacuation.

15. What actions must the Provider or FMSA take if a Service Provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?

- If a Service Provider does not clock in or clock out of the EVV System or an approved clock in or clock out method is not available, then the Provider must manually enter the visit in the EVV System.
- If a Service Provider makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the Provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer s selection on Form 1722 to manually enter the clock-in and clock-out information and other service delivery information, if applicable.
- If a CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to correct the inaccurate service delivery information in the EVV System.
- After the Visit Maintenance time frame has expired, the EVV System locks the EVV visit transaction and the program provider, FMSA or CDS Employer may only complete Visit Maintenance if the MCO approves a Visit Maintenance Unlock Request.
- The EVV Policy Handbook requires the Provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

EVV VISIT MAINTENANCE

16. Is there a timeframe in which Providers, FMSAs, and CDS Employers must perform Visit Maintenance?

In general, a Provider, FMSA, or CDS Employer must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in HHSC EVV Policy Handbook.

Note: The standard Visit Maintenance timeframe as set in EVV Policy Handbook may be changed by HHSC to accommodate Providers impacted by circumstances outside of their control.

17. Are Providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance?

Yes. Program providers, FMSAs or CDS Employers must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing Visit Maintenance in the EVV System.

- Reason Code Number(s) describe the purpose for completing Visit Maintenance on an EVV visit transaction.
- Reason Code Description(s) describe the specific reason Visit Maintenance is necessary.
- Free text is additional information the program provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.

https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification-evv

EVV TRAINING

18. What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training:
  - EVV System training provided by the EVV vendor or EVV PSO;
  - EVV Portal training provided by TMHP; and
  - EVV Policy training provided by HHSC or the MCO.
- CDS Employers must complete training based on delegation of Visit Maintenance on Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities:
  - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked In the EVV System;
    - EVV System training provided by the EVV vendor or EVV PSO;
    - Clock in and clock out methods; and
    - EVV Policy training provided by HHSC, the MCO or FMSA.

- Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
  - EVV System training provided by EVV vendor or EVV PSO; and
  - EVV Policy training provided by HHSC, the MCO or FMSA.
- Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
  - Overview of EVV Systems training provided by EVV Vendor or EVV PSO; and
  - EVV policy training provided by HHSC, the MCO or FMSA.

- Providers and CDS Employers must train Service Providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.

https://www.elpasohealth.com/providers/evv/

COMPLIANCE REVIEWS

19. What are EVV Compliance Reviews?

- EVV Compliance Reviews are reviews conducted by the MCO to ensure Providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies.
- The MCO will conduct the following reviews and initiate contract or enforcement actions if Providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:
  - EVV Usage Review – meet the minimum EVV Usage Score;
  - EVV Required Free Text Review – document EVV required free text; and
  - EVV Landline Phone Verification Review – ensure valid phone type is used.

https://www.elpasohealth.com/providers/evv/

EVV CLAIMS

20. Are Providers and FMSAs required to use an EVV System to receive payment for EVV required services?

Yes. All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim by the MCO. The MCO may deny or recoup an EVV claim that does not match an accepted visit transaction.

21. Where does a Provider or FMSA submit an EVV claim?

Providers and FMSAs must submit all EVV claims to the HHSC Claims Administrator in accordance with the MCO's submission requirements.

https://www.elpasohealth.com/providers/evv/

22. What happens if a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator?

If a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator, the MCO will reject or deny the claim and require the Provider or FMSA to submit the claim to the HHSC Claims Administrator.

23. What happens after the HHSC Claims Administrator receives an EVV claim from a Provider or FMSA?

The HHSC Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHSC Claims Administrator for further claims processing. After completing the EVV claims matching process, the HHSC Claims Administrator forwards the claim to the MCO for final processing.

24. How does the automated EVV claims matching process work?

The claims matching process includes:

- Receiving an EVV claim line item.
- Matching data elements from each EVV claim line item to data elements from one or more accepted EVV transactions in the EVV Aggregator.
- Forwarding an EVV claim match result code to the MCO once the claims matching process is complete.

The following data elements from the claim line item and EVV transaction must match:

- Medicaid ID;
- Date of service;
- National Provider Identifier (NPI) or Atypical Provider Identifier (API);
- Healthcare Common Procedure Coding System (HCPCS) code;
- HCPCS modifiers; and
- Billed units to units on the visit transaction, if applicable.

Note: No unit match is performed on CDS EVV claims and unit match is not performed on visit transactions against the billed units on the claim line item for specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the units matching process.

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match codes viewable in the EVV Portal are:

- EVV01 – EVV Successful Match
- EVV02 – Medicaid ID Mismatch
- EVV03 – Visit Date Mismatch
- EVV04 – Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 – Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 – Units Mismatch
- EVV07 – Match Not Required
- EVV08 – Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. The MCO will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHSC implements a bypass of the claims matching process for disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- The MCO will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- The MCO may still deny an EVV claim if other claim requirements fail the claims adjudication process.
- If allowed by HHSC, the MCO may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

25. How can a Provider and FMSA see the results of the EVV claims matching process?

Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and the MCO system. The MCO's Provider Portal also provides additional claims status information, such as whether the MCO has paid or denied the claim. In addition, the MCO provides an Explanation of Payment (EOP) to Providers and FMSAs to inform them of whether the MCO paid or denied the claim, and if denied, the reason for denial.

https://www.tmhp.com/topics/evv/evv-training

26. Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?

Yes. An MCO may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a Member's loss of program eligibility or the Provider's or FMSA's failure to obtain prior authorization for a service.

SECTION 14: MEMBER RIGHTS AND RESPONSIBILITIES

STAR AND STAR+PLUS MEMBER RIGHTS AND RESPONSIBILITIES

STAR AND STAR+PLUS 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 available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
    b. Get a timely answer to your complaint.
    c. Use the plan's appeal process and be told how to use it.

   d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive 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.

STAR AND STAR+PLUS MEMBER RESPONSIBILITIES

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.
   c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan's rules and Medicaid rules.
   b. Choose your health plan and a primary care Provider quickly.
   c. Make any changes in your health plan and primary care Provider in the ways established by Medicaid and by the health plan.

d. Keep your scheduled appointments.
e. Cancel appointments in advance when you cannot keep them.
f. Always contact your primary care Provider first for your non-emergency medical needs.
g. Be sure you have approval from your primary care Provider before going to a specialist.
h. Understand when you should and should not go to the emergency room.

3. You must share information about your health with your primary care Provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care Provider about your health.
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
   a. Work as a team with your Provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your Provider about all of your medications.

Additional Member Responsibilities while using NEMT Services.

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
3. You must follow all rules and regulations affecting your NEMT services.
4. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
5. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
6. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
7. You must only use NEMT Services to travel to and from your medical appointments.
8. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

CHIP MEMBER RIGHTS AND RESPONSIBILITIES

CHIP MEMBER RIGHTS

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals and other providers.
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 and/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 co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal.
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.

CHIP MEMBER RESPONSIBILITIES

You and El Paso Health 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 El Paso Health doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your El Paso Health you must try first to resolve it using the health plan's complaint process.
5. You must learn about what El Paso Health 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 co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other Members, or health plans.
9. Talk to your child's Provider about all of your child's medications.

CHIP PERINATE MEMBER RIGHTS AND RESPONSIBILITIES

CHIP PERINATE MEMBER RIGHTS

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals and other providers.
10. You have the right to talk to your Perinatal Provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

CHIP PERINATE MEMBER RESPONSIBILITIES

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Perinatal Member Handbook to understand how the rules work.
5. 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.
6. You must report misuse of CHIP Perinatal services by health care providers, other Members, or health plans.
7. Talk to your Provider about all of your medications.

CULTURAL SENSITIVITY

El Paso Health places great emphasis on the wellness of our Members. A large part of quality healthcare delivery is treating the whole patient and not just the medical condition. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a Provider's relationship with patients and in the long run the health and wellness of the patients themselves. We coordinate interpreter and translation services to meet the Member's needs. El Paso Health's Cultural Competency and Linguistic Services Plan is available to its Network Providers upon request.

Member Education

Members receive various pieces of information from El Paso Health through mailings, internet resources and face-to-face contact. These materials include:

- El Paso Health Member Handbook
- Quarterly Newsletters
- Targeted Disease Management Brochures
- El Paso Health Provider Directories
- El Paso Health website
- Special mailings

All educational materials, including videos and written text, are available in both English and Spanish and in other languages if needed. These materials are also modified for 4th to 6th grade reading levels.

SECTION 15: HIPAA

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is a federal law that has the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. The law also gives HHS the authority to mandate the use of standards for the electronic exchange of healthcare data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for healthcare patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable healthcare information.

The final version of the HIPAA Privacy regulations went into effect on April 14, 2002; enforcement began on April 14, 2003. The Omnibus Final Rule (January 2013) strengthened privacy and security provisions of the HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) Acts.

WHO IS AFFECTED BY HIPAA?

HIPAA directly affects:

- Healthcare Providers.
- The health insurance business.
- Employers who provide healthcare benefits – plan sponsors (if they have 50+ eligible employees *or* have a 3rd party administrator of their plan).
- Businesses that provide goods or services to healthcare practitioners and other covered entities, including those classified as “Business Associates.”

Under HIPAA, El Paso Health requires you to protect and secure our Members’ personal and medical information. You are required to have privacy and security measures in place and document those in policies and procedures. Both federal and state privacy laws require that your employees be trained in the law and the policies & procedures of your office.

In general, HIPAA health information privacy rules will require:

- Staff training and documentation of that training, along with a mechanism to provide training for new employees.
- Safeguards for protecting, using, and disclosing health information, both physical and electronic.
- A manual describing these physical and informational security measures.

How easy is it to face a HIPAA audit? ANYONE can turn a practice in. Ever had an unhappy employee leave, or experience the anger of a dissatisfied patient? One simple call can bring any

practice to the attention of the Health and Human Services' Office of Civil Rights or the Texas Attorney General. El Paso Health's staff is available to assist you if you have questions about the privacy laws and protecting our Members' information.

PATIENT RIGHTS

Notice of Privacy Practices

It is important that patients understand how they can protect their own health information and how providers protect, use and disclose their information. The Notice of Privacy Practices (Notice) explains this information.

First-time patients should receive your Notice before they begin receiving care. Anyone, regardless of whether they are patients at your facility, may request a copy of the Notice at any time. When patients have questions about HIPAA, their rights, or your facility's policies and practices, refer them to this Notice or to your facility's privacy official.

El Paso Health's Notice is posted in our facility and copies are available online at www.elpasohealth.com or by request. El Paso Health has HIPAA Privacy and Security Officers who are available to answer our Members' questions or to receive complaints.

SECTION 16: FRAUD REPORTING

As government-funded programs, the Medicaid and CHIP programs include an important element of fraud and abuse prevention, which includes the cooperation and participation of El Paso Health's Provider network in fraud and abuse prevention and reporting.

El Paso Health has a fraud and abuse plan that complies with State and federal law, including Tex. Rev. Civ. Stat. Ann. Art. 4413(502) §16A, Tex. Government Code, §532.112, and 31 U.S.C. §3729-3733. El Paso Health contracts its Fraud Special Investigation Unit with Cotiviti.

El Paso Health is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse. It is your responsibility as a participating Provider to report any Member or Provider suspected of fraud and abuse.

FRAUD INFORMATION

Reporting Waste, Abuse or Fraud by a Provider or Client

Medicaid Managed Care and CHIP

Do you want to report Waste, Abuse or Fraud?

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

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

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

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.texas.gov/ and click "Report Fraud" to complete the online form; or
- You can report directly to your health plan:

El Paso Health
Special Investigations Unit
1145 Westmoreland Dr. El Paso, TX 79925
1-866-356-8395 • www.elpasohealth.com

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

- When reporting a Provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of Provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the Provider and facility if you have it
  - Type of Provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse or fraud

All El Paso Health providers who receive five (5) million dollars or more from Medicaid in any given year must be aware of the Deficit Reduction Act of 2005. El Paso Health's Deficit Reduction Act of 2005 policy is readily available to all providers upon request.

A copy of the sample letter you would receive in the event you incur billing errors and we need to recoup money from you can be found on **ATTACHMENT 25**.

SPECIAL INVESTIGATIONS UNIT

Special Investigations Unit

El Paso Health's Special Investigations Unit (SIU) carries out the functions described in the Plan to Prevent and Reduce Waste, Abuse, Fraud. These functions include regular audits, verifications that Members receive services as they were billed, and OB audits (elective deliveries prior to 39 weeks). SIU staff is also available to provide education to Providers and their staff.

If you receive a records request, it is important to meet the submission dates and include all relevant documentation. You may not dispute or appeal a claims recoupment if you did not submit complete documentation for review.

For assistance, please call the SIU Program Manager at 915-532-3778 Ext. 1039 or Catherine Gibson, CHC, El Paso Health Chief Compliance Officer at 915-532-3778 Ext. 1258.

ATTACHMENTS

ATTACHMENT 1	List of Procedures & Services Requiring Preauthorization/Notification
ATTACHMENT 2	Behavioral Health Prior Authorization Form
ATTACHMENT 3	Applied Behavior Analysis (ABA)
ATTACHMENT 4	NICU Notification Form
ATTACHMENT 5	Pre-certification Fax Form for Outpatient/Scheduled Procedures
ATTACHMENT 6	Pre-certification Fax Form for Out-of-Area Inpatient/Scheduled Procedures
ATTACHMENT 7	STAR ID
ATTACHMENT 8	CHIP ID
ATTACHMENT 9	CHIP Perinatal Mother ID
ATTACHMENT 10	CHIP Perinatal Newborn ID
ATTACHMENT 11	CHIP Evidence of Coverage (EOC)
ATTACHMENT 12	CHIP Perinatal Evidence of Coverage
ATTACHMENT 13	CHIP Perinatal Newborn Evidence of Coverage
ATTACHMENT 14	Information Medicaid ID Card
ATTACHMENT 15	Request for Specialist as a PCP
ATTACHMENT 16	Member Appeal Form
ATTACHMENT 17	HHS Federal External Review Process Appointment of Representative Form
ATTACHMENT 18	HHS Federal External Review Request Form
ATTACHMENT 19	Member Complaint Form (English)
ATTACHMENT 20	Member Complaint Form (Spanish)
ATTACHMENT 21	CMS 1500 Claim Form Guide
ATTACHMENT 22	Corrected Claim Form/CMS 1500 or UB04 Claim Form
ATTACHMENT 23	Private Pay Form
ATTACHMENT 24	HealthX Fax System/Flowchart
ATTACHMENT 25	Compliance Sample of a Findings/Education Letter

ATTACHMENT 1

List of Services Requiring Prior Authorization

ATTACHMENT 2

BEHAVIORAL HEALTH PRIOR AUTHORIZATION FORM

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

Clear Form | Print

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:		
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #:		

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse
Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)
Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☐ No)
Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____

NOFR001 | 0415

Page 2 of 2

El Paso Health-Request for Behavioral Health Services

Page 2 and 3 Not for Use with Mental Health Rehab and Targeted Case Management

Member's Name: **Member I.D.**

Section VII. Identifying Information:			
Current Living Situation:	**With Parent(s)**	**Group/Foster Home**	**Other (list):**

Section VIII. Court Ordered Service?	Yes	No

Section IX. DFPS Directed Service:	Yes	No

Section X. Psychiatric Medications:

Medication	Dose	Frequency	Prescribing Physician

Section XI.	Continuation of Therapy Requests: Please indicate the following. (Complete all sections):
Current Symptoms:	
Response to Past Treatment: (Provide Detailed Information)	
Specific Therapeutic Interventions:	

Section XII. **Short Term Measurable Treatment Goals: (Note specific progress for each goal)**

Goal	Current Progress	Target Date

50175EPF102016 2

El Paso Health-Request for Behavioral Health Services

Page 2 and 3 Not for Use with Mental Health Rehab and Targeted Case Management

Member Name _____ **Member I.D.** _____

Section XIII.

Anxiety/Phobia	Risk Factors	Sleep Patterns	Eating Patterns	Substance Abuse
Anxiety	Social Isolation	Hypersomnia	Increase Appetite	Alcohol
Panic Attack	Impaired Judgment	Insomnia	Decrease Appetite	Drugs
Phobic Responses	Aggression	Nightmares	Bulimia	Active
Excessive Worry	Oppositional/Defiant	Traumatic Dreams	Anorexia	Remission
PTSD	Self injurious	Hyposomnia		Withdrawal Symptoms

Mood	Cognition	Thought Content	Functionality	Activity
Anger	Decrease Concentration	Flight of Ideas	Obsessions/Compulsions	Decrease in Energy
Apathy	Distractibility	Loose Association	Hypersexual	Psychomotor Retardation
Blunted/Flat Affect	Impaired Abstract Thinking	Hyper-talkative	Impaired ability to function at:	Restlessness
Depressed Mood	Memory Impairment	Pressured Speech	Home	Hyperactivity
Elevated/Expansive	Difficulty Making Decisions	Racing Thoughts	School	Impulsiveness
Grandiosity	Hallucinations	Delusions	Work	
Hopelessness		Grandiosity	High Risk Behavior	
Irritable		Paranoid Ideation	Anti-Social Behavior	
Low Self Esteem				
Tearfulness				
Mood Swings				

Section XIV.

Suicidal:	Yes	No	Explain:	_____
Homicidal:	Yes	No	Explain:	_____
Emotional Trauma:	Yes	No	Explain:	_____
Sexual Trauma:	Yes	No	Explain:	_____
Physical Trauma:	Yes	No	Explain:	_____

50175EPF102016 3

ATTACHMENT 3

APPLIED BEHAVIOR ANALYSIS (ABA)

The following forms will be accepted when requesting prior authorization for Applied Behavior Analysis services.

Texas Standard Prior Authorization Request Form for Health Care Services - NOFR001 (elpasohealth.com)

Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0415 — Texas Department of Insurance

Please read all instructions below before completing this form.
*Please send this request to the issuer from whom you are seeking authorization. **Do not send this form** to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a health care service. An issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:
Section I – Submission:
An issuer may have already entered this information on the copy of this form posted on its website.

Section II – General Information:
Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV – Provider Information:
- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI – Clinical Documentation:
- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

***Note:** Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.*
***Note:** If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.*

Texas Department of Insurance | 333 Guadalupe | Austin, Texas 78701 | (800) 578-4677 | www.tdi.texas.gov | @TexasTDI

10938-3 EPH PRIOR AUTHORIZATION FORM (elpasohealth.com)

CCP Prior Authorization Request Form

El Paso Health

Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.* **To submit by fax, please send to, 915-298-7866 or Toll-Free at 844-298-7866.**

Request for:	☐ ABA	☐ DME	☐ Supplies	☐ Private Duty Nursing	☐ PPECC	☐ Inpatient Rehabilitation	☐ Other

A: Client Information

Client Name (Last, First, M.I.)*:	
Medicaid Number*:	Date of Birth*:

B: Rendering Provider/Supplier/Vendor/Qualified Rehabilitation Professional (QRP) Information

Name*:		Telephone:	Fax:
Street Address*:			
City:		State:	Zip + 4*:
Tax ID*:	NPI*:	Taxonomy*:	Benefit Code*:
QRP Name:		QRP Tax ID:	QRP NPI:
QRP Taxonomy:		QRP Benefit Code:	
QRP Street Address:			
City:		State:	Zip + 4:

C: Type of Request

☐ ABA Evaluation	Requested Start Date*:	Requested End Date*:
☐ ABA Re-evaluation	Requested Start Date*:	Requested End Date*:
☐ ABA Treatment	Requested Start Date*:	Requested End Date*:
☐ Initial/New Client	Requested Start Date*:	Requested End Date*:
☐ Recertification	Requested Start Date*:	Requested End Date*:
☐ Revision**	Revised Start Date*:	End Date*: (Cannot extend beyond current authorization period.)

**Reason for Revision:

D: Diagnosis and Medical Necessity of Requested Services (Initial and Recertification)

*Essential/Critical field

EPHP8892202 Effective: 02/01/2022

Page 1 of 2

ATTACHMENT 4

Pre-certification Fax Form for
NICU Notification
Fax No. (915) 298-5278
Toll Free Fax No.: (844) 200-5278
Phone No. (915) 532-3778
Toll Free: (877) 532-3778

PLEASE NOTE: All services requiring pre-certification (other than on an emergency basis) must be approved in advance by a HMO Medical Director/designee. Pre-certification is subject to all terms and conditions of the Health Service Contract and is only valid for eligible health plan member at time of service.

NICU Notification

THIS FORM MUST BE ACCOMPANIED BY THE FACILITY FACE SHEET

DATE: _____ FACILITY NAME: _____

CONTACT PERSON: _____

PHONE: _____ FAX NO.: _____

TPI #: _____ NPI #: _____

MEMBER NAME & GENDER: _____ MOTHER'S PLAN I.D.: _____
(Ex.: NB FEMALE DOE, JANE)

INFANT'S DOB: _____ MR # _____ ACCT # _____

NICU ADMIT DATE: _____ ADMITTING MD: _____

TYPE OF DELIVERY: ☐ VAGINAL ☐ C-SECTION

ADMITTING DIAGNOSIS: _____

COMPLETE INFORMATION BELOW FOR ADDITIONAL BIRTH ONLY

TWIN A ☐ TWIN B ☐

MEMBER NAME & GENDER: _____ MOTHER'S PLAN I.D.: _____
(Ex.: NB FEMALE DOE, JANE)

INFANT'S DOB: _____ MR # _____ ACCT # _____

NICU ADMIT DATE: _____ ADMITTING MD: _____

TYPE OF DELIVERY: ☐ VAGINAL ☐ C-SECTION

ADMITTING DIAGNOSIS: _____

COMMENTS:

THIS PRECERTIFICATION DOES NOT GUARANTEE PAYMENT OF BENEFITS NOR VERIFY ELIGIBILITY. PAYMENT OF BENEFITS IS SUBJECT TO ALL TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THE MEMBER'S CONTRACT. REGARDLESS OF A DETERMINATION, MEDICAL DECISIONS REGARDING A COURSE OF TREATMENT ARE SOLELY BETWEEN THE PHYSICIAN AND THE PATIENT.

ATTACHMENT 5

Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0415 Texas Department of Insurance

Please read all instructions below before completing this form.
*Please send this request to the issuer from whom you are seeking authorization. **Do not send this form** to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a health care service. An Issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I – Submission:
An issuer may have already entered this information on the copy of this form posted on its website.

Section II – General Information:
Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV – Provider Information:
- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI – Clinical Documentation:
- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

***Note:** Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.*
***Note:** If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.*

Texas Department of Insurance | 333 Guadalupe | Austin, Texas 78701 | (800) 578-4677 | www.tdi.texas.gov | @TexasTDI

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

Clear Form | Print

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:		
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment		Prev. Auth. #:	

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse
Number of Sessions:_____ Duration:_____ Frequency: _____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)
Number of Visits: _____ Duration:_____ Frequency: _____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☐ No)
Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____

NOFR001 | 0415

Page 2 of 2

ATTACHMENT 6

El Paso Health

Out-of-Area INPATIENT Precertification Fax Form
Phone No. (915) 532-3778
Toll Free No. (877) 532-3778

NOTE: All services requiring pre-certification (other than on an emergency basis) must be approved in advance by a HMO Medical Director/designee. Pre-certification is subject to all terms and conditions of the Health Service Contract and is only valid for eligible health plan member at time of service.

PLEASE FAX INITIAL CLINICAL INFORMATION WITHIN 24 HOURS OF ADMISSION TO THE UM UNIT AT 915-298-5278 OR TOLL FREE AT 844-200-5278, FAILURE TO DO SO MAY RESULT IN DELAY OR DENIAL OF AUTHORIZATION. EL PASO HEALTH REQUESTS SUBSEQUENT CLINICALINFORMATION EVERY OTHER DAY.

FACILITY NAME: _____

FACILITY ADDRESS: _____

_____ City _____ State _____ Zip Code

TPI #: _____ NPI # _____

CONTACT PERSON: _____

PHONE: _____ FAX: _____

PROCEDURE CODES (CPT CODE): _____

IF PATIENT IS TRANSFER, FROM WHAT FACILITY: _____

WHAT HOSPITAL UNIT IS PATIENT BEING TRANSFERRED TO _____

PATIENT ARRIVED BY: ☐ AIR AMBULANCE ☐ LAND AMBULANCE ☐ PRIVATE TRANSPORT ☐ OTHER

OTHER INSURANCE: _____ ☐ SSI

MEMBER NAME: _____ MEMBER I.D.: _____

DOB: _____ MR # _____ ACCT # _____

ADMIT DATE: _____ RM # _____ UNIT: _____ DISCHARGE DATE (if applicable): _____

ADMITTING PHYSICIAN: _____ ADMITTING DIAGNOSIS (ICD-9): _____

OTHER DIAGNOSIS (ICD Code): _____

ADMITTING Physician's Name: _____

TPI #: _____ NPI # _____

CONTACT PERSON: _____

PHONE: _____ FAX: _____

PROCEDURE CODES (CPT CODE): _____ TYPE OF SERVICE: _____

SURGEON'S Name: _____

TPI #: _____ NPI # _____

CONTACT PERSON: _____

PHONE: _____ FAX: _____

PROCEDURE CODES (CPT CODE): _____ TYPE OF SERVICE: _____

OTHER Physician's Name: _____

TPI #: _____ NPI # _____

CONTACT PERSON: _____

PHONE: _____ FAX: _____

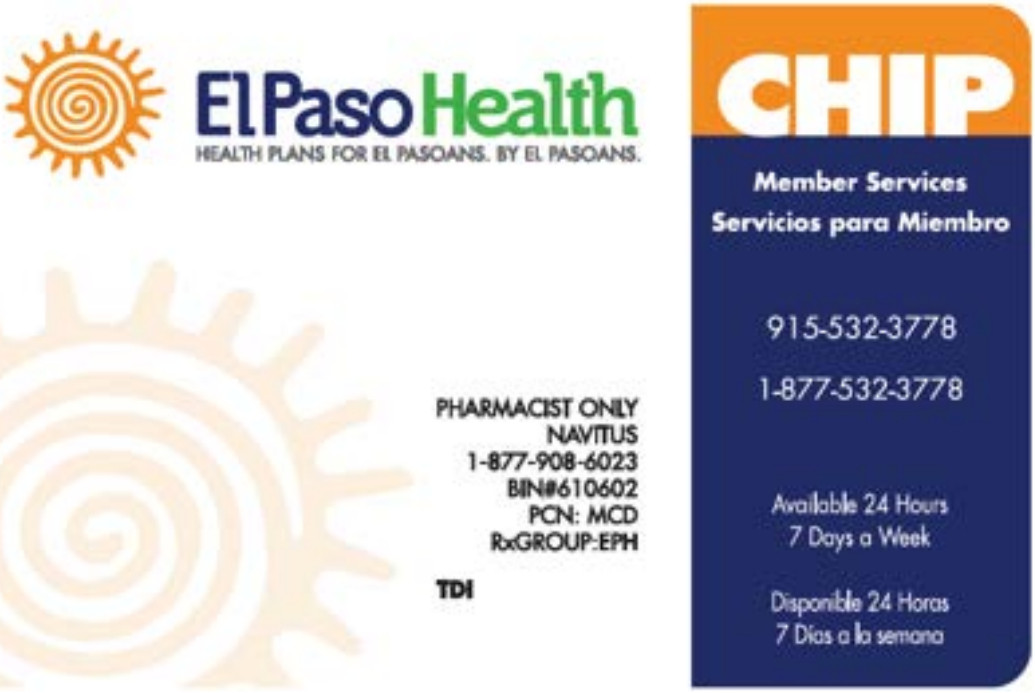
PROCEDURE CODES (CPT CODE): _____ TYPE OF SERVICE: _____

THIS PRECERTIFICATION DOES NOT GUARANTEE PAYMENT OF BENEFITS NOR VERIFY ELIGIBILITY. PAYMENT OF BENEFITS IS SUBJECT TO ALL TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THE MEMBER'S CONTRACT. REGARDLESS OF A DETERMINATION, MEDICAL DECISIONS REGARDING A COURSE OF TREATMENT ARE SOLELY BETWEEN THE PHYSICIAN AND THE PATIENT.

50178EPF111018

ATTACHMENT 7

ATTACHMENT 8



HOW TO USE THIS CARD: Always carry your ID card. Go to your primary care doctor for medical care. You need a written referral form from your primary care doctor before you go to a specialty doctor.
MEDICINE: Present this card at drug stores with a prescription from your doctor. Call 1-877-532-3778 if you have questions or problems getting your medicine.
BEHAVIORAL HEALTH AND SUBSTANCE ABUSE HOTLINE: Toll Free 1-877-377-6184, 24 hours/ 7 days a week.
DIRECTIONS FOR WHAT TO DO IN AN EMERGENCY: In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.
NAVITUS HEALTH SOLUTIONS is the pharmacy benefits provider for members of El Paso Health.

CÓMO USAR ESTA TARJETA: Cargue su tarjeta de identificación con usted siempre. Visite a su Proveedor de Cuidado Primario para recibir atención médica. Usted necesita ser referido por su Proveedor de Cuidado Primario antes de que pueda consultar a un especialista.
MEDICINA: Presente esta tarjeta de identificación en la farmacia junto con la receta de su doctor. Llame al 1-877-532-3778 si tiene preguntas o problemas para obtener la medicina.
LÍNEA DIRECTA DE SERVICIOS DE SALUD MENTAL Y ABUSO DE SUSTANCIAS: 1-877-377-6184, Disponible 24 Horas/7 Días a la semana.
INSTRUCCIONES EN CASO DE EMERGENCIA: En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.
NATIVUS HEALTH SOLUTIONS: es el proveedor de beneficios de farmacia para miembros de El Plan de Salud de El Paso Health.

ATTACHMENT 9

For Hospital Facility billing for members with FPL 0-185% please bill to:
Texas Medicaid and Healthcare
Partnership Claims
P.O. Box 200555
Austin, Texas 78720-0555

For members with FPL above 185% to 200% and for Professional/Other services billing, please bill to:
El Paso Health
P.O. Box 971370
El Paso, Texas 79997-1370

MEDICINE: Present this card at drug stores with a prescription from your doctor. Call 1-877-532-3778 if you have questions or problems getting your medicine.
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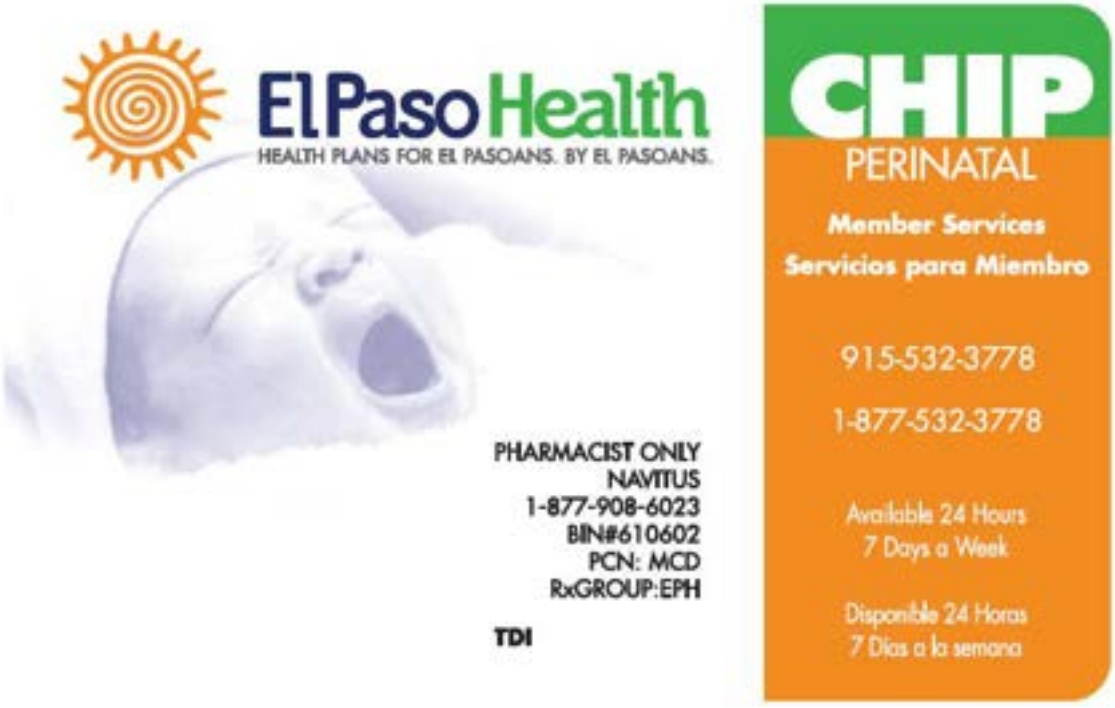
NATIVUS HEALTH SOLUTIONS: es el proveedor de beneficios de farmacia para miembros de El Plan de Salud de El Paso Health.

ATTACHMENT 10



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MEDICINA: Presente esta tarjeta de identificación en la farmacia junto con la receta de su doctor. Llame al 1-877-532-3778 si tiene preguntas o problemas para obtener la medicina.
LÍNEA DIRECTA DE SERVICIOS DE SALUD MENTAL Y ABUSO DE SUSTANCIAS: 1-877-377-6184, Disponible 24 Horas/7 Días a la semana.
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NATIVUS HEALTH SOLUTIONS: es el proveedor de beneficios de farmacia para miembros de El Plan de Salud de El Paso Health.

ATTACHMENT 11

CHILDREN'S HEALTH INSURANCE PROGRAM HEALTH BENEFIT PLAN
EVIDENCE OF COVERAGE
El Paso Health
NON-FEDERALLY QUALIFIED PLAN

THIS EVIDENCE OF COVERAGE (CONTRACT) IS ISSUED TO YOU, WHOSE CHILD HAS ENROLLED IN **EL PASO HEALTH** BENEFIT PLAN THROUGH THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP). YOU AGREE TO ADHERE TO THESE PROVISIONS FOR COVERED HEALTH SERVICES BY COMPLETING THE ENROLLMENT FORM, PAYING THE APPLICABLE PREMIUM AND ACCEPTING THIS EVIDENCE OF COVERAGE. THIS DOCUMENT DESCRIBES YOUR RIGHTS AND RESPONSIBILITIES IN RELATION TO YOUR CHILD RECEIVING COVERED HEALTH SERVICES AND BENEFITS FROM **EL PASO HEALTH** THROUGH THE CHIP PROGRAM.

Issued by

El Paso Health
1145 Westmoreland Dr. El Paso, Texas 79925
915-532-3778
1-877-532-3778

In association with:

Children's Health Insurance Program
P.O. Box 149276
Austin, TX 78714-9983
1-800-647-6558

CHIP-EOC

IMPORTANT NOTICE

To obtain information or make a complaint:

YOU may contact YOUR Customer Service Department at 915-532-3778 or toll free at 1-877-532-3778

El Paso Health
YOU may call El Paso Health toll-free telephone number for information or to make a complaint at

1-877-532-3778

YOU may also write to El Paso Health at
1145 Westmoreland Dr.
El Paso, TX 79925

YOU may contact the Texas Department of Insurance to obtain information on companies, Coverages, rights or complaints at

1-800-252-3439

YOU may write the Texas Department of Insurance
Consumer Protection
P.O. Box 149091
Austin, TX 78714-9091
FAX #512-475-1771
http://www.tdi.texas.gov/consumer/complfrm.html

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning YOUR premium or about a claim you should contact the (agent) (company) (agent or the company) first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Puede comunicarse con su Servicio al Cliente al 915-532-3778 o sin costo al 1-877-532-3778

El Paso Health
Usted puede llamar al número de telefono gratis de El Paso Health para informacion o para someter una queja' al
1-877-532-3778

Usted tambien puede escribir a El Paso Health al
1145 Westmoreland Dr.
El Paso, TX 79925

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al
1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
Consumer Protection
P.O. Box 149091
Austin, TX 78714-9091
FAX #512-475-1771
http://www.tdi.texas.gove/consumer/complfrm.html

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el (agente) (la compania) (agente o la compania) primero. So no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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I. INTRODUCTION

A. YOUR CHILD'S Coverage under EL PASO HEALTH

El Paso Health provides benefits to YOUR CHILD for Covered Health Services under CHIP and determines whether particular health services are Covered Health Services, as described in **Section [XI]**, **SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES,** below. If properly enrolled, YOUR CHILD is eligible for the benefits described in **Section [XI]**. All services must be provided by participating Physicians and Providers except for Emergency Services and for out-of-network services that are authorized by El Paso Health. YOU have a Contract with El Paso Health. regarding matters stated in this Section I.A, as more fully described in this Contract.

B. YOUR Contract with CHIP

CHIP has determined that YOUR CHILD is eligible to receive Coverage and under what circumstances the Coverage will end. CHIP also has determined YOUR CHILD'S eligibility for other benefits under the CHIP program.

II. DEFINITIONS

ADMINISTRATOR: The contractor with the state that administers enrollment functions for CHIP health plans.

Adverse Determination: A decision that is made by US or OUR Utilization Review Agent that the health care services furnished or proposed to be furnished to a CHILD are not medically necessary or are experimental or investigational.

CHILD: Any child who CHIP has determined to be eligible for Coverage and who is enrolled under this Plan.

CHIP: The Children's Health Insurance Program which provides Coverage to each CHILD in accordance with an agreement between El Paso Health and the Health and Human Services Commission of the State of Texas.

Copayment: The amount that You are required to pay when your CHILD uses certain Covered Health Services within the Health Benefit Plan. Once the Copayment is made, You are not required to make further payment for these Covered Health Services.

Covered Health Services or Covered Services or Coverage: Those Medically Necessary Services that are listed in **Section [XI], SCHEDULE OF BENEFITS, EXCLUDED SERVICES**

AND COVERED HEALTH SERVICES, of this Health Benefit Plan. Covered Services also include any additional services offered by the El Paso Health as Value Added Services (VAS) in **Section [XI] SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES**, of this Health Benefit Plan.

Disability: A physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Emergency Behavioral Health Condition: 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 a CHILD would present an immediate danger to themselves or others, or
2. that renders a CHILD incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Condition: means an Emergency Medical Condition or an Emergency Behavioral Health Condition.

Emergency Medical Condition: 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
    - in the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

Emergency Services and **Emergency Care:** covered inpatient and outpatient services furnished by a Provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including post-stabilization care services.

Experimental and/or Investigational: A service or supply is Experimental and/or Investigational if WE determine that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to Phase I. II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.

   WE will determine if this item 2. Is true based on:

a. Published reports in authoritative medical literature; and
b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.

3. In the case of a drug, a device or other supply that is subject to FDA approval:
   a. It does not have FDA approval; or
   b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;
   c. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:
      (i) included in one or more of the following medical compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services; or
      (ii) in addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.
4. The Physician's or Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to that board's approval.
5. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5, applies for protocols used by the CHILD'S Physician or Provider as well as for protocols used by other Physicians or Providers studying substantially the same service or supply.

Health Benefit Plan or Plan: The Coverage provided to CHILD issued by El Paso Health providing Covered Health Services.

HEALTH PLAN: El Paso Health otherwise referred to as US, WE, or OUR.

Home Health Services: Health services provided at a CHILD'S home by health care personnel, as prescribed by the responsible Physician or other authority designated by the El Paso Health.

Hospital: A licensed public or private institution as defined by Chapter 241, Texas Health and Safety Code, or in Subtitle C, Title 7, Texas Health and Safety Code.

Illness: A physical or mental sickness or disease.

Independent Review Organization: An entity that is certified by the Commissioner of Insurance under Chapter 4202 to conduct independent review of Adverse Determinations.

Injury or Accidental Injury: Accidental trauma or damage sustained by CHILD to a body part or system that is not the result of a disease, bodily infirmity or any other cause.

Life-threatening: A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medically Necessary Services: Health services that are:

Physical:

- reasonable and necessary to prevent Illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical malformation or limitations in function, threaten to cause or worsen a Disability, cause Illness or infirmity of a CHILD, or endanger life;
- provided at appropriate facilities and at the appropriate levels of care for the treatment of CHILD'S medical conditions;
- consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
- consistent with diagnoses of the conditions;
- no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- are not Experimental or Investigative; and
- are not primarily for the convenience of the CHILD or health care Provider.

Behavioral:

- reasonable and necessary for the diagnosis or treatment of a mental health or Chemical Dependency disorder to improve,-maintain, or prevent deterioration of function resulting from the disorder;
- provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- are not Experimental or Investigative; and
- are not primarily for the convenience of the CHILD or health care Provider.

Medically Necessary Services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service which can safely be provided and which could not be omitted without adversely affecting the CHILD'S physical and/or mental health or the quality of care provided.

Member: Any covered CHILD, up to age 19, who is eligible for benefits under Title XXI of the Social Security Act and who is enrolled in the Texas CHIP program.

Out-of-Area: Any location outside El Paso Health CHIP Service Area.

Pediatrician: A Physician who is board eligible/board certified in pediatrics by the American Board of Pediatrics.

Physician: Anyone licensed to practice medicine in the State of Texas.

Primary Care Physician or Primary Care Provider (PCP): A physician or Provider who has agreed with the El Paso Health to provide a medical home to a CHILD and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

Provider: Any institution, organization or person, other than a Physician, that is licensed to or otherwise authorized to provide a health care service in this state. The term includes, but is not limited to a hospital, doctor of chiropractic, pharmacist, registered nurse, optometrist, registered optician, pharmacy, skilled nursing facility, or home health agency.

Serious Mental Illness: The following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

1. schizophrenia;
2. paranoid and other psychotic disorders;
3. bipolar disorders (hypomanic, manic, depressive, and mixed);
4. major depressive disorders (single episode or recurrent);
5. schizo-affective disorders (bipolar or depressive);
6. pervasive developmental disorders;
7. obsessive-compulsive disorders; and
8. depression in childhood and adolescence.

Service Area: [Description of the HMO's geographic service area for the CHIP program]

Specialist Physician: A participating Physician, other than a Primary Care Physician, under Contract with El Paso Health to provide Covered Health Services upon referral by the Primary Care Physician or Primary Care Provider.

Urgent Behavioral Health Care: A behavioral health condition that requires attention and assessment within twenty-four (24) hours but that does not place the CHILD in immediate danger to himself or herself or others and the CHILD is able to cooperate with treatment.

Urgent Care: A health condition including an Urgent Behavioral Health Care 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 CHILD's PCP or PCP designee to prevent serious deterioration of the CHILD's condition or health.

Usual and Customary Charge: The usual charge made by a group, entity, or person who renders or furnishes covered services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies.

Utilization Review: The system for retrospective, concurrent, or prospective review of the medical necessity and appropriateness of Covered Health Services provided, being provided, or proposed to be provided to a CHILD. The term does not include elective requests for clarification of coverage.

Utilization Review Agent: An entity that is certified by the Commissioner of Insurance to conduct Utilization Review.

YOU and YOUR: The family or guardian of the CHILD.

III. WHEN DOES AN ENROLLED CHILD BECOME COVERED?

Children enrolling in CHIP for the first time, or returning to CHIP after disenrollment, will be enrolled the 1st day of the next month following completion of the enrollment process. Children covered by private insurance within 90 Days of application may be subject to a waiting period which extends for a period of 90 Days after the last date on which the applicant was covered under a health benefits plan.

IV. COST-SHARING

Enrollment fees and co-pays are based on your family's income. If you are required to pay an enrollment fee for your CHILD'S CHIP coverage, the fee is due with YOUR enrollment form.

No co-payments are required for preventive services or pregnancy-related assistance.

V. TERMINATION OF CHILD'S COVERAGE

A. Disenrollment due to loss of CHIP eligibility

Disenrollment may occur if YOUR CHILD loses CHIP eligibility. YOUR CHILD may lose CHIP eligibility for the following reasons:

1. "Aging-out" when CHILD turns nineteen;
2. Failure to re-enroll by the end of the 12-month coverage period;
3. Change in health insurance status, i.e., a CHILD enrolls in an employer-sponsored health plan;
4. Death of a CHILD;
5. CHILD permanently moves out of the state;
6. CHILD is enrolled in Medicaid or Medicare.
7. Failure to drop current insurance if CHILD was determined to be CHIP-eligible because health insurance cost under the current health plan totaled 10% or more of the family's net income.
8. CHILD'S parent or Authorized Representative requests (in writing) the voluntary disenrollment of a CHILD.
9. Failure to respond to a request of income verification during month six of the enrollment period (only required for certain families) or if the income information provided indicates that the family's income exceeds CHIP income limits.

B. Disenrollment by El Paso Health

YOUR CHILD may be disenrolled by US, subject to approval by the Health and Human Services Commission, for the following reasons:

1. Fraud or intentional material misrepresentation made by YOU after 15 Days written notice;

2. Fraud in the use of services or facilities after 15 Days written notice;
3. Misconduct that is detrimental to safe Plan operations and the delivery of services;
4. CHILD no longer lives or resides in the Service Area.
5. CHILD is disruptive, unruly, threatening or uncooperative to the extent that CHILD's Membership seriously impairs El Paso Health or Provider's ability to provide services to the CHILD or to obtain new Members, and the CHILD's behavior is not caused by a physical or behavioral health condition.
6. CHILD steadfastly refuses to comply with El Paso Health restrictions (e.g., repeatedly using emergency room in combination with refusing to allow El Paso Health to treat the underlying medical condition).

We will not disenroll a CHILD based on a change in the CHILD'S health status, diminished mental capacity, or because of the amount of Medically Necessary Services that are used to treat the CHILD'S condition. WE will also not disenroll a CHILD because of uncooperative or disruptive behavior resulting from his or her special needs, unless this behavior seriously impairs OUR ability to furnish services to the CHILD or other enrollees.

VI. PREGNANT MEMBERS AND INFANTS

When WE receive notice from YOU, YOUR CHILD or YOUR CHILD'S Physician or Provider that a pregnancy has been diagnosed, WE will notify the HHSC Administrative Service Organization.

Depending on YOUR income and family size, the HHSC Administrative Service Organization may notify YOU and YOUR CHILD about her potential eligibility for Medicaid and of her ability to apply for Medicaid. In that situation, the Administrator will also provide appropriate resource information. A Member who is potentially eligible for Medicaid must apply for Medicaid. A Member who is determined to be Medicaid-eligible will no longer be eligible for CHIP.

If YOUR CHILD is not eligible for Medicaid, the Administrator will extend YOUR CHILD'S eligibility period, if her eligibility would otherwise expire, to ensure that she continues coverage during her pregnancy and through the end of the coverage following the baby's birth.

The HHSC Administrative Service Organization will enroll the newborn in the mother's CHIP plan prospectively, following standard cut-off rules.

Medicaid Enrollment process for Newborns

How do I sign up my newborn baby?

When your baby is born, or as soon as possible, call your Health and Human Services caseworker so your baby can get Medicaid. It is important that you also call the El Paso Health Member Services Helpline at 915-532-3778 or 1-877-532-3778. Pick your baby's Primary Care Provider from the El Paso Health Primary Care Provider and Hospital List before your baby is born.

Can I switch my baby's health plan?

For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up by calling the Enrollment Broker at 1-800-964-2777. You cannot change health plans while your baby is in the hospital.

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take on June 1.

VII. YOUR CHILD'S HEALTH COVERAGE

A. Selecting YOUR CHILD'S Primary Care Physician or Primary Care Provider

YOU shall, at time of enrollment in the El Paso Health, select YOUR CHILD'S Primary Care Physician or Primary Care Provider (PCP). A female Member may select an Obstetrician/Gynecologist (OB/GYN) to provide Covered Health Services within the scope of the professional specialty practice of the OB/GYN. The selection shall be made from those Physicians and Providers listed in El Paso Health published list of Physicians and Providers. YOU have the option to choose as a PCP a Family Practice Physician with experience in treating children, a Pediatrician, or other age-appropriate and qualified health care Provider.

YOU shall look to the selected PCP to direct and coordinate CHILD'S care, and recommend procedures and/or treatment.

B. Changing YOUR CHILD'S Primary Care Physician or Primary Care Provider

YOU may request a change in YOUR CHILD'S Primary Care Physician or Primary Care Provider and a change in YOUR CHILD'S OB/GYN. YOUR request must be made to El Paso Health at least thirty (30) Days prior to the requested effective date of the change.

C. Children with Chronic, Disabling or Life-threatening Illnesses

A CHILD who has a chronic, disabling or Life-threatening Illness may be eligible to receive services above and beyond those normally provided. If YOUR CHILD is identified as having special health care needs, YOUR CHILD will be eligible for Case Management Services for Children with Special Health Care Needs (CSHCN) through the Texas Department of State Health Services.

A CHILD who has a chronic, disabling, or Life-threatening Illness may apply to El Paso Health medical director to use a non-primary Specialist Physician as a Primary Care Physician. The Specialist Physician must agree to the arrangement and agree to coordinate all of the CHILD'S health care needs.

D. Emergency Services

When YOUR CHILD is taken to a Hospital emergency department, free-standing emergency medical facility or to a comparable emergency facility, the treating Physician/Provider will perform a medical screening examination to determine whether a medical Emergency exists and will provide the treatment and stabilization of an Emergency Condition.

If additional care is required after the patient is stabilized, the treating Physician/Provider must contact El Paso Health. El Paso Health must respond within one hour of receiving the call to approve or deny Coverage of the additional care requested by the treating Physician/Provider.

If El Paso Health agrees to the care as proposed by the treating Physician/Provider, or if El Paso Health fails to approve or deny the proposed care within one hour of receiving the call, the treating Physician/Provider may proceed with the proposed care.

YOU should notify El Paso Health within twenty-four (24) hours of any out-of-network Emergency Services, or as soon as reasonably possible.

E. Out-of-Network Services

If Covered Health Services are not available to YOUR CHILD through network Physicians or Providers, El Paso Health, upon the request of a network Physician or Provider, shall allow referral to an out-of-network Physician or Provider and shall fully reimburse the out-of-network Physician or Provider at the Usual and Customary Charge or at an agreed upon rate. El Paso Health further must provide for a review by a specialist of the same or similar specialty as the type of Physician or Provider to whom a referral is requested before El Paso Health may deny a referral.

F. Continuity of Treatment

The contract between El Paso Health and a Physician or Provider must provide that reasonable advance notice be given to YOU of the impending termination from the Plan of a Physician or Provider who is currently treating YOUR CHILD. The contract must also provide that the termination of the Physician or Provider contract, except for reasons of medical competence or professional behavior, does not release El Paso Health from its obligation to reimburse the Physician or Provider who is treating YOUR CHILD of special circumstance, such as a CHILD who has a Disability, acute condition, Life-threatening Illness, or is past the twenty-fourth week of pregnancy, for YOUR CHILD'S care in exchange for continuity of ongoing treatment for YOUR CHILD then receiving medically necessary treatment in accordance with the dictates of medical prudence.

Special circumstance means a condition such that the treating Physician or Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to YOUR CHILD. Special circumstance shall be identified by the treating Physician or Provider who must request that YOUR CHILD be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from YOU for any amount for which YOU would not be responsible if the Physician or Provider were still on El Paso Health network. El Paso Health shall reimburse the terminated Physician or Provider for YOUR CHILD'S ongoing treatment for ninety

(90) Days from the effective date of the termination, or for nine months if YOUR CHILD has been diagnosed with a terminal Illness. For a CHILD who at the time of termination is past the twenty-fourth week of pregnancy, El Paso Health shall reimburse the terminated Physician or Provider for treatment extending through delivery, immediate postpartum care, and follow-up checkup within six weeks of delivery.

G. Notice of Claims

YOU should not have to pay any amount for Covered Health Services except for Copayments or Deductibles. If YOU receive a bill from a physician or Provider that is more than your authorized Copayment or Deductible amounts, contact El Paso Health.

H. Coordination of Benefits

Your CHILD'S coverage under CHIP is secondary when coordinating benefits with any other insurance coverage. This means that the coverage provided under CHIP will pay benefits for covered services that remain unpaid after any other insurance coverage has paid.

I. Subrogation

El Paso Health receives all rights of recovery acquired by YOU or YOUR CHILD against any person or organization for negligence or any willful act resulting in Illness or Injury covered by El Paso Health, but only to the extent of such benefits. Upon receiving such benefits from the El Paso Health, YOU and YOUR CHILD are considered to have assigned such rights of recovery to El Paso Health and YOU agree to give El Paso Health any reasonable help required to secure the recovery.**]**

VIII. HOW DO I MAKE A COMPLAINT?

A. Complaint Process

"Complaint" means any dissatisfaction expressed by YOU orally or in writing to US with any aspect of OUR operation, including but not limited to, dissatisfaction with plan administration;, procedures related to review or appeal of an Adverse Determination, the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions.

If YOU notify US orally or in writing of a Complaint, WE will, not later than the fifth (5th) Business Day after the date of the receipt of the Complaint, send to YOU a letter acknowledging the date WE received YOUR Complaint. If the Complaint was received orally, WE will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to US for prompt resolution.

After receipt of the written Complaint or one-page Complaint form from YOU, WE will investigate and send YOU a letter with OUR resolution. The total time for acknowledging, investigating and resolving your Complaint will not exceed thirty (30) Calendar Days after the date WE receive YOUR Complaint.

YOUR Complaint concerning an Emergency or denial of continued stay for hospitalization will be resolved in one (1) Business Day of receipt of YOUR Complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

YOU may use the appeals process to resolve a dispute regarding the resolution of YOUR Complaint.

B. Appeals to the El Paso Health

1. If the Complaint is not resolved to YOUR satisfaction, YOU have the right either to appear in person before a Complaint appeal panel where YOU normally receive health care services, unless another site is agreed to by YOU, or to address a written appeal to the Complaint appeal panel. WE shall complete the appeals process not later than the thirtieth (30th) Calendar Day after the date of the receipt of the request for appeal.

2. WE shall send an acknowledgment letter to YOU not later the fifth (5th) Day after the date of receipt of the request of the appeal.

3. WE shall appoint Members to the Complaint appeal panel, which shall advise US on the resolution of the dispute. The Complaint appeal panel shall be composed of an equal number of OUR staff, Physicians or other Providers, and enrollees. A Member of the appeal panel may not have been previously involved in the disputed decision.

4. Not later than the fifth (5th) Business Day before the scheduled meeting of the panel, unless YOU agree otherwise, WE shall provide to YOU or YOUR designated representative:

    a. any documentation to be presented to the panel by OUR staff;
    b. the specialization of any Physicians or Providers consulted during the investigation; and
    c. the name and affiliation of each of OUR representatives on the panel.

5. YOU, or YOUR designated representative if YOU are a minor or disabled, are entitled to:

    a. appear in person before the Complaint appeal panel;
    b. present alternative expert testimony; and
    c. request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

6. Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one (1) Business Day after YOUR request for appeal.

    Due to the ongoing Emergency or continued Hospital stay, and at YOUR request, WE shall provide, in lieu of a Complaint appeal panel, a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically

manages the medical condition, procedure, or treatment under discussion for review of the appeal.

7. Notice of OUR final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

C. Internal Appeal of Adverse Determination

An "Adverse Determination" is a decision that is made by US or OUR Utilization Review Agent that the health care services furnished or proposed to be furnished to a CHILD are not medically necessary or appropriate.

If YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record disagree with the Adverse Determination, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider may appeal the Adverse Determination orally or in writing.

Within five (5) Business Days after receiving a written appeal of the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider, a letter acknowledging the date of receipt of the appeal. The letter will also include a list of documents that YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider should send to US or to OUR Utilization Review Agent for the appeal.

If YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider orally appeal the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider a one-page appeal form. YOU are not required to return the completed form, but WE encourage YOU to because it will help US resolve YOUR appeal.

Appeals of Adverse Determinations involving ongoing emergencies or denials of continued stays in a Hospital will be resolved no later than one (1) Business Day from the date all information necessary to complete the appeal is received. All other appeals will be resolved no later than 30 Calendar Days after the date WE or OUR Utilization Review Agent receives the appeal.

D. External Review by Independent Review Organization

If the appeal of the Adverse Determination is denied, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When WE or OUR Utilization Review Agent deny the appeal, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a Life-threatening condition, YOUR CHILD is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of

Adverse Determinations. In Life-threatening situations, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record may contact US or OUR Utilization Review Agent by telephone to request the review by the IRO and WE or OUR utilization review agent will provide the required information.

When the IRO completes its review and issues its decision, WE will abide by the IRO's decision. WE will pay for the IRO review.

The appeal procedures described above do not prohibit YOU from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if YOU believe that the requirement of completing the appeal and review process places YOUR CHILD'S health in serious jeopardy.

E. Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through OUR complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. Complaints to the Texas Department of Insurance may also be filed electronically at www.tdi.texas.gov.

The Commissioner of Insurance shall investigate a complaint against US to determine compliance within sixty (60) Days after the Texas Department of Insurance's receipt of the Complaint and all information necessary for the Department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1. additional information is needed;
2. an on-site review is necessary;
3. WE, the Physician or Provider, or YOU do not provide all documentation necessary to complete the investigation; or
4. other circumstances beyond the control of the Department occur.

F. Retaliation Prohibited

1. WE will not take any retaliatory action, including refusal to renew coverage, against a CHILD because the CHILD or person acting on behalf of the CHILD has filed a Complaint against US or appealed a decision made by US.

2. WE shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a Physician or Provider, because the Physician or Provider has, on behalf of a CHILD, reasonably filed a Complaint against US or has appealed a decision made by US.

IX. GENERAL PROVISIONS

A. Entire Agreement, Amendments

This Contract, and any attachments or amendments are the Entire Agreement between YOU and El Paso Health. To be valid, any changes to this Contract must be approved by an officer of El Paso Health and attached to this Contract.

B. Release and Confidentiality of Medical Records

El Paso Health agrees to maintain and preserve the confidentiality of any and all medical records of YOUR CHILD or YOUR family. However, by enrolling in El Paso Health, YOU authorize the release of information, as permitted by law, and access to any and all of medical records of YOUR CHILD for purposes reasonably related to the provision of services under this Contract, to El Paso Health, its agents and employees, YOUR CHILD'S Primary Care Physician or Primary Care Provider, participating Providers, outside Providers of Utilization Review Committee, CHIP and appropriate governmental agencies. El Paso Health privacy protections are described in more detail in its Notice of Privacy Practices. The Notice of Privacy Practices is available at [list website or address] or you may request a copy by calling [ ].

C. Clerical Error

Clerical error or delays in keeping records for YOUR and YOUR CHILD'S Contract with CHIP:

1. Will not deny Coverage that otherwise would have been granted; and
2. Will not continue Coverage that otherwise would have terminated.

If any important facts given to the CHIP about YOUR CHILD are not accurate and they affect Coverage:

1. the true facts will be used by CHIP to decide whether Coverage is in force; and
2. any necessary adjustments and/or recoupments will be made.

D. Notice

Benefits under Workers' Compensation are not affected.

E. Validity

The unenforceability or invalidity of any provision of this Evidence of Coverage shall not affect the enforceability or validity of the rest of this Contract.

F. Conformity with State Law

Any provision of this Contract that is not in conformity with the Texas HMO Act, and state or federal laws or regulations governing CHIP, or other applicable laws or regulations shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Texas HMO Act, state and federal laws or regulations governing CHIP, and other applicable laws or regulations.

ATTACHMENT 12

CHILDREN'S HEALTH INSURANCE PROGRAM PERINATAL PROGRAM HEALTH BENEFIT PLAN FOR UNBORN CHILDREN
EVIDENCE OF COVERAGE
HEALTH MAINTENANCE ORGANIZATION
NON-FEDERALLY QUALIFIED PLAN

THIS EVIDENCE OF COVERAGE (CONTRACT) IS ISSUED TO YOU, WHOSE UNBORN CHILD HAS ENROLLED IN **EL PASO HEALTH** BENEFIT PLAN THROUGH THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) PERINATAL PROGRAM. YOU AGREE TO ADHERE TO THESE PROVISIONS FOR COVERED HEALTH SERVICES BY COMPLETING THE ENROLLMENT FORM AND ACCEPTING THIS EVIDENCE OF COVERAGE. THIS DOCUMENT DESCRIBES YOUR RIGHTS AND RESPONSIBILITIES IN RELATION TO YOUR UNBORN CHILD RECEIVING COVERED HEALTH SERVICES AND BENEFITS FROM **EL PASO HEALTH** THROUGH THE CHIP PERINATAL PROGRAM.

Issued by

El Paso Health
1145 Westmoreland Dr. El Paso, Texas 79925
915-532-3778
1-877-532-3778

In association with:

Children's Health Insurance Program Perinatal Program
P.O. Box 149276
Austin, TX 78714-9983
1-800-647-6558

CHIP PERINATAL PROGRAM-EOC

IMPORTANT NOTICE

To obtain information or make a complaint:

YOU may contact YOUR Customer Service Department at 915-532-3778 or toll free at 1-877-532-3778

El Paso Health
YOU may call El Paso Health toll-free telephone number for information or to make a complaint at

1-877-532-3778

YOU may also write to El Paso Health at
1145 Westmoreland Dr.
El Paso, TX 79925

YOU may contact the Texas Department of Insurance to obtain information on companies, Coverages, rights or complaints at
1-800-252-3439

YOU may write the Texas Department of Insurance
Consumer Protection
P.O. Box 149091
Austin, TX 78714-9091
FAX #512-475-1771
http://www.tdi.texas.gov/consumer/complfrm.html

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning YOUR fee or about a claim you should contact the (agent) (company) (agent or the company) first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para someter una queja:
Puede comunicarse con su Servicio al Cliente al 915-532-3778 o sin costo al 1-877-532-3778

El Paso Health
Usted puede llamar al número de teléfono gratis de El Paso Health para información o para someter una queja' al
1-877-532-3778

Usted también puede escribir a El Paso Health al
1145 Westmoreland Dr.
El Paso, TX 79925

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al
1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
Consumer Protection
P.O. Box 149091
Austin, TX 78714-9091
FAX #512-475-1771
http://www.tdi.texas.gov/consumer/complfrm.html

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el (agente) (la compañía) (agente o la compañía) primero. So no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para propósito de información y no se convierte en parte o condición del documento adjunto.

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IX. SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES

I. INTRODUCTION

A. YOUR UNBORN CHILD'S Coverage under El Paso Health

El Paso Health provides benefits to YOUR UNBORN CHILD for Covered Health Services under CHIP Perinatal Program and determines whether particular health services are Covered Health Services, as described in **Section [VIII]**, **SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES,** below. If properly enrolled, YOUR UNBORN CHILD is eligible for the benefits described in **Section [VIII]**. All services must be provided by participating Physicians and Providers except for Emergency Services and for out-of-network services that are authorized by El Paso Health. YOU have a Contract with El Paso Health regarding matters stated in this Section I.A, as more fully described in this Contract.

B. YOUR Contract with CHIP Perinatal Program

CHIP **Perinatal Program** has determined that YOUR UNBORN CHILD is eligible to receive Coverage and under what circumstances the Coverage will end. CHIP Perinatal Program also has determined YOUR UNBORN CHILD'S eligibility for other benefits under the CHIP Perinatal Program.

IV. DEFINITIONS

ADMINISTRATOR: The contractor with the State that administers enrollment functions for CHIP Perinatal Program health plans.

Adverse Determination: A decision that is made by US or OUR Utilization Review Agent that the health care services furnished or proposed to be furnished to YOUR UNBORN CHILD are not medically necessary or are experimental or investigational.

CHIP Perinatal Program: The Children's Health Insurance Program (CHIP) Perinatal Program, which provides Coverage to each UNBORN CHILD in accordance with an agreement between El Paso Health and the Health and Human Services Commission of the State of Texas.

Covered Health Services or Covered Services or Coverage: Those Medically Necessary Services that are listed in **Section [VIII], SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES**, of this Health Benefit Plan. Covered Services also include any additional services offered by the El Paso Health as Value Added Services (VAS) in **Section [VIII] SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES**, of this Health Benefit Plan.

Disability: A physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Emergency Behavioral Health Condition: 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 the mother of the UNBORN CHILD would present an immediate danger to UNBORN CHILD or others, or
2. that renders the mother of the UNBORN CHILD incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Condition: means an Emergency Medical Condition or an Emergency Behavioral Health Condition.

Emergency Medical Condition: 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 UNBORN CHILD'S health in serious jeopardy;
2. serious impairment to bodily functions to the UNBORN CHILD;
3. serious dysfunction of any bodily organ or part that would effect the UNBORN CHILD;
4. serious disfigurement to the UNBORN CHILD; or in the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

Emergency Services and **Emergency Care:** covered inpatient and outpatient services furnished by a Provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including post-stabilization care services related to labor and delivery of the UNBORN CHILD.

Experimental and/or Investigational: A service or supply is Experimental and/or Investigational if WE determine that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to Phase I. II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.
   WE will determine if this item 2. Is true based on:
   a. Published reports in authoritative medical literature; and
   b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.
3. In the case of a drug, a device or other supply that is subject to FDA approval:
   a. It does not have FDA approval; or
   b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;
   c. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:

(i) Included in one or more of the following medical compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services; or

(ii) In addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.

d. The Physician's or Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to that board's approval.

e. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5, applies for protocols used by the UNBORN CHILD'S Physician or Provider as well as for protocols used by other Physicians or Providers studying substantially the same service or supply.

Health Benefit Plan or Plan: The Coverage provided to the UNBORN CHILD issued by El Paso Health providing Covered Health Services.

HEALTH PLAN: El Paso Health otherwise referred to as US, WE, or OUR.

Home Health Services: Health services provided at a Member's home by health care personnel, as prescribed by the responsible Physician or other authority designated by the El Paso Health.

Hospital: A licensed public or private institution as defined by Chapter 241, Texas Health and Safety Code, or in Subtitle C, Title 7, Texas Health and Safety Code.

Illness: A physical or mental sickness or disease.

Independent Review Organization: An entity that is certified by the Commissioner of Insurance under Chapter 4202 to conduct independent review of Adverse Determinations.

Initial Admission: hospitalization from birth including ICU; includes transfers from another hospital to a hospital with an NICU and any readmission that is less than 24 hours post discharge from the initial admission.

Injury or Accidental Injury: Accidental trauma or damage sustained by the UNBORN CHILD or the mother of the UNBORN CHILD to a body part or system that is not the result of a disease, bodily infirmity or any other cause and could cause harm to the UNBORN CHILD.

Life-threatening: A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medically Necessary Services: Health services that are:

Physical:

- Reasonable and necessary to prevent Illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical malformation or limitations in function, threaten to cause or worsen a Disability, cause Illness or infirmity of an UNBORN CHILD, or endanger life of the UNBORN CHILD;
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of an UNBORN CHILD'S medical conditions;
- Consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
- Consistent with diagnoses of the conditions;
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- are not Experimental or Investigative; and
- are not primarily for the convenience of the mother of the UNBORN CHILD or health care Provider.

Behavioral:

- reasonable and necessary for the diagnosis or treatment of a mental health or Chemical Dependency disorder to improve, maintain, or prevent deterioration of function resulting from the disorder;
- provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- are not Experimental or Investigative; and
- are not primarily for the convenience of the mother of the UNBORN CHILD or health care Provider.

Medically Necessary Services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service which can safely be provided and which could not be omitted without adversely affecting the UNBORN CHILD'S physical health and/or or the quality of care provided.

Member: Any covered UNBORN CHILD who is eligible for benefits and who is enrolled in the Texas CHIP Perinatal Program.

Out-of-Area: Any location outside El Paso Health CHIP Perinatal Program Service Area.

Pediatrician: A Physician who is board eligible/board certified in pediatrics by the American Board of Pediatrics.

Physician: Anyone licensed to practice medicine in the State of Texas.

Perinatal Program Provider: A Physician, Physician Assistant, or Advanced Practice Nurse or other qualified health care providers who is contracted with El Paso Health to provide Covered

Health Services to an UNBORN CHILD and who is responsible for providing initial and primary care, maintaining the continuity of care, and initiating referrals for care.

Provider: Any institution, organization or person, other than a Physician, that is licensed to or otherwise authorized to provide a health care service in this State. The term includes, but is not limited to a hospital, doctor of chiropractic, pharmacist, registered nurse, optometrist, registered optician, pharmacy, clinic, skilled nursing facility, or home health agency.

Service Area: CHIP Perinatal Provider Service Area as defined by the Texas Health and Human Services Commission.

Specialist Physician: A participating Physician, other than a Perinatal Program Physician, under Contract with El Paso Health to provide Covered Health Services upon referral by the Perinatal Program Provider.

UNBORN CHILD (CHIP Perinate): Any child from conception to birth whom the CHIP Perinatal Program has determined to be eligible for Coverage and who is enrolled under this Plan.

Urgent Behavioral Health Care: A behavioral health condition that requires attention and assessment within twenty-four (24) hours but that does not place the mother of the UNBORN CHILD in immediate danger to the UNBORN CHILD or others and the mother of the UNBORN CHILD is able to cooperate with treatment.

Urgent Care: A health condition including an Urgent Behavioral Health Care 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 her condition as it relates to the UNBORN CHILD requires medical treatment evaluation or treatment within twenty-four (24) hours by the Prenatal Program Provider or the Prenatal Program Provider's designee to prevent serious deterioration of the UNBORN CHILD's condition or health.

Usual and Customary Charge: The usual charge made by a group, entity, or person who renders or furnishes covered services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies.

Utilization Review: The system for retrospective, concurrent, or prospective review of the medical necessity and appropriateness of Covered Health Services provided, being provided, or proposed to be provided to an UNBORN CHILD. The term does not include elective requests for clarification of coverage.

Utilization Review Agent: An entity that is certified by the Commissioner of Insurance to conduct Utilization Review.

YOU and YOUR: Mother of the UNBORN CHILD.

III. WHEN DOES AN ENROLLED UNBORN CHILD BECOME COVERED?

Coverage of the UNBORN CHILD begins on the first day of the month in which the UNBORN CHILD is determined eligible for the CHIP Perinatal Program.

IV. COST-SHARING

No enrollment fees or cost sharing (such as co-pays) are required for CHIP Perinatal covered services.

V. TERMINATION OF AN UNBORN CHILD'S COVERAGE

A. Disenrollment due to loss of CHIP Perinatal Program eligibility

Disenrollment may occur if your UNBORN CHILD loses CHIP Perinatal Program eligibility. Your UNBORN CHILD may lose CHIP Perinatal Program eligibility for the following reasons:

1. Change in health insurance status, e.g., a parent of an UNBORN CHILD enrolls in an employer-sponsored health plan;
2. Death of an UNBORN CHILD;
3. Mother of UNBORN CHILD permanently moves out of the State;
4. UNBORN CHILD'S parent or Authorized Representative requests (in writing) the voluntary disenrollment of an UNBORN CHILD;
5. Mother of UNBORN CHILD is enrolled in Medicaid or Medicare.

B. Disenrollment by El Paso Health

Your UNBORN CHILD may be disenrolled by US, subject to approval by the Health and Human Services Commission, for the following reasons

1. Fraud or intentional material misrepresentation made by YOU after 15 Days written notice;
2. Fraud in the use of services or facilities after 15 Days written notice;
3. Misconduct that is detrimental to safe Plan operations and the delivery of services;
4. Mother of the UNBORN CHILD no longer lives or resides in the Service Area.
5. Mother of UNBORN CHILD is disruptive, unruly, threatening or uncooperative to the extent that UNBORN CHILD's Membership seriously impairs El Paso Health or Provider's ability to provide services to the UNBORN CHILD or to obtain a new Members, and the mother of the UNBORN CHILD's behavior is not caused by a physical or behavioral health condition.
6. Mother of the UNBORN CHILD steadfastly refuses to comply with El Paso Health restrictions (e.g., repeatedly using emergency room in combination with refusing to allow El Paso Health to treat the underlying medical condition).

We will not disenroll an UNBORN CHILD based on a change in the UNBORN CHILD'S health status, diminished mental capacity of the mother of the UNBORN CHILD, or because of the amount of Medically Necessary Services that are used to treat the UNBORN CHILD'S condition. WE will also not disenroll an UNBORN CHILD because of uncooperative or disruptive behavior

resulting from the mother of the UNBORN CHILD's special needs, unless this behavior seriously impairs OUR ability to furnish services to the UNBORN CHILD or other enrollees.

VI. YOUR UNBORN CHILD'S HEALTH COVERAGE

A. Selecting YOUR UNBORN CHILD'S Perinatal Program Provider

YOU shall, at time of enrollment in the El Paso Health, select YOUR UNBORN CHILD'S Perinatal Program Provider. You may select an Obstetrician/Gynecologist (OB/GYN) to provide Covered Health Services within the scope of the professional specialty practice of the OB/GYN. The selection shall be made from those Physicians and Providers listed in El Paso Health published list of Physicians and Providers. YOU have the option to choose a Family Practice Physician with experience in prenatal care, or other qualified health care Providers as a Perinatal Program Provider.

YOU shall look to the selected Perinatal Program Provider to direct and coordinate your UNBORN CHILD'S care, and recommend procedures and/or treatment.

B. Changing YOUR UNBORN CHILD'S Perinatal Program Provider

YOU may request a change in YOUR UNBORN CHILD'S Perinatal Program Provider. YOUR request must be made to El Paso Health at least thirty (30) Days prior to the requested effective date of the change.

C. Emergency Services

When you are taken to a Hospital emergency department, free-standing emergency medical facility, or to a comparable emergency facility for care directly related to the labor or delivery of your covered UNBORN CHILD, the treating Physician/Provider will perform a medical screening examination to determine whether a medical Emergency directly related to the labor with delivery of the covered UNBORN CHILD exists and will provide the treatment and stabilization of an Emergency Condition.

If additional care directly related to the labor and delivery of the covered UNBORN CHILD is required after the UNBORN CHILD is stabilized, the treating Physician/Provider must contact El Paso Health. El Paso Health must respond within one hour of receiving the call to approve or deny Coverage of the additional care requested by the treating Physician/Provider.

If El Paso Health agrees to the care as proposed by the treating Physician/Provider, or if El Paso Health fails to approve or deny the proposed care within one hour of receiving the call, the treating Physician/Provider may proceed with the proposed care. Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinatal newborn are not a covered benefit.

YOU should notify El Paso Health within twenty-four (24) hours of any out-of-network Emergency Services, or as soon as reasonably possible.

D. Out-of-Network Services

If Covered Health Services are not available to YOUR UNBORN CHILD through network Physicians or Providers, El Paso Health, upon the request of a network Physician or Provider, shall allow referral to an out-of-network Physician or Provider and shall fully reimburse the out-of-network Physician or Provider at the Usual and Customary Charge or at an agreed upon rate. El Paso Health further must provide for a review by a specialist of the same or similar specialty as the type of Physician or Provider to whom a referral is requested before El Paso Health may deny a referral.

E. Continuity of Treatment

The contract between El Paso Health and a Physician or Provider must provide that reasonable advance notice be given to YOU of the impending termination from the Plan of a Physician or Provider who is currently treating YOUR UNBORN CHILD. The contract must also provide that the termination of the Physician or Provider contract, except for reasons of medical competence or professional behavior, does not release El Paso Health from its obligation to reimburse the Physician or Provider who is treating YOUR UNBORN CHILD of special circumstance, such as an UNBORN CHILD who has a Disability, an acute condition or a life-threatening Illness, or is past the twenty-fourth week of gestation, for YOUR UNBORN CHILD'S care in exchange for continuity of ongoing treatment for YOUR UNBORN CHILD then receiving medically necessary treatment in accordance with the dictates of medical prudence.

Special circumstance means a condition such that the treating Physician or Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to YOUR UNBORN CHILD. Special circumstance shall be identified by the treating Physician or Provider who must request that YOUR UNBORN CHILD be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from YOU for any amount for which YOU would not be responsible if the Physician or Provider were still on El Paso Health network. El Paso Health shall reimburse the terminated Physician or Provider for YOUR UNBORN CHILD'S ongoing treatment. For an UNBORN CHILD who at the time of termination is past the twenty-fourth week of gestation, El Paso Health shall reimburse the terminated Physician or Provider for treatment extending through delivery, immediate postpartum care, and follow-up checkups within sixty (60) Days of delivery.

F. Notice of Claims

YOU should not have to pay any amount for Covered Health Services. If YOU receive a bill from a physician or Provider, contact HEALTH PLAN.

G. Coordination of Benefits

Your UNBORN CHILD'S coverage under the CHIP Perinatal Program is secondary when coordinating benefits with any other insurance coverage. This means that the coverage provided under the CHIP Perinatal Program will pay benefits for covered services that remain unpaid after any other insurance coverage has paid.

H. Subrogation

El Paso Health receives all rights of recovery acquired by YOU or YOUR UNBORN CHILD against any person or organization for negligence or any willful act resulting in Illness or Injury covered by El Paso Health, but only to the extent of such benefits. Upon receiving such benefits from the El Paso Health, YOU and YOUR UNBORN CHILD are considered to have assigned such rights of recovery to El Paso Health and YOU agree to give El Paso Health any reasonable help required to secure the recovery.

VII. HOW DO I MAKE A COMPLAINT?

B. Complaint Process

"Complaint" means any dissatisfaction expressed by YOU orally or in writing to US with any aspect of OUR operation, including but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an Adverse Determination, the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions.

If YOU notify US orally or in writing of a Complaint, WE will, not later than the fifth (5th) Business Day after the date of the receipt of the Complaint, send to YOU a letter acknowledging the date WE received YOUR Complaint. If the Complaint was received orally, WE will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to US for prompt resolution.

After receipt of the written Complaint or one-page Complaint form from YOU, WE will investigate and send YOU a letter with OUR resolution. The total time for acknowledging, investigating and resolving your Complaint will not exceed thirty (30) Calendar Days after the date WE receive YOUR Complaint.

YOUR Complaint concerning an Emergency or denial of continued stay for hospitalization will be resolved in one (1) Business Day of receipt of YOUR Complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

YOU may use the appeals process to resolve a dispute regarding the resolution of YOUR Complaint.

B. Appeals to the El Paso Health

1. If the Complaint is not resolved to YOUR satisfaction, YOU have the right either to appear in person before a Complaint appeal panel where YOU normally receive health care services, unless another site is agreed to by YOU, or to address a written appeal to the Complaint appeal panel. WE shall complete the appeals process not later than the thirtieth (30th) Calendar Day after the date of the receipt of the request for appeal.
2. WE shall send an acknowledgment letter to YOU not later the fifth (5th) Day after the date of receipt of the request of the appeal.

3. WE shall appoint Members to the Complaint appeal panel, which shall advise US on the resolution of the dispute. The Complaint appeal panel shall be composed of an equal number of OUR staff, Physicians or other Providers, and enrollees. A Member of the appeal panel may not have been previously involved in the disputed decision.
4. Not later than the fifth (5th) Business Day before the scheduled meeting of the panel, unless YOU agree otherwise, WE shall provide to YOU or YOUR designated representative:
    a. Any documentation to be presented to the panel by OUR staff;
    b. The specialization of any Physicians or Providers consulted during the investigation; and
    c. The name and affiliation of each of OUR representatives on the panel.
5. YOU, or YOUR designated representative if YOU are a minor or disabled, are entitled to:
    a. Appear in person before the Complaint appeal panel;
    b. Present alternative expert testimony; and
    c. Request the presence of and question any person responsible for making the prior determination that resulted in the appeal.
6. Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one (1) Business Day after YOUR request for appeal.

    Due to the ongoing Emergency or continued Hospital stay, and at YOUR request, WE shall provide, in lieu of a Complaint appeal panel, a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

7. Notice of OUR final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

C. Internal Appeal of Adverse Determination

An "Adverse Determination" is a decision that is made by US or OUR Utilization Review Agent that the health care services furnished or proposed to be furnished to your UNBORN CHILD are not medically necessary or appropriate.

If YOU, YOUR designated representative or YOUR UNBORN CHILD'S Physician or Perinatal Program Provider of record disagree with the Adverse Determination, YOU, YOUR designated representative or YOUR UNBORN CHILD'S Physician or Perinatal Program Provider may appeal the Adverse Determination orally or in writing.

Within five (5) Business Days after receiving a written appeal of the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR UNBORN CHILD'S Physician or Perinatal Program Provider, a letter acknowledging the date of receipt of the appeal. The letter will also include a list of documents that YOU, YOUR designated representative or YOUR UNBORN CHILD'S Physician or Prenatal Care Provider should send to US or to OUR Utilization Review Agent for the appeal.

If YOU, YOUR designated representative or YOUR UNBORN CHILD'S Physician or Perinatal Program Provider orally appeal the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR UNBORN CHILD'S Physician or Perinatal Program Provider a one-page appeal form . YOU are not required to return the completed form, but WE encourage YOU to because it will help US resolve YOUR appeal.

Appeals of Adverse Determinations involving ongoing emergencies or denials of continued stays in a Hospital will be resolved no later than one (1) Business Day from the date all information necessary to complete the appeal is received. All other appeals will be resolved no later than 30 Calendar Days after the date WE or OUR Utilization Review Agent receives the appeal.

D. External Review by Independent Review Organization

If the appeal of the Adverse Determination is denied, YOU, YOUR designated representative or YOUR UNBORN CHILD'S Physician or Perinatal Program Provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When WE or OUR Utilization Review Agent deny the appeal, YOU, YOUR designated representative or YOUR UNBORN CHILD'S Physician or Perinatal Program Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a Life-threatening condition, YOU are entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In Life-threatening situations, YOU, YOUR designated representative or YOUR UNBORN CHILD'S Physician or Perinatal Program Provider of record may contact US or OUR Utilization Review Agent by telephone to request the review by the IRO and WE or OUR utilization review agent will provide the required information.

When the IRO completes its review and issues its decision, WE will abide by the IRO's decision. WE will pay for the IRO review.

The appeal procedures described above do not prohibit YOU, YOUR designated representative, or your UNBORN CHILD'S Perinatal Program Provider from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if YOU believe that the requirement of completing the appeal and review process places YOUR UNBORN CHILD'S health in serious jeopardy.

E. Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through OUR complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, Consumer Protection, P. O. Box 149091, Austin, Texas 78714-9091. Complaints to the Texas Department of Insurance may also send an email to http://www.tdi.texas.gov/consumer/complfrm.html.

The Commissioner of Insurance shall investigate a complaint against US to determine compliance within sixty (60) Days after the Texas Department of Insurance's receipt of the Complaint and all information necessary for the Department to determine compliance. The Commissioner may

extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1. Additional information is needed;
2. An on-site review is necessary;
3. WE, the Physician or Provider, or YOU do not provide all documentation necessary to complete the investigation; or
4. Other circumstances beyond the control of the Department occur.

F. Retaliation Prohibited

1. WE will not take any retaliatory action, including refusal to renew coverage, against an UNBORN CHILD because the UNBORN CHILD or person acting on behalf of the UNBORN CHILD has filed a Complaint against US or appealed a decision made by US.

2. WE shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a Physician or Perinatal Program Provider, because the Physician or Perinatal Program Provider has, on behalf of an UNBORN CHILD, reasonably filed a Complaint against US or has appealed a decision made by US.

VIII. GENERAL PROVISIONS

A. Entire Agreement, Amendment

This Contract, and any attachments or amendments are the Entire Agreement between YOU and El Paso Health. To be valid, any changes to this Contract must be approved by an officer of El Paso Health and attached to this Contract.

B. Release and Confidentiality of Medical Records

El Paso Health agrees to maintain and preserve the confidentiality of any and all your medical records. However, by enrolling in El Paso Health, YOU authorize the release of information, as permitted by law, and access to any and all of your medical records for purposes reasonably related to the provision of services under this Contract, to El Paso Health, its agents and employees, YOUR UNBORN CHILD'S Perinatal Program Provider, participating Providers, outside Providers of Utilization Review Committee, CHIP Perinatal Program and appropriate governmental agencies. El Paso Health privacy protections are described in more detail in its Notice of Privacy Practices. The Notice of Privacy Practices is available at [list website or address] or you may request a copy by calling [ ].

C. Clerical Error

Clerical error or delays in keeping your records for YOUR and YOUR UNBORN_CHILD’S Evidence of Coverage with CHIP Perinatal Program:

1. Will not deny Coverage that otherwise would have been granted; and
2. Will not continue Coverage that otherwise would have terminated.

If any important facts given to the CHIP Perinatal Program about YOU or your UNBORN CHILD are not accurate and they affect Coverage:

1. The true facts will be used by CHIP Perinatal Program to decide whether Coverage is in force; and
2. Any necessary adjustments and/or recoupments will be made.

D. Notice

Benefits under Workers' Compensation are not affected.

E. Validity

The unenforceability or invalidity of any provision of this Evidence of Coverage shall not affect the enforceability or validity of the rest of this Contract.

F. Conformity with State Law

Any provision of this Contract that is not in conformity with the Texas HMO Act, and State or federal laws or regulations governing CHIP, or other applicable laws or regulations shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Texas HMO Act, and State or federal laws or regulations governing CHIP, and other applicable laws or regulations.

ATTACHMENT 13

CHILDREN'S HEALTH INSURANCE PROGRAM PERINATAL PROGRAM HEALTH BENEFIT PLAN FOR PERINATAL NEWBORNS
EVIDENCE OF COVERAGE
El Paso Health
NON-FEDERALLY QUALIFIED PLAN

THIS EVIDENCE OF COVERAGE (CONTRACT) IS ISSUED TO YOU, WHOSE CHILD HAS ENROLLED IN EL PASO HEALTH BENEFIT PLAN THROUGH THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) PERINATAL PROGRAM. YOU AGREE TO ADHERE TO THESE PROVISIONS FOR COVERED HEALTH SERVICES BY COMPLETING THE ENROLLMENT FORM, PAYING THE APPLICABLE FEE AND ACCEPTING THIS EVIDENCE OF COVERAGE. THIS DOCUMENT DESCRIBES YOUR RIGHTS AND RESPONSIBILITIES IN RELATION TO YOUR CHILD RECEIVING COVERED HEALTH SERVICES AND BENEFITS FROM EL PASO HEALTH THROUGH THE CHIP PERINATAL PROGRAM.

Issued by

EL PASO HEALTH
1145 Westmoreland
El Paso, Texas 79925
915-532-3778
1-877-532-3778

In association with:

Children's Health Insurance Program Perinatal Program
P.O. Box 149276
Austin, TX 78714-9983
1-800-647-6558

CHIP PERINATAL PROGRAM NEWBORN-EOC

IMPORTANT NOTICE

To obtain information or make a complaint:

YOU may contact YOUR Compliance Director at 1-877-532-3778.

YOU may call El Paso Health toll-free telephone number for information or to make a complaint at

1-877-532-3778

YOU may also write to El Paso Health at
1145 Westmoreland
El Paso, Texas 79925

YOU may contact the Texas Department of Insurance to obtain information on companies, Coverages, rights or complaints at

1-800-252-3439.

YOU may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
FAX #512-475-1771
Web: http://www.tdi.texas.gov.
E-mail: ConsumerProtection@tdi.texas.gov.

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning YOUR fee or about a claim you should contact the El Paso Health first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Puede comunicarse con su Director de Quejas al1-877-532-3778..

Usted puede llamar al numero de telefono gratis de El Paso Health para informacion o para someter una queja' al
1-877-532-3778

Usted tambien puede escribir a El Paso Health a
1145 Westmoreland
El Paso, Texas 79925

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439.

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
FAX #512-475-1771
http://www.tdi.texas.gov.
ConsumerProtection@tdi.texas.gov.

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el El Paso Health primero. So no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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IX. SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES

I. INTRODUCTION

A. YOUR CHILD'S Coverage under HEALTH PLAN

HEALTH PLAN provides benefits to YOUR CHILD for Covered Health Services under CHIP and determines whether particular health services are Covered Health Services, as described in **Section [X]**, **SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES,** below. If properly enrolled, YOUR CHILD is eligible for the benefits described in **Section [X] ~~[XI]~~**. All services must be provided by participating Physicians and Providers except for Emergency Services and for out-of-network services that are authorized by HEALTH PLAN. YOU have a Contract with HEALTH PLAN regarding matters stated in this Section I.A, as more fully described in this Contract.

B. YOUR Contract with CHIP

CHIP has determined that YOUR CHILD is eligible to receive Coverage and under what circumstances the Coverage will end. CHIP also has determined YOUR CHILD'S eligibility for other benefits under the CHIP program.

V. DEFINITIONS

ADMINISTRATOR: The contractor with the State that administers enrollment functions for CHIP Perinatal Program health plans.

- **Adverse Determination:** A decision that is made by US or OUR Utilization Review Agent that the health care services furnished or proposed to be furnished to a CHILD are not medically necessary or not appropriate. This exclusion is an adverse determination and is eligible for review by an IRO (as described in D. External Review by Independent Review Organization).

CHILD: Any child who CHIP has determined to be eligible for Coverage and who is enrolled under this Plan.

CHIP or CHIP Perinatal Program: The Children's Health Insurance Program which provides Coverage to each CHILD in accordance with an agreement between HEALTH PLAN and the Health and Human Services Commission of the State of Texas.

Covered Health Services or Covered Services or Coverage: Those Medically Necessary Services that are listed in **Section [X] ~~[XI]~~, SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES**, of this Health Benefit Plan. Covered Services also include any additional services offered by the HEALTH PLAN as Value Added Services (VAS) in **Section [X] SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES**, of this Health Benefit Plan.

Disability: A physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Emergency Behavioral Health Condition: 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:

3. requires immediate intervention and/or medical attention without which a CHILD would present an immediate danger to themselves or others, or
4. that renders a CHILD incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Condition means an Emergency Medical Condition or an Emergency Behavioral Health Condition.

Emergency Medical Condition: 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:

5. placing the patient's health in serious jeopardy;
6. serious impairment to bodily functions;
7. serious dysfunction of any bodily organ or part;
8. serious disfigurement; or

- in the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child

Emergency Services and **Emergency Care:** covered inpatient and outpatient services furnished by a Provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including post-stabilization care services.

Experimental and/or Investigational: A service or supply is Experimental and/or Investigational if WE determine that one or more of the following is true:

6. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to Phase I. II and III clinical trials.
7. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.
   WE will determine if this item 2. Is true based on:
   a. Published reports in authoritative medical literature; and
   b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.
8. In the case of a drug, a device or other supply that is subject to FDA approval:
   f. It does not have FDA approval; or
   g. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;

h. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:
    (iii) Included in one or more of the following medical compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services; or
    (iv) In addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.
i. The Physician's or Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to that board's approval.
j. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5, applies for protocols used by the CHILD'S Physician or Provider as well as for protocols used by other Physicians or Providers studying substantially the same service or supply.

Health Benefit Plan or Plan: The Coverage provided to CHILD issued by HEALTH PLAN providing Covered Health Services.

HEALTH PLAN: El Paso Health otherwise referred to as US, WE, or OUR.

Home Health Services: Health services provided at a CHILD'S home by health care personnel, as prescribed by the responsible Physician or other authority designated by the HEALTH PLAN.

Hospital: A licensed public or private institution as defined by Chapter 241, Texas Health and Safety Code, or in Subtitle C, Title 7, Texas Health and Safety Code.

Illness: A physical or mental sickness or disease.

Independent Review Organization: An entity that is certified by the Commissioner of Insurance under Chapter 4202 to conduct independent review of Adverse Determinations.

Initial admission: Hospitalization from birth including ICU; includes transfers from another hospital to a hospital with an NICU and any readmission that is less than 24 hours post-discharge from the initial admission.

Injury or Accidental Injury: Accidental trauma or damage sustained by CHILD to a body part or system that is not the result of a disease, bodily infirmity or any other cause.

Life-threatening: A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medically Necessary Services: Health services that are:

Physical:

- Reasonable and necessary to prevent Illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical malformation or limitations in function, threaten to cause or worsen a Disability, cause Illness or infirmity of a CHILD, or endanger life;
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of CHILD'S medical conditions;
- Consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
- Consistent with diagnoses of the conditions; ~~and~~
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- are not Experimental or Investigative; and
- are not primarily for the convenience of the CHILD or health care Provider.

Behavioral:

- Reasonable and necessary for the diagnosis or treatment of a mental health or Chemical Dependency disorder to improve, maintain, or prevent deterioration of function resulting from the disorder;
- Provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- are not Experimental or Investigative; and
- are not primarily for the convenience of the CHILD or health care Provider.

Medically Necessary Services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service which can safely be provided and which could not be omitted without adversely affecting the CHILD'S physical and/or mental health or the quality of care provided.

Member: Any covered CHILD, up to age 19, who is eligible for benefits under Title XXI of the Social Security Act and who is enrolled in the Texas CHIP program.

Out-of-Area: Any location outside HEALTH PLAN'S CHIP Perinatal Service Area.

Pediatrician: A Physician who is board eligible/board certified in pediatrics by the American Board of Pediatrics.

Physician: Anyone licensed to practice medicine in the ~~s~~State of Texas.

Primary Care Physician or Primary Care Provider (PCP): A physician or Provider who has agreed with the HEALTH PLAN to provide a medical home to a CHILD and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

Provider: Any institution, organization or person, other than a Physician, that is licensed to or otherwise authorized to provide a health care service in this State. The term includes, but is not limited to a hospital, doctor of chiropractic, pharmacist, registered nurse, optometrist, registered optician, pharmacy, skilled nursing facility, or home health agency.

Serious Mental Illness: The following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

10. Schizophrenia;
11. Paranoid and other psychotic disorders;
12. Bipolar disorders (hypomanic, manic, depressive, and mixed);
13. Major depressive disorders (single episode or recurrent);
14. Schizo-affective disorders (bipolar or depressive);
15. Pervasive developmental disorders;
16. Obsessive-compulsive disorders; and
17. Depression in childhood and adolescence.

Service Area: CHIP Perinatal Program service area as defined by the Texas Health and Human Services Commission.

Specialist Physician: A participating Physician, other than a Primary Care Physician, under Contract with HEALTH PLAN to provide Covered Health Services upon referral by the Primary Care Physician or Primary Care Provider.

Urgent Behavioral Health Care: A behavioral health condition that requires attention and assessment within twenty-four (24) hours but that does not place the CHILD in immediate danger to himself or herself or others and the CHILD is able to cooperate with treatment.

Urgent Care: A health condition including an Urgent Behavioral Health Care 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 CHILD's PCP or PCP designee to prevent serious deterioration of the CHILD's condition or health.

Usual and Customary Charge: The usual charge made by a group, entity, or person who renders or furnishes covered services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies.

Utilization Review: The system for retrospective, concurrent, or prospective review of the medical necessity and appropriateness of Covered Health Services provided, being provided, or proposed to be provided to a CHILD. The term does not include elective requests for clarification of coverage.

Utilization Review Agent: An entity that is certified by the Commissioner of Insurance to conduct Utilization Review.

YOU and YOUR: The family or guardian of the CHILD.

III. WHEN DOES AN ENROLLED CHILD BECOME COVERED?

Children enrolling in CHIP for the first time, or returning to CHIP after disenrollment, will be enrolled the first (1st) Day of the next month following completion of the enrollment process. Children covered by private insurance within 90 Days of application may be subject to a waiting period which extends for a period of 90 Days after the last date on which the applicant was covered under a health benefits plan. CHIP Perinatal Program Members are exempt from the waiting period.

IV. COST-SHARING

No enrollment fees or cost sharing (such as co-pays) are required for CHIP Perinatal covered services.

V. TERMINATION OF CHILD'S COVERAGE

A. Disenrollment due to loss of CHIP eligibility

Disenrollment may occur if YOUR CHILD loses CHIP eligibility. YOUR CHILD may lose CHIP eligibility for the following reasons:

8. "Aging-out" when CHILD turns nineteen;
9. Failure to re-enroll by the end of the 12-month coverage period;
10. Change in health insurance status, i.e., a CHILD enrolls in an employer-sponsored health plan;
11. Death of a CHILD;
12. CHILD permanently moves out of the State;
13. CHILD is enrolled in Medicaid or Medicare.
14. Failure to drop current insurance if child was determined to be CHIP-eligible because health insurance cost under the current health plan totaled 10% or more of the family's net income.

8. Child's parent or Authorized Representative requests (in writing) the voluntary disenrollment of a child.
9. Failure to respond to a request of income verification during month six of the enrollment period (only required for certain families) or if the income information provided indicates that the family's income exceeds CHIP income limits.

B. Disenrollment by HEALTH PLAN

YOUR CHILD may be disenrolled by US, subject to approval by the Health and Human Services Commission, for the following reasons:

4. Fraud or intentional material misrepresentation made by YOU after 15 Days written notice;
5. Fraud in the use of services or facilities after 15 Days written notice;
6. Misconduct that is detrimental to safe Plan operations and the delivery of services;

4. CHILD no longer lives or resides in the Service Area.
5. CHILD is disruptive, unruly, threatening or uncooperative to the extent that CHILD's Membership seriously impairs HEALTH PLAN's or Provider's ability to provide services to the CHILD or to obtain new Members, and the CHILD's behavior is not caused by a physical or behavioral health condition.
6. CHILD steadfastly refuses to comply with HEALTH PLAN restrictions (e.g., repeatedly using emergency room in combination with refusing to allow HEALTH PLAN to treat the underlying medical condition).

We will not disenroll a CHILD based on a change in the CHILD'S health status, diminished mental capacity, or because of the amount of Medically Necessary Services that are used to treat the CHILD'S condition. WE will also not disenroll a CHILD because of uncooperative or disruptive behavior resulting from his or her special needs, unless this behavior seriously impairs OUR ability to furnish services to the CHILD or other enrollees.

VI. YOUR CHILD'S HEALTH COVERAGE

A. Selecting YOUR CHILD'S Primary Care Physician or Primary Care Provider

YOU shall, at time of enrollment in the HEALTH PLAN, select YOUR CHILD'S Primary Care Physician or Primary Care Provider (PCP). A female Member may select an Obstetrician/Gynecologist (OB/GYN) to provide Covered Health Services within the scope of the professional specialty practice of the OB/GYN. The selection shall be made from those Physicians and Providers listed in HEALTH PLAN'S published list of Physicians and Providers. YOU have the option to choose as a PCP a Family Practice Physician with experience in treating children, a Pediatrician, or other age appropriate and qualified health care Provider.

YOU shall look to the selected PCP to direct and coordinate CHILD'S care, and recommend procedures and/or treatment.

B. Changing YOUR CHILD'S Primary Care Physician or Primary Care Provider

YOU may request a change in YOUR CHILD'S Primary Care Physician or Primary Care Provider and a change in YOUR CHILD'S OB/GYN. YOUR request must be made to HEALTH PLAN at least thirty (30) Days prior to the requested effective date of the change.

C. Children with Chronic, Disabling or Life-threatening Illnesses

A CHILD who has a chronic, disabling or Life-threatening Illness may be eligible to receive services above and beyond those normally provided. If YOUR CHILD is identified as having special health care needs, YOUR CHILD will be eligible for Case Management Services for Children with Special Health Care Needs (CSHCN) through the Texas Department of State Health Services.

A CHIILD who has a chronic, disabling, or Life-threatening Illness may apply to HEALTH PLAN'S medical director to use a non-primary Specialist Physician as a Primary Care Physician.

The Specialist Physician must agree to the arrangement and agree to coordinate all of the CHILD'S health care needs.

D. Emergency Services

When YOUR CHILD is taken to a Hospital emergency department, free-standing emergency medical facility, or to a comparable emergency facility, the treating Physician/Provider will perform a medical screening examination to determine whether a medical Emergency exists and will provide the treatment and stabilization of an Emergency Condition.

If additional care is required after the patient is stabilized, the treating Physician/Provider must contact HEALTH PLAN. HEALTH PLAN must respond within one hour of receiving the call to approve or deny Coverage of the additional care requested by the treating Physician/Provider.

If HEALTH PLAN agrees to the care as proposed by the treating Physician/Provider, or if HEALTH PLAN fails to approve or deny the proposed care within one hour of receiving the call, the treating Physician/Provider may proceed with the proposed care.

YOU should notify HEALTH PLAN within twenty-four (24) hours of any out-of-network Emergency Services, or as soon as reasonably possible.

E. Out-of-Network Services

If Covered Health Services are not available to YOUR CHILD through network Physicians or Providers, HEALTH PLAN, upon the request of a network Physician or Provider, shall allow referral to an out-of-network Physician or Provider and shall fully reimburse the out-of-network Physician or Provider at the Usual and Customary Charge or at an agreed upon rate. HEALTH PLAN further must provide for a review by a specialist of the same or similar specialty as the type of Physician or Provider to whom a referral is requested before HEALTH PLAN may deny a referral.

F. Continuity of Treatment

The contract between HEALTH PLAN and a Physician or Provider must provide that reasonable advance notice be given to YOU of the impending termination from the Plan of a Physician or Provider who is currently treating YOUR CHILD. The contract must also provide that the termination of the Physician or Provider contract, except for reasons of medical competence or professional behavior, does not release HEALTH PLAN from its obligation to reimburse the Physician or Provider who is treating YOUR CHILD of special circumstance, such as a CHILD who has a Disability, acute condition, or Life-threatening Illness–for YOUR CHILD'S care in exchange for continuity of ongoing treatment for YOUR CHILD then receiving medically necessary treatment in accordance with the dictates of medical prudence.

Special circumstance means a condition such that the treating Physician or Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to YOUR CHILD. Special circumstance shall be identified by the treating Physician or Provider who must request that YOUR CHILD be permitted to continue treatment under the Physician’s or Provider’s

care and agree not to seek payment from YOU for any amount for which YOU would not be responsible if the Physician or Provider were still on HEALTH PLAN'S network. HEALTH PLAN shall reimburse the terminated Physician or Provider for YOUR CHILD'S ongoing treatment for ninety (90) Days from the effective date of the termination, or for nine months if YOUR CHILD has been diagnosed with a terminal Illness.

G. Notice of Claims

YOU should not have to pay any amount for Covered Health Services except for Copayments or Deductibles. If YOU receive a bill from a physician or Provider, contact HEALTH PLAN.

H. Coordination of Benefits

Your CHILD'S coverage_under CHIP is secondary when coordinating benefits with any other insurance coverage. This means that the coverage provided under CHIP will pay benefits for covered services that remain unpaid after any other insurance coverage has paid.

I. Subrogation

HEALTH PLAN receives all rights of recovery acquired by YOU or YOUR CHILD against any person or organization for negligence or any willful act resulting in Illness or Injury covered by HEALTH PLAN, but only to the extent of such benefits. Upon receiving such benefits from the HEALTH PLAN, YOU and YOUR CHILD are considered to have assigned such rights of recovery to HEALTH PLAN and YOU agree to give HEALTH PLAN any reasonable help required to secure the recovery.

VII. HOW DO I MAKE A COMPLAINT?

C. Complaint Process

"Complaint" means any dissatisfaction expressed by YOU orally or in writing to US with any aspect of OUR operation, including but not limited to, dissatisfaction with plan administration;, procedures related to review or appeal of an Adverse Determination, the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions.

If YOU notify US orally or in writing of a Complaint, WE will, not later than the fifth (5th) Business Day after the date of the receipt of the Complaint, send to YOU a letter acknowledging the date WE received YOUR Complaint. If the Complaint was received orally, WE will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to US for prompt resolution.

After receipt of the written Complaint or one-page Complaint form from YOU, WE will investigate and send YOU a letter with OUR resolution. The total time for acknowledging, investigating and resolving your Complaint will not exceed thirty (30) Calendar Days after the date WE receive YOUR Complaint.

YOUR Complaint concerning an Emergency or denial of continued stay for hospitalization will be resolved in one (1) Business Day of receipt of YOUR Complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

YOU may use the appeals process to resolve a dispute regarding the resolution of YOUR Complaint.

B. Appeals to the HEALTH PLAN

8. If the Complaint is not resolved to YOUR satisfaction, YOU have the right either to appear in person before a Complaint appeal panel where YOU normally receive health care services, unless another site is agreed to by YOU, or to address a written appeal to the Complaint appeal panel. WE shall complete the appeals process not later than the thirtieth (30th) Calendar Day after the date of the receipt of the request for appeal.

9. WE shall send an acknowledgment letter to YOU not later the fifth (5th) Day after the date of receipt of the request of the appeal.

10. WE shall appoint Members to the Complaint appeal panel, which shall advise US on the resolution of the dispute. The Complaint appeal panel shall be composed of an equal number of OUR staff, Physicians or other Providers, and enrollees. A Member of the appeal panel may not have been previously involved in the disputed decision.

11. Not later than the fifth (5th) Business Day before the scheduled meeting of the panel, unless YOU agree otherwise, WE shall provide to YOU or YOUR designated representative:

    d. Any documentation to be presented to the panel by OUR staff;

    e. The specialization of any Physicians or Providers consulted during the investigation; and

    f. The name and affiliation of each of OUR representatives on the panel.

12. YOU, or YOUR designated representative if YOU are a minor or disabled, are entitled to:

    d. Appear in person before the Complaint appeal panel;

    e. Present alternative expert testimony; and

    f. Request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

13. Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one (1) Business Day after YOUR request for appeal.

Due to the ongoing Emergency or continued Hospital stay, and at YOUR request, WE shall provide, in lieu of a Complaint appeal panel, a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

14. Notice of OUR final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

C. Internal Appeal of Adverse Determination

An "Adverse Determination" is a decision that is made by US or OUR Utilization Review Agent that the health care services furnished or proposed to be furnished to a CHILD are not medically necessary or appropriate.

If YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record disagree with the Adverse Determination, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider may appeal the Adverse Determination orally or in writing.

Within five (5) Business Days after receiving a written appeal of the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider, a letter acknowledging the date of receipt of the appeal. The letter will also include a list of documents that YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider should send to US or to OUR Utilization Review Agent for the appeal.

If YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider orally appeal the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider a one-page appeal form. YOU are not required to return the completed form, but WE encourage YOU to because it will help US resolve YOUR appeal.

Appeals of Adverse Determinations involving ongoing emergencies or denials of continued stays in a Hospital will be resolved no later than one (1) Business Day from the date all information necessary to complete the appeal is received. All other appeals will be resolved no later than 30 Calendar Days after the date WE or OUR Utilization Review Agent receives the appeal.

D. External Review by Independent Review Organization

If the appeal of the Adverse Determination is denied, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When WE or OUR Utilization Review Agent deny the appeal, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a Life-threatening condition, YOUR CHILD is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In Life-threatening situations, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record may contact US or OUR Utilization Review Agent by telephone to request the review by the IRO and WE or OUR utilization review agent will provide the required information.

When the IRO completes its review and issues its decision, WE will abide by the IRO's decision. WE will pay for the IRO review.

The appeal procedures described above do not prohibit YOU from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if YOU believe that the requirement of completing the appeal and review process places YOUR CHILD'S health in serious jeopardy.

E. Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through OUR complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. Complaints to the Texas Department of Insurance may also be filed electronically at www.tdi.texas.gov.

The Commissioner of Insurance shall investigate a complaint against US to determine compliance within sixty (60) Days after the Texas Department of Insurance's receipt of the Complaint and all information necessary for the Department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

4. Additional information is needed;
5. An on-site review is necessary;
6. WE, the Physician or Provider, or YOU do not provide all documentation necessary to complete the investigation; or
4. Other circumstances beyond the control of the Department occur.

F. Retaliation Prohibited

2. WE will not take any retaliatory action, including refusal to renew coverage, against a CHILD because the CHILD or person acting on behalf of the CHILD has filed a Complaint against US or appealed a decision made by US.

2. WE shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a Physician or Provider, because the Physician or Provider has, on behalf of a CHILD, reasonably filed a Complaint against US or has appealed a decision made by US.

VIII. GENERAL PROVISIONS

A. Entire Agreement, Amendment

This Contract, and any attachments or amendments are the Entire Agreement between YOU and HEALTH PLAN. To be valid, any changes to this Contract must be approved by an officer of HEALTH PLAN and attached to this Contract.

B. Release and Confidentiality of Medical Records

HEALTH PLAN agrees to maintain and preserve the confidentiality of any and all medical records of YOUR CHILD or YOUR family. However, by enrolling in HEALTH PLAN, YOU authorize the release of information, as permitted by law, and access to any and all of medical records of YOUR CHILD for purposes reasonably related to the provision of services under this Contract, to HEALTH PLAN, its agents and employees, YOUR CHILD'S Primary Care Physician or Primary Care Provider, participating Providers, outside Providers of Utilization Review Committee, CHIP and appropriate governmental agencies. HEALTH PLAN’s privacy protections are described in more detail in its Notice of Privacy Practices. The Notice of Privacy Practices is available at [list website or address] or you may request a copy by calling [ ].

C. Clerical Error

Clerical error or delays in keeping records for YOUR and YOUR CHILD'S Contract with CHIP:

1. Will not deny Coverage that otherwise would have been granted; and

2. Will not continue Coverage that otherwise would have terminated.

If any important facts given to the CHIP about YOUR CHILD are not accurate and they affect Coverage:

1. The true facts will be used by CHIP to decide whether Coverage is in force; and

2. Any necessary adjustments and/or recoupments will be made.

D. Notice

Benefits under Workers' Compensation are not affected.

E. Validity

The unenforceability or invalidity of any provision of this Evidence of Coverage shall not affect the enforceability or validity of the rest of this Contract.

F. Conformity with State Law

Any provision of this Contract that is not in conformity with the Texas HMO Act, and State or federal laws or regulations governing CHIP, or other applicable laws or regulations shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Texas HMO Act, and State or federal laws or regulations governing CHIP, and other applicable laws or regulations.

[CHIP Perinatal Newborn EOC BENEFIT SCHEDULE A]

ATTACHMENT 14

About the Your Texas Benefits Medicaid Card

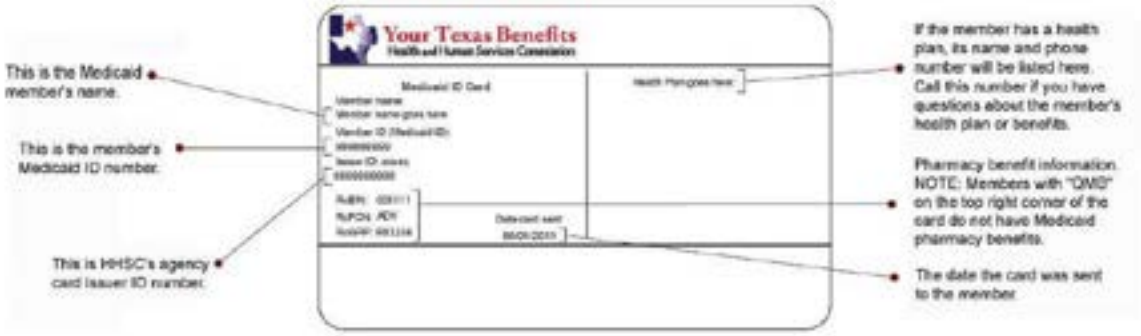
The design of the new card conforms to the standards of the Workgroup for Electronic Data Interchange (WEDI). It is designed to show the same type of information shown on private health insurance cards.

The ***front of the card*** has:

- Member name and Medicaid ID number. (i.e. patient control number – PCN).
- Managed care program name, if applicable (STAR, STAR Health, STAR+PLUS).
- Date the card was issued.
- Billing information for pharmacies.
- Health plan names and plan phone numbers.
- Pharmacy and physician information for members in the Medicaid Limited program.

The ***back of the card*** has:

- A statewide toll-free number that members can call if they need help or have questions about using the card.
- A website (www.YourTexasBenefits.com) where members can get more information about the Medicaid card and access their personal Medicaid health history. The website will be fully functional in a later phase of the project.



Visit the website for providers:
https://www.yourtexasbenefitscard.com/

ATTACHMENT 15

SPECIALIST AS A PCP REQUEST FORM
Children with Special Health Care Needs (CSHCN) Identification Form

Date of Request:	**Received in Member Services**
Member Name:	**Member ID Number:**
Member Address:	**Member Phone Number:**
PCP on Record	**Specialist Requesting PCP Status**
Member Diagnosis	
Clinical Data	

I hereby request to serve as a Primary Care Physician for the above named Member with special healthcare needs. I am willing to accept responsibility for the coordination of all of the Members health care needs as well as abide by any and all contractual obligations.	
Specialist Signature	
Member's Reason for Request	
Member Signature	
Approved YES NO	**Effective Date:** ***Note the effective date will not be retroactive"**
Medical Director Signature: **Date:**	
Date Sent to Provider Relations	**Date Sent to Member Services**
Provider Relations Director Signature	**Member Services Director Signature (Confirming PCP change)**

ATTACHMENT 16

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

MEMBER APPEAL FORM

Here is a copy of the appeal you gave us over the phone on [Date **Oral** Appeal Received]. Read the information carefully. You can call us if the information is wrong or you do not understand it. You can reach us at 915-532-3778, or toll free at 1-877-532-3778. You would like to appeal the decision made by El Paso Health on [Date of Adverse Determination]. Please review, sign and return the form with the information listed on your letter of acknowledgement to help us with your appeal to:

El Paso Health
Attention: Complaints and Appeals Department
1145 Westmoreland Drive
El Paso, TX 79925

Member Name: _____ Date of Birth: _____

Member Address: _____
Street City Zip

Member I.D. _____ Phone No.: _____

Plan: _____

Provider's Name: _____ Phone No: _____

Reason for Appeal:

Member's Signature: _____ Date: _____

We will let you or your representative know within thirty (30) days from the date on this form the decision on your appeal.

Do not write below this line.

Date Form Received: _____ Reviewed By: _____

Resolution: ☐ Uphold Denial ☐ Decision Reversed

TEXAS STAR Your Health Plan • Your Choice

TEXAS Health and Human Services

EPHM3032103

Flesch-Kincaid Readability Level: 4.9

IMPORTANT NOTICE TO MEMBERS

If you have any questions or need help, please call our Member Services Department at **915-532-3778** or toll free at **1-877-532-3778** from 7 A.M. to 5 P.M. Mountain Time, Monday thru Friday. Our toll free TTY phone number for the hearing impaired is **1-855-532-3740**. We can provide you with written or oral interpretation of the services provided. Call us toll free at **1-877-532-3778** to receive support aids and services, including this material in another format.

AVISO A LOS MIEMBROS

Si tiene alguna pregunta o necesita ayuda, llame a nuestro Departamento de Servicios para Miembros al **915-532-3778** o al número gratuito 1**-877-532-3778** de 7 A.M. a 5 P.M. horario de la montaña, de lunes a viernes. Nuestro número de teléfono TTY gratuito para personas con discapacidad auditiva es **1-855-532-3740**. Podemos proporcionar una interpretación escrita u oral de los servicios brindados. Llámenos sin cargo al **1-877-532-3778** para asistencia técnica y servicios, incluyendo material en otro formato.

EPHM3032103 Flesch-Kincaid Readability Level: 4.9

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

FORMULARIO DE APELACIÓN DE MIEMBRO

Aquí esta una copia de la apelación que usted nos dio por teléfono en [Date **Oral** Appeal Received]. Lea la información cuidadosamente. Puede llamarnos si la información es incorrecta o no la entiende. Puede comunicarse con nosotros al 915-532-3778, o llamada gratuita al 1-877-532-3778. **Usted desea apelar la decision tomada por El Paso Health el** [Date of Adverse Determination]. Revise, firme y devuelva el formulario con la información que figura en su carta de reconocimiento para ayudarnos con su apelación a:

El Paso Health
Atención: Departamento de quejas y apelaciones
1145 Westmoreland Drive
El Paso, TX 79925

Nombre del Afiliado: _____ Fecha de Nacimiento: _____

Dirección del Afiliado: _____
Calle Cuidad Código Postal

Número de Identificación _____ Número de teléfono _____

Plan: _____

Nombre del Proveedor y Dirección del Proveedor: _____ Número de teléfono _____

Razón de su Apelación:

Firma del Afiliado: _____ Fecha: _____

Le informaremos a usted o a su representante dentro de los treinta (30) días a partir de la fecha de este formulario, la decisión sobre su apelación.

Do not write below this line.

Date Form Received: _____ Reviewed By: _____

Resolution: ☐ Uphold Denial ☐ Decision Reversed

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

EPHM3032103 Flesch-Kincaid Readability Level: 4.9

ATTACHMENT 17

MAXIMUS Federal Services

HHS Federal External Review Process Appointment of Representative Form

Please return this signed and completed form to the following address:
HHS Federal External Review Process
MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Section 1: APPOINTMENT OF REPRESENTATIVE

NAME OF CLAIMANT	*PLAN\INSURANCE IDENTTIFICATION NUMBER*

To be completed by the claimant:

I appoint this individual:_____ to act as my representative in connection with my request for external review by the HHS Federal External Review Process. I authorize this individual to make any request; to present or to produce evidence; to obtain external review information; and to receive any notice in connection with my external review, wholly in my place. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF CLAIMANT		*DATE*
STREET ADDRESS		*PHONE NUMBER*
CITY	*STATE*	*ZIP*

Section 2: ACCEPTANCE OF APPOINTMENT
To be completed by the representative:

I, _____ hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; and that I am not, as a current or former employee of the United States, disqualified from acting as the claimant's representative.

I am a / an _____
(Professional Status Or Relationship To The Claimant, E.G., Attorney, Relative, Etc.)

SIGNATURE OF REPRESENTATIVE		*DATE*
STREET ADDRESS		*PHONE NUMBER*
CITY	*STATE*	*ZIP*

Questions? Call 1-**888-866-6205** Monday – Friday 8:00am – 5:00pm EST

ATTACHMENT 18

MAXIMUS Federal Services

HHS-Administered Federal External Review Request Form

MAXIMUS Federal Services needs the information on this form to review your medical claim. We may not be able to do the review without this information.

In most cases, you must complete any mandatory appeals or opportunities for reconsideration offered by your health plan or insurance issuer before we can do an external review. In urgent situations, we may be able to do a review even if you have not made all appeals and reconsiderations.

We must receive the completed form within four months of the date your insurer sent you a final decision denying your services or your claim for payment.

Please read and complete all sections of this form.

Section 1: Covered person

This section is about the person who received or will receive the benefit or treatment.

Name:	Email address:		
Street address:			
City:	County:	State:	Zip code:
Daytime phone:	Evening phone:		

Please complete this section if you are the covered person's parent or legal guardian

Name:	Email address:		
Street address:			
City:	County:	State:	Zip code:
Daytime phone:	Evening phone:		

Questions?	Call **1-888-866-6205** Monday – Friday 8:00am – 5:00pm EST

Section 2: Insurance company information

2

Please complete this section for each insurance company involved with your claim.

Insurance company #1:	Insurance plan or plan option (if applicable):
Policyholder:	Policy number:
Claim number:	Insurance company phone number:

Please attach a copy of the claim that was denied or any correspondence you have received from your insurance carrier. **Please do not send originals. Send only copies.**

Insurance company #2:	Insurance plan or plan option (if applicable):
Policyholder:	Policy number:
Claim number:	Insurance company phone number:

Please attach a copy of the claim that was denied or any correspondence you have received from your insurance carrier. **Please do not send originals. Send only copies.**

Section 3: Services in dispute

Please describe the health services that were denied by your health insurance plan or issuer:

Have you already received these health services? ☐ Yes ☐ No

If so, when were the services received? *(Month, day, year)* _____

Please state the reason that you believe the health insurance company's decision was not correct:

Questions? Call **1-888-866-6205** Monday – Friday 8:00am – 5:00pm EST

Section 4: Claims for urgent care situations

3

If you believe your situation is urgent, you may ask for an expedited (fast) review.

An urgent care situation is one in which your health may be in serious jeopardy or, in your doctor's opinion you may have pain that cannot be controlled while you wait for the external review decision.

To ask for an expedited external review:

Fax this form to 1-888-866-6190 **OR** mail this form to:

HHS Federal External Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.

In urgent care situations, MAXIMUS Federal Services will accept a request for external review from a medical professional who knows about the claimant's condition. The medical professional will not be required to submit proof of authorization.

If you have questions about your external review, call: **1-888-866-6205**.

Is this external review for urgent care? ☐ Yes ☐ No

Section 5: Claims involving a rescission of coverage

A **rescission** is an action by a health insurance issuer to retroactively cancel (back to an earlier date) or discontinue a policyholder's coverage.

Is this request for external review of a rescission of health insurance coverage? ☐ Yes ☐ No

Section 6: Additional information you may give

MAXIMUS Federal Services will use the information on this form to get the relevant information and documents from your insurer. You may add supporting information and documents you think the insurer may not be able to provide.

For example, you may choose to give us:

- Documents to support the claim, such as physicians' letters, reports, bills, medical records, and Explanation of Benefits (EOB) forms
- Letters you sent to your insurance plan or issuer about the claim
- Letters the plan or issuer sent to you about the claim

You do not have to give us this additional information. However, if you do not give us any additional information, MAXIMUS Federal Services may decide your case based only on the information your insurance issuer or plan gives us.

You can give MAXIMUS additional information for your external review by sending it with this form:

Fax to 1-888-866-6190 **OR** mail this form to:

HHS Federal External Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.

If you have questions about your external review, call **1-888-866-6205**.

Questions? Call **1-888-866-6205** Monday – Friday 8:00am – 5:00pm EST

Sign the consent form. 4

Please sign and date the form.

Signature: _____ Date: _____

Printed name: _____

I am the: ☐ Covered person ☐ Parent or legal guardian ☐ Authorized Representative

NOTE: The covered person must sign this consent form, unless they have a legal guardian, personal representative, are incapacitated, or have otherwise delegated authority to complete this form. If the covered person cannot sign this form, the authorized representative must give written proof of his or her authority to sign. You may write or call MAXIMUS in order to obtain a form to allow appointment of an Authorized Representative.

Privacy Act Statement: The following website provides a notice of your rights under the Privacy Act and includes information about how the information on this form will be used and about our legal authority to collect this information: **http://cciio.cms.gov/resources/other/index.html**.

Questions? Call **1-888-866-6205** Monday – Friday 8:00am – 5:00pm EST

ATTACHMENT 19

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

MEMBER COMPLAINT FORM
Please print all information clearly.

Instructions: Please use this form to give us as much information as you can about your complaint. The information you give will help us look into your complaint. El Paso Health will acknowledge, investigate, and resolve your complaint no later than 30 calendar days after we receive your complaint.

By signing this form, you are also saying El Paso Health can get medical records relating to your complaint if needed.

Member Name: _____ Member ID Number: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: ( ) _____

Doctor's Name: _____
Date of Service: _____

Reason for Complaint:
Tell us, in detail, about your complaint?

_____
_____
_____
_____

Has the complaint been settled?

_____
_____
_____
_____

What would you like El Paso Health to do to settle your complaint?

_____
_____
_____
_____

Form Completed By: _____ Date: _____
Relationship to Member: _____

If additional space is needed, use back or attach separate sheet of paper.

Please return this form to: El Paso Health
1145 Westmoreland Dr.
El Paso, TX 79925

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

EPF/CHIP CF English
30199EPH121118

ATTACHMENT 20

FORMULARIO DE QUEJAS PARA EL MIEMBRO
Favor de imprimir toda la información claramente.

Instrucciones: Favor de usar este formulario para proporcionarnos el mayor número de información respecto a su queja. La información que usted nos brinda nos ayudara a investigar su queja. El Paso Health reconoce e investigara, y resolverá su queja a no más tardar de 30 días de haber recibido sus quejas.

Al firmar este formulario, usted le está dando permiso a El Paso Health de obtener archivos médicos relacionados a su queja, si se requiere.

Nombre del Miembro: _____ Numero de ID del Miembro: _____
Domicilio: _____
Ciudad: _____ Estado: _____ Código Postal: _____
Número de Teléfono: ( ) _____

Nombre Del Doctor: _____
Fecha de Servicio: _____

La razón de la Queja:
En detalle, díganos sobre su queja.

_____
_____
_____
_____

¿Ha sido resuelta la queja?

_____
_____
_____
_____

¿Qué le gustaría que hiciera El Paso Health sobre su queja?

_____
_____
_____
_____

Formulario llenado por: _____ Fecha: _____
Relación del Miembro: _____

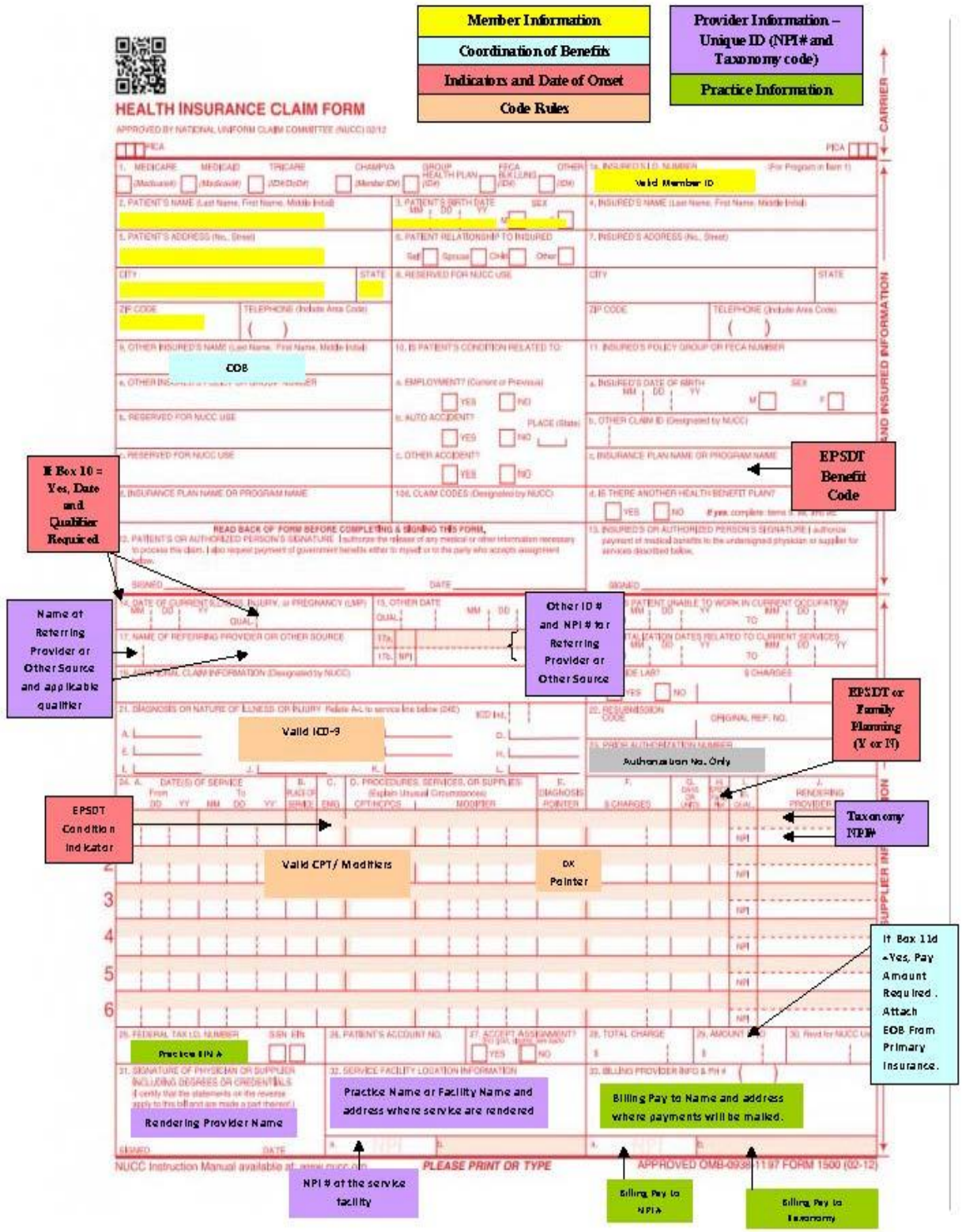
Si requiere espacio adicional, utilice la parte de atrás o adjunte una hoja de papel separada.

Por favor de regresar a: El Paso Health
1145 Westmoreland Dr.
El Paso, TX 79925

EPF/CHIP CF Spanish
30199EPH121118

ATTACHMENT 21

CMS 1500 CLAIM FORM GUIDE



ATTACHMENT 22

CORRECTED CLAIM FORM/CMS 1500 OR UB04 CLAIM FORM

Corrected Claim Form

Provider Name:	Date:
Member Name:	Member ID:
Claim Number:	Date of Service:

Reason for Corrected Claim:
(Please check appropriate box)

- ☐ Correct Member Demographic
- ☐ Correct Billing Code (HCPCS, CPT, Revenue Code or DRG)
- ☐ Correct Billing Modifier
- ☐ Correct Diagnosis Code (ICD-10)
- ☐ Correct Provider Billing Information
- ☐ Recoupment Request (Claim billed in error) Please provide claim number:_____
- ☐ Proof of timely filing (Please attach Remittance Advice or EDI Report)
- ☐ Other Insurance Payment (Attach EOB)
- ☐ Other (Use comments section to give a detailed explanation)

Comments:

Please mail completed form along with corrected claim and a copy of the Remittance Advice to:

ATTN: Claims
El Paso Health
P.O. Box 971370
El Paso, TX 79997

Reminder

All appeals of denied claims and requests for adjustments on paid claims must be received by El Paso Health within 120 days from the date of the Remittance Advice on which the claim appears.

ATTACHMENT 23

PRIVATE PAY FORM

Today's Date:_____

Name:_____ DOB:_____

Address:_____

City: _____ State:_____

"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 (Program Name) as being reasonable and medically necessary for my care. I understand that El Paso Health through its contract with HHSC 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 I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

Signature:_____ Date:_____

ATTACHMENT 24

HEALTHX FAX SYSTEM/FLOWCHART

HEALTHX FAX SYSTEM/FLOWCHART

El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS

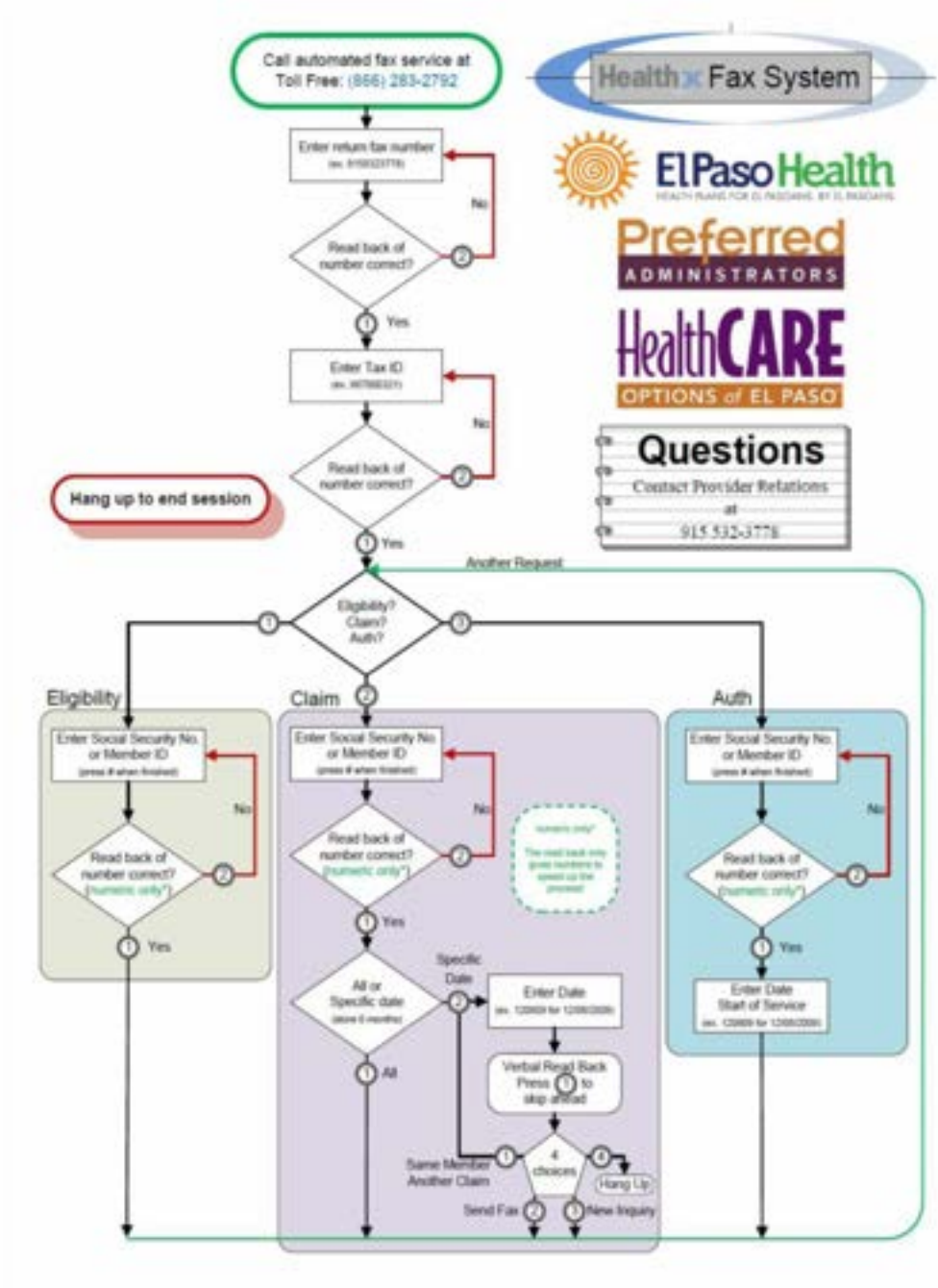
HealthX Fax System is an automated fax system created to assist you on a timely manner whenever you cannot access a live person. This system will provide you **status** on:

- Member eligibility
- Claims (6 months history per member)
- Pre-authorizations (not to be confused with the submission of pre-authorizations with the appropriate form via fax as you normally due)

All you need to do is dial (866) 283-2792 toll free and follow the instructions that the automated system will request from you.

Please look at the flow chart enclosed so you know what steps to follow. As long as you do not hang up, you can check status on as many members as you want. You should receive a fax within minutes or a voice play back message if that is what you prefer.

If you have any questions on the HealthX Fax System please contact the Provider Relations Department at 915-532-3778. Thank you!


Call automated fax service at
Toll Free: (866) 283-2792
Health Fax System
Enter return fax number
No
Read back of number correct?
Yes
Enter Tax ID
No
Read back of number correct?
Yes
Hang up to end session
ElPasoHealth
Preferred ADMINISTRATORS
HealthCARE OPTIONS of EL PASO
Questions
Contact Provider Relations
at
915 532-3778
Another Request
Eligibility? Claim? Auth?
Eligibility
Enter Social Security No. or Member ID
No
Read back of number correct? (numeric only)
Yes
Claim
Enter Social Security No. or Member ID
No
Read back of number correct? (numeric only)
Yes
All or Specific date
Specific Date
Enter Date
All
Verbal Read Back
Press 1 to skip ahead
Same Member Another Claim
4 choices
Hang Up
Send Fax
New Inquiry
Auth
Enter Social Security No. or Member ID
No
Read back of number correct? (numeric only)
Yes
Enter Date Start of Service

ATTACHMENT 25

SAMPLE OF A FINDINGS/EDUCATION LETTER

Date
Provider
Address
El Paso, TX Zip Code

Secure Email Sent to (provider**'s biller's email address) confirmed by (provider employee) via phone on (date) at (time).**

Re: Notice of Education and Recoupment in the amount of (Identified Overpayment)

Thank you for the service you have provided to El Paso Health and our Members. This is to inform you of the findings identified during a recent audit of your claims submitted.

As you are probably aware, the federal and state governments have been making a combined effort to reduce waste, abuse and fraud in all government funded healthcare programs, including CHIP and STAR. Providers making minor coding violations, without intent, are required to be educated in efforts to avoid future claim errors. El Paso Health is responsible for recouping all identified overpayments up to $100,000.

Pursuant to these efforts, Texas enacted House Bill 2292 to require all managed care payers, like El Paso Health, to establish a Special Investigations Unit (SIU) and establish a plan to prevent and reduce waste, abuse and fraud in the various managed care programs, such as CHIP and STAR. This law requires El Paso Health to establish a plan to monitor and improve the accuracy of claims payments made to physicians and other providers in efforts to prevent and reduce the possibilities of waste, abuse, or fraud.

El Paso Health retains Cotiviti as its hired claims analyst. The following is the analysis of your claims for dates X/XX/XX to X/XX/XX.

(INDIVIDUAL AUDIT FINDINGS AND EDUCATION)

Recoupment for No Documentation/Inappropriate Coding
The service dates that did not meet appropriate documentation for the services billed and the subsequent overpayment amount is documented in the "Notice of Recoupment" (Attachment A).
The amount of recoupment for these services is **$X.XX.** It is the expectation of El Paso Health that all network providers submit all the requested medical documentation for audit at the time of the initial certified request for medical records letter. Any medical record or

documentation for a billed service that was not submitted with the certified request was subject for full recoupment. This type of finding cannot be appealed due to Office of Inspector General (OIG) guidance that post audit submission could be suspect as being potentially doctored or created after the fact. Your medical records were submitted with an Attestation certifying medical records were original and complete or exact duplicates of the original records on file.

You have the right to appeal the findings, please be advised that your written appeal must submitted no later than 30 Calendar Days from receipt of this letter.

El Paso Health will recoup a total of **(Identified Overpayment)** via claims adjustments on **(30 Days After Date of Letter)** unless a written appeal is received. Please note that appeals requesting to submit documentation that originally was not submitted will not change the outcome of the recoupment. You have the option of refunding overpayments via check but must inform El Paso Health before the 30-Days deadline.

El Paso Health requests that you please take the necessary steps to eliminate the occurrence of these coding issues.

If you would like to further discuss the findings, you may contact me at (915) 298-7198 ext. 1039.

Sincerely,

Special Investigations Unit Program Manager

Enclosure: Attachment A – Claims Data

Cc: Jorge Guzman, M. D., El Paso Health Medical Director
Catherine Gibson, CHC, El Paso Health Chief Compliance Officer
Erika Ozuna, El Paso Health Senior Director of Provider Relations, Contracting & Credentialing

El Paso Health

HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

1145 Westmoreland Dr.
Toll Free 1-877-532-3778
www.elpasohealth.com

STAR/CHIP Program
1-877-532-3778 Toll Free

STAR+PLUS Program
1-833-742-3127 Toll Free