Parkland Community Health Plan
Medicaid and CHIP
Provider Manual

January 2019

2777 Stemmons Freeway, Suite 1450, Dallas, TX 75207
www.Parklandhmo.com
To learn more, please call 1-888-672-2277 HEALTHfirst or 1-888-814-2352 KIDSfirst

Dallas Service Area - Dallas, Collin, Ellis, Hunt, Kaufman, Navarro and Rockwall

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How long will it take to investigate and resolve my Complaint?

If I am not satisfied with the outcome, who else can I call?

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Important Contact Information

This Manual has been designed as a reference source for your use in working with Parkland Community Health Plan (PCHP) and its Covered Persons. Should you have additional questions, please write or call the following:

Parkland Community Health Plan, Inc.
PO Box 569005
Introduction

Welcome to Parkland Community Health Plan (PCHP). PCHP is pleased you have decided to participate with the Parkland HEALTHfirst STAR (Medicaid), KIDSfirst, the Children’s Health Insurance Program (CHIP)/CHIP Perinate Newborn and/or the CHIP Perinate (future reference is CHIP) or other programs sponsored by PCHP.

The PCHP programs are dedicated to delivering quality health care to the community we serve and the impact that these problems have on our Covered Persons’ ability to function and live productive lives. PCHP actively seeks to understand and then focus on barriers to care created by social needs. PCHP currently offers...
Medicaid and CHIP benefits to eligible recipients who live in the Dallas Service Area, which includes Dallas, Collin, Rockwall, Kaufman, Navarro, Hunt and Ellis counties.

This Manual contains information to assist you in doing business with PCHP and the State Programs, and allows you more time to focus on what’s important to you – the health and wellbeing of your patients.

**Objectives of program**

We have identified specific objectives to effectively manage and provide quality health care for the Parkland Community Health Plan Medicaid and CHIP Members. The objectives are:

- To ensure network adequacy and timely access to care
- To provide timely claim payment
- To provide comprehensive behavioral health care
- To incorporate a cultural competency program to address the diverse cultural needs of our members and provide disease management programs appropriate for the populations we serve.

**Definitions**

Capitalized words in this Manual are defined terms; the definitions are below.

**Admission.** An Admission occurs when a Covered Person is admitted to an acute care Facility for at least 24 hours.

**Ancillary Services Provider.** Ancillary Services Providers include chiropractors; home health services providers; DME suppliers; mental health, behavioral health and chemical dependency service providers; emergency ambulance and related services; pharmacies; optometrists; labs; diagnostic imaging facilities; registered dieticians; audiologists; physical, occupational, speech and related therapists; and other providers which may provide Covered Services, all of which must be licensed by the State of Texas and credentialed by PCHP.

**Appeal.** If PCHP terminates a Participating Provider’s contract, or denies a Provider credentials, the Provider may appeal the Initial Decision under the process described by state law, PCHP’s Quality of Care Policy and its Credentialing Plan available at www.parklandhmo.com.

**Appeals/Peer Review Sub-committee** is a committee composed of Participating Providers that will be constituted according to state law and NCQA standards to review any Participating Provider Appeal of an Initial Decision and recommend to PCHP whether the Initial Decision should be upheld or reversed. If necessary, to comply with State Law or NCQA requirements, PCHP may request a non-contracted provider not in direct competition with the Participating Provider who has filed an Appeal to serve on the Appeals/Peer Review Committee. This sub-committee may also be asked to oversee other peer review activities.

**Associated Health Professional.** Nurse practitioner; clinical nurse specialist; certified registered nurse anesthetist; midwife; or physician’s assistant who is employed by or is an independent contractor to the Provider, provided that the Provider bills directly for the Covered Services provided by the Associated Health Professional, using CPT Codes and modifiers as needed to reflect the use of an Associated Health Professional.

**Authorized Representative.** An Authorized Representative of a Covered Person is legally authorized to act on behalf of the Covered Person with respect to health care and related decisions. Authorized Representatives may be
parents or foster parents of a minor, a legal guardian or a person authorized in writing to act on behalf of the Covered Person.

**Checkup.** Checkup is a Texas Health Step Checkup upon enrollment, for preventative visits, and for pregnant teens.

**CHIP Perinatal.** CHIP Perinatal describes when HHSC contracts with PCHP to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn Covered Persons.

**CHIP Perinate.** CHIP Perinate means a pregnant female Covered Person who is enrolled to receive Covered Services from PCHP.

**CHIP Perinate Newborn.** CHIP Perinate Newborn means a CHIP Perinate Covered Person.

**Clean Claim.** The content of a Clean Claim is set forth in Appendix U to this Provider Manual.

**Complaint.** A Complaint is any dissatisfaction, expressed by a complainant orally or in writing to PCHP, with any aspect of PCHP’s operations, including, but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of claim denials or pre-authorization/referral requests; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. A Complaint is not related to misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the PCHP provider.

**Corrective Action Plan (“CAP”).** A Corrective Action Plan may be offered to a Participating Provider who PCHP has reason to believe may not be complying with his/her/its contract with PCHP and/or is engaging in practices which raise a Quality of Care Issue or a Quality of Care Concern or a Service Issue for Covered Persons and/or PCHP.

**Covered Person/Member.** A Covered Person (or a “Member”) is eligible for participation in a State Program and is either assigned to PCHP by the State Agency supervising the specific State Program or chooses PCHP and is properly enrolled in one of PCHP’s health plans.

**Covered Services.** Covered Services are health care services/supplies/items which a Covered Person is entitled to receive under the State Programs and the Parties’ agreement.

**Credentialing Application.** An application for credentialing or recredentialing provided by PCHP to a Provider, and then completed by the Provider, together with all its attachments and attestations.

**Credentialing Authorities** include the State Agencies that set forth credentialing requirements, NCQA and the Centers for Medicare and Medicaid Services.

**Data Bank** is the information source regarding Providers maintained by the United States Department of Health and Human Services, which merged the former National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

**Delegated Entity.** A Delegated Entity is an organization or person to which PCHP has made a delegation of credentialing authority.

**DSHS** is the Texas Department of State Health Services.
Emergency Care. Emergency Care means health care services provided in a hospital emergency facility or comparable facility needed to evaluate and stabilize an “emergency medical condition,” as further defined in the Texas Medicaid Provider Procedures Manual.

Facility is a hospital, ambulatory surgery center or behavioral health center that provides in-patient medical care or residential or out-patient mental health or substance abuse treatment.

Facility Services. Facility Services are surgical and related medical Covered Services for Covered Persons who are not anticipated to require an Admission and/or overnight care and are generally offered to the public by Facility.

Final Decision is PCHP’s ultimate decision about whether to terminate a Participating Provider’s contract or deny a Provider credentials, made after the Initial Decision, any appeal and the recommendation of the Appeals/Peer Review sub-committee, and its communication of the final termination to the Provider.

HIPAA is the Health Insurance Portability and Accountability Act, as amended, and its implementing regulations, including those regulations related to the privacy and security of a Covered Person’s information.

His/Her, Him/Her includes its and their.

Imminent Threat to Patient Safety means a threat that is immediate in time, so severe in nature that the patient is being exposed to an unreasonable risk of death or serious bodily or mental injury, and may only be reasonably mitigated by taking the proposed action.

Initial Decision. PCHP’s Initial Decision is its decision to terminate the contract of a Participating Provider or deny credentials to a Provider. If the Provider does not appeal the Initial Decision, the Initial Decision becomes PCHP’s Final Decision.

Material Restriction is a loss, suspension or change in professional licensure or certification status, including but not limited to a requirement to obtain a second opinion from another practitioner regarding patient diagnosis or treatment or to have a second person present during any examination or procedure; any limitation on prescribing authority; or (if applicable) any change in hospital staff privileges, including resignation in lieu of discipline or termination, if the Participating Provider normally admits patients to a Facility.

Member Responsibility Amount. The Member Responsibility Amount is any amount set forth by the controlling laws and regulations that the Provider must collect from the Covered Person at the time of providing Covered Services. The amount (if any) should appear on the Covered Person’s ID card.

NCQA is the National Committee on Quality Assurance.

Parkland Community Health Plan, Inc. (“PCHP”) is the entity licensed by State Agencies that offers State Programs and/or other health plans or programs.

Participating Provider. A facility, Specialist Provider, PCP, Ancillary Services Provider or other person or entity that has a contract with PCHP to provide services or supplies for Covered Persons.

Party/Parties. A Participating Provider and PCHP are each a “Party,” and together are the “Parties.”
**PCHP Administrator.** The PCHP Administrator is any third-party vendor retained by PCHP to assist PCHP in performing its responsibilities under the State Programs.

**Peer Review** is the evaluation of a Quality of Care Issues or Quality of Care Concerns regarding a Participating Provider by other professionals with similar expertise/experience or the review of a Credentialing Application to determine if a Provider should be eligible to become a Participating Provider.

**Peer Review Process** is the confidential process carried out by fellow Providers to evaluate a Quality of Care Issue or Quality of Care Concern, and to make recommendations to PCHP regarding the subject Provider’s status. A flow chart setting forth the process is available at www.parklandhmo.com.

**Primary Care Provider (“PCP”).** A licensed physician who is credentialed as a primary care physician by PCHP to provide and coordinate Covered Services for Covered Persons.

**Provider.** Any provider of health care services that does not have a contract and/or is not credentialed by PCHP.

**Provider Manual.** This Provider Manual or Manual is meant to inform the Participating Provider of relevant information, policies, procedures and both Provider’s and PCHP’s duties under the State Programs and the Parties’ agreement. The Provider Manual may be changed from time to time, and the then-current version will be available at www.parklandhmo.com.

**Provider Quality Assurance Committee** is a Committee of Participating Providers and other appointed Providers which will provide support to its sub-committees and provide input to PCHP on medical and business matters facing the Provider Community.

**Quality Assurance and Performance Improvement Plan.** PCHP’s Quality Assurance Plan and Performance Improvement Plan is described in this Provider Manual, and includes its Credentialing and Recredentialing Plan, the quality management, quality improvement, utilization management and care coordination programs, and any other quality-related activities mandated by law.

**Quality of Care** involves whether Covered Services are provided to Covered Persons in an appropriate and timely manner, including but not limited to the Covered Person obtaining timely access to diagnosis and treatment, proper continuity of care and referrals to specialist care when warranted; whether the Participating Provider’s expertise is sufficient to provide a particular Covered Service; whether the environment where the Covered Services are provided is safe; whether the Covered Person does not have material substantive complaints; whether the outcome (e.g., Covered Person’s health status, death or disability, prescription/treatment) is reasonable given the Covered Person’s medical status; and whether the Covered Services provided are adequately documented.

**Quality of Care Issues** involve complaints or questions raised by the PCHP Administrator; PCHP staff; Covered Persons; Credentialing Entities; facilities; Participating Providers, providers or others regarding Quality of Care provided by a specifically identified Participating Provider. Quality of Care Issues may be raised either verbally or in writing.

**Quality of Care Concerns** are Quality of Care Issues where the Medical Director determines that there is an Imminent Threat to Patient Safety or sufficient reason to refer a Quality of Care Issue to a Third-Party Expert for further evaluation. The evaluation of a Quality of Care Concern is to be based on current medical knowledge and standards applicable to the Participating Provider.

**Service Area.** PCHP’s Service Area consists of Dallas, Collin, Rockwall, Kaufman, Navarro, Hunt and Ellis
Service Issues. Service Issues are raised by a Covered Person or other person which are not Quality of Care Issues or Quality of Care Concerns but requires some action by PCHP staff and/or the State Agencies. Service Issues do not involve a threat to the Covered Person’s health or safety. Service Issues include but are not limited to issues related to HIPAA and the Covered Persons and his/her family’s confidentiality, privacy and respectful treatment by the Participating Provider and his/her staff. Service Issues may include perceived Quality of Care Issues which does not rise to the level of Quality of Care Concerns.

Specialist Provider. A licensed physician who is credentialed by PCHP as a Specialist to provide specialty Covered Services for Covered Persons (and in some limited circumstances to serve as a PCP when approved to do so by PCHP).

State Agencies. The “State Agencies” are the Texas Department of Insurance (“TDI”); the Texas Department of State Health Services (“DSHS”); the Texas Health and Human Services Commission (“HHSC”); and any other agencies or their agents charged with oversight and/or regulation of the State Programs.

State Licensing Agencies. State Licensing Agencies are those agencies responsible for the licensing/certification and investigation of professional conduct for Facilities, Ancillary Service Providers and Associated Health Professionals.

State Programs. The State Programs include the Texas Medicaid Managed Care Program (STAR) and the Texas Children’s Health Insurance Program (CHIP) and other programs for low-income persons regulated by the State Agencies and which are offered by PCHP, all of which may be changed from time to time.

Third Party Expert is a physician (or other relevant health care professional) who has expertise regarding the Covered Services at issue in a potential Quality of Care Concern that has been referred by PCHP to the Third-Party Expert for evaluation. The Third-Party Expert may not be in direct economic competition with the Participating Provider about whom a potential Quality of Care Concern is raised.

THSteps. THSteps is Texas Health Steps, also known as Early and Periodic Screening, Diagnosis and Treatment. THSteps is a children's benefit under Texas Medicaid which provides medical and dental preventative care and treatment to Medicaid clients who are birth through 20 years of age.


Urgent Care is care sought by a Covered Person based on a health condition which does not require Emergency Care 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 evaluation or treatment within 24 hours to prevent serious deterioration to his or her condition or health. Severe vomiting, earaches, sore throats or fever are considered “urgent.” Preventive care services and other routine treatment for conditions such as minor colds and flu are not considered “urgent.”

Written Notice or Notice. Any Written Notice or Notice required by this Agreement may be given by either of the Parties addressed to the other at the address set forth immediately below the recipient Party’s signature to this Agreement and sent by US certified mail, return receipt requested, which is deemed delivered three (3) business days from the date sent. Any failure to give Written Notice of a change in the contact address will result in any Written Notice given to the “old” address to be deemed received.
PCHP Duties

PCHP will comply with its contractual obligations and the requirements of the State Programs. In addition, PCHP has the following obligations:

Covered Person Benefits
PCHP provides all benefits covered under the State Programs, as well as some value-added services. If you are unsure whether a particular service or treatment is covered under a Covered Person’s plan, please refer to Appendices F and J, call Provider Services, or you may consult the current edition of the TMPPM.

Covered Person Communications
PCHP does not impose restrictions on a PCHP’s Medicaid or CHIP providers’ free communication with a Covered Person about the Covered Person’s medical conditions, treatment options, referral policies, and other policies, including financial incentives or arrangements and all managed care plans with which the network provider contracts.

Termination
PCHP will follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a Participating Provider.

Plan termination
Physicians and other providers must inform Parkland Community Health in writing of their intent to terminate their participation with us at least 90 days prior to termination from the plan. This information can be sent to:

Parkland Community Health
Provider Relations PO Box 569150
Dallas, TX 75356-9150
Fax: 1-866-510-3710

Within 15 calendar days after receipt or issuance of a termination notification, we will notify 1) all Members in a PCP’s panel and 2) all Members who have had two or more visits with the Network Provider for home-based or office-based care in the past 12 months and assist them in selecting new providers or coordinate the transition of care.

Actions to Collect Payment
PCHP will initiate and maintain any action necessary to stop a Participating Provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against any State Agency or Covered Person or anyone acting on their behalf to collect payment, excluding payment for non-Covered Services for which there is a properly executed private pay agreement (Appendix O) or for an authorized Member Responsibility Amount.

Participating Provider Qualifications
All Participating Providers must have a contract with PCHP, be credentialed per the PCHP Credentialing Plan, and be eligible to participate in the State Programs.

Primary Care Provider Qualifications
Participating Providers from any of the following practice areas may act as PCP’s for Covered Persons: general practice, family practice; internal medicine; pediatrics; obstetrics/gynecology (Ob/Gyn); certified nurse midwives (CNM), pediatric and family advanced practice nurses and physician assistants (PA’s) practicing
under the supervision of a physician, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) or similar community clinics.

With approval by the PCHP Medical Director, Specialist Providers may act as PCP’s for designated Covered Persons who are chronically ill or have medically complex or other special health care needs; these Specialist Providers must comply with the requirements applicable to PCP’s. If you are a Specialist and wish to serve as a PCP for a specific Covered Person, contact PCHP to initiate the process of review.

**CHIP and CHIP Perinate Provider Qualifications**

A CHIP perinatal provider can be an obstetrician/gynecologist (OB/GYN), a family practice doctor or another qualified health care Provider that provides prenatal care and is also credentialed by PCHP as a PCP or Specialist.

**Specialist Qualifications**

A Participating Provider is a “Specialist” if he/she is credentialed as a Specialist by PCHP by virtue of the Provider’s education, training, experience and/or certification by relevant professional societies.

**Participating Provider Duties Regarding Provision of Covered Services**

**Primary Care Provider/Medical Home**

The Primary Care Provider (PCP) is the medical home for the Covered Person, working with the Covered Person, the Covered Person’s family and other Providers to coordinate care that is comprehensive, culturally sensitive and designed to meet the Covered Person’s needs.

**Provision of Covered Services by PCP**

PCP’s provide all primary care Covered Services within the scope of the PCP’s practice, including appropriate health education and instructions to the Covered Person and/or to family Covered Persons or primary caregivers. PCP’s also arrange for the provision of Covered Services outside their scope of practice via referrals to other Participating Providers; a link to the referral form is found at Appendix N.

Covered Services are defined and pertinent coverage limitations and exclusions are described in the TMPPM and at Appendices F and J.

All Covered Persons should receive the following “Routine Services,” which are defined as preventative and medically necessary Covered Services within the scope of the PCP’s license, which are not Emergency Care or non-urgent Covered Services outside of the Dallas Service Area:

- For CHIP Covered Persons under the age of 20, well child health checkups in accordance with the American Academy of Pediatric recommendations.
- For Medicaid Covered Persons under the age of 21, Checkups in accordance with the THSteps periodicity schedule; please consult Appendix M for more details.
- For Medicaid Covered Persons under the age of 21, the Primary Care Provider must either be enrolled as a Texas Health Steps provider or refer Covered Persons due for a Checkup to a Texas Health Steps provider.
- For adult Covered Persons over the age of 21, adult health care oversight and care based on the recommendations of the U.S. Preventative Services Task Force.

PCP’s are also required to do the following in connection with providing Covered Services:

- Assess the medical and behavioral health needs of Covered Persons based on the PCP’s established
procedures. If treatment is needed, the PCP may provide mental health treatment when appropriate to do so, or should make a referral to the Specialty Behavioral Health Providers shown on Appendix A. If the PCP elects to provide mental health Covered Services, the PCP must use the THSteps behavioral health forms and submit completed THSteps screening and evaluation results to the behavioral health vendor at the number shown on the first page of this Provider Manual and at Appendix A. Note: Covered Persons may self-refer to PCHP’s behavioral health vendor.

- Obtain pre-authorization from PCHP for those services that require it; a list of services requiring pre-authorization can be found at Appendix N. Claims for services that are not pre-authorized when pre-authorization is required will be denied.
- Make appropriate referrals (except in the case of Emergency Care, referrals to non-Participating Providers required PCHP’s prior authorization; the form for referrals is found at Appendix N). Note: Covered Persons do not need PCP referrals for behavioral health, obstetrical/gynecological or family planning care, basic vision care, and for certain Specialists who are Participating Providers, as defined at Appendix N. Claims resulting from Covered Person visits where a referral was not received by the Specialist or other Participating Provider will be denied.
- For Covered Persons with disabilities or chronic or complex conditions, develop a plan of care that meets the special preventative, primary acute care and specialty care needs of the Covered Person based on his/her health needs, Specialist recommendations, and provide periodic reassessments of the Covered Person’s status and needs.
- Provide timely follow-up after Out-of-Area Urgent Care, Emergency Care or Admission. Once the attending physician determines that the Covered Person is stable, post-stabilization care should be coordinated by the Primary Care Provider, who must record all pertinent information about the care received and the post-stabilization services in the Covered Person’s medical records.
- Coordinate the Covered Person’s care, including transfers of medical information between Providers and community support services.
- Work to ensure that family Covered Persons are involved in decision making for their dependents.
- Provide information concerning appropriate support services (e.g., WIC, ECI) within the community. In the case of children and youth with Texas Health Steps benefits; coordinate with existing State Agencies’ approved providers and/or case managers within ECI, DARS, TCB, and the DSHS targeted case management program for high risk pregnant women and infants. DSHS can offer various mental health and mental retardation programs, such as psychiatric treatment, child and adolescent counseling, and crisis intervention.
- Coordinate care for hospitalized Covered Persons, including following:
  - *Ensure that pre-admission planning for all non-Emergency Care Admissions is complete prior to the date of admission;
  - *Ensure that discharge planning is complete prior to the date of discharge, including confirmation that home and community arrangements are in place if needed to care for the Covered Person.
- Assist in the development of alternatives to hospitalization when medically appropriate.

**Provision of Covered Services by Perinatal Providers.**

Perinatal Providers provide Covered Services related to the Covered Person’s pre-natal visits, labor and delivery. They may also be responsible for providing Covered Services as a PCP or Specialist. They must also provide information concerning appropriate support services (for example, WIC, ECI, etc.) and the DARS, TCB, and the DSHS targeted case management program for high risk pregnant women and infants, where appropriate.

**Provision of Covered Services by Specialists and Other Participating Providers**

Specialists and other Participating Providers must provide the following Covered Services and related
assistance to Covered Persons:

- Provide Covered Services within the scope of the Provider’s license, specialization and/or certification.
- Assess the medical and behavioral health needs of Covered Persons for referral to Specialty Behavioral Health Providers when warranted.
- Obtain pre-authorization from PCHP for those services that require it; a list of services requiring pre-authorization can be found at Appendix N. Claims for services that are not pre-authorized when pre-authorization is required will be denied.
- Receive from PCP’s and making appropriate referrals (except in the case of Emergency Care, referrals to non-Participating Providers required PCHP’s prior authorization; the form for referrals is found at Appendix N). Claims resulting from Covered Person visits where a referral was not received by the Specialist or other Participating Provider will be denied. Note: Covered Persons do not need PCP referrals for behavioral health, obstetrical/gynecological or family planning care, basic vision care, and for certain Specialists who are Participating Providers, as defined at Appendix N.
- Coordinate the Covered Person’s care with the PCP, including transfers of medical information regarding the Covered Person’s status, the Specialist’s recommendations and course of treatment.
- Work to ensure that family Covered Persons are involved in decision making for their dependents.
  - Provide information concerning appropriate support services (for example, WIC, ECI, etc.) within the community. In the case of children and youth with Texas Health Steps benefits, coordinate with existing State Agencies’ approved providers and/or case managers within ECI, DARS, TCB, SHARS the DSHS targeted case management program for high risk pregnant women and infants, and hospice through Department of Aging and Disability Services.
  - Coordinate care for hospitalized Covered Persons, including ensuring that:
    - pre-admission planning for all non-Emergency Care Admissions is complete prior to the date of admission; discharge planning is complete prior to the date of discharge, including confirmation that home and community arrangements are in place if needed to care for the Covered Person.
  - Assist in the development of alternatives to hospitalization when medically appropriate.

**Medicaid Managed Care Covered services**

The following chart details the Member benefit package available to Parkland Community Health Plan Members. Please refer to the current Texas Medicaid Provider Procedures Manual, found at [www.tmhp.com](http://www.tmhp.com) at [www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx](http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx) for the listing of limitations and exclusions.

<table>
<thead>
<tr>
<th>Medicaid covered services</th>
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<tbody>
<tr>
<td><strong>Hospital – (Inpatient Services)</strong></td>
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| Hospital – (All Outpatient Services) | Hospital outpatient services include those services performed in the emergency room or clinic setting of a hospital.  
| | o This includes services provided to members in a hospital setting who are not confined for inpatient care.  
| | o Benefits include those diagnostic, therapeutic, rehabilitative, or palliative items or services deemed medically necessary and furnished by or under the direction of a physician to an outpatient by a hospital.  
| | o This does not include drugs or biologicals taken home by the member.  
| | o Supplies provided by a hospital supply room for use in physician’s offices in the treatment of patients are not reimbursable as outpatient services. |

| Inpatient Mental Health Services | o Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders.  
| | o Medically necessary inpatient admissions for adults and children to acute care hospitals for psychiatric conditions are a benefit of the Medicaid Program and are subject to UR requirements.  
| | Includes inpatient psychiatric services, up to annual limit, ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation.  
| | Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition. |

| Outpatient Mental Health Services | o Medically Necessary Services for the treatment of mental, emotional or chemical dependency disorders.  
| | Includes outpatient psychiatric services, up to annual limit, ordered under the provisions of the Texas Health and Safety Code, Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. We also provide benefits for Medicaid-covered medically necessary substance use disorder treatment services required as a condition of probation.  
| | Provider types include Psychiatrist, Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional |
Counselors (LPC), Licensed Marriage and Family Therapist (LMFT).
- Covered services are a benefit for clients suffering from a mental psychoneurotic or personality disorder when provided in the office, home, SNF, outpatient hospital, nursing home or other outpatient setting.
- Does not require a primary care provider referral.
- Psychological and Neuropsychological testing are covered for specific diagnoses.
- Psychological testing
- Neuropsychological test battery
- Additional services such as mental health screenings are covered under the Texas Health Steps-CCP program.
- Medicaid clients age 21 years and older may receive mental health counseling provided by a Licensed Psychologist, a Licensed Professional Counselor, a Licensed Clinical Social Worker, and a Licensed Marriage and Family Therapist.

### Inpatient Medical with Substance Abuse Treatment Services
- Admissions for chronic diagnoses such as MR, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition.
- Admissions for a single diagnosis of chemical dependency or abuse (alcohol, opioids, barbiturates, amphetamines) without an accompanying medical complication are not a benefit.

### Outpatient Substance Abuse Treatment Services
- Counseling for children and adolescents must be rendered in accordance with the DSHS Chemical Dependency Treatment Facility Licensure Standards and determined by a qualified credentialed counselor to be reasonable and necessary for a person who is chemically dependent.
- Counseling is available for children and adolescents age 13-17 years.
- Younger children (age 10-12 years) and young adults (age 18-20 years) may receive counseling when assessment criteria is met.
- Group counseling is limited to 135 hours per client, per calendar year.
- Individual counseling is limited to 26 hours per client per calendar year.
- Inpatients residing in a DSHS facility are not eligible for outpatient services.
- Does not require a Primary Care Provider referral.

### Federally Qualified Health Clinics (FQHCs)
- Members may seek professional medical services with any PCPH contracted FQHC.

### Rural Health Clinic Services (RHCs)
The following services are benefits of Rural Health Clinics under Texas Medicaid:
- Physician services
- Advanced nurse practitioner, clinical nurse specialist, certified nurse midwife, clinical social worker, or physician assistant services
| Services and supplies furnished as incidental to physician, nurse practitioner or physician assistant services |
| Visiting nurse services on part time or intermittent basis to home bound members in areas determined to have a shortage of home health agencies |
| Basic lab services essential to immediate diagnosis and treatment. |

**Professional Services**

- Services provided by or under the personal supervision of a physician within their scope of practice are covered when reasonable and medically necessary. This includes visits in the office, home, inpatient, or outpatient location under Medicaid guidelines further identified in the most current *Texas Medicaid Provider Procedures Manual*. Services provided by advanced nurse practitioners and behavioral health services that fall under general medicine, are included in this category.

**OB/GYN Services**

Females may seek Obstetrics and Gynecological Services from any participating network obstetrician/gynecologist (OB/Gyn) provider without a referral from their primary care provider. These care providers must perform services within the scope of their professional specialty practice. A properly credentialed OB/Gyn must practice in accordance with Section 4, Article 21.53D of the Texas Insurance Code and follow rules promulgated by the Texas Department of Insurance (TDI).

**Lab and X-Ray Services**

Medicaid benefits are provided for professional and technical services ordered by a qualified practitioner and provided under the personal supervision of a qualified practitioner in a setting other than a hospital (inpatient or outpatient). Medicaid does not reimburse baseline or screening laboratory studies. All laboratory testing sites providing services must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

**Podiatry Services**

Podiatrists eligible to be enrolled as Medicaid providers are authorized to perform procedures on the ankle or foot as approved by the Texas Legislature under their license as DPM and when such procedures would also be reimbursable to a physician (M.D. or D.O.) under Texas Medicaid. Podiatry services are only eligible for members under the age of 21. Some of these services may be provided by the Primary Care Provider.

**Vision Services**

Members under age 21 are limited to one examination with refractions for the purpose of obtaining eyewear once every state fiscal year (September 1 through August 31). For members under the age of 21, this can be exceeded where a school nurse or teacher requests the eye exam, or when determined to be medically necessary. Members age 21 and over are allowed one eye exam for refractive error once every 24 months. Eye examinations for aphakia and disease or injury to the eye are not subject to any of the limitations listed above. Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction which cannot be accomplished by glasses. Vision services provided through Superior Vision.
<table>
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<tr>
<th>Service</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Medicaid reimbursement is limited to basic life support ambulance services and air ambulance services (fixed wing and helicopter) and for instances of emergency and in non-emergency situations for the severely disabled only where use of an ambulance is the only appropriate means of transportation. Prior Authorization is needed for Air Transport and Non-emergent Ambulance Services</td>
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<tr>
<td><strong>Home Health Services</strong></td>
<td>The member must exhibit a condition where leaving their home is medically inadvisable. Benefits include fifty (50) home visits per year, selected medical supplies, durable medical equipment, and necessary repairs of this equipment. Visits beyond the 50-visit limit and additional services are allowed, if determined to be medically necessary and authorized prior to delivery.</td>
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<tr>
<td><strong>Hearing Aid Services</strong></td>
<td>o Persons under 21 years of age should be referred to the Department of State Health Services (DSHS) Program for Amplification for Children of Texas (PACT). o Hearing aid evaluation with combined audiometric assessment is available for Medicaid members over 21 years of age.</td>
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<tr>
<td><strong>Chiropractic Services</strong></td>
<td>The following chiropractic services are available only to Medicaid members under 21 years of age: o Texas Medicaid reimburses the treatment of spinal subluxation requiring manual manipulation of the spine. Benefits include up to 12 treatments per benefit period. A benefit period is defined as 12 consecutive months, beginning with the date the member receives the first covered chiropractic treatment.</td>
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<td><strong>Ambulatory Surgical Center (ASC) Services</strong></td>
<td>Covered services are minor surgical services that normally do not require hospital admission or inpatient stay. Only the procedures specified on the Centers for Medicare and Medicaid Services (CMS) approved list and selected Medicaid-only procedures are covered services provided in an ASC. Covered services are based on CMS Ambulatory Surgical Code groupings 1 through 9 and HHSC group 10.</td>
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<tr>
<td><strong>Certified Nurse Midwife (CNM) Services</strong></td>
<td>Covered services include those services that are normally outside of the maternity cycle to the extent that the midwives are authorized to perform under state law. CNMs may be reimbursed for primary care services provided to women throughout the life span and newborns for the first two (2) months of life, in addition to the maternity cycle (antepartum, intrapartum, and postpartum).</td>
</tr>
<tr>
<td><strong>Birthing Center</strong></td>
<td>A Birthing Center is: o A facility that is not administrative, organizational, or financial part of a hospital. o Organized and operated to provide maternity services to outpatients. o Complies with all applicable federal, state, and local laws and regulations.</td>
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<td><strong>Birthing Center services include:</strong></td>
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<tr>
<td>o Admission</td>
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<tr>
<td>o Labor – ante-partum care</td>
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<tr>
<td>o Delivery</td>
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<tr>
<td>o Postpartum care</td>
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<tr>
<td>o Total obstetrical care</td>
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<tr>
<th><strong>Maternity Clinic Services (MCS)</strong></th>
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<tr>
<td>A maternity service clinic is:</td>
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<tr>
<td>o A facility that is not an administrative, organizational, or financial part of a hospital.</td>
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<tr>
<td>o Organized and operated to provide maternity services to outpatients.</td>
</tr>
<tr>
<td>o Complies with all applicable federal, state, and local laws and regulations.</td>
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<tr>
<td>o Maternity clinic services are those medical services provided by registered nurses and determined with or by a licensed physician to be reasonable and medically necessary for the care of a pregnant adolescent or woman during her prenatal period and subsequent 60-day postpartum period. MCS benefits do not include deliveries. Covered clinic services include, but are not necessarily limited to, risk assessment, medical services, specific laboratory/screening services, case coordination/outreach, nutritional counseling, psychosocial counseling, family planning counseling, and patient education regarding maternal and child health.</td>
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<th><strong>Family Planning Services</strong></th>
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<tr>
<td>Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. Covered services must include, but are not limited to:</td>
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<tr>
<td>o Family planning annual visit</td>
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<td>o Comprehensive health history and physical examination</td>
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<td>o Follow-up office visit</td>
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<tr>
<td>o Member education and counseling to include preconception counseling</td>
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<tr>
<td>o Laboratory tests, prescriptions and contraceptive devices</td>
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<tr>
<td>o Pregnancy testing</td>
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<td>o Sterilization services (federal sterilization consent form required)</td>
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<td>o Federal law requires under §1915(b) waivers that members be allowed to retain the right to choose any Medicaid participating family planning provider.</td>
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<th><strong>Genetic Services</strong></th>
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<td>Genetic services are services to evaluate members regarding the possibility of a genetic disorder, diagnose such disorders, counsel members regarding such disorders, and follow members with known or suspected disorders. These services must be prescribed and performed by or under the supervision of a clinical geneticist (M.D. or D.O.). Covered services include genetic history and physical examination; genetic laboratory services and echography; genetic radiological services; genetic diagnostic procedures; and genetic counseling.</td>
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<th><strong>Transplant Services</strong></th>
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<tr>
<td>Transplant services include liver, heart, lung, heart/lung, bone marrow, cornea, peripheral stem cell, and kidney transplants. Coverage of organ transplants is limited to those services that are determined reasonable,</td>
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medically necessary, and standard medical procedures. Coverage does not include donor expenses or services. Coverage of each type of solid organ transplant is limited to a lifetime benefit of one initial transplant and one subsequent re-transplant due to rejection. Coverage for solid organ transplant includes procurement of the organ and services associated with the procurement. Benefits are not available for any experimental or investigational services, supplies, or procedures.

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<tr>
<th>Respiratory Care</th>
<th>Covered respiratory services include: oxygen, nebulizers, breathing treatments, medication for breathing treatments, and inhalers.</th>
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<tr>
<td>Adult Well-Check</td>
<td>Annual physical for adults age 21 and over once per calendar year.</td>
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<tr>
<td>Texas Health Steps Medical Checkups</td>
<td>Texas Health Steps is federally mandated and provides basic primary care medical screening services for all Medicaid members under 21 years of age. Medical checkups are covered for persons under 21 when delivered in accordance with the periodicity schedule. The periodicity schedule specifies the screening procedures recommended at each stage of the member’s life and identifies the time period, based on the member’s age, when screening services are covered.</td>
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<tr>
<td>Texas Health Steps-Comprehensive Care Program (CCP)</td>
<td>A federally mandated program that provides for any health care service that is medically necessary and appropriate for all members under 21 years of age, regardless of the limitations of Texas Medicaid.</td>
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| Renal Dialysis | Renal dialysis services are available for members with one of the following diagnosis:  
  - Acute renal disease – a renal disease with a relatively short course, the cause of which is usually correctable.  
  - Chronic renal disease (end-stage renal disease) – a stage of renal disease that requires continuing dialysis or kidney transplantation to maintain life or health. Medicaid coverage begins with the original onset date and continues until Medicare coverage begins. |
| Total Parenteral Nutrition (TPN)/Hyper-alimentation | TPN is a covered benefit for eligible members who require long-term support because of extensive bowel resection and/or severe advanced bowel disease in which the bowel cannot support nutrition. Covered services include but are not necessarily limited to:  
  - Parenteral hyperalimentation solutions and additives as ordered by member’s physician.  
  - Supplies and equipment including refrigeration, if necessary, that are required for the administration of prescribed solutions and additives.  
  - Education of the member and/or appropriate family members or support persons regarding the administration of TPN before administration initially begins. (Education must include the use and maintenance of required supplies and equipment.)  
  - Visits by a Registered Nurse appropriately trained in the administration of TPN.  
  - Customary and routine laboratory work required to monitor the member’s status.  
  - Enteral supplies and equipment, if medically necessary in conjunction with TPN. |
| **Physical Therapy** | Covered benefits include services to members suffering from an acute musculoskeletal and/or neuromusculoskeletal condition.  

Services provided as a result of an exacerbation of a chronic condition necessitating therapy to restore function may also be covered. The Physical Therapist must have the following on file for each member treated:  
  o A treatment plan established by the member’s physician and/or Physical Therapist that identifies diagnosis, modalities, frequency of treatment, expected duration of treatment, and anticipated outcomes.  
  o A written prescription by the member’s physician for the therapy services. |
| **Occupational Therapy** | Occupational therapy services are a covered benefit if performed in an inpatient or outpatient hospital setting and if it meets the following criteria:  
  o It is prescribed by the member’s physician and performed by a qualified occupational therapist.  
  o The therapy is prescribed for an acute condition with a diagnosis involving the muscular, skeletal, and neurological body systems.  
  o It is designed to improve or restore an individual’s ability to perform those tasks required for independent functioning.  
  o The physician expects the therapy to result in a significant practical improvement in the individual’s level of functioning within 30 days.  
  o For members less than 21 years of age, additional services must be provided under the Texas Health Steps – CCP Program if they are federally allowable, medically necessary, and appropriate. |
| **Speech and Language Therapy** | Speech and language evaluations are used to assess the therapeutic needs of patients having speech and/or language difficulties as a result of disease or trauma. Speech-language pathology therapy is allowed only for acute or sub-acute pathological or traumatic conditions of the head or neck that would affect speech production. To be covered, benefits must be:  
  o Prescribed by a physician and provided as an inpatient or outpatient hospital service.  
  o Prescribed by a physician and performed by or under his personal supervision.  
  o The therapy may be performed by either a speech-language pathologist or audiologist if they are either on staff at the hospital or under the personal supervision of the physician.  
For members less than 21 years of age, additional services must be provided under the Texas Health Steps – CCP Program if they are federally allowable, medically necessary, and appropriate. |
| **Pharmacy** | All members are entitled to a pharmacy benefit as described later in this manual. |
| **Durable Medical Equipment and** | All providers must obtain prior authorization for the member’s use of medical equipment and supplies over $1000. The member’s Primary |
| Supplies (DME) | Care Provider/Specialist must complete the Title XIX Home Health DME/Medical Supplies Physician Order Form (Title XIX form) prescribing the DME and/or supplies must be signed before requesting prior authorization for DME equipment and supplies. All signatures must be current, unaltered, original and handwritten.

Computerized or stamped signatures will not be accepted. The Title XIX form must include the procedure code and quantities for services requested. The Title XIX must be maintained by the DME provider and the prescribing physicians in the client’s medical record. The completed Title XIX form with the original signature must be maintained by the prescribing physician. |
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<tr>
<td>Emergency Services</td>
<td>Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and furnished within the United States by a provider qualified to furnish emergency services. Emergency services includes health care provided in an in-network or out-of-network hospital emergency department or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize medical conditions. Emergency services also include, but are not limited to, any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether or not an emergency exists.</td>
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<tr>
<td>Screening, Brief Intervention and Referral to Treatment Benefit (SBIRT)</td>
<td>Parkland Community Health Plan provides for SBIRT, a comprehensive approach to the delivery of early intervention and treatment services for Members with substance use disorders and those at risk of developing such disorders. Substance use screenings performed in hospital emergency departments can be covered and reimbursed and are encouraged as a means of early identification and resolution of substance use problems. To learn more about the screening, brief intervention and referral to treatment benefit (SBIRT) and how it can be provided and billed, please refer to the following TMHP links: Screening Brief intervention and Referral to Treatment Benefit for Texas Medicaid <a href="http://www.tmhp.com/Texas_Medicaid_Bulletin/228_M.pdf">http://www.tmhp.com/Texas_Medicaid_Bulletin/228_M.pdf</a></td>
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**Coordination with Non-Medicaid Managed Care Covered Services**

In addition to Parkland Community Health Plan’s coverage, STAR members are eligible for the services described below. Parkland Community Health and our network providers are expected to refer to and coordinate with these programs. These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM); list is not all-inclusive. Please see TMPPM for more information and an all-inclusive list.

- 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 (non-capitated service coordinated by LMHAs until August 31, 2014)
• DSHS Mental health rehabilitation (non-capitated until August 31, 2014)
• Case Management for Children and Pregnant Women
• Texas School Health and Related Services (SHARS)
• Department of Assistive and Rehabilitative Services (DARS) Blind Children’s Vocational Discovery and Development Program
• Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
• Health and Human Services Commission’s Medical Transportation Program (MTP) (Parkland Community Health will use HHSC's provided language - Attachment E.)
• HHSC 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
• 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

Provision of Specific Covered Services by all Participating Providers

Vaccinations. PCP’s that are enrolled providers in the Texas Vaccines for Children (TVFC) program should be provided with free vaccines for administration to Covered Persons from birth to age 18. You may enroll in the TVFC program by completing the form found at (first link):
http://www.dshs.state.tx.us/immunize/tvfc/default.shtm.

PCHP will not pay PCP’s for their own private stock of vaccines unless TVFC posts that it does not have vaccine stock available, which you may determine by visiting its web site:
http://www.dshs.state.tx.us/immunize/tvfc/default.shtm. You are responsible for checking the TVFC web site each day, as it may replenish stocks that were previously depleted.

If TVFC was out of vaccine on the date of your vaccination of a Covered Person, you may submit a claim for the vaccines with the U-1 modifier.

Tuberculosis. Participating Providers must contact the local TB control program regarding all Covered Persons with confirmed or suspected TB, and these Covered Persons must receive Directly Observed Therapy from the Provider. Participating Providers must report to DSHS and/or the local TB control program if a Covered Person poses a public health threat, which includes not taking the recommended drugs under the Provider’s observation or has a drug-resistant strain of TB.

Behavioral Health. PCP’s who provide behavioral health services should consult Appendix L for additional requirements.

PCP’s who provide behavioral health services must comply with the Psychotropic Medication Utilization Parameters for Foster Children found at:
http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp.

Continuity of Care

Pregnant Women

Parkland Community Health allows pregnant members past the 24th week of pregnancy to remain under the care
of their current OB/GYN through the Member’s postpartum checkup, even if the provider is out-of-network. She may select an OB/GYN within the network if she chooses to do so and if the provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

**Member moves out-of-service area**
Members who move out of the service area are responsible for obtaining a copy of their medical records from their current primary care provider to provide to their new primary care provider. Participating providers must furnish Members with copies of their medical records.

**Pre-existing condition**
Parkland Community Health does not have a pre-existing condition limitation. We are responsible for providing all covered services to each eligible Member beginning on the Member’s date of enrollment into the PCPH Medicaid or CHIP programs, regardless of any pre-existing conditions, prior diagnosis and/or receipt of any prior health services.

Coverage will be authorized for care being provided by nonparticipating providers to Members who are in an “active course of treatment” at the time of enrollment until the Member’s records, clinical information and care can be transferred to a network provider or until such time the Member is no longer enrolled in the plan. Coverage will be provided until the active course of treatment has been completed or 90 days, whichever is shorter.

Out-of-network care will be coordinated for Members who have been diagnosed and are receiving treatment for a terminal illness at the time of enrollment for up to nine months or until they are no longer enrolled in the plan.

“Active Course of Treatment” is defined as:
- A planned program of services rendered by a physician, behavioral health provider or DME provider
- Starts on the date a provider first renders a service to correct or treat the diagnosed condition, and
- Covers a defined number of services or period of treatment
- Allowing a pregnant woman to remain under the Member’s current Ob/Gyn care through the Member’s post-partum checkup even if the Ob/Gyn provider is, or becomes, out-of-network
- In order to provide transitional coverage for the nonparticipating provider, the following conditions must be met. The Member must:
  - Be enrolling as a new Member, and receiving ongoing treatment for a chronic or acute medical condition from a nonparticipating provider
  - Have initiated an “active course of treatment” prior to the initial enrollment date.
  - If services are received prior to the approval of transition of benefits, the services must be approved by the Medical Director in order for coverage to be extended at the new Plan level. PCPH’s Medical Management department will coordinate all necessary referrals, or any other authorizations so that the continuity of care is not disrupted.

In order for a nonparticipating provider to continue treating Plan Members during a transition period, the provider must agree to:
- Continue to provide the Member’s treatment and follow-up
- Accept Plan rates and/or fee schedules
- Share information regarding the treatment plan with the Plan
- Use the Plan network for any necessary referrals, lab work or hospitalizations.

Any exceptions will be reviewed on a case-by-case basis by the Medical Management staff in consultation with the Medical Director. All requests that do not meet the conditions for continuity of care will be forwarded to the Medical Director who will review the request on a priority basis.
Network limitations
We have an open provider network for all Parkland Community Health Medicaid and CHIP Members. We do limit a Member’s selection of a primary care provider or a referral to a specialist to the Parkland Community Health Medicaid and CHIP networks.

Medical Consent Requirements
Participating Providers must obtain informed consent from the Covered Person or his/her legally authorized representative prior to providing Covered Services. Please consult Appendix P for a sample form.

Out-of-Network Referrals
PCHP will arrange for Covered Services to be provided by out-of-network (non-contracted) Providers if a medically necessary Covered Service is not available from a Participating Provider. Please contact PCHP Medical Management if you believe an out-of-network referral is needed.

Member moves out-of-service area
Members who move out of the service area are responsible for obtaining a copy of their medical records from their current primary care provider to provide to their new primary care provider. Participating providers must furnish Members with copies of their medical records.

Pre-existing condition
Parkland Community Health does not have a pre-existing condition limitation. We are responsible for providing all covered services to each eligible Member beginning on the Member’s date of enrollment into the Parkland Community Health Plan’s Medicaid or CHIP programs, regardless of any pre-existing conditions, prior diagnosis and/or receipt of any prior health services.

Coverage will be authorized for care being provided by nonparticipating providers to Members who are in an “active course of treatment” at the time of enrollment until the Member’s records, clinical information and care can be transferred to a network provider or until such time the Member is no longer enrolled in the plan. Coverage will be provided until the active course of treatment has been completed or 90 days, whichever is shorter.

Emergency Transportation
When the Member’s condition is life-threatening and trained attendants must use special equipment, life support systems or close monitoring while in route to the nearest appropriate facility, the ambulance transport is deemed an emergency service.

Non-Emergency Medical Transportation
When a Member has a medical problem requiring treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transfer, the ambulance service requires prior authorization and coordination by Parkland Community Health.

Medical Transportation Program (MTP)

What is MTP?
MTP is a state administered program that provides Non-Emergency Medical Transportation (NEMT) services statewide for eligible Medicaid clients who have no other means of transportation to attend their covered healthcare appointments. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place you get Medicaid services.

What services are offered by MTP?
- Passes or tickets for transportation such as mass transit within and between cities or states, to include rail, bus, or commercial air
- Curb to curb service provided by taxi, wheelchair van, and other transportation vehicles
- Mileage reimbursement for a registered individual transportation participant (ITP) to a covered healthcare event. The ITP can be the responsible party, family member, friend, neighbor, or client.
- Meals and lodging allowance when treatment requires an overnight stay outside the county of residence
- Attendant services (a responsible adult who accompanies a minor or an attendant needed for mobility assistance or due to medical necessity, who accompanies the client to a healthcare service)
- Advanced funds to cover authorized transportation services prior to travel

Call MTP:
For more information about services offered by MTP, clients, advocates and providers can call the toll free line at 1-877-633-8747. In order to be transferred to the appropriate transportation provider, clients are asked to have either their Medicaid ID# or zip code available at the time of the call.

Member Rights and Responsibilities

Medicaid Managed Care Member Rights and Responsibilities

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, and fair hearings. That includes the right to:
   a) Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
b) Get a timely answer to your complaint.
c) Use the plan’s appeal process and be told how to use it.
d) Ask for a fair hearing from the state Medicaid program and get information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a) Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   b) Get medical care in a timely manner.
   c) Be able to get in and out of a health care provider’s office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d) Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e) Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else’s convenience, or is meant to force you to do something you do not want to do, or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

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.
CHIP Member Rights and Responsibilities

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 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 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 Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child’s health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.
Member Responsibilities
You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers 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 Perinatal Member Rights and Responsibilities

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 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.

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 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.

Member’s Right to Designate an OB/GYN
Parkland Community 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.

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

A referral to a specialist doctor within the network

Right to designate a Specialist as their Primary Care Provider
Members with disabilities, special health care needs, and or Chronic or Complex conditions, have the right to designate a specialist as their Primary Care Provider as long as the specialist agrees.

Right to select and have access to a Network ophthalmologist or therapeutic optometrist

Parkland Community Health/Provider coordination
Parkland Community Health will comply with the HHSC standards regarding care for persons with disabilities or chronic and complex conditions. We will provide information, education and training programs to Members, families, primary care providers, specialty physicians, and Community Agencies about the care and treatment available within Parkland Community Health for Members with disabilities or chronic or complex conditions. Specialists may function as a primary care provider for treatment of Members with chronic/complex conditions when approved by Parkland Community Health.

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of ethnicity, sex, age, religion, color, mental or physical disability, national origin, marital status, sexual orientation, or health status (including, but not limited to, chronic communicable diseases such as AIDS or HIV positive status). All
participating physicians and health care professionals may also have an obligation under the Federal Americans with Disabilities Act to provide physical access to their offices and reasonable accommodations for patients and employees with disabilities.

For each person with disabilities or chronic or complex conditions, the Primary Care Provider is required to develop a plan of care that meets the special preventive, primary acute care and specialty care needs of the Member. The plan must be based on:

- Health needs
- Specialist recommendations
- Periodic reassessment of the Member’s functional status and service delivery needs.

The Primary Care Provider must maintain an initial plan of care in the medical records of persons with disabilities or chronic or complex conditions and that plan must be updated as often as the Member’s needs change, but at least annually.

Parkland Community Health will ensure the members with special health care needs have adequate access to primary care providers and specialists skilled in treating persons with disabilities or chronic or complex conditions. Case Management services are available to assist members with special health care needs, their families and health care providers to facilitate access to care, continuity and coordination of services.

*Reading/grade level consideration*

Adhering to the policies and procedures set by HHSC, any literature that is published for informational use by Parkland Community Health Plan Members needs to be written at or below a 6th grade reading level and in English and Spanish. This will help to enhance the communication between the population, providers and Parkland Community Health Plan.

**All Participating Providers Access and Availability Requirements**

All Participating Providers must make Covered Services available and accessible to Covered Persons during normal business hours. All Participating Providers must provide telephone access to Covered Persons 24 hours a day, 7 days per week, regarding urgent or Emergency Care questions, and must meet the following standards:

<table>
<thead>
<tr>
<th>Service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>Routine Specialist care referrals must be provided within 30 calendar days of the referral</td>
</tr>
<tr>
<td>After-hours</td>
<td>Coverage must be available after normal posted business hours 7 days a week, 365 days a year</td>
</tr>
<tr>
<td>After-hours calls returned</td>
<td>≤30 minutes</td>
</tr>
<tr>
<td>In-office wait time</td>
<td>≤30 minutes</td>
</tr>
</tbody>
</table>

**PCP Access and Availability Requirements**

Each PCP shall provide covered services at their offices during normal business hours, and be accessible to Covered Persons 24 hours per day, 7 days per week. The PCP shall arrange for appropriate coverage with other Participating Providers if he/she is unavailable due to vacation, illness, or leave of absence. PCP’s must be accessible to Covered Persons 24 hours a day, 7 days a week, via one of the following methods: (1) office phone answered by answering service, with calls returned by PCP within 30 minutes; (2) office phone answered by recording in each language of the major population groups served by the PCP, with a recording giving the PCP’s or another Participating Provider’s direct number, which must be answered (referring the Covered Person to another recording is not acceptable); (3) office phone transferred to another location that answers and contacts the PCP or another designated Participating Provider, with the call to be returned within 30 minutes. PCP’s may
The following are the established PCHP access standards for PCPs:

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standard</th>
</tr>
</thead>
</table>
| **New Covered Person**      | New Covered Persons should be offered appointments as soon as possible after enrollment but in no case later than within:  
   - 14 calendar days of enrollment for newborns  
   - 60 calendar days of enrollment for all other Covered Persons |
|                             | **Preventive Care**  
   - Newborns  
   - Children < 21  
   - Adult ≥ 21  
   - For CHIP – Physicals/Well-child checkups for  
     As soon as possible for Covered Persons who are due or overdue for services in accordance the AAP guidelines  
   - For Medicaid – Covered Persons under the age of 21, per THSteps Periodicity Schedule, but in no case later than 60 days from date of request.  
     For all newly enrolled Covered Persons (Medicaid and CHIP), appointments must be offered within  
     - 14 days of enrollment for newborns;  
     - 60 days for all others. |
| Routine Primary Care        | Within 14 calendar days of request. |
| Urgent Care                 | Within 24 hours of request |
| Emergency Care              | Upon presentation |
| Prenatal Care               | Within 14 calendar days of request, except for high risk pregnancies or new Covered Persons in the third trimester for whom an appointment must be offered within 5 calendar days, or immediately, if an emergency exists. |
| Initial Behavioral Health Care | Within 14 calendar days of request |
Specialty Care Providers Access and Availability Requirements

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Medical Care</td>
<td>Within 14 calendar days of request</td>
</tr>
<tr>
<td>Urgent Medical Care</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Upon presentation</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Within 14 calendar days of request, except for high risk pregnancies or</td>
</tr>
<tr>
<td></td>
<td>Covered Persons in the third trimester for whom an appointment must be</td>
</tr>
<tr>
<td></td>
<td>offered within 5 calendar days, or immediately, if an emergency exists</td>
</tr>
<tr>
<td>Initial Behavioral Health Care</td>
<td>Within 14 calendar days of request</td>
</tr>
<tr>
<td>Routine Behavioral Health Care</td>
<td>Within 14 calendar days of request</td>
</tr>
</tbody>
</table>

Specialists shall arrange for appropriate coverage by a participating provider when unavailable due to vacation, illness or leave of absence. As a participating PCHP physician, you must be accessible to Covered Persons 24 hours a day, 7 days a week. The following are acceptable and unacceptable phone arrangements for contacting physicians after normal business hours.

CHIP Perinatal Provider Access and Availability Requirements.

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Routine care</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>Within 2 weeks of request</td>
</tr>
<tr>
<td>High risk pregnancy or new covered person visits</td>
<td>Within 5 days</td>
</tr>
</tbody>
</table>

Other Participating Provider Duties

Compliance with State and Federal Laws.
Participating Providers must comply with the currently effective version of all state and federal rules, including but not limited to the following:

1. Environmental protection laws:
   a) Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;
   c) Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, “Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans”);
   d) State Clean Air Implementation Plan (42 U.S.C. §740 et seq.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and

2. State and federal anti-discrimination laws:
a) Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15;
b) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
c) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
d) Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
e) Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
g) Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16;
h) The HHS agency’s administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

3. The Immigration and Nationality Act (8 U.S.C. § 1101 et seq.) and all subsequent immigration laws and amendments;
4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and
5. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 et seq.

Updating contact information
Network providers must inform Parkland Community Health Plan and HHSC’s administrative services contractor of any changes to your address, telephone number, group affiliation and/or any other relevant contact information for the purposes of:
• The production of an accurate provider directory
• The support of an accurate online provider lookup function
• The ability to contact you or your office with requests for additional information for prior authorization or other medical purposes, or on behalf of a member’s PCP
• The guarantee of accurate claim payment delivery information

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 HHSC, 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 HHSC;
• Adult day care centers; or
• Licensed adult foster care providers

Contact HHSC at 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 HHSC;
• 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, HHSC, 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, HHSC, 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.

Justification regarding Out-of-Network referrals
If a required service is not available within the Parkland Community Health Medicaid or CHIP network, the Member’s primary care provider may request an out-of-network referral. However, the primary care provider must obtain authorization from the Parkland Community Health Medical Management Department.

The steps for an out-of-network referral are as follows:
1. The Member’s Primary Care Provider must complete a referral request and specify the services required of the out-of-network provider including the rationale for requesting out-of-network services.
2. The Primary Care Provider can call Medical Management or fax the referral form and all pertinent clinical information to the Parkland Community Health Medical Management Department by calling 1-800-306-8612 or faxing 1800-240-0410 to obtain authorization.
3. The Primary Care Provider will provide authorization information to the specialist.

The out-of-network referral is valid for 90 days for a maximum of three visits unless otherwise authorized by the Medical Management Department. A new authorization must be obtained if the original authorization is over 60 days old or if more than two visits are required, unless additional visits have been authorized by the medical management department.
Compliance with PCHP Requirements
Notify PCHP and HHSC of changes to contact information. Participating Providers must notify PCHP and HHSC of changes to their address, telephone number, group affiliation, etc.

Maintain adequate insurance or approved substitute. Participating Providers must maintain Professional Liability Insurance of $100,000 per occurrence and $300,000 in the aggregate or, if higher, the limits required by the Facility(ies) at which they have admitting privileges, or substitute coverage approved by specific state law.

Maintain adequate medical and claims/billing records and give PCHP access to them. Participating Providers must maintain contemporaneous medical records that reflect all aspects of patient care, including ancillary services. Medical records must be sufficiently detailed, organized and comprehensive to permit PCHP or the State Programs to quickly determine and understand the care provided and be able to compare the care provided with the claims submitted.

Participating Providers must likewise maintain contemporaneous claims and billing/accounting records that reflect claims submitted (including copies of the claim form), when submitted, Member Responsibility Amounts collected, date and amount of payments from PCHP, and all other claims/billing/accounting information to permit

Participating Providers must give PCHP access to or copies of medical and claims/billing records, whichever PCHP’s chooses, free of charge.

Confidentiality and Consent to Disclosure of Protected Health Information
Participating Providers must treat all information obtained through the performance of the Covered Services as confidential information to the extent required by law, including but not limited to HIPAA. This includes, but is not limited to, information relating to applicants or recipients of State Programs.

Participating Providers may not use information obtained through the performance of Covered Services in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Participating Provider’s Agreement with PCHP.

Before disclosing confidential information, Participating Providers must give Covered Persons a Notice of Privacy Practices and obtain their Authorization for Release. These documents may be found at Appendix P.

Provide Covered Person’s Medical Records
Participating Providers must furnish Covered Persons with a copy of their medical records free of charge.

Patient Advocacy
Participating Providers should be advocates for their patients and must be familiar with the Covered Person Rights and Responsibilities described in Appendices F and J.

Family Planning (Medicaid Only)
Participating Providers must provide counseling and education about contraceptive and/or family planning services if the Covered Person request this information. Parental consent may not be required. Participating Providers must comply with the laws governing Covered Persons’ (including minors’) confidentiality when providing information on family planning and/or contraceptive services.

Covered Person Right to Self Determination of Medical Care
Participating Providers must comply with a Covered Person’s or his/her Authorized Representative’s wishes
with respect to what and how much (if any) medical care to receive. Links to specific policies on and forms for Advanced Directives (e.g., “do not resuscitate” orders or directives regarding provision of specified services during terminal illnesses) and for Durable Powers of Attorney are found at Appendix Q.

**Covered Person Disenrollment**
Participating Providers are prohibited from taking any retaliatory action against Covered Persons who have requested to be or who have been disenrolled from any State Program or from PCHP. Participating Providers must provide to PCHP all documentation requested by PCHP in connection with a Covered Person’s request to disenroll from a PCHP program, and HHSC will make a final decision.

**Cultural Sensitivity/ Comprehension**
Texas Medicaid & CHIP recipients will vary in language and culture (e.g., customs, religion, backgrounds). Participating Providers must provide Covered Services to all Covered Persons in a manner that recognizes and respects the worth and dignity of each Covered Person, including providing simplified explanations for those with limited comprehension. For additional information, there is a free online provider education course on cultural competency at [www.txhealthsteps.com](http://www.txhealthsteps.com). Note: The material included in the module is applicable to all Covered Persons, not just those receiving Medicaid or THSteps services.

**Providers that Offer Delivery of Products that are Covered Services**
Participating Providers that offer delivery of covered products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products must reduce, cancel or stop delivery if the Covered Person or his/her authorized representative submits an oral or written request for the reduction or cancellation. The Participating Provider must maintain records documenting the request.

**Comprehensive Care Program**
PCP’s should be aware of the Comprehensive Care Program (CCP) provides additional benefits for certain very ill Medicaid recipients under age 21. Services are available under CCP for Covered Persons ineligible for Texas Medicaid home health services and for some services not provided under home health coverage. For more information, consult the TMPPM.

**Pregnant Teens**
Participating Providers must notify PCHP’s Case Management when a CHIP patient is pregnant. Please see Appendix X for further information on pregnant teens.

**Physician Selection/Primary Care Provider Changes**
Covered Persons may choose and change their own PCP’s. If a Covered Person fails to select a PCP, PCHP will do so because it is important that each Covered Person have a medical home and PCP to coordinate their care. A monthly listing of Covered Persons assigned to the PCP is available at [www.parklandhmo.com](http://www.parklandhmo.com), in the provider portal section.

**Termination of Physician/Patient Relationship**
Participating Providers may request that PCHP transfer a Covered Person’s assignment to another Participating Provider in the event of material breakdown in the physician/patient relationship.

**Covered Services**

**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.

<table>
<thead>
<tr>
<th>Coverage in prenatal period</th>
<th>Coverage at delivery</th>
<th>Coverage for newborn</th>
<th>Breast pump coverage &amp; billing</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR</td>
<td>STAR</td>
<td>STAR</td>
<td>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.</td>
</tr>
<tr>
<td>CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*</td>
<td>Emergency Medicaid</td>
<td>Medicaid fee-for-service (FFS) or STAR**</td>
<td>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.</td>
</tr>
<tr>
<td>CHIP Perinatal, with income above 198% FPL</td>
<td>CHIP Perinatal</td>
<td>CHIP Perinatal</td>
<td>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.</td>
</tr>
<tr>
<td>STAR Kids</td>
<td>STAR Kids</td>
<td>Medicaid FFS or STAR**</td>
<td>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.</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>STAR+ PLUS</td>
<td>Medicaid FFS or STAR**</td>
<td>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.</td>
</tr>
<tr>
<td>STAR Health</td>
<td>STAR Health</td>
<td>STAR Health</td>
<td>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.</td>
</tr>
</tbody>
</table>

*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.
General Listing of Covered Services and Exclusions
All Covered Services must be Medically Necessary as defined by the State Programs (consult the TMPPM for the current definition). A link to a list of Covered Services and exclusions from and limitations to coverage is found at Appendix F (CHIP/CHIP Perinate) and Appendix J (Medicaid).

CHIP Member Prescriptions
CHIP members are eligible to receive and unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

Emergency and Urgent Care Covered Services
Information about Urgent and Emergency Services, including information about this care outside of the PCHP Service Area, is found at Appendix T.

Texas Health Steps Services (Medicaid Only)
THSteps is a children's benefit under Texas Medicaid which provides medical and dental preventative care and treatment to Medicaid clients from birth to 20 years of age. More information about the THSteps program and its requirements is found at Appendix M.

For more information about THSteps, please refer to the Texas Health Steps website at http://www.dshs.state.tx.us/thsteps/ or the Texas Medicaid Provider Procedures Manual (TMPPM) at www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx.

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.

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.
Attention Deficit Hyperactivity Disorder (ADHD)
Treatment of children diagnosed with ADHD, including follow-up care for children who are prescribed ADHD medication, is covered as outpatient mental health services. Reimbursement for these services will be determined according to the Provider Agreement. Covered benefits are as outlined in the TMPPM. Providers should complete follow-up of members receiving these medications including a minimum of a one-month follow-up to first fill of the prescription and two subsequent OV during the next 9 months.

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.

Behavioral Health Benefits
Information about behavioral health benefits and the behavioral health vendor are found at Appendices A and L.

Behavioral Health Scope of Services
Beacon will coordinate the behavioral health services, which include, but are not limited to, the services listed in the CHIP and Medicaid Managed Care Covered Services section of the Beacon Provider Manual. These services include acute, diversionary, and outpatient services. For more detail on the behavioral health benefits, please contact us at 1-800-945-4644.

Beacon will work with PCHP and other participating behavioral health care practitioners, primary care providers (PCPs), medical/surgical specialists, organizational providers and other community and state resources to develop relevant primary and secondary prevention programs for behavioral health. These programs may include:

- Educational programs to promote prevention of substance use disorders
- Parenting skills training
- Developmental screening for children
- ADHD screening
- Postpartum depression screening
- Depression screening in adults

Member access to behavioral health services

Self-Referral
Eligible members may self-refer to a participating behavioral specialist or participating behavioral health facility. Referral assistance is available 24 hours per day, 7 days per week by calling the Parkland Community Health Texas hotline. Members may also use the provider search tool on the Parkland Community Health Texas website at www.parklandhmo.com. Members do not need a referral from their PCP for mental health or substance use disorder services.

Referral Information
Members must obtain care from Beacon Health a participating provider to obtain behavioral health services. Contact us online at [www.beaconhealthoptions.com](http://www.beaconhealthoptions.com) or by phone at 1-800-888-3944. Providers must use DSM-IV multi-axial classifications and other assessment instruments or outcome measures required by HHSC when assessing Members for behavioral health services.

**Focus studies and utilization reporting requirements**

PCHP, along with Beacon, has integrated behavioral health into its Quality Assessment and Performance Improvement (QAPI) Program to ensure a systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of behavioral health services provided to PCHP members. A special focus of these activities is the improvement of physical health outcomes resulting from behavioral health integration into the member’s overall care. PCHP and Beacon will routinely monitor claims, encounters, referrals and other data for patterns of potential over- and under-utilization, and target areas where opportunities to promote efficient and effective use of services exist.

**Members Discharged from Inpatient Psychiatric Facilities**

Beacon requires that all members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Beacon providers will follow up with Medicaid members and attempt to reschedule missed appointments.

**Consent for disclosure of information**

Members are encouraged to share information about their other health care providers during their initial visit. This will promote communication and collaboration between their health care providers, such as primary care, behavioral health (mental health/substance use disorder), and long-term services and supports. The member’s consent is required to release verbal and/or written information from their health record. Providers may use the “Authorization to Release Protected Health Information Form,” which is available on the Parkland Community Health Texas website.

**Coordination of Care**

Behavioral health service providers are expected to communicate at least quarterly and more frequently if necessary, regarding the care provided to each member with other behavioral health service providers and PCP's. Behavioral health service providers are required to refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment. Copies of prior authorization/referral forms and other relevant communication between providers should be maintained in both providers' files for the member. Coordination of care is vital to ensuring members receive appropriate and timely care. Compliance with this coordination is reviewed closely during site visits for credentialing and recredentialing, as well as during quality improvement and utilization management reviews.

**Coordination between Physical and Behavioral Health**

Beacon is committed to coordinating medical and behavioral care for members who will be appropriately screened, evaluated, treated and/or referred for physical health, behavioral health or substance use, dual or multiple diagnoses, mental retardation, or developmental disabilities. Beacon will designate behavioral health liaison personnel to facilitate coordination of care and case management efforts.
Coordination with the Local Behavioral Health Authority

Beacon will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities 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. Beacon will comply with additional behavioral health services requirements relating to coordination with the LMHA and care for special populations. Covered services will be provided to members with Severe and Persistent Mental Illness (SPMI)/Severe Emotional Disturbance (SED) when medically necessary, whether or not they are receiving targeted case management or rehabilitative services through the LMHA.

Coordination with Texas Department of Family and Protective Services (DFPS)

Providers must coordinate with DFPS and foster parents for the care of a child who is receiving services from, or has been placed in, the conservatorship of DFPS and must respond to requests from DFPS including:
- Providing medical records
- Recognition of abuse and neglect, and appropriate referral to DFPS
- Schedule appointments within 14 days unless requested earlier by DFPS

Coordination with Non-CHIP and Non-Medicaid Managed Care Covered Services

There are other services that are available to PCHP/Beacon members, which may not be accessible through the PCHP/Beacon network. The services listed below are available and accessible to members outside of the PCHP/Beacon network.

- Primary and preventative dental services
- Texas agency-administered programs and case management services
- Essential public health services
- School Health and Related Services (SHARS)
- Early childhood intervention case management/services coordination
- Case management for children and pregnant women
- Texas Health Steps medical case management
- Texas Commission for the Blind case management
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Medical transportation services available through the Texas Health and Human Services Commission for STAR members only

SB-58 Behavioral Health Changes

*Effective September 1, 2014*

Targeted case management (TCM) and mental health rehabilitative services (MH rehab) will now be the responsibility of managed care plans. Local Mental Health Authorities (LMHA) and applicable behavioral health practitioners will be required to coordinate care with Beacon, and these claims will be processed by Beacon. This benefit will be available only to Medicaid STAR members who are assessed to have:
- A severe and persistent mental illness, such as schizophrenia, major depression, bipolar disorder or another severely disabling mental disorder
- Children and adolescents ages 3 through 20 years with a diagnosis of a mental illness or who exhibit a serious emotional disturbance
Providers must attest to Beacon that they have the ability to provide, either directly or through sub-contract, Members with the full array of MHR and TCM services as outlined in the Dept. of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG).

Adults Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths Assessment (CANS) must be used to evaluate Medicaid patients for services as required by the Uniform Managed Care Manual (UMCM) Chapter 15.1. Providers can use the DSHS Clinical Management for Behavioral Health Services (CMBHS) Web-based system. However, they must sign a user agreement with DSHS prior to completing an assessment in the system.

Providers must also complete the Mental Health Rehab and/or Targeted Case Management Request forms and submit them to Beacon. All authorizations and claims processing must be submitted to Beacon. Authorization forms can be faxed to 512.329.6010.

The rendering provider must be indicated on the CMS 1500 form, as usual, in box 24 I/J. Any non-licensed individuals who will be clinically supervised by a licensed professional will not need to submit rendering provider information and box 24 I/J can be left blank.

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<thead>
<tr>
<th>Modifiers Accepted by Beacon</th>
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<tbody>
<tr>
<td>ET</td>
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<td>HA</td>
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<td>HQ</td>
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Beacon is not required to credential providers of TCM and MH rehab who are not licensed provider types enrolled in Medicaid.

**Adult Day Program**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Service</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
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</thead>
<tbody>
<tr>
<td>H2012</td>
<td>Adult day program for acute needs</td>
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**Medication Training and Support**

<table>
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<tr>
<th>Procedure Code</th>
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<th>Modifier 2</th>
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<tbody>
<tr>
<td>H0034</td>
<td>Individual services for adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H0034</td>
<td>Group services for adult</td>
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### Medication Training and Support

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<th>Procedure Code</th>
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<tbody>
<tr>
<td>H0034</td>
<td>Individual services for hild/adolescent</td>
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<td>Group services for child/adolescent</td>
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### Crisis Intervention

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<thead>
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<th>Procedure Code</th>
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<tbody>
<tr>
<td>H2011</td>
<td>Adult services</td>
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<tr>
<td>H2011</td>
<td>Child and adolescent services</td>
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### Skills Training and Development

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Service</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
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</thead>
<tbody>
<tr>
<td>H2014</td>
<td>Individual services for adult</td>
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<td>H2014</td>
<td>Group services for adult</td>
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<tr>
<td>H2014</td>
<td>Individual services for child/adolescent</td>
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<td>group services for child/adolescent</td>
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### Psychosocial Rehabilitative Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
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<tr>
<td>H2017</td>
<td>Individual services</td>
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<td>H2017</td>
<td>Group services</td>
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<td>H2017</td>
<td>Group services rendered by RN</td>
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<td>TD</td>
</tr>
<tr>
<td>H2017</td>
<td>Individual crisis services</td>
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Mental Health Targeted Case Management

<table>
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<th>Procedure Code</th>
<th>Service</th>
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<th>Modifier 2</th>
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<tbody>
<tr>
<td>T1017</td>
<td>Routine MH targeted case management (adult)</td>
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<tr>
<td>T1017</td>
<td>Routine MH targeted case management (child)</td>
<td>TF</td>
<td>HA</td>
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<tr>
<td>T1017</td>
<td>Intensive case management (child and adolescent)</td>
<td>TG</td>
<td>HA</td>
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</table>

Intensive case management and routine case management are benefits for clients who are 20 years of age and younger. Intensive case management and routine case management are not payable on the same day. Routine case management is a benefit for clients who are 21 years of age and older. Providers must use procedure code T1017 and the appropriate modifier for MHTCM.

**Definition of severe and persistent mental illness (SPMI)**
SPMI includes a diagnosis of bipolar disorder, major depression, schizophrenia, or other behavioral health disorder for persons 18 and older, as defined by the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, accompanied by:
1. Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or
2. Impaired emotional or behavioral functioning that interferes substantially with the Member’s capacity to remain in the community without supportive treatment or services.

**Definition of severe emotional disturbance (SED)**
SED describes psychiatric disorders in children and adolescents, up to age 18, which cause severe disturbances in behavior, thinking and feeling. This includes a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the latest edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

**Provider Requirements**
As a provider¹ contracted to provide services to Medicare Advantage and/or Medicaid members under the PSA, the provider shall:
- Not distribute any marketing materials, as such term is defined in 42 CFR Section 422.2260, to Medicare Advantage members or prospective Medicare Advantage members unless such materials have received the prior written approval of: (a) Beacon and, if required, (b) CMS and/or the applicable Plan. The provider shall further not undertake any activity inconsistent with CMS marketing guidelines as in effect from time to time. [42 CFR 422.2260, et seq.]

¹ Providers contracted to provide services to Medicaid members who are not also covered by Medicare shall comply with the requirements set forth above to the extent that a state has adopted the requirements as part of its Medicaid program.
- Ensure that covered services are provided in a culturally competent manner. [42 CFR 422.112(a)(8)]
- Maintain procedures to inform Medicare Advantage members of follow-up care and, if applicable, provide training in self-care as necessary. [42 CFR 422.112(b)(5)]
- Document in a prominent place in the medical record of Medicare Advantage members if the member has executed an advance directive. [42 CFR 422.128(b)(1)(ii)(e)]
- Provide continuation of care to Medicare Advantage members in a manner and according to time frames set forth in the PSA, and if CMS imposes additional continuation of care criteria or time frames applicable to Medicare Advantage members, the provider shall comply with such additional CMS requirements as well as any requirements set forth in the PSA. [42 CFR 422.504(g)(2)(i) and (ii) and 42 CFR 422.504(g)(3)]
- In the event that the provider provides influenza and/or pneumococcal vaccines to patients, for any Medicare Advantage member, the provider shall provide such vaccines to Medicare Advantage members with no cost sharing. [42 CFR 422.100(g)(1) and (2)]
- Not discriminate against any Medicare Advantage member based upon the member’s health status. [42 CFR 422.110(a)]
- Be accessible to Medicare Advantage members 24 hours per day, seven days per week when medically necessary. [42 CFR 422.112(a)(7)]
- Comply, as set forth in the PSA, with all applicable federal laws, including but not limited to, those federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse such as the False Claims Act and the federal anti-kickback statute. [42 CFR 422.504(h)(1)]
- Agree that Beacon and/or the applicable plan may notify all impacted Medicare Advantage members of the termination of the provider’s participation in Beacon or the plan’s provider network, as applicable. [42 CFR 422.111(e)]
- Disclose to CMS and to Beacon or the plan, quality and performance indicators, including disenrollment rates, member satisfaction rates and health outcomes to enable the plan to satisfy applicable CMS reporting requirements. [42 CFR 422.504(f)(2)(iv)(A), (B), and (C)]
- Safeguard the privacy of any information that identifies a particular Member and maintain records in an accurate and timely manner. [42 CFR 422.118]
- Maintain and distribute to all employees and staff written standards of conduct that clearly state the provider’s commitment to comply with all applicable statutory, regulatory, and Medicare program requirements (Code of Conduct) and require all employees and staff to certify that they have read, understand, and agree to comply with the standards. Require employees and staff to certify that in administering or delivering Medicare benefits, they are free of any conflict of interest as set forth in the provider’s conflict of interest policy. [42 CFR 422.503(b)(4)(vi)(A), (E), and (F)] (Beacon may request annual certifications and documentation necessary to satisfy a regulatory audit of Beacon or the plan.)
- Comply with the requirements of the compliance programs (which include measures to prevent, detect, and correct Medicare non-compliance as well as measures to prevent, detect, and correct fraud, waste, and abuse) of plans that are Part C and Part D sponsors. Comply with and participate in, and require employees and staff to comply with and participate in, training and education given as part of the plan’s compliance plan to detect, correct, and prevent fraud, waste, and abuse. [42 C.F.R. §422.503 and 42 C.F.R. §423.504]
- Monitor employees and staff on a monthly basis against the List of Excluded Individuals and Entities posted by the Office of the Inspector General of the Department of Health and Human Services and any applicable State Office of the Inspector General on their respective websites, the Excluded Parties List System, and the System for Award Management. [42 CFR 422.503(b)(4)(vi)(F)]
- Provide Beacon with written attestations documenting satisfaction of the requirements set forth above specific to the provider’s Code of Conduct, compliance with the plan’s fraud, waste, and abuse training, and the performance of monthly monitoring of employees and staff. [42 CFR 422.503(b)(4)(vi)(A), (C), and (D)]
The provider further acknowledges that:

- Beacon and/or plans may offer benefits in a continuation area for the members who move permanently out of the plan’s service area. [42 CFR 422.54(b)]
- Beacon and/or plans will make timely and reasonable payment to, or on behalf of, a Medicare Advantage member for emergency or urgently needed services obtained by a member from a non-contracted provider or supplier to the extent provided by 42 CFR 422.100(b)(1)(ii).
- Though it may not be applicable to the services provided by the provider, the plan will make available, through direct access and/or without member cost share as, and to the extent required by CMS, out-of-area renal dialysis services and certain other services, such as mammography, women’s preventive services and certain vaccines. [42 CFR 422.100(b)(1)(iv), 42 CFR 422.100(g)(1) and (2)]

**HHSC-established qualification and supervisory protocols**

Mental Health Rehabilitative Services, as well as any limitations to these services, are described in the most current Texas Medicaid Provider Procedures Manual (TMPPM), which includes the Behavioral Health, Rehabilitation, and Case Management Services Handbook. Mental Health Rehabilitative Services must be billed using appropriate procedure codes and modifiers as listed in the TMPPM. Parkland Community Health is not responsible for providing Criminal Justice Agency funded procedure codes with modifier HZ because these services are excluded from the capitation.

**Quality Management**

*What is quality?*

Quality health care means doing the right thing, at the right time, in the right way, for the right person – and having the best possible results. Although we would like to think that every health plan, doctor, hospital, and other provider gives high quality care, this is not always so. Quality varies for many reasons. The Quality Improvement Program is tailored to the unique needs of the membership, in terms of age groups, disease categories and special risk status. Parkland Community Health complies with all State and federal requirements regarding Quality Improvement (QI). The QAPI Program is overseen by the governing board and committees whose membership broadly represents the network of participating providers and Members.

Clinical Practice Guidelines summarize evidence-based management and treatment options for specific diseases or conditions. They are based on scientific clinical and expert consensus information from nationally recognized sources and organizations, national disease associations, and peer-reviewed, published literature.

Practice guidelines are developed nationally and adopted locally through Medical Advisory Committees that include practicing physicians who participate in the Plan. This group also suggests topics for guideline development, based on relevance to enrolled membership, with selection of high volume, high risk, problem prone conditions as the first priority.

The Parkland Community Health Medicaid and CHIP programs have adopted the following guidelines:

- Addiction – American Society of Addiction Medicine Behavioral Health Checklist for ASAM Adult Patient Placement Criteria-Second Edition Revised. This guideline can be found online at: http://www.asam.org/
- Asthma: National Heart Lung and Blood Institute (NHLBI) Full text and a summary report of the guidelines, along with supporting material and tools can be found at https://www.nhlbi.nih.gov/guidelines/asthma/
- Attention-Deficit/Hyperactivity Disorder - American Academy of Pediatrics (AAP): Diagnosis,
Vision Benefits
Information about vision benefits can be obtained by calling the vision benefits vendor number listed in the “Important Contact Information” section of this Provider Manual. Covered Persons are entitled to access Participating Provider ophthalmologists or optometrists without a PCP referral.

Member’s right to obtain medication from any Network pharmacy
All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies will not be covered.

Pharmacy Providers
Pharmacy must submit claims using Electronic eligibility verification, e.g., NCPDP E1 Transaction

Added Benefits
“Spell of illness” limitation removed
Members of the Parkland Community Health Medicaid program members are not limited by the “spell of illness” limitation, which is specified in the current Texas Medicaid Provider Procedures Manual. The annual limit of $200,000 on inpatient services does not apply for Medicaid Members.

Value Added Services * certain restrictions may apply

24 Hours Nurse line *
You can talk to a nurse 24 hours a day, 7 days a week. The nurse can help you with questions or help you decide what to do about your health needs. Call your doctor first with any questions or concerns about your health care needs. Please call the toll-free nurse line number on your ID card.

Sport Physical *
Members ages 3 to 19 can get one sports physical exam per school year. This is a different exam from the Well-Child Exam.

Extra Help for Pregnant Women *
We provide services to help women stay healthy at all times, especially during pregnancy. Members can access prenatal classes at no cost to you by calling the Parkland Community Health Member Services hotlines at 1-888-672-2277 (Parkland HEALTH/first Medicaid) to get a list of locations for the classes at Parkland Health & Hospital System. Members electing to go elsewhere for prenatal classes at her own expense can obtain a list of health plan approved prenatal classes by calling the Parkland Community Health Member Services hotline. Our programs will help you stay healthy throughout your pregnancy and get the health care services you need.

Health Play and Exercise *
Parkland KIDS/first members ages 6 to 18 can join the Boys and Girls Club of Greater Dallas.

Car Seat *
Parkland KIDS/first members can receive a car seat and gift bag for pregnant members. Pregnant Members will need to complete 8 prenatal visits and deliver while a Parkland Member.

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: Pharmacy transmits claim as they would any other prescription and will receive a message that a prior authorization is required. The pharmacy will also receive a message to dispense a 72-hour emergency prescription supply if provider is not available for a prior authorization. Call 1-844-787-5437 for more information about the 72-hour emergency prescription supply policy.

Provider Portal
Providers can call Provider Services at 1-844-787-5437 to request access to the Parkland Provider Web Portal which is found at https://www.parklandhmo.com/login

Pregnant teens
Providers should contact Parkland Community Health Plan immediately when they have identified a CHIP member who is pregnant by calling Member Services at 1-888-814-2352.

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.

Role of 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.

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.

Emergency Dental Services

Medicaid Emergency Dental Services:
Parkland Community 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:**
Parkland Community 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.

**Non-Emergency Dental Services**

**Medicaid Non-emergency Dental Services:**

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

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

**Billing guidelines**
• In conjunction with a Texas Health Steps medical checkup, utilize CPT code 99429 with U5 modifier.
• Must be billed with one of the following medical checkup codes:
  — 99381
  — 99382
  — 99391
  — 99392
• Reimbursed at $34.16 in addition to the Texas Health Steps checkup reimbursement.

**Federally qualified health centers and Rural Health Centers do not receive additional encounter**

• Reimbursement. 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.

**Documentation Criteria**
• Must document all components of OEFV on the documentation form provided during the training.
• Keep record of the referral to a dental home.
• 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 and document Member’s Main Dental Home choice in the Members’ file.
• Texas Health Steps providers must assist Members with establishing a Main Dental Home (see Attachment D) and document Member’s Main Dental Home choice in the Members’ file.

**CHIP Non-emergency Dental Services:**
Parkland Community 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.

Parkland Community Health is **responsible** for paying for treatment and devices for craniofacial anomalies.

**Durable Medical Equipment and Other Products Normally Found in a Pharmacy**
Parkland Community 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), Parkland Community 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.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20 call **1-844-787-5437** for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

**Verifying Member Medicaid Eligibility**
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](http://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](http://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.

Verify Member eligibility or authorizations for service

All Members have a Parkland Community Health Medicaid or CHIP ID card. Eligibility should be verified prior to rendering services via:

- Utilizing our website at [www.parklandhmo.com](http://www.parklandhmo.com)
- Contacting Parkland Community Health at **1-888-672-2277** (HEALTH first); **1-888-814-2352** (KIDS first).  
- All Members must be referred by their Primary Care Provider for specialist services other than for behavioral health, Ob/Gyn, vision services, or plan specific benefits (for example, ECI, family planning, etc.).

When a Parkland Community Health Medicaid or CHIP Member presents for services:

- Confirm Member eligibility with Parkland Community Health at [www.parklandhmo.com](http://www.parklandhmo.com)
- Contacting Parkland Community Health at **1-888-672-2277** (HEALTH first); **1-888-814-2352** (KIDS first).
- Upon arrival for their appointment, verify the Parkland Community Health Medicaid and their Your Texas
Benefits Medicaid Card

- If a CHIP Member, ask him/her to present his/her Parkland Community Health CHIP ID card.

Eligibility determination notices are sent to families determined eligible based on completed applications. The enrollment packet mailed to families contains:

- Explanation of CHIP benefits
- Comparison table showing value-added services by health plan
- A place to indicate a child with special health care needs
- A place to indicate whether a medical support order is applicable
- How to pick a health plan, primary care provider, and the choice to pick a specialist as Primary Care
- Provider
- Provider directories
- Cost-sharing information specific to the income level of the family and payment coupon book for families with net income over 150% Federal Poverty Level
- Simple form to track cost-sharing expenses relative to caps
- Information concerning the grievances and appeals process

Reminder notices are sent 14 days after enrollment packages are mailed to members. Concurrent notice is sent to the Community Based Organization (CBO) when there is a record of past involvement with the family. A follow-up letter is mailed 14 days after the reminder notices. Families who are unresponsive to the two follow-up attempts are timed out after 60 days.

Post-enrollment letters are sent as temporary evidence of coverage, pending receipt of the health plan ID card. Enrollment letters will contain the following information:

- Member ID numbers
- First date of coverage
- Health plan and Primary Care Provider sections
- Applicable co-payments
- If a CHIP Member, ask him/her to present his/her PCPH CHIP ID card.

**Your Texas Benefits gives providers access to Medicaid health information**

Medicaid providers can log into the site to see a patient's Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). All of this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It's FREE and requires a one-time registration.

To access the portal, visit [YourTexasBenefitsCard.com](https://www.YourTexasBenefitsCard.com) and follow the instructions in the “Initial Registration Guide for Medicaid Providers”. For more information on how to get registered, download the “Welcome Packet” on the home page.

**YourTexasBenefitsCard.com** allows providers to:

- View available health information such as:
  - Vaccinations
  - Prescription drugs
  - Past Medicaid visits

**Temporary ID card (Form 1027-A)**

A Member may have a temporary Medicaid ID (Form 1027-A) which will include the plan indicator. This is issued
prior to receipt of the Form 3087.

**Parkland Community Health Medicaid ID card**
We will issue a Member ID card to the Member within five (5) days of receiving notice of enrollment of the Member into the Parkland Community Health Medicaid program. The ID card will include at a minimum the following: Member’s name; Member’s Medicaid number; primary care provider’s name and telephone number; primary care provider effective date; plan eligibility effective date; the 24-hour, 7-day per-week Member Services eligibility telephone number; the toll-free number for behavioral health and vision services; and directions on what to do in an emergency.

Copies of the Parkland Community Health Medicaid ID card are included in Appendix A to this manual.

**If the Member also received Medicare benefits, Medicare is responsible for most primary and acute services and some behavioral health services; therefore, the Primary Care Provider’s name, address, and telephone number are not listed on the Member’s ID card. (STAR Kids Dual Members)**

**Call Parkland Community Health**
Call Parkland Community Health Providers may also verify eligibility through the Parkland Community Health website ([www.parklandhmo.com](http://www.parklandhmo.com)), or by calling Parkland Community Health Member Services department at 1-888-672-2277 (HEALTHfirst) and 1-888-814-2352 (KIDSfirst).

AIS line/TXMedConnect
Call Automated Inquiry System (AIS) at **1-800-925-9126**

**Medicaid Managed Care Member Enrollment and Disenrollment from Parkland Community Health**

**Enrollment**
HHSC, in coordination with their Enrollment Broker, administers the enrollment process for Medicaid-eligible. The Enrollment Broker initiates the enrollment process by sending the Medicaid-eligible person an enrollment packet. It is at that time the Medicaid-eligible person picks a health plan and a primary care provider. All enrollments into Parkland Community Health Medicaid must occur only through the Enrollment Broker. The enrollment counselors can be reached at **1-800-964-2777**.

**Newborn Process**
Newborns of current Parkland Community Health Medicaid Members are automatically covered by Parkland Community Health Medicaid for the first 90 days of life. However, it is the responsibility of the Member to notify HHSC to add the newborn in the STAR program to continue benefits. Parkland Community Health Medicaid will assign the newborn an internal “proxy ID” in order to expedite the payment of claims and systematically track the newborn. Once the newborn is enrolled with the STAR program, the “proxy ID” will be updated with the State-assigned Medicaid ID.

Practitioners and facility providers can report information about each child born to a mother eligible for Medicaid. To report this information, Federally Qualified Health Centers (including FQHCs with birthing centers), hospitals, and birthing centers should complete the “Hospital Report” (Newborn Child or Children) HHSC (Form 7484) and submit it to HHSC Data Control within five days of the child's birth.
For more detailed information on Newborn Services, please refer to Section 2.3.2.3 in the Physician section of the Texas Medicaid Provider Procedures Manual found at: [www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html](http://www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html).

**Automatic Reenrollment**
Members who are dis-enrolled because they are temporarily ineligible for Medicaid will be automatically re-enrolled into their previously selected health plan and primary care provider. Temporary loss of eligibility is defined as a loss of eligibility for a period of six months or less. When Parkland Community Health informs Members of their rights and responsibilities, they will also inform them of the automatic re-enrollment process including the option to change health plans after re-enrollment. This information is given to the Member in the Member Handbook.

**Disenrollment**
Parkland Community Health has a limited right to request a Member be dis-enrolled from the Plan without the Member’s consent. Request to disenroll a Member from the Plan will require medical documentation from the Member’s primary care provider or documentation that indicates sufficiently compelling circumstances that merits disenrollment. HHSC must approve and will make the final decision on any request by Parkland Community Health for disenrollment of a Member for cause.

We will take reasonable measures to correct a Member’s behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

- If all reasonable measures fail to remedy the problem, Parkland Community Health will notify the Member of the decision to recommend disenrollment to HHSC. The notice will include the process available to the Member to file an appeal or request a Fair Hearing.
- We cannot request a disenrollment based on adverse change in the Member’s health status or utilization of services that are medically necessary for treatment of a Member’s condition.
- Additionally, a provider cannot take retaliatory action against a Member who is dis-enrolled from Parkland Community Health Medicaid.

**CHIP Member enrollment and disenrollment**

**Enrollment (12-month eligibility)**
Parents and guardians can apply telephonically for CHIP coverage by contacting CHIP at **1-800-647-6558**. Applicants can ask for a blank form or CHIP will print completed applications based on phone information and mail to the requesting party for signature and return. Applicants can download and complete application forms from the internet at [www.chipmedicaid.com](http://www.chipmedicaid.com). Once enrolled, the CHIP eligibility remains continuous for 12 months. Eligibility determination is the responsibility of the HHSC Administrative Services Contractor.

**Enrollment process**
Eligibility determination notices are sent to families determined eligible based on completed applications. The enrollment packet mailed to families contains:

- Explanation of CHIP benefits
- Comparison table showing value-added services by health plan
- A place to indicate a child with special health care needs
- A place to indicate whether a medical support order is applicable
- How to pick a health plan, primary care provider, and the choice to pick a specialist as Primary Care
- Provider
- Provider directories
- Cost-sharing information specific to the income level of the family and payment coupon book for families with net income over 150% Federal Poverty Level
- Simple form to track cost-sharing expenses relative to caps
- Information concerning the grievances and appeals process
Reminder notices are sent 14 days after enrollment packages are mailed to members. Concurrent notice is sent to the Community Based Organization (CBO) when there is a record of past involvement with the family. A follow-up letter is mailed 14 days after the reminder notices. Families who are unresponsive to the two follow-up attempts are timed out after 60 days.

Post-enrollment letters are sent as temporary evidence of coverage, pending receipt of the health plan ID card. Enrollment letters will contain the following information:

- Member ID numbers
- First date of coverage
- Health plan and Primary Care Provider sections
- Applicable co-payments

**Re-enrollment**

At the beginning of the tenth month of coverage, the Administrative Services Contractor will send a notice to the family outlining the next steps for renewal for continuation of coverage. The Administrative Services Contractor will also send a notice to the Health Plan regarding its members and to a community-based outreach organization providing follow-up assistance in the members’ areas. To promote continuity of care for children eligible for re-enrollment, the HMO can ease re-enrollment through reminders to members and other appropriate means. Failure of the family to respond to the Administrative Services Contractor’s renewal notices will result in disenrollment from the plan and from CHIP.

**Disenrollment**

For those members who are disenrolled because they are no longer eligible for CHIP, the HMO will receive from the Administrative Services Contractor notice informing the HMO that the members’ coverage will end on a particular date. Disenrollment due to loss of eligibility includes, but is not limited to; “aging-out” when a child turns 19, failure to re-enroll at the conclusion of the 12-month eligibility period, change in health insurance status, failure to meet monthly cost-sharing obligation, death of the child, child permanently moves out of the state, and data match with the Medicaid system indicates dual enrollment in Medicaid and CHIP.

Parkland Community Health has a limited right to ask for a member to be disenrolled from the Plan without the member’s consent. Parkland Community Health’s request to disenroll a member from the Plan will require medical documentation from the member’s Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merits disenrollment. HHSC must approve and will make the final decision on any request by Parkland Community Health for disenrollment of a member for cause.

Parkland Community Health will make sure that punitive action is not taken in retaliation against a member who requests an appeal or a provider who requests an expedited resolution or supports a member’s appeal.

- We will take reasonable measures to correct a member’s behavior before asking for disenrollment.
- Reasonable measures can include providing education and counseling regarding the offensive acts or behaviors.
- If all reasonable measures fail to remedy the problem, Parkland Community Health will inform the member of the decision to recommend disenrollment to HHSC.
- We cannot ask for a disenrollment based on adverse change in the member’s health status or utilization of services that are medically necessary for treatment of a member’s condition.
- Additionally, a provider cannot take retaliatory action against a member who is disenrolled from Parkland Community Health.
Plan Changes:
Members are allowed to make health plan changes under the following circumstances:

- For any reason within the 90 days of enrollment in CHIP and once thereafter;
- For cause at any time;
- If the client moves to a different service area; and
- During the annual re-enrollment period.

HHSC must approve and will make the final decision on any request by members to change health plans.

CHIP Perinatal member enrollment and disenrollment

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 member’s enrollment period. Copayments, 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.

Disenrollment
HHSC must approve and will make the final decision on any request for disenrollment of a member for cause. A provider cannot take retaliatory action against a member who is disenrolled from Parkland Community Health CHIP Perinate or Parkland Community Health CHIP Perinate Newborn.

Plan Changes
- A CHIP Perinate (unborn child) who lives in 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 the CHIP Program 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 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 PARKLAND COMMUNITY HEALTH within 15 calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into an PARKLAND COMMUNITY HEALTH and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another PARKLAND COMMUNITY HEALTH.
- 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; or 2) the end of the traditional CHIP members’ enrollment period. In the 10th month of the CHIP Perinatal Newborn’s coverage, the family will receive a CHIP renewal form, which will be prepopulated to include the CHIP Perinatal 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.

- CHIP Perinatal Members may request to change health plans under the following circumstances:
- For any reason within the 90 days of enrollment in CHIP Perinatal;
- If the Member moves to a different service delivery area; and
- For cause at any time.

Medicaid Managed Care/CHIP Special Access

General transportation and ambulance/wheelchair van

Medicaid reimburses for emergency and non-emergency transports for those clients that meet the severely disabled criteria. Severely disabled means that “the clients’ physical condition limits mobility and requires the client to be bed-confined at all times or unable to sit unassisted at all times or requires continuous life support systems (including oxygen or IV infusion) or monitoring of unusual physical or chemical restraint.” All non-emergency transports require prior authorization. Emergency transports do not require prior authorization. For more information regarding ambulance services and/or limitations, please refer to Section 8.2.5 of the Texas Medicaid Provider Procedures Manual found at www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html

Interpreter/translation services

Parkland Community Health provides language interpretation services to translate multiple languages. We do this through a language line which may be accessed by calling our Member Services line and our Member Services Staff will then contact the language line as a third-party conversation. For persons who are deaf or hearing impaired, please call TTY line at 1-800-735-2989 and ask them to call the Member Services Line.

Parkland Community Health also maintains a current list of interpreters who remain available to provide interpreter services. We will arrange, with 72-hour notice, to have someone that speaks the Member’s language meet the patient at the provider’s office when they come for their appointment. For Members in need of a sign language interpreter, Parkland Health will provide an approved interpreter from the American Sign Language Association. Interpreter services will be paid for by Parkland Community Health Plan. Trained interpreters must be used when technical, medical, or treatment information is to be discussed. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality or confidentiality is critical unless specifically requested by the Member.

Pre-authorization and Referral Requirements

Check Appendix N for a list of services and supplies that require pre-authorization and a list for services/types of Providers that require referrals. The required form is also provided at Appendix N.

Check and Collect any Member Responsibility Amounts; Do Not Seek any Additional Monies from Covered Person or HHSC

The Covered Person’s Covered Person ID card will indicate whether the Covered Person is responsible for any co-payment. If the Covered Person has a co-payment, the Participating Provider is required collect Member Responsibility Amounts, and should do so at the time Covered Services are provided.

Participating Providers shall not charge: cost-sharing or deductibles to PCHP Covered Persons who are: CHIP
Covered Persons of Native American Tribes or Alaskan Natives; CHIP Covered Persons with an ID card that indicates the Covered Person has met his or her cost-sharing obligation for the balance of their term of coverage; or presenting for well-child or well-baby visits or immunizations (CHIP MCO and CHIP RSA).

**Payment in Full for Covered Services**
A Participating Provider must accept any amount paid by PCHP (plus any Member Responsibility Amount) as payment in full for Covered Services. The payment to you from PCHP is generally the allowable amount reflected on your Payment Attachment/Fee Schedule, less any Member Responsibility Amount; the payment may be further adjusted based on the additional terms of your agreement and its Payment Attachment/Fee Schedule and may not try to collect any additional money from the Covered Person, even if PCHP failed to pay claims due to bankruptcy or for any other reason.

**Payment for Non-Covered Services**
If a Participating Provider wishes to seek payment from a Covered Person for non-Covered Services, the Participating Provider must explain the nature of the non-Covered Services, that non-Covered will not be paid for by PCHP or the State Agencies, that the Covered Person is responsible for payment, and they must obtain a signed Private Pay Agreement before the services are provided. A link to a sample Private Pay Agreement is found at Appendix O.

**Timely Submission of Clean Claims**
The Participating Provider must submit a clean claim within 95 days of the date of service, or the claim will be denied as not timely filed. If the Covered Person has other insurance/coverage that is the primary carrier, then the secondary claim to PCHP must be submitted within 95 days of the primary carrier’s Explanation of Benefits (“EOB”) form. A copy of the primary carrier’s EOB should be provided to PCHP along with the claim for secondary coverage. PCHP follows the definitions of the State Agencies in defining what is required for a “clean claim” as defined in the TMPPP.

The State Agencies and PCHP also require specific information for specific types of claims, as noted below. If a claim does not contain the required data elements, PCHP will reject the claim and notify the Participating Provider that it was not clean.

**Where to Submit Clean Claims; Proper Forms**
Participating Providers may submit claims in paper or electronic form as described below. Claims for behavioral health, vision, etc. should be submitted to the vendor with the information the vendor requires in the vendor’s provider manual or rules.

**Electronic Claim Filing.** Electronic claims should be submitted through the PCHP clearing house Emdeon. The claims must be submitted using the payer ID#66917. CMS 1500s can be submitted in the standard NSF 2.0 format and the UB-04s (previously known as UB-92 a/k/a CMS 1450) can be submitted in the standard ANSI format. Emdeon can also accept electronic claims in the MCDS and HCDS formats. Please contact Emdeon Customer Service for more information at 1-800-735-8254.

**Provider Portal Functionality (both online and batch claims processing)**
Providers can verify the status of a claim via the web portal.

**Paper Claim Filing.** Paper claims should be mailed to:

Parkland Community Health Plan  
Attn: Claims Department  
PO Box 61088  
Phoenix, AZ 85082
PCHP will give 30 days’ Written Notice of a change to the claim filing addresses/contact information, or grant the Participating Providers an extension of time in which to file their claims.

**Clean Claim Elements and Billing Guidance for Specific Types of Claims**
The information listed below provides information regarding specific clean claim elements; all of the required elements can be found at:

Appendix U also provides a list of these elements current as of the date of this Provider Manual. Participating Providers are responsible for using the clean claim elements specified by the TMPPP and this Provider Manual as of the date they submit a claim.

**Covered Person ID number.** All claims must include the Covered Person’s ID number (from his/her ID card) in box 1A of the CMS 1500 or box 60A on the UB-04 (previously called UB-92) claim forms.

**NPI and TPI number.** All claims must include the Participating Provider’s National Provider Identifier (NPI) and Texas Provider Identifier (TPI).

**Claims that are more than one page.** If billing on a paper CMS claim form that requires more than 1 page to include all claim detail lines, do not total each page. The total must appear only on the final page of the multi-page claim.

**Claims for Vaccines/Immunizations.** Participating Providers must follow all State Agency requirements when providing vaccines/immunizations. When submitting a claim, the vaccine procedure code should be followed by the immunization procedure code(s), and all immunization/procedure codes that correspond to a vaccine/toxoid procedure code(s) must be submitted on the same claim. Even if the vaccine itself is not separately reimbursable, it must be shown on the claim form.

Each vaccine or toxoid procedure code must note whether it was administered with or without counseling. For “administration with counseling” use procedure code(s) 90460 and 90461. For “administration without counseling,” typically with a child or a Covered Person who does not require any counselling, use procedure codes code 90471, 90472, 90473, or 90474.

For the initial “without counseling” vaccine or toxoid administration that is submitted on the claim, procedure code 90471 must be submitted if an injection is administered, or procedure code 90473 must be submitted if the administration is oral or nasal. Only one initial “without counseling” procedure code may be reimbursed on the claim. All subsequent “without counseling” vaccine or toxoid administrations must be submitted using procedure code 90472 or 90474 depending on the route of administration.

Participating Providers must record immunizations/vaccinations into ImmTrac.

**Obstetrics (delivery) claims.** Claims that are submitted for obstetric delivery procedure codes 59409, 59410, 59514, 59515, 59612, 59614, 59620, or 59622 require one of the following modifiers:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>To Indicate</th>
</tr>
</thead>
<tbody>
<tr>
<td>U1</td>
<td>Medically necessary delivery prior to 39 weeks of gestation</td>
</tr>
<tr>
<td>U2</td>
<td>Delivery at 39 weeks of gestation or later</td>
</tr>
<tr>
<td>U3</td>
<td>Non-medically necessary delivery prior to 39 weeks of gestation</td>
</tr>
</tbody>
</table>

Claims for Cesarean section, labor induction, or any delivery following labor induction will not be reimbursed
unless: (1) gestational age of the fetus is determined to be at least 39 weeks or fetal lung maturity is established before delivery; or (2) when the delivery occurs prior to 39 weeks, maternal and/or fetal medical condition make the delivery medically necessary.

If a delivery does not meet these criteria, PCHP will seek recoupment of the funds paid to the Participating Provider and for related additional Provider and Facility fees.

Present on Admission (POA) indicators. Facility Participating Providers that are reimbursed by diagnosis related group (DRG) must submit a ‘present on admission’ (POA) indicator value for all diagnoses on Facility in-patient claims.

Facility claims for CHIP Perinate and CHIP Perinate Newborn. Facility charges related to a PCHP CHIP Perinate Covered Person’s labor with delivery, and the initial hospital admission of a CHIP Perinate Newborn Covered Person is covered by Emergency Medicaid. The Facility must work with the Covered Person to apply for Emergency Medicaid upon presentation to the Facility for Admission. These claims will be billed to Texas Medicaid and Healthcare Partnership (TMHP) through the TMHP normal billing processes, which you can learn about by calling TMHP at 1-800-925-9126 or visiting their website at www.tmhp.com for details their billing process.

Changes to Claims Guidelines
PCHP will provide Participating Providers at least 90 days’ notice prior to implementing a change in the above-referenced claims guidelines, unless the change is required by statute or regulation in a shorter timeframe.

Proper Coding of Claims
Compliance with TMPPP. Participating Providers must comply with all coding guidelines set forth in the TMPPM: http://www.tmhp.com.

ICD-10. Participating Providers must use ICD-10 codes by no later than claims submitted on or after October 1, 2015.

Most descriptive code available must be used. Claims must be coded according to the Current Procedural Terminology (CPT) Manual, with the code(s) that most specifically and accurately describes the services provided.

Medical records just support coding. The medical record must document each of the specific elements necessary to satisfy the criteria for the level of service described by the CPT code.

What Happens to a Claim: Pended (Usually Due to a Request for More Information), Denied or Paid
When PCHP receives a claim, it will send the Participating Provider an Explanation of Benefits (“EOB”) form for that explains what action PCHP has taken with the claim. Those actions include: paying the claim; pending the claim (so that the claim is awaiting adjudication for the reasons stated on the EOB, such as a request for medical records or Coordination of Benefits information); or denying the claim (e.g., because it is not for a Covered Person or for a Covered Service, was not timely filed, pre-authorization was not obtained).

Requests for Information
When PCHP requests additional information, the time for PCHP to pay the claim is extended by the amount of time it takes the Participating Provider to provide the requested information. Participating Providers must give any requested information within 15 days of their receipt of PCHP’s request, or the claim will be considered denied.

Payment
PCHP will pay, pend or deny a claim within the statutory time frame and will pay the statutory penalty on any late paid claim. PCHP may reprocess claims when the State Agencies retroactively adjust the Medicaid fee schedule.
and may either recoup money from the Participating Provider or make additional payments to the Participating Provider based on the retroactive change to the fee schedule. A notice of either of these actions will appear on the EOB, and no further notice is required for PCHP to either recoup or make an additional payment in these circumstances. PCHP will not owe any statutory penalties for “late” payment of these claims when they are reprocessed based on retroactive changes to the fee schedule.

**Claims payment:**

30-day Clean Claim payment for professional and institutional claim submission

Parkland Community Health will pay providers interest at an 18 percent annual rate, calculated daily, for the full period in which the Clean Claim or portion of the Clean Claim remains un-adjudicated beyond the 30-day Claims Processing deadline. The principal amount on which the interest payment will be calculated is the amount due but unpaid at the contracted rate for the service.

**18-day Clean Claim payment for electronic pharmacy claim submission**

Payment Cycle

Clean claims for outpatient pharmacy benefits must be adjudicated no later than: (1) 18 days after receipt if submitted electronically, or (2) 21 days after receipt if submitted non-electronically. Once a clean claim is received for a pharmacy claim, the MCOs are required, within the periods described above, 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 the MCO, or (2) electronic transmission, if payment is made electronically.

**Emergency Services Claims**

Payment for emergency services is made based on the “Prudent Layperson” standard. Utilization of the emergency department for routine follow-up services such as suture removal, dressing change or well-person checkups is not appropriate. Claims for routine services provided in the emergency room will be denied.

Parkland Community Health does not require prior authorization for emergency services and does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The attending emergency physician or the provider actually treating the Member is responsible for determining when the Member is stable. Post-stabilization care provided to maintain, improve, or resolve the Member's stabilized condition is subject to prior authorization and notification requirements. We require notice of inpatient admission on the next business days following a non-elective admission.

Services are covered for the period of time it takes for us to make a determination, including times Medical Management cannot be contacted, does not respond to a request for approval within an hour, or a Medical Director is not available for consultation when medical necessity is questioned by the Medical Management staff.

The Parkland Community Health Plan’s Medical Management Department has staff available by toll-free telephone at least 40 hours per week during normal business hours, Monday through Friday, except for State approved holidays. The phone system is capable of accepting and recording messages for incoming phone calls during non-business hours and the Medical Management staff responds to such calls the next business day in most cases and no later than 2 working days.

In the event a provider requests post stabilization care subsequent to emergency treatment when Medical Management staff is available, notification will occur within a time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from request. In such
circumstances, notification shall be provided verbally to the treating physician or health care provider. In any instance where a service authorization request or authorization of service in an amount, duration or scope less than that requested is questioned, the health care provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment for the patient with the clinical basis for the decision with a physician prior to the issuance of a determination.

At least 1 documented attempt at peer to peer between the Medical Director and the treating physician will be made prior to an adverse determination. Benefits may be continued for the period of time it takes an appeal of the adverse determination to be resolved, both at the health plan appeal level and the external review by a Fair Hearing officer or the HHS-Administered external reviewer – Maximus.

**What services are included in the monthly capitation**
Please call Parkland Community Health at 1-888-672-2277, if you have any questions about the member benefits.

**Cost sharing schedule for Parkland Community Health CHIP members**
The chart below is the complete cost sharing table for all CHIP eligible members depending on their income level. Copayments for medical services or prescription drugs are paid to the health care provider at the time of service. No copayments are paid for well-child and well-baby services, preventive services or pregnancy-related assistance. No copayments are required for CHIP Members who are Native Americans or Alaskan Natives.

The Parkland Community Health CHIP ID card lists the copayments that apply to each family’s situation. Parkland Community Health CHIP members should present their ID card when they receive physician or emergency room services or have a prescription filled.

No co-payments for MMC 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.

<table>
<thead>
<tr>
<th>CHIP Cost-Sharing</th>
<th>Effective January 1, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrollment Fees (for 12-month enrollment period):</strong></td>
<td></td>
</tr>
<tr>
<td>At or below 151% of FPL*</td>
<td>$0</td>
</tr>
<tr>
<td>Above 151% up to and including 186% of FPL</td>
<td>$35</td>
</tr>
<tr>
<td>Above 186% up to and including 201% of FPL</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Co-Pays (per visit):</strong></td>
<td></td>
</tr>
<tr>
<td>At or below 151% FPL</td>
<td></td>
</tr>
<tr>
<td>Office Visit (non-preventative)</td>
<td>$5</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$5</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$0</td>
</tr>
<tr>
<td>Brand Drug</td>
<td>$5</td>
</tr>
<tr>
<td>Facility Co-pay, Inpatient (per admission)</td>
<td>$35</td>
</tr>
</tbody>
</table>
### CHIP Cost Sharing Caps

Members receive a guide from the CHIP Enrollment Broker when they enroll in the CHIP program. Included in the guide is a tear-out form that can be used to track CHIP expenses. To ensure that members do not exceed their cost-sharing limit, guardians must keep track of CHIP-related expenses on the form. The enrollment packet welcome letter tells the Member exactly what their cost-sharing cap is, based on family income.

Members may contact the CHIP Helpline at **1-800-647-6558** to verify their annual limit.

When members reach their annual cap, they may send the form to CHIP Enrollment Broker and CHIP Services will notify Parkland Community Health of this information and we will issue a new Member ID card. This new card will show that no copayments are due when the Member receives services.

#### Billing Members

Except as specifically indicated in the Medicaid benefit descriptions, a provider may not bill or require payment from Members for Medicaid covered services. Providers may not bill or take recourse against Members for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the STAR Program. For more information, please refer to Section 1.4.9 of the Texas Medicaid Provider Procedures Manual found at [www.tmhp.com/HTML manuals/TMPPM/2011/ Frameset.html](http://www.tmhp.com/HTML manuals/TMPPM/2011/ Frameset.html).

#### Private Pay Agreement/Member Acknowledgement

If a Parkland Community Health Plan Member decides to go to a provider that is not within the Parkland Community Health plan’s network or chooses to get services that have not been authorized or are not a covered benefit, the Member must document his/her choice by signing the Private Pay Agreement and the Member Acknowledgement form.

If a claim is not received by Parkland Community Health within 95 days, the claim will be denied unless exempted.
from the claims filing deadline. For more information, refer to the Texas Medicaid Provider Procedures Manual, Section 6.1.3, “Claims Filing Deadlines,” which includes exceptions for inpatient facility claims, claims by newly-enrolled Medicaid providers, claims by out-of-state providers, and other exceptions www.tmhp.com/HTMLmanuals/TMPPM/2011/Frameset.html.

Participating providers shall be paid by us, no later than 30 working days after receipt of a completed “clean” claim for covered services. A clean claim is one that is accurate, complete (that is, includes all information necessary to determine Parkland Community Health liability), not a claim on appeal, and not contested (that is, not reasonably believed to be fraudulent and not subject to a necessary release, consent or assignment). Parkland Community Health will indicate to participating providers within 30 days of receipt if claims received by Parkland Community Health, are not clean claims.

Special billing (newborns, Value-Added Services, SSI, compounded medications, etc.)

Special Billing for Newborns
Providers may bill claims for newborns using the mother’s ID. The name of the member should be listed as the same last name of the mother and then Baby Girl or Baby Boy. The baby’s actual date of birth should be used.

Payment/accrual of interest by Parkland Community Health
Parkland Community Health reimburses at an 18 percent annual rate, calculated daily, for the full period in which the Clean Claim, or portion of the Clean Claim remains un-adjudicated beyond the 30-Day Claims Processing deadline.

How to find a list of covered drugs
Check the list of covered drugs at www.txvendordrug.com.

How to find a list of PA required services and codes

No Prior Authorization required
If a request for services is submitted to Parkland Community Health’s Utilization Management department which doesn’t require prior authorization, the request will be returned stating PA not required or Prior Authorization not required. "PA Not Required” does not mean that service is covered.

Audit Cooperation
PCHP and the State Agencies may audit your claims and related records. Participating Providers are required to cooperate with the audit process, including but not limited to providing timely access to records, interviews with employees, meetings with the Participating Provider, and responding to follow up requests for information, all without cost to PCHP or the State Agencies.

Audit Process
When PCHP and the State Agencies perform an audit, they may select a sample of claims and then extrapolate the results of the sample review to the entire “universe” of your claims for the stated time period.

PCHP will communicate the results of the audit in writing and will provide Written Notice of a request for repayment/refund of monies it believes were overpaid. Before PCHP engages in any recoupment of monies owed against future claims payments, it will give the Participating Provider an opportunity to provide additional information.
Timing of Requests for Refund and Recoupment by PCHP, Requests for Additional Payment by Participating Providers

PCHP and the Participating Provider may generally recover for overpayments (PCHP) and underpayments (Participating Provider’s pended or denied claims) if a Written Notice requesting a refund or additional payment is timely filed. PCHP must give Written Notice that it is seeking repayment/recoupment within 180 days of its original processing of the claim. The Participating Provider must give Written Notice requesting additional payment within 120 days of the date of PCHP’s original processing of the claim. However, there is no time limit on how long PCHP may recover money based on the Participating Provider’s fraud or abuse.

Reimbursement Appeal Process: What to do if you Disagree About a Declined Referral or Pre-authorization Request or Refund Request/What to do if you Disagree with the Amount of Payment

If a Participating Provider believes that: (1) a referral/pre-authorization request has been improperly declined or the provider has been underpaid; or (2) a PCHP request for refund or recoupment is not based on any actual overpayment, the Participating Provider must follow this Reimbursement Appeal Process as outlined below, being sure to meet the required time deadlines. If the Participating Provider fails to meet the deadlines, the Reimbursement Appeal will be denied.

Step 1: The first mandatory step in the Reimbursement Appeal Process is to contact PCHP to try to resolve the issue on an informal basis. Participating Providers may contact PCHP 1-888-672-2277 (Medicaid) and 1-888-814-2352 (CHIP).

Step 2: If informal discussions do not resolve the issue, the next mandatory step is to give PCHP Written Notice of your disagreement, which must occur within 120 days of PCHP’s original processing of the claim for alleged underpayments or within 30 days of receiving a request for refund. The Written Notice of dispute that must specify the claims involved (including providing copies of the claims and related EOB’s or a spreadsheet with the information contained on the claim forms/EOB’s); and explain why the Participating Provider believes there has been an underpayment or no overpayment (when PCHP has requested a refund).

Participating Provider must meet face-to-face with a PCHP representative to discuss the content of the Written Notice and attempt to resolve the issue if PCHP requests such a meeting. PCHP will provide a written statement regarding its decision about the claims covered by the Written Notice.

Step 3: If there is any remaining dispute after engaging in the Reimbursement Appeal Process, the next mandatory step is to resolve that dispute and any related issues through the Dispute Resolution Process.

Recoupment and Timing to Engage in Reimbursement Appeal Process

If the Participating Provider concedes that additional money is owed or does not file a Written Notice of dispute within 30 days of receiving a request for refund, PCHP may recoup (offset) the monies owed against future claims payments and may also seek recovery directly from the provider. If after receiving the Written Notice and following the Reimbursement Appeal Process, PCHP again asserts that additional monies are owed, it may begin recoupment (offset) against future claims if the Participating Provider does not then follow the steps in the Dispute Resolution Process within 30 days of receiving PCHP’s Written Notice regarding the Participating Provider’s Written Notice of dispute.

Basis and Timing of Termination or Denial of Credentials

The Parties may terminate their Participating Provider Agreement for the reasons and at the times specified in that Agreement. PCHP may deny a Provider’s Credentialing Application based on the criteria in the Credentialing Plan or for lack of network need.

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**Appeal of Termination or Denial of Credentials**

If PCHP terminates the Parties’ Agreement or denies the Provider’s Credentialing Application, the Provider may appeal this Initial Decision.

The Initial Decision will be reviewed by the Peer Review and Appeals Sub-Committee, which will consist of Participating Providers and other Providers as required to meet the State Agencies’ “non-competitor” and “same specialty” rules. The Provider who appeals may present evidence that he/she believes is relevant to the termination/denial of credentials. After consideration of the information presented, the Peer Review and Appeals Sub-Committee will make its recommendation that the Initial Decision be upheld or overturned.

PCHP will make a Final Decision about the Provider’s status and communicate that to the Provider within the time required by law. If the Provider is dissatisfied with the Final Decision, the Provider must resolve any dispute through the Dispute Resolution Process described in this Provider Manual.

**Notification of Covered Persons**

PCHP will notify all Covered Persons in a PCP’s panel and all Covered Persons who have had two or more visits with the Participating Provider for home-based or office-based care in the past 12 months of the termination as required by law.

**Cooperation in Transition**

The Provider must cooperate in assisting PCHP and the Covered Person with the transition of care to a new Participating Provider.

**Provision of Continuing Treatment Post-termination**

Participating Providers are obligated to continue to provide certain Covered Services even after termination of their contract with PCHP, and PCHP is required to pay for that treatment at the contracted rates. Examples include:

- **Medically fragile or terminal Covered Persons.** Covered Persons whose health or behavioral health condition has been treated by Specialty Participating Providers; who have a terminal condition; or whose health could be placed in jeopardy if Covered Services are disrupted or interrupted shall remain under the care of a formerly Participating Provider until an appropriate transition of care can take place.

- **Late Pregnancy.** Covered Persons past the 24th week of pregnancy (16 weeks or less until the expected delivery date) will be allowed to remain under the care of their current Obstetrician/Gynecologist through the post-partum checkup or may select another Participating Provider.

**Payment for Covered Services Post-termination**

In order to obtain payment for this continuing treatment, the Provider must obtain PCHP’s pre-authorization when required by Appendix N and cooperate with PCHP’s Case Management regarding the Covered Person’s course of treatment. Payment for continuing treatment will be at the previously contracted rate.

**Covered Person Rights and Responsibilities**

For Medicaid Managed Care (Star) Covered Person (member) rights and responsibilities, see Appendix K. For CHIP Managed Care Covered Person (member) rights and responsibilities, see Appendix G. For Parkland CHIP Perinate Covered Person (member) rights and responsibilities, see Appendix H.

**Provider Complaints and Appeals**

Contact information for Complaint/Appeal to PCHP:

- Parkland Community Health Plan
- Provider Relations Department
Documentation
Retention of fax cover pages, emails to and from Parkland Community Health Plan are logged. Additionally telephone communications are also logged. Parkland Community Health stores documentation related to Providers Complaints in a digital database.

Provider Complaints to PCHP
PCHP will document any verbal complaint in writing. Within five (5) business days of receipt of a Complaint by a Provider, PCHP will send written acknowledgement of receipt of the Complaint. This acknowledgement letter will indicate a description of the Complaint process and the thirty (30) calendar day-time frame for resolution of the Complaint. Once the Complaint has been resolved, PCHP will send a response letter to the Provider with the resolution of the complaint, including the process to appeal the Complaint when the provider is not satisfied with PCHP’s decision.

Provider Appeals to PCHP
In the event that the Complaint is not resolved to the satisfaction of the Participating Provider, the Provider may request an appeal to the address noted above within thirty (30) days from the date of the response letter to the Complaint. If the appeal is received verbally, PCHP will send a verbal appeal form documenting the verbal appeal. Once the Participating Provider has reviewed and agrees with this documentation, the Provider will return the form to PCHP for processing. PCHP will send a written acknowledgement letter within five (5) business days of receipt of the written request for an appeal of the complaint decision. This acknowledgement letter will indicate that PCHP has thirty (30) calendar days to process and respond to the appeal. PCHP will send a resolution letter indicating the final determination and criteria used to reach the final decision and notice of the provider’s right to file a Complaint with HHSC.

If the Complaint or Appeal involves the right to additional reimbursement or PCHP’s allegation that the Provider should repay money, the Provider must also follow the requirements of the Reimbursement Appeal Process described in this Manual, which generally follow this process but give the Provider and PCHP additional rights to attempt to resolve this most common type of dispute more efficiently.

Provider Complaint/Appeal Process to HHSC
A Provider who believes that they did not receive full due process from PCHP may file a Complaint with HHSC. HHSC is only responsible for management of the Complaints. Appeals, hearing or dispute resolutions are the responsibility of PCHP. Providers must exhaust the Complaint/appeal process with PCHP before filing a Complaint with HHSC. Complaints must be in writing and received by HHSC within sixty (60) calendar days from PCHP’s notification of final action. Providers should refer to the Texas Medical Provider Procedures Manual for additional information, and mail Complaints or appeals to the following addresses:
   (For Medicaid claims)
   Texas Health and Human Services Commission
   Re: Provider Complaint
   Health Plan Operations, H-320
   PO Box 85200
   Austin, TX 78708
   Email: HPM_Complaints@hhsc.state.tx.us (for CHIP claims)

Provider Appeal Process to HHSC
A provider who believes that they did not receive full due process from Parkland Community Health may file a
complaint with HHSC. HHSC is only responsible for management of the complaints. Appeals, hearing or dispute resolutions are the responsibility of Parkland Community Health. Providers must exhaust the complaint/appeal process with Parkland Community Health before filing a complaint with HHSC. Providers should refer to the Texas Medical Provider Procedure’s Manual for specific information on complaint requirements. Complaints should be mailed to the following address:

Texas Health and Human Services Commission
Health Plan Operations, H-320
Resolution Services
PO Box 85200
Austin, TX 78708-5200
Email: HPM_Complaints@hhsc.state.tx.us

The network provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiries and to conduct investigations into provider and Member complaints.

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 both the valid NPI 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

Texas Department of Insurance
HMO Quality Assurance Section
Mail Code 103-6A
PO Box 149104
Austin, Texas 78714-9104

Medicaid Managed Care Member Complaint/Appeal Process

Member Complaint Process

Definition of a “Complaint” – Any dissatisfaction expressed by a complainant orally or in writing to Parkland Community Health Plan about any matter related to Parkland Community Health Plan other than an Action. Complaints may include, but are not limited to, dissatisfaction with plan administration; the quality of care of
services provided; and aspects of interpersonal relationships such as rudeness of a provider or Parkland Community Health Plan employee, or failure to respect the Member’s rights. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member.

Within 5 business days of receipt of a complaint by a Member or Member’s designee, the Member Advocate will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 30 calendar day time frame for resolution of the complaint.

Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization will be concluded in accordance with the medical immediacy of the case but may not exceed 1 business day from receipt of the complaint. Once the complaint has been resolved, the Member Advocate will send a response letter to the Member or Member’s designee with the resolution of the complaint, including the process to appeal the decision when the Member or Member’s designee is not satisfied with PCPH’s decision.

The Member’s right to file complaints to Parkland Community Health Plan and HHSC
A Member or a Member’s designee can file a complaint with PCPH or HHSC either in writing or verbally by contacting the Member Advocate at:

Member Advocate
Parkland Community Health Plan PO Box 569005
Dallas, TX 75356-9005

Or call us at 1-888-672-2277 (Option 2); 1-888-814-2352 (Option 2).
Or by contacting HHSC at 1-866-566-8989.

The requirements and timeframes for filing a complaint
The Parkland Community Health Plan Member Advocate will be available to assist the Member or Member’s designee with understanding and using the complaint and appeals process. If the complaint is received verbally, the Member Advocate will send a verbal complaint form documenting the verbal complaint. Once the Member or Member’s designee has reviewed and agrees with this documentation of the verbal complaint, the Member or Member’s designee must return the verbal complaint form to the Member Advocate.

Within 5 business days of receipt of a complaint by a Member or Member’s designee, the Member Advocate will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 30 calendar day time frame for resolution of the complaint.

Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization will be concluded in accordance with the medical immediacy of the case, but may not exceed 1 business day from receipt of the complaint. Once the complaint has been resolved, the Member Advocate will send a response letter to the Member or Member’s designee with the resolution of the complaint, including the process to appeal the decision when the Member or Member’s designee is not satisfied with Parkland Community Health Plan’s decision.

The availability of assistance in the filing process
The Parkland Community Health Plan’s Member Advocate will be available to assist the Member or Member’s designee with understanding and using the complaint and appeals process. If the complaint is received verbally, the Member Advocate will send a verbal complaint form documenting the verbal complaint. Once the Member or Member’s designee has reviewed and agrees with this documentation of the verbal complaint, the Member or Member’s designee must return the verbal complaint form to the Member Advocate.
The toll-free numbers that the Member can use to file a Complaint
Parkland HEALTHfirst - 1-888-672-2277
Parkland KIDSfirst - 1-888-814-2352

Member Appeal Process to Parkland Community Health Plan

What can I do if Parkland denies or limits my Member’s request for a Covered Service?

A Member or person authorized to act on behalf of the Member, including the Member’s physician or health care provider with written consent from the member, may appeal the action or adverse determination orally or in writing.

How will I find out if services are denied?

Our Medical Management Department will notify the Member or a person acting on behalf of the Member and the Member’s provider of a determination made in a utilization review. A notice of action or adverse determination will be provided in writing in case of a denial or limited authorization of a requested service, including the denial in whole or part of payment for a service; the denial of a type or level of service; and/or the reduction, suspension or termination of a previously authorized service. Notification of an adverse determination will include:

- The action taken or proposed
- Principal reasons for the action or adverse determination
- The clinical basis for the action or adverse determination A description or the source of the screening criteria that were utilized as guidelines in making the determination
- A description of the procedure for the appeal process, including:
  - Notification of the right for the Member to appeal an action or adverse determination orally or in writing and the procedures to request an appeal
  - A statement explaining that HMO must make its decision within 30 days from the date the appeal is received by HMO, or 3 business days in the case of an expedited appeal and
  - Notification of the right to request a Fair Hearing within 120 days from date of notice of Action or adverse determination.
- An explanation that Members may represent themselves, or be represented by a provider, a friend, a relative, legal counsel or another spokesperson;
- A statement that if the Member wants a HHSC Fair Hearing on the action or adverse determination, Member must make, in writing, the request for a Fair Hearing within 120 days of the date on the notice or the right to request a hearing is waived;
- A statement explaining that the hearing officer must make a final decision within 120 days from the date a Fair Hearing is requested;
- A description of the circumstances under which expedited resolution is available and how to request it;
- Notification of right to an expedited Fair Hearing after exhausting the health plan’s expedited appeal process;
- Notification of the right for the Member to request continuation of benefits pending resolution of the appeal and the circumstances under which the enrollee may be required to pay the costs of services;
- The date that the action or adverse determination will be taken.

Timeframes for the Appeals process

All appeals must be received within 60 calendar days from the date of the notice of an adverse determination. When an oral appeal of adverse determination is received, a one-page verbal appeal form, documenting the verbal appeal, will be sent to Member for review and signature. The time frame in which the appeal is resolved will be based on the medical immediacy of the condition, procedure, or treatment under review, but will not exceed 30 calendar days unless an extension is requested by the Member or the Member designee is notified of the reason an extension would be in the Member’s best interest. Within 5 working days from receipt of the written or verbal appeal, the Member Advocate will send an acknowledgement letter. The acknowledgement letter will include:
• The date of receipt of the appeal
• A description of the appeal procedure and time frames,
• The right of the Member or authorized representative to examine the Member’s case file, including medical records and any other information, at any time before or during the appeal process
• The right of the Member to present evidence, and allegations of fact or law, in person, as well as in writing
• A list of the documents that will need to be submitted for review during the appeal process.

The time frame for an Appeal may be extended up to 14 days. If the Member or his or her representative requests an extension or if we show that there is a need for additional information and how the delay is in the Members interest. If we extend the timeframe we must provide written notice of the delay and the reason the delay is in the Member’s best interest. The extension may be no longer than 14 calendar days.

The services being received by the Member, including the benefit that is the subject of the appeal, will be continued if all of the following criteria are met:
• The Member or his or her representative files the appeal timely as defined in the contract
• The appeal involves the termination, suspension, or reduction of a previously authorized service
• The services were ordered by an authorized provider;
• The period covered by the original authorization has not expired; and
• The Member or his or her representative timely requests an extension of the benefits.
• If, at the Member’s request, Parkland continues or reinstates the Member’s benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
  • The Member withdraws the appeal
  • 10 days pass after Parkland mails the notice, providing the resolution of the appeal against the Member, unless the Member, within the 10-day time frame, has requested a State Fair Hearing.
  • A State Fair Hearing Officer issues a hearing decision adverse to the Member
  • 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.

Every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless an Expedited Appeal is requested.

**When does Member have the right to request an Appeal?**
Member has the right to request an appeal any time Parkland Community Health denies service or payment.

**Attention Members:** in order to ensure continuity of current authorized services, the Member must file the Appeal on or before the latter of:
• 10 days following the Parkland Community Health Plan ’s mailing of the notice of the Action, or
• The intended effective date of the proposed Action.

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.

Every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless an Expedited Appeal is requested.

**Can someone from Parkland Community Health Plan help me file an Appeal?**
Parkland Community Health Plan will make resources available to assist members or member’s designee in filing an Appeal.
**Member’s option to request a State Fair Hearing after the Parkland Community Health Plan’s Appeals process**

If a Member disagrees with the health plan’s decision, the Member has the right to ask for a fair hearing during the Parkland Community Health Plan Appeals process. The Member may name someone to represent him or her by writing a letter to the health plan telling Parkland Community Health Plan 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 fair hearing within 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 fair hearing within days, the Member may lose his or her right to a fair hearing. To ask for a fair hearing, the Member or the Member’s representative should either send a letter to the health plan:

Member Advocate  
Parkland Community Health Plan  
PO Box 569005  
Dallas, TX 75356-9005

Or contact us at: **1-888-672-2277** (Option 2); **1-888-814-2352** (Option 2)

If the Member asks for a 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, and at least until the final hearing decision is made. If the Member does not request a fair hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

**Member Expedited Parkland Community Health Plan Appeal**

The Member or Member’s designee may ask for an expedited appeal if he/she believes that taking the time for the standard appeal process could seriously jeopardize the life or health of the Member.

**How to request an Expedited Appeal**

Requests for an expedited appeal can be made verbally or in writing as indicated in the Member Appeal Process to HMO Process listed above.

**Timeframes**

Expedited appeals for ongoing emergencies or denial of continued hospitalizations must occur in accordance with the medical or dental immediacy of the case and not later than 1 business day after the Member or Member’s designee request for the appeal is received. PCHP will follow up in writing within 3 business days on a decision for an expedited appeal.

**What happens if Parkland denies the request for an Expedited Appeal?**

If the Member or Member’s designee requests an expedited appeal for a denial that does not involve an emergency, an ongoing hospitalization or services that are already being provided they will be notified that the appeal review cannot be expedited. If the Member or Member’s designee does not agree with this decision they may submit a request for a State Fair Hearing as indicated below.

**Who can help me file an Expedited Appeal?**

The Parkland Community Health Plan’s Member Advocate will be available to assist the member or member’s designee with understanding and using the complaint and appeals process including expedited appeals.

**Covered Person Complaints, Appeals, Independent Review and State Fair Hearings**

Covered Persons may file a Complaint about PCHP and/or about Participating Providers with PCHP’s
Customer Service Department either in writing or verbally by contacting:
   Member Advocate
   Parkland Community Health Plan
   PO Box 569005
   Dallas, TX 75356-9005

Or contact us 1-888-672-2277 (Option 2); 1-888-814-2352 (Option 2)
CHIP Provider Complaint and Appeal Processes

Provider Complaint process to Parkland Community Health Plan
Definition of a “Complaint” – Any dissatisfaction, expressed by a Complainant, orally or in writing to Parkland Community Health Plan, with any aspect of Parkland’s 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.

Providers can file a complaint with Parkland Community Health Plan either in writing or verbally by contacting:
- Parkland Community Health Plan
  Provider Relations Department
  PO Box 569005
  Dallas, TX 75356-9005
  1-888-672-2277 or use the provider portal

Parkland will make resources available to assist providers in filing a complaint. If the complaint is received verbally, Parkland Community Health will send a verbal complaint form documenting the verbal complaint. Once the provider has reviewed and agrees with this documentation of the verbal complaint, the provider will return the verbal complaint form to Parkland Community Health. If the complaint form is not returned to Parkland within 15 calendar days from date on letter, a determination will be made based on the available information. Within 5 business days of receipt of a complaint by a Provider, Parkland will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the calendar day time frame for resolution of the complaint.

Once the complaint has been resolved, PCPH will send a response letter to the provider with the resolution of the complaint, including the process to appeal the complaint when the provider is not satisfied with Parkland Community Health’s decision. PCPH will appoint members to a Complaint Appeal Review Panel to advise Parkland on the resolution of a disputed decision on a complaint. Members of the Complaint Appeal Review Panel may not have been previously involved in the disputed decision. Parkland Community Health will notify the provider of the time and date of the Complaint Appeal Review Panel meeting. At least 5 days prior to the Complaint Review Panel meeting, PCPH will provide the Provider documentation to be presented to the Panel by Parkland Community’s Health staff.

Provider Complaint process to Texas Department of Insurance (TDI)
Parkland will send a resolution letter indicating the final determination and criteria used to reach the final decision and notice of the Provider’s right to file a complaint with the Texas Department of Insurance (TDI).

Provider Appeal of Claims Determinations Process to Parkland Community Health Plan
The provider may request an appeal to the address noted above within 60 days from the date of an adverse determination. If the appeal is received verbally, we will send a verbal appeal form documenting the verbal appeal. Once the provider has reviewed and agrees with this documentation, the provider will return the verbal appeal form to Parkland Health for processing. PCPH will send a written acknowledgement letter within 5 business days of receipt of the written request for an appeal of the complaint decision. This acknowledgement letter will indicate that Parkland has 60 calendar days to process and respond to the appeal. PCPH will send a resolution letter indicating the final determination and criteria used to reach the final decision and notice of the provider’s right to file a complaint with TDI.
Provider Appeal process to TDI
A provider who believes that they did not receive full due process from Parkland Community Health Plan, may file a complaint with TDI by calling toll free 1-800-252-3439 or in writing at:

Texas Department of Insurance
PO Box 149104
Austin, Texas 78714-9104

The network provider understands and agrees that TDI reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into provider and Member complaints.

CHIP Member Complaint Process

What should I do if I have a complaint?
Definition of a “Complaint” – Any dissatisfaction expressed by a complainant orally or in writing to Parkland Community Health with any aspect of Parkland Health Plan’s operations, 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 expressed by a complainant. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member.

Who do I call?
CHIP Members, or a CHIP Member’s designee, can file a complaint with PCPH either in writing or verbally by contacting the Member Advocate at:

Member Advocate
Parkland Community Health Plan
PO Box 569005
Dallas, TX 75356-9005

Can someone from Parkland Community Health Plan help me file a Complaint?
Parkland Community Health Plan’s Member Advocate will be available to assist the Member or Member’s designee with understanding and using the complaint process. If the complaint is received verbally, the Member Advocate will send a verbal complaint form documenting the verbal complaint. Once the Member or Member’s designee has reviewed and agrees with this documentation of the verbal complaint, the Member or Member’s designee will return the verbal complaint form to the Member Advocate. If the complaint form is not returned to the Member Advocate within 15 calendar days from date on letter, a determination will be made based on information available.

How long will it take to investigate and resolve my Complaint?
Within 5 business days of receipt of a complaint by a Member or Member’s designee, the Member Advocate will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 30 calendar day time frame for resolution of the complaint. Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization will be concluded in accordance with the medical immediacy of the case, but may not exceed 1 business day from receipt of the complaint. Once the complaint has been resolved, the Member Advocate will send a response letter to the Member or Member’s designee with the resolution of the complaint, including the process to appeal the decision when the Member or Member’s designee is not satisfied with Parkland’s decision.

If I am not satisfied with the outcome, who else can I call?
If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll free to 1-800-252-3439. If you would like to make your request in writing send it to:
If you can get on the internet, you can send your complaint in an email to

Can someone from Parkland Community Health Plan help me file a Complaint?
Parkland Community Health Plan’s Member Advocate will be available to assist the Member or Member’s designee with understanding and using the complaint process. If the complaint is received verbally, the Member Advocate will send a verbal complaint form documenting the verbal complaint. Once the Member or Member’s designee has reviewed and agrees with this documentation of the verbal complaint, the Member or Member’s designee will return the verbal complaint form to the Member Advocate. If the complaint form is not returned to the Member Advocate within 15 calendar days from date on letter, a determination will be made based on information available.

How long will it take to investigate and resolve my Complaint?
Within 5 business days of receipt of a complaint by a Member or Member’s designee, the Member Advocate will send written acknowledgement of receipt of the complaint. This acknowledgement letter will indicate a description of the complaint process and the 30 calendar day time frame for resolution of the complaint. Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization will be concluded in accordance with the medical immediacy of the case, but may not exceed 1 business day from receipt of the complaint. Once the complaint has been resolved, the Member Advocate will send a response letter to the Member or Member’s designee with the resolution of the complaint, including the process to appeal the decision when the Member or Member’s designee is not satisfied with Parkland Community Health Plan’s decision.

If I am not satisfied with the outcome, who else can I call?
If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll free to 1-800-252-3439. If you would like to make your request in writing send it to:

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

If you can get on the internet, you can send your complaint in an email to

CHIP Member Appeal Process

What can I do if the Parkland Community Health Plan denies or limits my patient’s request for a Covered Service?
A Member, a person acting on behalf of the Member, or the Member’s physician or health care provider with written consent from the member, may appeal an adverse determination orally or in writing. Any complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of the adverse determination.

How will I find out if the Appeal is denied?
Our Utilization Review Department will notify the Member or a person acting on behalf of the Member and the Member’s provider of a determination made in a utilization review. A notice of action or adverse determination will be provided in writing in case of a denial or limited authorization of a requested service, including the denial in whole or part of payment for a service; the denial of a type or level of service; and/or the reduction, suspension or termination of a previously authorized service. Notification of an adverse determination will include:
• The action taken or proposed
• Principal reasons for the action or adverse determination
• The clinical basis for the action or adverse determination A description or the source of the screening criteria that were utilized as guidelines in making the determination
• A description of the procedure for the appeal process, including:
  o Notification of the right for the Member to appeal an action or adverse determination orally or in writing and the procedures to request an appeal
  o A statement explaining that HMO must make its decision within 30 days from the date the appeal is received by HMO, or 3 business days in the case of an expedited appeal and
  o Notification of the right to request a Fair Hearing within 120 days from date of notice of Action or adverse determination.
• An explanation that Members may represent themselves, or be represented by a provider, a friend, a relative, legal counsel or another spokesperson;
• A statement that if the Member wants a HHSC Fair Hearing on the action or adverse determination, Member must make, in writing, the request for a Fair Hearing within 120 days of the date on the notice or the right to request a hearing is waived;
• A statement explaining that the hearing officer must make a final decision within 120 days from the date a Fair Hearing is requested;
• A description of the circumstances under which expedited resolution is available and how to request it;
• Notification of right to an expedited Fair Hearing after exhausting the health plan’s expedited appeal process;
• Notification of the right for the Member to request continuation of benefits pending resolution of the appeal and the circumstances under which the enrollee may be required to pay the costs of services;
• The date that the action or adverse determination will be taken.

Timeframes for the Appeal process
All appeals must be received within 60 calendar days from the date of the notice of an adverse determination. When an oral appeal of adverse determination is received, a one-page verbal appeal form, documenting the verbal appeal, will be sent to Member for review and signature. The time frame in which the appeal is resolved will be based on the medical immediacy of the condition, procedure, or treatment under review, but will not exceed 30 calendar days unless an extension is requested by the Member or the Member designee is notified of the reason an extension would be in the Member’s best interest. Within 5 working days from receipt of the written or verbal appeal, the Member Advocate will send an acknowledgement letter. The acknowledgement letter will include:
• The date of receipt of the appeal
• A description of the appeal procedure and time frames,
• The right of the Member or authorized representative to examine the Member’s case file, including medical records and any other information, at any time before or during the appeal process
• The right of the Member to present evidence, and allegations of fact or law, in person, as well as in writing
• A list of the documents that will need to be submitted for review during the appeal process.

The services being received by the Member, including the benefit that is the subject of the appeal, will be continued if all of the following criteria are met:

• The Member or his or her representative files the appeal timely as defined in the contract
• The appeal involves the termination, suspension, or reduction of a previously authorized service
• The services were ordered by an authorized provider;
• The period covered by the original authorization has not expired; and
• The Member or his or her representative timely requests an extension of the benefits.
• If, at the Member’s request, Parkland continues or reinstates the Member’s benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
  • The Member withdraws the appeal
  • 10 days pass after Parkland Community Health mails the notice, providing the resolution of the appeal against the Member, unless the Member, within the 10-day time frame, has requested an External Review.
  • The External Review Organization issues a hearing decision adverse to the Member
  • 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.

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

In the event that the complaint is not resolved to the satisfaction of the Member, the Member or Member’s designee may request an appeal through the Member Advocate at the address noted above.

**Can someone help me file an Appeal?**

If the appeal is received verbally, the Member Advocate will send a verbal appeal form documenting the verbal appeal. Once the Member or Member’s designee has reviewed and agrees with this documentation of the verbal appeal, the Member or Member’s designee will return the verbal appeal form to the Member Advocate for processing. All oral appeals received must be confirmed by a written, signed appeal by the Member or Member’s designee, unless an expedited appeal is requested.

**Member Expedited PCPH Appeal**

**How to request an Expedited Appeal**

The Member or Member’s designee may ask for an expedited appeal if he/she believes that taking the time for the standard appeal process could seriously jeopardize the life or health of the Member. Requests for an Expedited Appeal can be made verbally or in writing as indicated in the Member Complaint to HMO Process listed above. Expedited appeals for emergency care denials and denials of continued hospital stays will be reviewed by a Medical Director that was not involved in the original denial and is of the same or a similar specialty as typically manages the medical condition, procedure, or treatment under review.

**Timeframes**

The time frame in which the appeal is completed will be based on the medical immediacy of the condition, procedure, or treatment, but will not exceed 1 working day from the date all information necessary to complete the appeal is received.

**What happens if Parkland denies the request for an Expedited Appeal?**

If the Member or Member’s designee requests an expedited appeal for a denial that does not involve an emergency, an ongoing hospitalization or services that are already being provided they will be notified that the appeal review cannot be expedited and include the reason for the denial with instructions on how the member can file a complaint. If the Member or Member’s designee does not agree with this decision they may submit a request for an External Review as described below.

Members may also file a complaint to the TDI by calling **1-800-252-3439** or writing to:

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

**Who can help me file an Expedited Appeal?**

The Parkland Community Health Plan Member Advocate will be available to assist the member or member’s
designee with understanding and using the complaint and appeals process including expedited appeals.

**Member Independent Review Organization Process**

**What is an Independent Review (IRO)?**
An independent review (IRO) is done by an organization that has no connection to Parkland Community Health or with health care providers that were previously in your treatment or decisions made by Parkland Community Health about services that have not been provided.

**How do I request a review by an IRO through the External review Process?**
The Member or someone acting on the member’s behalf and the provider of record (with members written consent) have the right to request a Standard External Review through MAXIMUS within 4 months after the date of this notification. To request the standard External Review, complete the HHS Federal External Review Request Form enclosed. Mail or fax the form along with this letter directly to MAXIMUS at:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax number: 1-888-866-6190

Or the member can submit your request online at externalappeal.com under the “Request a Review Online” heading.

**Expedited IRO**
The member or an individual acting on behalf of the member, or member’s provider of record (with written consent from the member) can ask that the External Review of the appeal be handled right away. If the member believes waiting for a decision would cause you harm.

To ask for an expedited external review:

- The member can e-mail the request to FERP@maximus.com
- Call the Federal External review Process at 888-866-6205 ext. 3326 or
- Selecting “expedited” when submitting the review request online

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.

**Timeframes**

For standard External Review request:

The MAXIMUS Federal Services examiner will contact Parkland Community Health when they receive the request for External Review. Within five (5) business days, Parkland Community Health will give the examiner all documents and information used to make the internal appeal decision.

The member or someone acting on the member’s behalf will receive written notice of the final External Review decision as soon as possible, but no later than 45 days after the examiner receives the request for an External Review.

For expedited or fast External Review request:

The MAXIMUS examiner will give Parkland Community Health and the member or the person filing on the
member’s behalf the External Review decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request.

The member or someone acting on the member’s behalf will receive the decision over the phone, but MAXIMUS will also send a written version of the decision within 48 hours of the phone call notification.

**State Fair Hearing Information**

**Can a Member ask for a State Fair Hearing?**
If a Member, as a member of the health plan, disagrees with the health plan’s decision, the Member has the right to ask for a fair hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the Parkland Community 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 fair hearing within 90 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 fair hearing within 90 days, the Member may lose his or her right to a fair hearing. To ask for a fair hearing, the Member or the Member’s representative should either send a letter to the health plan at P.O. Box 569150 Dallas, TX 75356-9150 or call 1-888-672-2277 (Parkland HEALTHfirst); 1-888-814-2352 (Parkland KIDSfirst).

If the Member asks for a 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, and at least until the final hearing decision is made. If the Member does not request a 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 fair hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most fair hearings are held by telephone. 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.

**PCHP’s Quality Assurance and Performance Improvement Plan**
PCHP’s Quality Assurance and Performance Improvement Plan (“QAPI”) is designed to meet state law requirements, and is described at Appendix R.

**Dispute Resolution**
The Parties will resolve any dispute between them according to the Commercial Dispute Resolution Rules of the American Arbitration Association, or through such other entity or other rules as they may agree upon.

Any arbitration must be filed within: (1) 30 days of the Final Decision if it involves a termination of the Parties’ contract or PCHP denying credentials to a Provider; (2) one year of giving Written Notice about the claim(s) if it involves an underpayment or overpayment Issue; and (3) one year of the act or omission giving rise to the legal or equitable claim of the Party initiating the arbitration.

Each Party will bear its own costs, expenses and attorneys’ fees in any arbitration.

**Conclusion**
Should you have questions, please contact PCHP at the phone numbers listed in the “Important Contact Information” section of this Manual and in Appendix A.