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INTRODUCTION

Thank you for your participation in the Texas Health Network. Your participation is appreciated and is essential to the success of Medicaid managed care in Texas.

Texas STAR Program Background
The Texas STAR (State of Texas Access Reform) Program was established in 1993 when the Texas Legislature adopted legislation which authorized the Texas Health and Human Services Commission (HHSC) to undertake a comprehensive restructuring of the Texas Medicaid Program. This restructuring introduced to the Medicaid Program two managed care delivery systems: a Health Maintenance Organization (HMO) model, and an enhanced Primary Care Case Management (PCCM) model. Eligible Medicaid clients residing in one of the service delivery areas and who receive Temporary Assistance to Needy Families (TANF) or TANF-related benefits are required to choose from one of the above options.

HMO Model
The HMO model consists of a network of providers, contracted with the individual health maintenance organizations (HMO). The client chooses an HMO, then a contracted primary care provider (PCP) for the delivery of care. The health plan is responsible for educating and supporting their provider network, performing utilization management, and the majority of claims processing.

STAR+PLUS (Harris County Only)
STAR+PLUS is a demonstration pilot that integrates acute, long term, and primary care into one managed care delivery system. It is designed to improve access to care, emphasize community-based care, and provide more accountability and cost control. The Texas Health and Human Services Commission (HHSC) is the operating agency for STAR+PLUS.

Enhanced PCCM Model
The Texas Health Network is an enhanced PCCM model, a primary care provider network developed by the Texas Health and Human Services Commission (HHSC). Texas Health Network members select or are assigned a PCP from among those who have contracted with the HHSC. In addition to the standard covered benefits of the Texas Medicaid program, Texas Health Network members, as part of the Texas STAR Program, are eligible for the following expanded benefits:

- Unlimited prescriptions
- Unlimited medically necessary inpatient days
- Annual adult physical exams (performed by the PCP)

Texas STAR Program Goals
Through the development and implementation of these two managed care delivery systems, the principle objectives of the Texas STAR Program can be achieved. These goals are:

- Improve access to care for Texas STAR Program clients
- Increase quality and continuity of care
- Ensure appropriate utilization of services
- Improve cost effectiveness
- Improve provider and member satisfaction

Primary Care Provider
The primary care provider is responsible for establishing a “medical home” for those members who have either selected or who have been assigned to them. This means either furnishing or arranging for 24-hour, 7-day a week availability, providing or coordinating all of the client’s health care needs, and documenting all medically necessary services in the patient’s medical record. A complete list of the primary care provider’s responsibilities can be found in Chapter II.
Facilities
Though the primary care provider’s role is a crucial one, the role of the hospital, emergency room, and other facilities is equally as important and should not be overlooked. Through constant communication with the PCP, and on-going member education, these facilities have the opportunity to reduce the inappropriate use of emergency rooms and services, reduce the incidence of repeat services for the same medical condition, and reinforce the need for a medical home.

Specialists
The Texas Health Network has an open specialty network. Texas Health Network members may be referred to any specialist within the State that accepts Texas Medicaid. Specialists are responsible for furnishing medically necessary services to Texas Health Network members who have been referred by their PCP for specified treatment and/or diagnosis. In order to ensure continuity of care, the specialist is required to maintain communication with the member’s PCP. This communication ensures that the member’s medical record adequately documents the services provided, all results or findings, and all recommendations.

Additional Features
As a PCP in the Texas Health Network you receive fee-for-service reimbursement for the care you provide plus a case management fee to manage the needed services for each member, whether or not you see the member during that month.

All Texas Health Network providers receive:

- Fee-for-service reimbursement for services provided
- Services and support, including a toll-free helpline, informational workshops, and data to help you analyze your practice
- A local advocate—A Provider Relations Representative available in your area who serves as an advocate for providers
- A toll-free, 24-hour, 7-day nurse line for your Texas Health Network members to call for clinical assistance

As part of the Texas STAR Program, Texas Health Network members receive the following:

- All Medicaid-covered services
- Unlimited medically necessary prescriptions
- Annual adult physical exams
- Unlimited medically necessary inpatient days
- A local advocate—a Member Outreach Representative available in your area who serves as an advocate for Texas Health Network members. This includes assisting the member with access to appropriate services and providing plan and benefits information

The pages that follow document in greater detail the roles and responsibilities of all involved in Medicaid managed care and specifically the Texas Health Network. We ask that you review this manual with your staff and encourage them to familiarize themselves with its contents and provisions. We welcome your suggestions on improving the policies, procedures, and practices described herein and look forward to assisting you in your successful participation in the Texas Health Network.
**QUICK REFERENCE**

These Texas Health Network numbers will be helpful:

<table>
<thead>
<tr>
<th>Texas Health Network Helplines</th>
<th>The Nurse Line</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider Helpline</strong>*&lt;br&gt;Monday through Friday 7:00 am – 6:00 pm&lt;br&gt;1-888-834-7226&lt;br&gt;Fax: 1-512-302-5068</td>
<td><strong>The Nurse Line: Clinical Helpline</strong>&lt;br&gt;24 hours a day, 7 days a week&lt;br&gt;1-800-304-5468</td>
</tr>
<tr>
<td><strong>Member Helpline</strong>&lt;br&gt;Monday through Friday 7:00 am – 6:00 pm&lt;br&gt;1-888-302-6688</td>
<td><strong>MAXIMUS</strong>&lt;br&gt;Texas STAR Program Enrollment Broker&lt;br&gt;(Member Enrollment, Plan Changes)&lt;br&gt;1-800-964-2777</td>
</tr>
<tr>
<td><strong>Utilization Management Helpline</strong>&lt;br&gt;(Precertification, Inpatient Notification, Continued Stay Requests, etc.)&lt;br&gt;Monday through Friday 7:30 am – 5:30 pm&lt;br&gt;1-888-302-6167&lt;br&gt;Fax: 1-512-302-5039</td>
<td><strong>Member Eligibility</strong>&lt;br&gt;Verification of Member Eligibility&lt;br&gt;Verify electronically using TDHconnect, or call the&lt;br&gt;Automated Inquiry System (AIS),&lt;br&gt;24 hours a day, 7 days a week&lt;br&gt;1-800-925-9126&lt;br&gt;or (512) 345-5948 or (512) 345-5949&lt;br&gt;See the AIS User’s Guide in the Texas Medicaid Provider Procedures Manual</td>
</tr>
<tr>
<td><strong>Case Management Helpline</strong>&lt;br&gt;(Case management intake, Wellness &amp; Health Promotion)&lt;br&gt;Monday through Friday 8:00 am - 5:00 pm&lt;br&gt;1-888-276-0702</td>
<td><em>For questions on claims filing procedures, please refer to the current Texas Medicaid Provider Procedures Manual.</em></td>
</tr>
<tr>
<td><strong>Prenatal Care Line</strong>&lt;br&gt;(Initial appointments for obstetrical care for pregnant members)&lt;br&gt;1-877-518-0899</td>
<td></td>
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</table>

*For questions on claims filing procedures, please refer to the current Texas Medicaid Provider Procedures Manual.*
TERMS AND DEFINITIONS

The following terms and definitions are used throughout this manual.

AFDC  Aid to Families with Dependent Children. See TANF.

AIS  Automated Inquiry System. A telephonic system to verify the eligibility of Medicaid clients and obtain the status of claims submitted.

BBS  Bulletin Board System

C21  Compass21. Claims and encounters processing system developed for the Texas Health and Human Services Commission (see HHSC).

CCP  Comprehensive Care Program. Expanded medical benefits available through Texas Health Steps (THSteps) for children and youth who require services that are not normally provided in the Texas Medicaid Program.

CMS  Centers for Medicare and Medicaid Services. The federal agency responsible for administering Medicare and overseeing state administration of Medicaid. Formerly known as Health Care Financing Administration (HCFA).

COB  Close of Business

CQI  Continuous Quality Improvement. An ongoing process to identify opportunities to improve the delivery of medical care or services, define corrective actions, and follow-up to assess the effectiveness of the improvement efforts.

DHS  Department of Human Services.


EB  Enrollment Broker. The contractor to the Texas Health and Human Services Commission responsible for the identification and enrollment of eligible Medicaid clients into managed care programs. The State contracted Enrollment Broker is MAXIMUS Corporation. The Enrollment Broker assists Medicaid clients in the initial enrollment into managed care by providing client education on the Texas STAR Program, assisting members in choosing a plan and primary care provider (PCP) within that health plan, and by processing plan change requests.

EPSDT  Early and Periodic Screening, Diagnosis and Treatment. See THSteps.

EQRO  External Quality Review Organization. See also ICHP.

HHSC  Health and Human Services Commission. The State agency responsible for the administration of the Texas Medicaid Program, which includes the Texas STAR Program.

HIPAA  Healthcare Information Portability and Accountability Act.

ICHP  Institute for Child Health Policy. Contractor responsible for oversight of Quality Improvement Programs and activities of managed care organizations participating in the Texas STAR Program.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance. An organization dedicated to the definition and measurement of health care quality through process and outcome indicators using standardized data collection methodologies.</td>
</tr>
<tr>
<td>OIE</td>
<td>Office of Investigations and Enforcement. Office through which HHSC establishes criteria for identifying cases of possible fraud and abuse, investigates cases of program abuse, and recoups all overpayments to a provider.</td>
</tr>
<tr>
<td>PCCM</td>
<td>Primary Care Case Management. In the Texas STAR Program, a managed care option in which a member selects or is assigned a primary care provider who manages his or her health care and who must authorize most other medical services before these services will be reimbursed by the Texas STAR Program.</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Provider. A physician with a specialty in family practice, general practice, pediatrics, internal medicine or obstetrics and gynecology; a Federally Qualified Health Center; a Rural Health Clinic; a Certified Nurse Midwife; or an Advanced Practice Nurse with a specialty in pediatrics, family practice, general practice, or women’s health. Specialists providing primary care services to chronically ill or disabled Medicaid clients may serve as PCPs. Texas Health Network members select, or are assigned, a PCP to manage their health care.</td>
</tr>
<tr>
<td>Phoenix</td>
<td>Software system used for processing all facets of state-run health care information by the Texas Medicaid Claims Administrator.</td>
</tr>
<tr>
<td>QARI</td>
<td>Quality Assurance Reform Initiative. A set of standards developed by the CMS (formerly HCFA) to ensure the quality of Medicaid managed care programs.</td>
</tr>
<tr>
<td>QIP</td>
<td>Quality Improvement Plan. Developed by a health plan to meet the standards established by NCQA or QARI to measure and improve quality in managed care programs.</td>
</tr>
<tr>
<td>QMIC</td>
<td>Quality Management and Improvement Committee. Organized by a health plan to develop, implement, and assess the effectiveness of a quality improvement program.</td>
</tr>
<tr>
<td>STAR</td>
<td>State of Texas Access Reform. The Texas Medicaid reform initiative that will move most Medicaid clients into managed care programs. The Texas STAR Program has two managed care options: a capitated Health Maintenance Organization, and a fee-for-service Primary Care Case Management plan.</td>
</tr>
<tr>
<td>TANF</td>
<td>Temporary Assistance to Needy Families and TANF-Related. A federally funded program that provides financial assistance to single parent families with children who meet the categorical requirements. TANF recipients are eligible for Medicaid services. Federal welfare reform legislation retitled AFDC to TANF.</td>
</tr>
<tr>
<td>TDH</td>
<td>Texas Department of Health. The state agency responsible for the administration of programs such as Medical Transportation, THSteps, and family planning.</td>
</tr>
<tr>
<td>TDHconnect</td>
<td>Software system used to submit claims electronically to the Texas Medicaid Claims Administrator. TDHconnect is offered free to all Texas Medicaid Providers.</td>
</tr>
<tr>
<td>TDHS</td>
<td>Texas Department of Human Services.</td>
</tr>
<tr>
<td><strong>THSteps</strong></td>
<td>Texas Health Steps. The Texas Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. EPSDT is a federally mandated Medicaid program designed to prevent, identify, and treat potentially disabling diseases in eligible infants, children, and youths up to the age of 21.</td>
</tr>
<tr>
<td><strong>TMMIS</strong></td>
<td>Texas Medicaid Management Information System. The Medicaid Management Information System (MMIS) that meets required Federal standards and is a joint effort of the Texas Department of Health, the Texas Department of Human Services, and the Texas Medicaid Claims Administrator.</td>
</tr>
<tr>
<td><strong>TPI</strong></td>
<td>Texas Provider Identifier. A unique nine-character provider number composed of a seven-character base and a two-character suffix, which replaces the traditional Medicaid provider number assignment methodology.</td>
</tr>
</tbody>
</table>
CHAPTER I
COVERED SERVICES

Overview

Eligible Medicaid clients enrolled in the Texas Health Network can receive all services detailed in the Texas Medicaid Provider Procedures Manual. In addition, as part of the Texas STAR Program, Texas Health Network members can receive added benefits and services. This chapter describes the services covered under the traditional Medicaid program as well as additional benefits for Texas Health Network members.

Medicaid Covered Services........................................................................................................................................... I-2
Additional Benefits of the Texas STAR Program ................................................................................................. I-4
Behavioral Health Services ........................................................................................................................................ I-8
NorthSTAR Program (Dallas Service Area Only) .................................................................................................. I-9
Medicaid Covered Services

Texas Health Network members are entitled to all medically necessary services currently covered under the Texas Medicaid Program. Please refer to the current Texas Medicaid Provider Procedures Manual for details on coverage and limitations, and for specific claims filing procedures for each service listed below:

- Adult Well Check
- Advanced Practice Nurse (APN)
- Ambulance Services
- Ambulatory Surgical Center Services (ASC)
- Behavioral Health*
- Birthing Center Services
- Case Management
- Certified Nurse Midwife Services (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Chemical Dependency Services
- Chiropractic Services*
- Dental Services
- Emergency Services
- Family Planning Services
- Federally Qualified Health Centers (FQHC)
- Genetics Services
- Hearing Aid Services*
- Home Health Services
- Inpatient Hospital Care
- Inpatient Surgery
- Laboratory and Radiology Services
- Licensed Marriage and Family Therapist*
- Licensed Master Social Worker – Advanced Clinical Practitioner (LMSW-ACP)*
- Licensed Professional Counselors (LPC)*
- Maternity Clinic Services
- Mental Health Services
- Occupational Therapy
- Outpatient Surgeries
- Pediatric Services
- Physical Therapy
- Psychologist*
- Podiatry Services*
- Respiratory Care
- Renal Dialysis Facility Services
- Routine Care (Physician Services)
- Rural Health Services
- School Health and Related Services (SHARS)
- Speech/Language Therapy
- Texas Health Steps Services
- Total Parenteral Hyperalimentation
- Transplant Services
- Tuberculosis Clinics (TB)
- Vision Care*

*These services were affected by recent changes made to the Medicaid Program. Please refer to Texas Medicaid Bulletin number 174, HIPAA Special Bulletin Update for specific benefit limitations.
Except as specified below, PCPs shall provide (directly or through referrals) all Medicaid-covered services.

**Freedom-of-Choice Services (Self-Referred)**
Texas Health Network members may select any Medicaid-enrolled provider to access the following services without a referral:

- **Emergency Services**—In case of a true medical emergency, members may seek emergency medical services from the nearest facility. To ensure continuity of care, the emergency facility is asked to contact the member’s PCP within 24 hours or the next business day after providing services. PCPs or a PCP’s designee must be available to respond to an ER call promptly. If the emergency visit results in an admission, the facility also must notify the Texas Health Network within 24 hours or the next business day after the admission (see the notification guidelines in Chapter III of this manual for details).

- **Family Planning Services**—Family planning services include preventive health, medical counseling, and educational services that assist individuals in planning and/or preventing pregnancy and achieving optimal reproductive and general health. Texas Health Network members are free to select a Texas Medicaid family planning provider to access family planning services. PCPs are encouraged to provide these services if requested by a member. Members are not required to obtain Family Planning services through their PCP. While family planning is a Freedom-of-Choice service, any inpatient services should be delivered in a Texas Health Network-contracted facility.

- **Texas Health Steps (THSteps)**—Texas Health Network members are free to select any THSteps enrolled Texas Medicaid provider to perform THSteps services (EPSDT Program screenings). All Medicaid clients are eligible for THSteps screening services through the end of the month of their 21st birthday (in accordance with the medical screening, immunization, and adolescent screening periodicity schedules published in the *Texas Medicaid Provider Procedures Manual*.) If THSteps screening is performed by a provider who is not the member’s PCP, this information should be forwarded to the member’s PCP so that the member’s medical record can be updated. (See Chapter VII of this manual for details.)

- **Vision Services**—Members do not need a referral to access necessary covered vision services for refractive errors. However, any diagnosed condition or abnormality of the eye that requires treatment or additional services beyond the scope of an exam for refractive errors must be referred back to the member’s PCP. Vision care providers who furnish additional services must have a referral from the member’s PCP. Covered vision services are:
  - One eye exam each state fiscal year (September 1 through August 31) for clients under 21 years of age unless there is a diopter change of 0.5 or more
  - No limitation for clients under 21 years of age on the number of replacements for lost or damaged eyeglasses
  - One eye exam every 24 months for assessing the need for eyeglasses for adults
  - Unlimited medically necessary eye exams for a diagnosis of illness or injury

- **Behavioral Health Services**—Except in the Dallas Service Area (see page I-9), behavioral health services are Freedom-of-Choice services. These services include mental health and substance abuse services provided by a Medicaid-enrolled psychiatrist, psychologist, LPC, or LMSW-ACP, LMFTs, and TCADA licensed facilities. However, these services were affected by recent changes made to the Medicaid Program. Please refer to *Texas Medicaid Bulletin number 174, HIPAA Special Bulletin Update* for specific benefit limitations.
In addition, many services are offered through the Texas Department of Mental Health and Mental Retardation (MHMR) that do not require a referral. These include case management for mental health and mental retardation, mental health rehabilitative services, and mental retardation diagnosis and assessment.

- **ECI**—Case management for Early Childhood Intervention (ECI).
- **PWI**—Case Management for the Pregnant Women and Infants program (PWI).
- **School Health and Related Services (SHARS)**—Members may select any qualified provider to access medically necessary and reasonable services to ensure that Medicaid-eligible children with disabilities receive the benefits mandated by federal and state legislation that guarantees a free and appropriate public education.
- **School-Based Clinic Services**—Members may receive services from school-based clinics without a referral from their PCP.

### Additional Benefits of the Texas STAR Program

In addition to the standard covered benefits of the Texas Medicaid Program, Texas Health Network members, as part of the Texas STAR Program, are eligible for the following expanded benefits:

- **Unlimited Prescriptions**—The three prescription per month limit has been eliminated. Texas STAR Program members receive unlimited medically necessary prescriptions, as listed on the Vendor Drug formulary.
- **Unlimited Medically Necessary Inpatient Days**—The 30-day inpatient “spell of illness” limitation has been removed for Texas STAR Program members age 21 and over. Members under the age of 21 have this benefit through the Comprehensive Care Program (CCP) of THSteps.
- **Annual Adult Physical Exams**—Annual physical exams performed by the PCP are a covered benefit for members age 21 and older. Physical exams are provided in addition to family planning services for the purpose of promoting health and preventing illness or injury, including counseling concerning family problems, nutrition, exercise, substance abuse, sexual practices, and injury prevention. Providers should encourage their members to schedule a physical exam each year.

The annual adult physical exam is permitted once every State fiscal year (September 1 through August 31) for each adult member and is reimbursable only when performed by the member’s PCP. The CPT codes listed below should be used for billing the annual adult physical exam, based on the age of the patient. Reimbursement is at the Medicaid fee schedule rate.

<table>
<thead>
<tr>
<th>CPT Codes</th>
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<tbody>
<tr>
<td><strong>New Patient</strong></td>
<td></td>
</tr>
<tr>
<td>99385</td>
<td>18-39 years (payable only for members age 21 and older* )</td>
</tr>
<tr>
<td>99386</td>
<td>40-64 years</td>
</tr>
<tr>
<td><strong>Established Patient</strong></td>
<td></td>
</tr>
<tr>
<td>99395</td>
<td>18-39 years (payable only for members age 21 and older* )</td>
</tr>
<tr>
<td>99396</td>
<td>40-64 years</td>
</tr>
</tbody>
</table>

*For patients ages 18-20, bill the appropriate Medicaid-only THSteps Medical code (see section 40-16 of the Texas Medicaid Provider Procedures Manual).
**OB/GYN Services**
Texas Health Network members may select a Texas Health Network-contracted OB/GYN as their PCP. As a PCP, the OB/GYN is responsible for providing or arranging for all medically necessary services. Texas Health Network members may also seek direct services of any Medicaid-enrolled OB/GYN who is not their PCP for the following services:

- One well-woman examination per year
- Care related to pregnancy
- Care for all active gynecological conditions and
- Diagnosis, treatment, and referral to a Medicaid-enrolled specialist for any disease or condition within the scope of the designated professional practice of a licensed obstetrician or gynecologist, including treatment of medical conditions concerning the breasts

PCPs shall continue to provide their Texas Provider Identifier (TPI) to any Medicaid-enrolled OB/GYN providing these services to Texas Health Network members.

The Texas Health Network assists with the scheduling of members’ initial prenatal appointments via the Prenatal Care Line (1-877-518-0899).

**Case Management Services**
The goal of the Texas Health Network’s case management program is to facilitate coordination of health-related services required by Texas Health Network members. This means collaborating with providers, members, and their families in identifying problems, resources and removing barriers in accessing treatment and services. Texas Health Network case managers are located in all Texas Health Network service areas. Services offered by case management staff include:

- The management of high-risk OB in conjunction with the member’s physician
- Pediatric case management services of acute and chronically ill children
- Case management for all chronic and/or complex cases identified and eligible for case management services
- Assistance in accessing State and community resources

By offering the above services, the Texas Health Network assists both providers and members with early, expedited access and intervention, increasing the likelihood of improved health outcomes.

Providers interested in referring a member for case management services may do so through the following methods:

- Completing the Texas Health Network Referral Form found in Appendix C of this manual and faxing to 1-512-302-0318
- Calling the Intake Department at 1-888-276-0702

**Wellness and Health Promotion Services**
Health Educators and Wellness Coordinators work in the Texas Health Network service areas to provide health education services to members to increase access to care and improve healthy behaviors and treatment compliance. The intent of wellness and health promotion is to educate members, thereby
enabling them to recognize health problems and risky behaviors in order to prevent illness and future health conditions.

Health Educators provide a variety of health education classes on topics such as childhood illnesses, asthma, diabetes, Texas Health Steps, immunizations, prenatal care, and STDs/HIV. These classes are held at different locations within the community such as schools, WIC clinics, community centers, and doctor’s offices. In addition, Health Educators also provide one-to-one education to members through a referral system.

Members can be referred to a Texas Health Network Health Educator for education on the following subjects:

- A newly diagnosed condition
- Dental health
- Nutrition
- Safety
- Asthma management
- Diabetes management
- Prenatal education
- Puberty education

Wellness Coordinators can assist members in obtaining food, clothing, and other resources by linking them with organizations in the community.

Providers interested in scheduling a health education program in their office or referring a Texas Health Network member for health education or community resources can do so by:

- Completing the Texas Health Network Referral Form found in Appendix C of this manual and faxing to 1-512-302-0318; or
- Calling the Intake Department at 1-888-276-0702.

TDHS Hospice Services

TDHS Long Term Care Policy Section manages the Hospice Program through provider enrollment contracts with hospice agencies. These agencies must be licensed by the state and Medicare-certified as hospice agencies. Service coverage follows the amount, duration, and scope of services specified in the Medicare Hospice Program. The Texas Medicaid Claims Administrator pays for services unrelated to the treatment of the client’s terminal illness and for certain physician services (not the treatments).

Medicaid Hospice provides palliative care to all Medicaid-eligible clients (no age restriction) who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal illnesses run their normal courses. Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

When clients elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness. Medicare and Medicaid clients must elect both the Medicare and Medicaid Hospice programs. Individuals who elect hospice care are issued a Medicaid Identification (Form 3087) with “HOSPICE” printed on it. Clients may cancel their election at any time.
For hospice program policy questions, call the TDHS Long Term Care policy section at 512-438-3169.

TDHS Hospice pays the provider and all services related to the treatment of the terminal illnesses. The Provider Claims Payment Unit (TDHS Medicaid Hospice) pays for a variety of services under a per diem rate for any particular hospice day in one of the following categories:

- Routine home care
- Continuous home care
- Respite care
- Inpatient care

For TDHS Hospice billing questions, call 512-490-4666.

When the services are unrelated to the terminal illness, Medicaid pays providers directly. Providers are required to follow Medicaid guidelines for prior authorization when filing claims for hospice clients.

For questions about hospice billing, call 1-800-626-4117. Fax authorization requests to 512-514-4209.

Non-hospice providers may be reimbursed for services rendered to a Medicaid hospice client. Paper claims can be mailed to the following address:

Texas Medicaid Claims Administrator
PO Box 200105
Austin, Texas  78720-0105

Appeal claims by writing to the following address:

Texas Medicaid Claims Administrator
PO Box 200645
Austin, Texas  78720-0645

**Medical Transportation Program (MTP)**
The Medical Transportation Program (MTP) was created in 1975 as a result of a federal court order. Funded by Title XIX and State funds, MTP provides eligible Medicaid clients with non-emergency transportation to reasonably close and medically appropriate care facilities. MTP ensures that Medicaid clients who have no other means of transportation have access to medical facilities that provide medically necessary Medicaid-covered services.

**Contacting MTP**
Members should contact the Statewide MTP office to request transportation services at least 48 hours before the scheduled medical appointment. The following number should be used to obtain more information or to schedule transportation services:

Statewide
1-877-MEDTRIP
(1-877-633-8747)
Behavioral Health Services

Behavioral health services are provided for the treatment of mental disorders, emotional disorders, and chemical dependency disorders. Except in the Dallas Service Area (see page I-9), behavioral health services are Freedom-of-Choice services. Texas Health Network members may self-refer to any Medicaid-enrolled behavioral health provider for treatment. A referral from the member’s PCP is not required. A PCP may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A PCP may also provide behavioral health services within the scope of their practice.

Texas Health Network members may receive any behavioral health service that is medically necessary, currently covered by the Texas Medicaid Program, and provided by a Medicaid-enrolled behavioral health provider. Behavioral health providers include psychiatrists, psychologists, LMSW-ACPs, LPCs, LMFTs, and TCADA licensed facilities. However, these services were affected by recent changes made to the Medicaid Program. Please refer to Texas Medicaid Bulletin number 174, HIPAA Special Bulletin Update for specific benefit limitations.

There are other services provided through the Texas Department of Mental Health and Mental Retardation (MHMR) such as case management for mental health and mental retardation, mental health rehabilitation services, and mental retardation diagnosis and assessment services.

Behavioral health providers are encouraged to contact a member’s PCP to discuss the patient’s general health. PCPs are encouraged to maintain contact with the behavioral health provider to document behavioral health assessments and treatments and to inform the behavioral health provider of any condition the member may have that could impact the behavioral health service delivery. However, member approval for any exchange of information between the PCP and behavioral health provider is required.

Please use the Behavioral Health Consent Form found in Appendix C.

PCPs are responsible for documenting referrals to behavioral health providers and any known self-referrals for behavioral health services in each member’s medical record.

Outpatient Services

Outpatient Behavioral health services that exceed 30 visits per member, per calendar year must be prior authorized by the Texas Medicaid Claims Administrator. All claims for Medicaid managed care behavioral health covered services are filed to the Texas Medicaid Claims Administrator in accordance with the procedures specified in the Texas Medicaid Provider Procedures Manual. Please contact the Texas Medicaid Claims Administrator at 1-800-925-9126 for prior authorization.

Inpatient Services

The Texas Health Network requires authorization for inpatient psychiatric care in an acute care facility. Texas Health Network Utilization Management staff provides concurrent review on all inpatient psychiatric admissions in an acute care facility.

Prior authorization is required for psychiatric admissions of patients under the age of 21 to a freestanding psychiatric facility. Please contact the Texas Medicaid Claims Administrator at 1-800-846-7470 to obtain authorization. Inpatient psychiatric admissions to freestanding facilities for members 21 and older are not covered under the Medicaid Program.

Detection and Treatment

An external quality review organization (EQRO) annually conducts focused studies for the purpose of improving the detection and treatment of specific disorders (i.e., depression and ADHD) by PCPs providing behavioral health services to Texas Health Network members. These studies are referenced in Chapter IX of this manual.
Program Overview
Effective July 1, 1999, the NorthSTAR program was introduced as an innovative managed care approach to delivery of mental health and chemical dependency services. The program offers publicly funded behavioral health (mental health and chemical dependency) services to residents of Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties. Using Medicaid, state general revenue, and federal block grant funds, NorthSTAR is designed to create a better-coordinated system of public behavioral health care.

NorthSTAR is a pilot project created by the following state agencies:

- Texas Department of Mental Health and Mental Retardation (MHMR)
- Texas Commission on Alcohol and Drug Abuse (TCADA)
- Texas Health and Human Services Commission (HHSC)

Working in partnership with the seven counties, these agencies are using the pilot to evaluate a managed care approach to delivery of publicly funded behavioral health care. Expected outcomes include:

- Increased access to care
- Improved quality of services
- Improved member and provider satisfaction
- Improved cost effectiveness
- Integrated mental health and chemical dependency service delivery systems

NorthSTAR Client Enrollment
Individuals who are eligible for Medicaid managed care, and individuals who are eligible for MHMR and TCADA services, will be served through NorthSTAR. Most Medicaid clients in the seven counties are required to enroll in and receive services through the NorthSTAR program in order for providers to be eligible for reimbursement.

NorthSTAR also covers some Medicaid-eligible clients not covered by STAR, such as dual Medicare/Medicaid eligibles.

Other residents of the service area, who are not eligible for Medicaid, may also receive services through NorthSTAR if they meet clinical and financial eligibility criteria. Non-Medicaid individuals, depending upon financial status, may be charged a co-pay for services based on a sliding fee scale.

Medicaid clients who enroll in NorthSTAR also enroll with ValueOptions, the Behavioral Health Organization (BHO) charged with overseeing the coordination of the client’s care.

Coordination with the Texas STAR Program
HHSC manages the Texas STAR Program’s physical health care plans, while MHMR and TCADA operate the NorthSTAR behavioral health program. Medicaid mental health and chemical dependency specialty services for STAR-eligible clients are separated or “carved out” from the Texas STAR program into NorthSTAR.
Coordination of Care
Providers treating Texas Health Network members are responsible for coordinating care with Behavioral Health Providers (BHP) to ensure continuity of care. The Texas Health Network has Care Coordinators available to assist both the PCP and the BHP with coordination of care and referrals.

Referrals and Release of Information
All providers must obtain a release of information from the member before referring care to the BHO or BHP. This release is valid for 60 days. Providers must use the Authorization to Release Confidential Information Form found in Appendix C of this manual.

Providers should share pertinent test results from the patient’s medical record with the BHP to coordinate care. NorthSTAR providers shall conduct a physical health assessment and refer members with physical medical needs to the PCP.

Inpatient Hospital Care
The primary diagnosis upon inpatient admission determines the party responsible for the reimbursement of services provided to Texas Health Network members. Providers should continue to follow the established guidelines for specialist referrals, admissions, and discharges according to the utilization management guidelines set forth by either the health plan or BHO.

In most cases, the BHO is responsible for the reimbursement of inpatient services with behavioral health diagnoses, emergency room services rendered in psychiatric facilities, and professional services rendered by BHPs. The Texas STAR Program covers inpatient general acute facility services when the primary diagnosis is not a behavioral health diagnosis and the professional services are provided by a physical medicine provider.

If a diagnosis change occurs during an inpatient stay, the health plan and BHO must coordinate care and services.

The health plan and BHO Medical Directors, in collaboration with the treating provider, will determine the most appropriate setting and treatment plan for those patients who have both medical and behavioral health diagnoses. Providers will need to file claims for services to the appropriate party according to established claim filing guidelines.

Laboratory Services
Texas Health Network PCPs may continue to refer members to any Medicaid-enrolled laboratory. For common laboratory tests, the BHP is required to contact the PCP to determine if usable test data exists, and to share test results with the PCP. The PCP is required to share information on relevant lab tests with the BHP. Providers are responsible for obtaining a signed release of information from the member (see Appendix C).

Provider Reimbursement
Effective July 1, 1999, behavioral health providers do not send claims to the Texas Medicaid Claims Administrator for most Medicaid clients in the Dallas Service Area. Providers must seek reimbursement through the NorthSTAR BHO, ValueOptions. The only exceptions are dual-eligible Medicaid/Medicare NorthSTAR members whose Medicare Part B co-insurance is paid by the Texas Medicaid Claims Administrator.
A few Medicaid clients are not eligible to join ValueOptions (clients who live in nursing facilities or ICFs/MR Intensive care facilities/Mental Retardation), or IMDs (institutions for mental disease), or who are in the custody of the TDPRS (Texas Department of Protective and Regulatory Services). The Texas Medicaid Claims Administrator continues to pay their Medicaid claims.

Mental health and chemical dependency specialists, and institutions that provide such services, should follow these guidelines to be reimbursed for services to Medicaid clients who are eligible to join NorthSTAR:

- Join the network of the NorthSTAR BHO to treat its members
- The BHO may require that you obtain prior approval for non-emergency services. If you do not obtain approval, you may not be paid
- Effective, July 1, 1999, providers will no longer send NorthSTAR behavioral health claims to the Texas Medicaid Claims Administrator for reimbursement for Medicaid-covered services
- Effective July 1, 1999, if you bill for a NorthSTAR-eligible client, the Texas Medicaid Claims Administrator will recoup the dollars paid to you

The BHO instructs the providers in their respective networks how and where to file claims for behavioral health services. If you are not a behavioral health specialist, any services you provide to treat mental health or chemical dependency disorders may be covered by a STAR HMO or the Texas Medicaid Claims Administrator. Consult with each enrollee's STAR HMO, or the Texas Medicaid Claims Administrator for fee-for-service enrollees, to confirm covered services.

**NorthSTAR Program Assistance**
If you are a mental health or chemical dependency specialist or a facility that provides such services, and you have questions or problems with billing or payment, call the NorthSTAR BHO, ValueOptions (1-888/800-6799). If you have further questions or problems, call the NorthSTAR Helpline at 1-972-906-2500.

**Guidelines for Working with NorthSTAR Clients**
Keep in mind that clients enrolled in NorthSTAR, like any other clients, have these rights:

- To be treated with respect, dignity, privacy and confidentiality, and without discrimination
- To consent to or refuse treatment and actively participate in treatment decisions
- To use each available complaint process and to receive a timely response to complaints
- To receive timely access to care that does not have any communication or physical access barriers
CHAPTER II
PROVIDER RESPONSIBILITIES

Overview

All Medicaid clients enrolled in the Texas Health Network are required to select a primary care provider (PCP). As a PCP, you are responsible for providing primary and preventive care and managing all acute and educational medical services. This chapter describes the role of the PCP and specialist in the Texas Health Network and specifies the requirements for PCP participation.

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Role of the Primary Care Provider

You are responsible for establishing a “medical home” for your patients who enroll in the Texas Health Network and select you as their PCP or are assigned to you. You and your staff are responsible for teaching your patients how to use available health services appropriately. Patients should understand that they should call your office first, before using any health service, except in emergency situations.

Contractual Obligations

PCP obligations are identified in the contract between the Texas Health and Human Services Commission (HHSC) and each PCP. These obligations are intended to assure members that they have access to quality health care from trained and credentialed providers. These obligations specify that a PCP will:

- Maintain any and all licenses in the State of Texas required by the laws governing the provider’s profession or business.
- Notify the Texas Health Network immediately of any limitation, suspension, or revocation of any license or medical staff membership.
- Obtain and maintain an acceptable general liability insurance policy as well as a professional liability insurance policy in an appropriate amount. At a minimum, the limits of liability are $100,000 per occurrence and $300,000 in the aggregate.
- Meet all HHSC credentialing and recredentialing requirements.
- Maintain all medical records relating to Texas Health Network members for a period of at least five years (six years for freestanding Rural Health Clinics and 10 years for hospital-based Rural Health Clinics) from the initial date of service, or until all audit questions, appeal hearings, investigations, or court cases are resolved.
- Comply with requests to provide copies of medical records and related documents (at no cost to the requestor) from:
  - The Texas Health and Human Services Commission (HHSC)
  - The Texas Attorney General’s Medicaid Fraud Control Unit
  - The Texas Health Network
  - The Texas Medicaid Claims Administrator
  - Texas Health Network members
- Comply with State and Federal laws and administrative regulations concerning nondiscrimination on the grounds of race, color, national origin, age, sex, disability, political beliefs, or religion.
  - These nondiscrimination requirements apply to participation in, or denial of, any aid, care, service or other benefits provided by Federal and/or State funding.
  - These laws and codes include Title VI of the Civil Rights Act of 1964 (Public Law 88-352); Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112); the Americans with Disabilities Act of 1990 (Public Law 101-336); Title 40, Chapter 73, of the Texas Administrative Code; and all amendments to each and all requirements imposed by the regulations issued pursuant to these acts.
Additional Criteria for Primary Care Providers

All PCPs must meet credentialing/recredentialing criteria. PCPs are also required to meet the following criteria:

- **Ability to Perform or Directly Supervise the Ambulatory Primary Care Services of Members**—Provider performance is monitored on an ongoing basis through the Texas Health Network’s Continuous Quality Improvement Program. The Texas Health Network Administrator follows up on evidence of poor performance and addresses identified problems immediately to ensure that high-quality care is delivered to members.

- **Admitting Privileges**—The PCP must maintain admitting privileges with a hospital which is a participating provider in the Texas Health Network, or make arrangements with another Texas licensed physician who is an eligible Medicaid provider and who maintains admitting privileges with a contracted Texas Health Network hospital.

- **Education Sessions**—The Texas Health Network disseminates UM, CQI and case management policies and procedures to each Texas Health Network PCP. The Texas Health Network also provides a series of educational sessions regarding all aspects of UM, CQI and case management. PCPs are encouraged to attend at least one educational session on UM, CQI, and case management policies and procedures each year.

When a PCP’s Texas Health Network credentialing file is complete, the Texas Health Network Medical Director, in conjunction with an internal Texas Health Network Credentialing Committee, verify all credentials and present their findings to the HHSC Medical Director for Medicaid and CHIP Programs (HHSC Medical Director), at the Credentialing Committee meeting. The HHSC Medical Director reviews the credentials and determines whether the applicant meets HHSC credentialing criteria. The decision to accept a provider as a Texas Health Network PCP is made by the HHSC in accordance with basic credentialing standards.

**Credentialing Committee**

**Purpose and Function of the Credentialing Committee**

The Credentialing Committee is charged with the responsibility of reviewing each provider applicant’s file to ensure that he or she meets the minimum requirements established in QARI Standard IX (see Chapter IX) and by the National Committee for Quality Assurance.

The Credentialing Committee shares the responsibility to ensure that physicians and other health care professionals are qualified to perform services as Texas Health Network providers.

The Committee reviews each provider applicant’s file and decides whether the provider should be recommended to the HHSC Medical Director as a member of the Texas Health Network provider network. If the HHSC approves the recommendation, the provider is accepted as a participating provider for three years.
The Credentialing Committee is also charged with the responsibility of recredentialing Texas Health Network providers, which occurs every three years after initial credentialing.

The Credentialing Committee also reviews and approves credentialing policies and procedures for the Texas Health Network.

**Members of the Credentialing Committee**
The Credentialing Committee is comprised of the following members:

- Chair: Medical Director, HHSC Medicaid and CHIP Programs
- Co-Chair: Medical Director, Texas Health Network
- Associate Medical Director, Texas Health Network
- Contracting and Credentialing Manager/Supervisor, Texas Health Network
- CQI Director, Texas Health Network
- Quality Improvement Manager, HHSC Medicaid and CHIP Programs

If a committee member is unable to attend a meeting, he/she may appoint a designee.

**Credentialing Committee Frequency/Logistics**
The Credentialing Committee meets monthly, or as required, to review new applications for credentialing/recredentialing. The Texas Health Network Contracting and Credentialing staff will have previously completed the initial screening for each provider in accordance with the standards of the National Committee for Quality Assurance.

**Credentialing Committee Action**
The Texas Health Network Medical Director, as the Co-Chair, is charged with implementing the credentialing and recredentialing standards for participating providers in the Texas Health Network. The HHSC Medical Director also reviews submitted documentation and recommends acceptance or rejection of each provider.

Based on this action, the HHSC executes the contract of approved providers. The Texas Health Network then notifies each approved applicant in writing of the status of his or her application. For approved providers, the notification includes:

- A fully executed provider contract
- The date upon which his or her contract is effective
- Conditions of participation in the Texas Health Network
- Recredentialing requirements

Applicants who are not approved are notified by certified mail of the denial, the reason for the denial, and the process for reconsideration. Applicants may request reconsideration by submitting evidence that the deficiency(ies) for which the original application was denied has/have been corrected.
A provider has 30 days to request a reconsideration of a recredentialing denial to the Credentialing Grievance Committee. Such requests must be in writing and submitted to the following address:

Texas Health Network
Credentialing Grievance Committee
P.O. Box 14685
Austin, TX 78761
1-888-834-7226

Credentialing Grievance Committee

Purpose and Function of the Credentialing Grievance Committee
The Credentialing Grievance Committee reviews providers’ requests for reconsideration of credentialing decisions.

Members of the Credentialing Grievance Committee
The Credentialing Grievance Committee is composed of the following members:

- Medical Director, HHSC Medicaid and CHIP Programs, or designee
- Medical Director, Texas Health Network
- Contracting and Credentialing Manager/Supervisor, Texas Health Network
- Provider/Member Services Director, Texas Health Network
- CQI Director, Texas Health Network
- Staff person from HHSC Medicaid/CHIP Program Development

Credentialing Grievance Committee Frequency/Logistics
The Credentialing Grievance Committee convenes within 60 days after receipt of a grievance or request for reconsideration. The provider is notified of the date, time, and location of the grievance hearing before the Credentialing Grievance Committee. The provider may attend the grievance hearing.

Notification of the Credentialing Grievance Committee’s Decision
The provider is notified in writing of the decision of the Credentialing Grievance Committee within 45 days after adjournment of the hearing. The Credentialing Grievance Committee forwards its recommendations to HHSC following the hearing.

A decision of the Credentialing Grievance Committee may be submitted for reconsideration to:

Texas Health and Human Services Commission
Office of General Counsel
4900 N. Lamar, 4th Floor
Austin, TX 78751
Termination/Disenrollment

PCP termination and disenrollment provisions are described below:

- You may terminate the agreement by providing the Texas Health Network with ninety (90) days’ prior written notice.
- If you are an individual practitioner, the agreement will terminate automatically upon your death or the sale of your practice or your termination as a participant in the Texas Medicaid program.
- Clinics shall notify the Texas Health Network within thirty (30) days when a provider employee leaves the employ of or terminates his or her contract with the clinic or is no longer willing to function as a PCP.
- HHSC may terminate an agreement by providing a PCP with thirty (30) days’ prior written notice.

Termination or disenrollment notification should be sent to the following address:

Texas Health Network  
Contracting and Credentialing Department  
P.O. Box 14685  
Austin, TX 78761

Please refer to Appendix C for the Provider Information Change Form. For more information, call 1-888-834-7226.

Miscellaneous Provisions

Several other provisions apply to PCP participation in the Texas Health Network:

- A PCP agreement may be modified only by written agreement signed by all parties.
- A PCP agreement is not assignable by a PCP, either in whole or in part, without the prior written consent of the HHSC.
- PCP agreements shall be governed and construed in accordance with the laws of the State of Texas.
- A PCP shall be required to bring all legal proceedings against HHSC in the Texas State courts.
- An agreement shall become effective only upon the PCP’s completion of the provider credentialing process and a determination by the HHSC or its designee that the PCP meets all of the requirements for participation in the Texas Health Network.
Services to be Provided

The Texas Health Network defines the services to be provided and the responsibilities to be assumed by a PCP as follows:

• The PCP agrees to provide primary care services to Texas Health Network members. Primary care services are all medical services required by a member for the prevention, detection, treatment and cure of illness, trauma, or disease, which are covered and/or required services under the Texas Medicaid Program. The PCP must ensure that members under the age of 21 receive all services required by the Texas Health Steps (THSteps) program (formerly EPSDT). All services must be provided in compliance with all generally accepted medical standards for the community in which services are rendered.

• Provide 24-hour, 7-day a week telephone access to needed medical care for members, either directly or through on-call arrangements. PCPs or the on-call provider must respond to an ER call in a timely manner.

• Provide or arrange for medically necessary care within the following guidelines:
  — **Urgent Care**: within 24 hours after the request
  — **Routine Care**: within two weeks after the request
  — **Physical/Wellness Exams**: within four to eight weeks after the request
  — **Prenatal Care**: initial visit within 14 calendar days of the request or by the 12th week of gestation

• Refer members to an approved Texas Medicaid provider or Texas Health Network-contracted facility when the needed services are not available through your office or clinic. Specialists to whom you refer members also should schedule appointments within the timeframes described above. For a list of contracted facilities, please contact the Texas Health Network Provider Helpline at 1-888-834-7226.

• Coordinate, monitor, and document medical treatment and covered services delivered by all providers to each member, including treatment during inpatient stays.

• Comply with all precertification and notification requirements of the Texas Health Network.

• Verify the eligibility of each member prior to providing covered services to determine whether the member is eligible for services under the Texas Health Network on the date of service.

• Coordinate care for children receiving services from or who have been placed in the conservatorship of the Texas Department of Protective and Regulatory Services (TDPRS). PCPs are responsible for furnishing or arranging for all medically necessary services while the child is under the conservatorship of TDPRS and until the child is placed in foster care and is no longer eligible for Texas STAR Program enrollment.

• Cooperate with and participate in the Texas Health Network Quality Improvement and Utilization Management Programs, as described in Chapter IX of this manual.

• Maintain hospital admitting privileges at a Texas Health Network-contracted facility as applicable or maintain a referral relationship with a provider with admitting privileges.

• Provide preventive services using clinically accepted guidelines and standards.
Continuous Coverage

Continuous coverage is an important feature of the Texas Health Network. 24-hour PCP availability enables members to access and use services appropriately, instead of relying on emergency rooms for after-hours care.

As a PCP, you are responsible for ensuring that Texas Health Network members have access to needed medical care 24 hours a day, 7 days a week.

Continuous coverage can be provided through direct access to your office and/or through on-call arrangements with another office or service. Members should be informed of your normal office hours and should be instructed how to access urgent medical care after normal office hours.

After-Hours Guidelines

You are required to have at least one of the following arrangements in place to provide 24-hour, 7-day a week coverage for Texas Health Network members:

- Have your office phone answered after hours by a medical exchange or a professional answering service. If an answering service is used, the following must be met:
  - The answering exchange or service must be able to contact you or a designated back-up provider for immediate assistance.
  - The PCP, or designated back-up provider, must be notified of all calls.
  - All calls must be returned in a timely manner by the PCP or designated back-up.
  - The answering service must meet the language requirements of the major Medicaid population groups in your area.

- Have your office phone transferred after hours to another location where someone will answer and be able to contact you or your designated back-up provider.

Unacceptable Phone Arrangements

The telephone answering procedures listed below are not acceptable:

- An office phone that is answered only during office hours
- An office phone that is answered by a recording or an answering service that directs members to go to the emergency room
- An office phone answered after hours by an answering machine recording that tells members to leave a message
- An office phone answering machine recording that informs members of regular office hours and requests that they call back during those hours
Referrals

Referrals are an integral component of the Texas Health Network’s health care delivery program. Referrals ensure that members gain access to all necessary and appropriate covered services and that care is delivered in the most clinically suitable and cost-effective setting.

Referral procedures are designed to capture the information needed to support and manage the utilization of services by the provider network. Proper documentation of referrals is necessary for accurate medical record keeping. It also enables the Texas Health Network to collect and disseminate information for PCP profiling and practice pattern analysis.

As a PCP in the Texas Health Network, you function as the coordinator of health services for your members, whether services are delivered within or outside your office. You are responsible for arranging and coordinating appropriate referrals to other providers and specialists, and for managing, monitoring, and documenting the services of other providers. If a member wishes to get a second opinion about any service or diagnosis, they may ask you for a referral.

As a PCP, you are responsible for the appropriate coordination and referral of Texas Health Network members for the following services:

- THSteps Dental (including orthodontics)
- ECI case management services
- MR targeted case management
- PWI Services
- THSteps medical case management
- SHARS
- Texas Commission for the Blind (TCB) case management services
- TB Services
- Vendor drugs

Please refer to the *Texas Medicaid Provider Procedures Manual* for details.

Open Specialty Referral Network

The Texas Health Network operates an open specialty referral network, which means that you may refer patients to any Texas Medicaid-approved specialist within the State of Texas that accepts Texas Health Network members for covered health services that you cannot provide. Medically necessary referrals to specialists do not require precertification from the Texas Health Network.

For all referrals, PCPs should furnish the specialist with complete information on treatment procedures and diagnostic tests performed prior to the referral. The referral should specify:

- The initial diagnosis/diagnoses
- The reason for the referral
- The services requested from the referral specialist
- The number of authorized visits (optional)

You may make a referral to another PCP or a specialist during your absence or unavailability. You may make a referral if a member requests a second medical opinion.

After receiving a referral specialist’s report, if ongoing treatment for an illness is required, you have the discretion to specify the period of time or number of visits authorized for ongoing treatments to be given by the specialist.

Your Texas Provider Identifier (TPI) must be entered on all claims submitted by the specialist, indicating that you authorized these services. It is the responsibility of the treating specialist to ensure that the patient continues to be an eligible Texas Health Network member throughout the period of treatment.
**Referral Form**

No form for a referral to a specialist is required. However, you are encouraged to use the Texas Health Network Referral Form. This form reflects accepted practices in the Texas medical community. The use of this form will simplify:

- Dissemination of necessary information to the specialist
- Documentation for the member’s medical record of the specialist’s diagnosis and treatment
- Assisting in timely identification of case management and health education needs

The Texas Health Network has designed the Referral Form to include several diagnoses that often reflect a need for case management. The Texas Health Network Health Services staff request that providers complete and fax the Referral Form to the Texas Health Network Case Management Department at 1-512-302-0318, when referring for any of the listed diagnoses. This allows Texas Health Network staff to assist providers with chronic and catastrophic cases. See the Referral Form in Appendix C for target diagnoses.

Primary care providers should call or fax the completed Texas Health Network Referral Form to the Case Management Department within 24 hours or the next business day after the referral is made. Please note:

- One copy of the referral form should be given to the specialist.
- One copy should be maintained in the member’s medical record.

PCPs shall continue to provide their contracted Texas Provider Identifier (TPI) to OB/GYN providers for services directly accessed by Texas Health Network members.

**Advanced Directives**

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

- a member’s right to self-determination in making health care decisions; and
- the Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
  - a member’s right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition;
  - a member’s right to make written and non-written Out-of-Hospital Do-Not-Resuscitate Orders; and
  - a member’s right to execute a Medical Power of Attorney to appoint an agent to make health care decisions on the member’s behalf if the member becomes incompetent.
These policies can include a clear and precise statement of limitation if a participating provider cannot or will not implement a Member’s advance directive. A statement of limitation on implementing a Member’s advance directive should include at least the following information:

- a clarification of the provider’s conscience objections;
- identification of the state legal authority permitting a provider’s conscience objections to carrying out an advance directive; and
- a description of the range of medical conditions or procedures affected by the conscience objection.

A provider cannot require a member to execute or issue an advance directive as a condition for receiving health care services. A provider cannot discriminate against a member based on whether or not the member has executed or issued an advance directive.

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

**Release of Confidential Information**

Information concerning the identity, history, diagnosis, evaluation, or treatment of a Medicaid patient by a person licensed or certified to diagnose, evaluate, or treat any medical, mental, or emotional disorder or drug abuse is normally confidential information that the provider may disclose only to authorized persons.

Family planning information is particularly sensitive, and confidentiality must be ensured for all patients, especially minors.

Patient confidentiality must be maintained. The provider must obtain written authorization from the member/head of household prior to releasing confidential medical information:

- A release may be obtained by having the member sign the indicated block on the claim form after he or she has read the statement of release of information printed on the back of the form.
- An authorization for release of such information *is not required* when the release is requested by and made to the HHSC, TDH, DHS, the Texas Medicaid Claims Administrator, the EQRO, the Centers for Medicare & Medicaid Services (CMS), the Texas Attorney General’s Medicaid Fraud Control Unit, the Texas Health Network, or a Texas Health Network member requesting his/her own information.
- Medical documentation and information may be released to other entities if the patient/member gives a written consent to release the information.

**Specialist Responsibilities**

Specialists are responsible for furnishing medically necessary services to Texas Health Network members who have been referred by their PCP for specified treatment or diagnosis. While the specialist does not contract with the Texas Health Network, all facility services should be delivered in a contracted Texas Health Network facility.

Specialists are responsible for verifying the eligibility of the referred member prior to providing treatment. See Chapter V for more information on verifying member eligibility.
To ensure continuity of care for members, the specialist must maintain communication with the member’s PCP. This communication should ensure that the PCP’s medical records adequately document the specialist services provided, all results or findings, and all recommendations. The specialist may use the lower half of the Texas Health Network Referral Form for this purpose.

When a PCP refers a member to a specialist, the specialist should review the case with the PCP to fully understand the services being requested. Services requiring more than one visit should be coordinated with the PCP for approval of additional visits. Referrals from a PCP must be documented in both the PCP’s and the specialist’s records.

If a specialist determines that a member’s condition warrants attention (i.e., hospitalization or diagnostic procedures), the specialist should seek precertification from:

Texas Health Network Utilization Management Department
Phone: 1-888-302-6167
Fax: 1-512-302-5039

**OB/GYN Providers:** Please contact the member’s PCP to obtain his or her Texas Provider Identifier (TPI) for inclusion on your claim form.

Emergency treatment does not require precertification (see Chapter III for more information).

**Specialist-to-Specialist Referrals**
Referrals from one specialist to another for a medically necessary service must be authorized by the member’s PCP or by the Texas Health Network Utilization Management Department.

**Claims for Specialist Services**
Claims for specialists’ services must reference the PCP’s assigned Texas Provider Identifier (TPI) as the referring provider in the appropriate field of the electronic submission or paper claim form. Additional information about reimbursement and claims submission is located in the *Texas Medicaid Provider Procedures Manual.*

### Cultural Competency and Sensitivity

The Texas Health Network values the diversity of the Texas Medicaid population and has programs to support multicultural plan membership.

All member materials are written at an appropriate reading level and printed in both English and Spanish. Helplines are staffed by Spanish- as well as English-speaking customer service representatives who, at any time, may access a multi-language translation service for assistance.

Provider newsletters and educational workshops include topics that focus on cultural sensitivity and the need for culturally competent staff in PCP offices. Providers are expected to comply with the laws concerning discrimination on the basis of race, color, national origin, or sex (see below).

The Texas Health Network staff is culturally diverse, multilingual, and sensitive to the diverse needs of Texas Medicaid clients.
Linguistic Services
Although it is the provider’s responsibility to ensure that interpretive services are available to his/her practice, as a Texas Health Network provider you may receive assistance to arrange for these services for Texas Health Network members. Interpretive services include language interpreters, American Sign language interpreters, and TDD access. When interpretive services are necessary to ensure effective communications regarding treatment, medical history, or health education you may contact the Texas Health Network Member Helpline at 1-800-302-6688. For assistance to members who are hearing impaired, call RELAY TEXAS (TDD) at 1-800-735-2988. If your staff is in need of translation services to meet requirements on Limited English Proficiency (LEP), you may contact 1-800-752-0093.

Limited English Proficiency (LEP)
Medicaid providers are required to provide services in the languages of the major Medicaid population groups they serve, and to ensure quality appropriate translations. Title VI, section 601, of the Civil Rights Act of 1964 states that “no person in the United States shall on the basis of race, color, or national origin, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

The HHSC requires its Medicaid providers to ensure that persons with limited English proficiency have equal access to the medical services to which they are legally entitled.

Meeting the requirements of Title VI may require the PCP to take all or some of the following steps at no cost or additional burden to the beneficiary with limited English proficiency:

- Have a procedure for identifying the language needs of patients/clients.
- Have access to proficient interpreters during hours of operation.
- Develop written policies and procedures regarding interpreter services.
- Disseminate interpreter policies and procedures to staff and ensure staff awareness of these policies and procedures and of their Title VI obligations to persons with limited English proficiency.

In order to meet his or her interpretation requirements, a provider may choose to incorporate into their business practice any of the following (or equally effective) procedures:

- Hire bilingual staff.
- Hire staff interpreters.
- Use qualified volunteer staff interpreters.
- Arrange for the services of volunteer community interpreters (excluding the member’s family or friends).
- Contract with an outside interpreter service.
- Use a telephone interpreter service such as Language Line Services.
- Develop a notification and outreach plan for beneficiaries with limited English proficiency.

Complaints and reports of non-compliance with Title VI regulations are handled by the OCR.
Additional information, including the complete guidance memorandum on non-discrimination of persons with limited English proficiency issued by the OCR, can be found on the Internet at http://www.hhs.gov/ocr/lep/guide.html.

If your staff is in need of translation services to meet LEP requirements, you may contact 1-800-752-0093. If a Texas Health Network member is in immediate need of linguistic services, please call the Texas Health Network Member Helpline at 1-888-302-6688.
CHAPTER III
UTILIZATION MANAGEMENT

Overview

The Texas Health Network Utilization Management Department works to ensure that medically necessary services are delivered to Texas Health Network members in a cost effective manner while eliminating barriers that may impede quality healthcare. This chapter details the Texas Health Network's utilization management policies, including precertification and admission notification guidelines.

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Definitions

Precertification: The demonstration of medical necessity prior to the delivery of services.

Precertification number: The number given to the provider requesting precertification once clinical documentation has been received and substantiates medical necessity.

Routine/Non-Emergent Condition: A symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical and/or diagnostic studies prior to diagnosis and treatment.

Urgent Condition: A symptom or condition that is not an emergency, but requires further diagnostic work-up and/or treatment within 24 hours to avoid a subsequent emergent situation.

Emergent/Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction to any bodily organ or part

Emergency services means covered inpatient and outpatient services that are as follows:

(1) Furnished by a provider that is qualified to furnish these services under this title.
(2) Needed to evaluate or stabilize an emergency medical condition.

Poststabilization Services: Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee’s condition.

Observation services: Services received within a hospital setting, which are “reasonable and necessary” to evaluate an outpatient condition or determine the need for possible admission to the hospital as an inpatient.

Notification: the process by which a facility informs the Texas Health Network that a member has been admitted as an inpatient to their facility on an urgent or emergent basis.

Concurrent review: the process by which, the facility supplies clinical information to the Texas Health Network to substantiate the medical necessity of continued inpatient hospitalization.

Authorization number: The number given to the facility following clinical verification of medical necessity and length of stay for inpatient services.

Final Coding and/or DRG Validation: the process by which the facility supplies the Texas Health Network with final diagnosis coding and, if appropriate, the DRG. The information submitted is validated against clinical information received during the inpatient hospitalization to ensure appropriate match to diagnoses and care rendered.
Professional Services

Emergency Room Services
PCPs should become actively involved in educating Texas Health Network members regarding the appropriate use of the emergency room and other emergency services. Providers should notify the Texas Health Network of any member who may need further education by calling the Member Helpline at 1-888-302-6688, or by using the Member Education Request Form. See Appendix C.

Precertification
Precertification is required for all non-emergent inpatient and selected outpatient medical and surgical procedures—including procedures performed during authorized hospital admissions. (Exception: Scheduled inpatient chemotherapy does not require precertification.) Precertification is a condition of reimbursement. It is not a guarantee of payment. Precertification numbers are issued to the facility and requesting provider and are valid only if the member is eligible for services at the time the services are rendered. Precertification numbers are valid for, and must be used within, 180 days from the date initially approved by the Texas Health Network. The total number of visits or services is limited to the number authorized on the approved precertification.

Precertification can be requested by completing the Precertification Request Form found in Appendix C and faxing it to the Texas Health Network Utilization Management Department at 1-512-302-5039, or by calling the Texas Health Network Utilization Management Department at 1-888-302-6167.

The provider requesting the precertification should allow at least four business days from receipt of a completed Precertification Request Form and related documentation for a request to be processed. If the request is for a scheduled/elective inpatient service, a length of stay will be assigned at the time of precertification. Both the requesting provider and the facility will receive the precertification number, the length of stay, procedure codes, and estimated discharge date.

Procedures/Services Requiring Precertification

Office
- All Laser Surgeries
- All Podiatry Procedures
- Endoscopic Procedures
- Polysomnogram/Sleep study
- Specialist-to-Specialist Referrals

Outpatient Services
- MRI
- Endoscopic Procedures
- Sleep Studies
- MRA
- All Podiatry Procedures
- All Non-Emergent Surgical Procedures
- All Laser Surgeries
- pH Probe Tests

Inpatient
- All non-emergent inpatient admissions (excluding routine deliveries/routine newborn care)
- All non-emergent surgical procedures
- Surgical procedures performed during certified hospital admissions require notification

IMPORTANT: Effective August 6, 2001, the Texas Health Network precertifies all transplants and surgical procedures previously prior authorized by the Texas Medicaid Claims Administrator for Texas Health Network members. Home health, DME, and ambulance services, will continue to require prior authorization.
tion from the Texas Medicaid Claims Administrator. Non-covered Medicaid services remain unchanged under the Texas Health Network. For more information on prior authorization, see the current Texas Medicaid Provider Procedures Manual.

Procedures/Services Not Requiring Precertification

The following procedures do not require precertification:

• Scheduled inpatient chemotherapy
• Anesthesia services (type of service 7)
• Surgeries performed on an emergent basis (retrospective authorization must occur for claims payment)
• Application/removal of casts, splints, or strapping (excluding podiatry office procedures and services)
• Burns-local treatment (does not include skin grafts, or long-term wound care)
• Catheterization of blood vessels (excluding heart caths) for diagnosis or therapy (includes venous access, puncture of shunt, etc.)
• Circumcision, newborn and for phimosis (up to age 21)
• Fractures/Dislocations - closed or open treatment
• Incision and drainage of abscesses
• Injection procedures for radiology or in conjunction with surgical procedures
• Intubation/trach tube changes
• Removal of foreign bodies
• Removal of PE tubes with or without grafts
• Repair of lacerations/wounds (includes the eye)
• Replacement of G-tubes
• Replantation of limbs/digits
• Sterilization procedures (male and female)
• Urodynamics
• Esophageal manometry
• Ultrasounds
• Holter monitors
• Tympanostomy

Information Required for Precertification

To expedite the processing of your precertification request, please ensure the following information is submitted to the Texas Health Network UM Department:

• Clinical information:
  — Date of service
  — Lab or X-ray results
  — Treatment plan
  — Procedure/service(s) requested
  — Pertinent history
  — ICD-9-CM diagnosis codes
  — CPT procedure codes
  — Type of setting (inpatient or outpatient hospital, office, or other)
• Demographic information:
  — Member’s name, date of birth, and Medicaid number
  — Requesting provider’s name, TPI, fax number, and phone number
  — Office contact name for requesting provider
  — PCP’s name, TPI, and phone number
  — Facility’s name and TPI

If your precertification request meets criteria, you will receive a precertification number by phone or fax. This number must be on your claim in the “prior authorization number” field. (Refer to the Texas Medicaid Provider Procedures Manual for specific instructions on claim filing.) An approval letter will follow.

If UM staff do not receive sufficient information to approve the request, you will be instructed to provide further appropriate information before the service is provided. The request will be held for no more than 5 business days. If further information is not received, the request will require resubmission by the requesting provider.

If the information provided is complete but review criteria indicate that the admission or procedure is not medically necessary, the request is referred to the Texas Health Network Medical Director or physician consultant for review. Medical necessity denials are issued only by the Texas Health Network Medical Director.

The requesting provider will receive verbal notification of a medical necessity denial within 24 hours of determination. A denial letter will follow.

**Denials and Appeals of Requests for Precertification**

If your precertification request for admission or service is denied, you will receive a denial letter from the Texas Health Network UM Department. Where appropriate, the hospital or facility involved is also notified of the denial.

If you are dissatisfied with a determination by the Texas Health Network UM Department, you may file an appeal.

To file an appeal with the Texas Health Network, send a copy of the denial letter you received, an explanation of the appeal, and clinical documentation to support approval of the service(s). Appeals may be mailed or faxed to the Texas Health Network Complaints and Appeals Resolution Unit. Please refer to Chapter IV of this manual for additional information on the appeal process.

**NOTE:** For appeals of denied claims, reference the Appeals section of the current Texas Medicaid Provider Procedures Manual.
Facility/Hospital Services

Emergency Room (ER) providers are authorized by the Texas Health Network to furnish the medically necessary appropriate treatment of the Texas Health Network members. The ER provider must perform the medical screening examination, i.e. assess the medical needs of a Texas Health Network member who appears in the ER to determine the medical necessity of services and the appropriate setting for rendering services.

ER providers must determine a patient’s status based on the emergent, urgent and non-emergent definitions noted earlier. In some cases, medically necessary services are needed to determine the patient’s condition. The necessity of these services must be documented in the medical record. ER providers are paid for medically necessary services required to determine and stabilize the patient’s condition.

If a determination is made that the member has a routine/non-emergent condition, the member’s PCP should be notified by phone, fax, or electronic mail, so that follow-up care can be arranged by the PCP as appropriate.

If a determination is made that the member has an urgent condition, the member’s PCP should be notified by phone, fax, or electronic mail, so that follow-up care can be arranged within 24 hours.

If the member has an emergent condition, the ER must treat the member until the condition is stabilized or until the member can be admitted or transferred. Once the member is stabilized, the ER staff must notify the member’s PCP to arrange for medically necessary hospital admission or follow-up care. If the ER staff is unable to contact the PCP (or designated on-call provider) within 1 hour, the ER staff should treat the member and report the PCP’s unavailability by contacting the Texas Health Network Provider Helpline at 1-888-834-7226.

ER services guidelines are illustrated in figure 3.1 on the following page:
Observation Services

Observation services are those received within a hospital setting, which are “reasonable and necessary” to evaluate an outpatient condition or determine the need for possible admission to the hospital as an inpatient. Some patients, while not requiring hospital admission, may require a period of observation in the hospital environment as an outpatient. Observation services may be provided in any part of the hospital where a patient placed in observation can be assessed, examined, monitored, and/or treated in the course of the customary handling of patients by the facility. Observation services after the 23rd hour are not payable by Medicaid. If the patient is going to be admitted, the patient’s status must be changed from observation to inpatient prior to the 24th hour.

If an emergent inpatient admission occurs from an observation status, the hospital must notify the Texas Health Network UM Department of the admission by COB the day following the change to the inpatient status.
status for admissions that occur Monday through Thursday. For admissions that occur Friday, Saturday, or Sunday, notification must be received by COB Tuesday. See the example below:

<table>
<thead>
<tr>
<th>Member Placed in Observation</th>
<th>Member Admitted as Inpatient</th>
<th>Notification Due to the Texas Health Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday</td>
<td>Wednesday</td>
<td>COB Thursday</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Thursday</td>
<td>COB Friday</td>
</tr>
<tr>
<td>Thursday</td>
<td>Friday</td>
<td>COB the following Tuesday</td>
</tr>
<tr>
<td>Friday</td>
<td>Saturday</td>
<td>COB the following Tuesday</td>
</tr>
<tr>
<td>Holiday</td>
<td></td>
<td>COB the following business day</td>
</tr>
</tbody>
</table>

If a member initially placed in observation status is admitted as an inpatient, the date of the initial placement in observation serves as the admit date for claims purposes.

If notification is not received by COB the day following the change in admission status, a technical denial will be issued from the date of initial placement into observation status.

**Notification of Inpatient Admission**

Precertified, elective/scheduled admissions do not require notification by the facility upon admission. If an emergent inpatient admission occurs from an observation status, the hospital must notify the Texas Health Network UM Department. The Texas Health Network’s UM Department must be notified of urgent/emergent inpatient admissions by COB the next business day for admissions that occur Monday through Thursday (excluding routine deliveries and routine newborn care). For admissions that occur Friday, Saturday, or Sunday, notification must be received by COB the following Tuesday. When notification deadlines occur on a Texas Health Network-recognized holiday (see Appendix G), notification must be received by COB the following business day. This notification also initiates the concurrent review process for an inpatient stay (see the Notification Form in Appendix C). Concurrent review must be received by COB the day following notification of admission.

Notification is not required for 23-hour observation stays, unless the stay is converted to an inpatient status. The following information should be included on the notification:

- Facility name and TPI, phone number, fax number, and facility UM contact person
- Last name, first name, middle initial, date of birth, and sex of patient
- Client’s Medicaid number (PCN)
- Date of admission
- PCP name and TPI
- Attending physician name (if not PCP) and TPI
- Admitting diagnosis
- Procedure or service (if known)

If the facility does not meet the notification requirement, the admission will be denied up to the date the initial notification is received. Any inpatient days incurred prior to the notification will be denied regardless
of medical necessity. This is a technical denial. Inpatient days on or after the date of notification will be approved if clinical data supplied by the facility supports medical necessity.

**OB/Newborn Notification**

The Texas Health Network requires notification of all non-routine deliveries and newborns. Non-routine includes a stay that extends beyond 2 days for vaginal deliveries, 4 days for a C-section, or a condition exists that complicates the care or DRG.

For DRG facilities, notification of routine length of stays with non-routine clinical status is due within 5 business days following discharge (seven calendar days). Notification of non-routine length of stays with routine or non-routine clinical status is due on the 4th inpatient day for vaginal deliveries and the 6th inpatient day for C-sections. The following table illustrates the notification guidelines for DRG facilities:

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>Clinical Status</th>
<th>Notification Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine</td>
<td>Routine</td>
<td>None</td>
</tr>
<tr>
<td>Routine</td>
<td>Non-routine</td>
<td>Within 5 business days of discharge</td>
</tr>
</tbody>
</table>
| Non-routine    | Routine         | 4th inpatient day for vaginal deliveries  
|                |                 | 6th inpatient day for C-sections |
| Non-routine    | Non-routine     | 4th inpatient day for vaginal deliveries  
|                |                 | 6th inpatient day for C-sections |

For per diem facilities, notification of non-routine stays with routine or non-routine clinical status is due on the 4th inpatient day for vaginal deliveries and the 6th inpatient day for C-sections. The following table illustrates the notification guidelines for per diem facilities:

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>Clinical Status</th>
<th>Notification Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine</td>
<td>Routine</td>
<td>None</td>
</tr>
<tr>
<td>Routine</td>
<td>Non-routine</td>
<td>Prior to discharge</td>
</tr>
</tbody>
</table>
| Non-routine    | Routine         | 4th inpatient day for vaginal deliveries  
|                |                 | 6th inpatient day for C-sections |
| Non-routine    | Non-routine     | 4th inpatient day for vaginal deliveries  
|                |                 | 6th inpatient day for C-sections |

Supporting clinical documentation for the billed diagnosis should be forwarded to the Texas Health Network. Providers should not submit the entire medical record.

When the clinical documentation is received, the Texas Health Network will complete the clinical review and provide authorization determination within 2 business days.
Concurrent Review/Length of Stay Assignment

Notification of an inpatient stay initiates concurrent review and length of stay assignment. Once notification is received, the Texas Health Network will forward a request for initial clinical information to the facility. Clinical information is expected from the facility within 24 hours of the Texas Health Network request. A technical denial will be issued if this does not occur. The clinical review is essential to medical necessity and length of stay determinations. After the clinical information is received, the Texas Health Network UM nurse will assign an initial length of stay. This will be communicated to the facility via phone/fax within 24-48 hours.

Once the length of stay assignment is completed, the Texas Health Network will not initiate a request for subsequent reviews. The hospital is responsible for monitoring the approved length of stay and clinical condition of the patient. The hospital should contact the Texas Health Network by the end of the second business day following the last approved inpatient day, should changes in the length of stay, clinical condition or additional surgical procedures be identified. If the clinical information is received beyond the timeframe stated above, a technical denial will be issued.

Texas Health Network Utilization Management Helpline
Phone: 1-888-302-6167
Option 1 – concurrent review
Option 2 - precertification
Fax: 1-512-302-5039

If the clinical information provided at that time does not demonstrate the need for continued inpatient stay, the case is referred to the Texas Health Network Medical Director for review. If the Medical Director determines that medical necessity has not been met, then a medical necessity denial will be issued. This will be communicated by the Texas Health Network UM nurse to the facility within 24 hours of determination. Only a Texas Health Network Medical Director can issue a medical necessity denial.

The clinical information outlined below must be supplied by the hospital to the Texas Health Network Utilization Management Department for review:

- The member’s Medicaid number (PCN)
- Diagnosis
- A summary of the medical/surgical condition (including medications, consults, vital signs, treatments, procedures and any other ancillary reporting – lab/x-ray, if appropriate)
- Facility’s unique patient identification number
- Level of care during the stay in the facility
- Anticipated Length of Stay
- Discharge planning, case management, and/or health education needs if applicable
- Case management needs
- Health education needs

**NOTE:** Please do not send entire charts for review unless requested.
Elective/Scheduled Admissions
Elective, scheduled admissions require precertification from the Texas Health Network. A length of stay is assigned at the time of precertification. Notification of admission is not required. However, the hospital is expected to monitor changes in length of stay, clinical conditions and/or additional surgical procedures. If any of the above changes are noted, the Texas Health Network should receive additional clinical information by the end of the 2nd business day following the last approved inpatient day.

ICD-9-CM and DRG Confirmation
A final DRG or ICD-9-CM code will be confirmed following discharge. It is the hospital’s responsibility to inform the Texas Health Network of the final coding (to include the DRG,) within 10 business days post discharge. The authorization cannot be released for payment until final coding has been received and verified with clinical information.

UM Concurrent Review Nurses conduct final coding review for ICD-9 and DRG validation to evaluate the effectiveness of the concurrent review process. Charges for inappropriate inpatient stays/days and related services may be recouped as determined by a Texas Health Network Medical Director during the final coding review process.

**NOTE:** The final coding requirement is applicable only to facilities paid by DRG reimbursement methodology and all inpatient claims billed for SSI recipients admitted to per diem facilities (excludes TEFRA).

Table 3.3 on the following page illustrates the differences between the precertification and notification processes.
### TABLE 3.3 Precertification vs. Notification Process

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Precertification</th>
<th>Notification of Urgent/Emergent admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>Clinical information determines the medical necessity of the stay and appropriate level of care</td>
<td>Communication of an admission status to initiate concurrent review</td>
</tr>
<tr>
<td>Services</td>
<td>All non-emergent inpatient admissions (except for chemotherapy) Non-emergent surgical procedures Specific office and/or outpatient procedures</td>
<td>Inpatient admissions (except routine deliveries and routine newborn care. Includes: Urgent/Emergent inpatient admissions All admissions from observation All non-routine deliveries/newborn care, including conditions affecting DRG</td>
</tr>
<tr>
<td>Who</td>
<td>Physicians or hospital specialty clinics</td>
<td>Physicians, hospital UM Nurses, or other hospital staff (business office)</td>
</tr>
<tr>
<td>When</td>
<td>At least 4 business days before the requested date of service</td>
<td>By COB the next business day for admissions that occur Monday - Thursday. For Friday-Sunday admissions, notification must be received by COB Tuesday The above guidelines also apply for admissions from observation status</td>
</tr>
<tr>
<td>How</td>
<td>Phone, fax, or mail</td>
<td>Phone or fax</td>
</tr>
<tr>
<td>Information needed</td>
<td>Member’s name, date of birth and Medicaid number (PCN) Name, TPI, fax number and phone number of requesting provider PCP name, TPI and phone number Facility name and TPI Date of Service Procedure/Service(s) requested Type of setting (inpatient or outpatient hospital, office, other) Treatment plan Pertinent history Lab or X-ray results Admitting diagnosis ICD-9-CM code(s) CPT procedure code(s)</td>
<td>Facility name, TPI, phone number, fax number and UM contact person Member’s last name, first name, middle initial, date of birth Medicaid ID number (PCN) Date of admission PCP name and TPI Attending physician name (if not PCP) and TPI Admitting diagnosis CPT procedure codes/service (if known) Facility’s unique patient identification number, i.e. medical record number</td>
</tr>
</tbody>
</table>
Out-of-Network Services

Inpatient
Out-of-network hospitals are reimbursed only for inpatient services provided to Texas Health Network members as the result of an emergency admission, and then only until the patient is stabilized. Notification of admission must occur for any admission to a non-contracted hospital. Concurrent review is also required to determine medical appropriateness of the admission. Scheduled medical and surgical admissions or any non-emergent admission must be precertified indicating the reason why the patient must be admitted or transferred to an out-of-network facility (i.e., the services needed are not provided in a network facility, the patient had an emergent condition requiring admission while away from the service area).

After a patient in an out-of-network hospital is stabilized following an emergent admission, additional services are considered non-covered benefits. The out-of-network hospital may, however, request an exception to the stabilization policy during the concurrent review process. Please refer to Chapter VI for information on how to request a stabilization exception.

PCPs referring members to specialists should make the specialist aware of the Texas Health Network non-contracted hospital admission policy.

Outpatient
Non-contracted facilities will not be reimbursed for out-of-network medical care or services except under the following conditions:

- A medical emergency is documented by the attending provider or consultant.
- The member’s health is endangered if travel is required.
- The delivered service is a physician consultation directed by PCP referral.
- Outpatient freedom-of-choice services are delivered.
- Diagnostic or surgical services are precertified by the Texas Health Network.

If a member moves outside of a county in which the Texas Health Network operates, but requires medically necessary services before the member’s demographic information can be updated, the above conditions apply.

Emergency Transportation Services

Medicaid clients are eligible to receive emergency transportation or ambulance services. Coverage is limited to ambulance services provided to eligible clients in two situations:

- Emergency
- Non-emergency for the severely disabled

When the condition of the member is life threatening (as defined on page III-2) and requires the use of special equipment, life support systems, and monitoring by trained attendants while en route to the nearest appropriate facility, the ambulance transport is considered an emergency service.
When the client has a medical condition requiring treatment in another location and is so severely disabled that the use of an ambulance is the only appropriate means of transportation, the ambulance transport is considered a non-emergency service.

“Severely disabled” is defined as a physical condition that limits mobility and requires the client to be bed-confined at all times, unable to sit unassisted at all times, or requires continuous life support systems including oxygen or IV infusion.

Information regarding reimbursement for ambulance services can be found in the *Texas Medicaid Provider Procedures Manual*.

**Non-Emergency Transportation**

Additional transportation services are available to eligible Medicaid clients who have no other means of transportation. This service is known as the Medical Transportation Program (MTP) and is detailed in Chapter I of this manual.
CHAPTER IV
COMPLAINTS AND APPEALS

Overview

Members and providers have the right to appeal any of the utilization review decisions reached by the Texas Health Network. This chapter describes the process for resolution of provider complaints and grievances.

Complaints ..............................................................................................................................................IV-2
Provider Complaints and Appeals ............................................................................................................IV-2
Complaints

A complaint is any dissatisfaction, expressed orally or in writing to the Texas Health Network, with any aspect of the Texas Health Network’s operation, including but not limited to dissatisfaction with plan administration, the way a service is provided, an action taken by the Texas Health Network, an appeal of an adverse determination, or disenrollment decisions.

A complaint is not (1) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the member or provider or (2) a request for a fair hearing to the HHSC.

Conflict Resolution
The relationship between a member and his or her PCP may become unsatisfactory to one or both parties. The PCP or the member should contact the Texas Health Network Member Services Helpline or write to request assistance in resolving the situation.

The Texas Health Network will initiate one or more of the following steps:

- Contact the member and the provider to assess the situation and provide educational information that may clarify the situation, if applicable.
- Reassign the member to another PCP.
- Refer the situation to the Complaint/Appeal Resolution Team, if applicable (see below).
- Begin complaint/grievance resolution.
- Refer the situation to the Member Outreach Staff for education or to help clarify the situation.

Provider Complaints and Appeals

Provider Complaints
The Texas Health Network provides for due process in resolving provider complaints. Procedures governing the provider complaints process are designed to identify and resolve provider complaints in a timely and satisfactory manner. The majority of complaints are resolved within 30 business days.

Complaints must be submitted in writing to:

Texas Health Network
Complaints and Appeals Resolution Unit
PO Box 14685
Austin, TX 78761
Or faxed to: 1-888-235-8399

Question regarding the status of a complaint or the complaint process should be directed to the Texas Health Network Provider Helpline at 1-888-834-7226.

Provider Complaint Policy
The Texas Health Network takes seriously and acts on each provider complaint. Depending on the level and nature of the complaint, the Texas Health Network works with the provider to resolve the issue or directs the complaint to the appropriate Texas Health Network department.
• **Provider/Member Services Division** – Complaints that concern the relationship between a provider or provider’s staff and a member.

• **Health Services Division** – Complaints that relate to utilization of services (including emergency room use), denial of continued stay, and all clinical and access issues. This includes provider’s appeal of an adverse precertification decision.

• **Texas Health Network Administration** – Complaints that concern the relationship between a provider and any Texas Health Network staff person or complaints about the overall plan management.

If the complaint relates to a medical issue, the Health Services staff may assist in the resolution of the complaint.

The provider complaints process applies only to the resolution of disputes within the control of the Texas Health Network, such as administrative or medical issues. The provider complaint process does not apply to allegations of negligence against third parties, including other participating providers. These complaints are referred to the HHSC for review and evaluation and are resolved by HHSC staff with support from Texas Health Network staff.

**Provider Complaint Procedures**

The Texas Health Network Complaints and Appeals Resolution Unit handles all provider complaints. The processing of provider complaints is described below:

• Providers must submit their complaint in writing to the Texas Health Network, Complaints and Appeals Resolution Unit.

• Providers will receive a written acknowledgement letter from the Texas Health Network within 5 business days of receipt of the complaint.

• Referrals to other departments, such as Provider/Member Services or Health Services, are made as appropriate.

• Complaints dealing with the quality of, access to, or continuity of care are referred to the Texas Health Network PCP Contract Compliance Department for follow-up and inclusion in the provider file.

• If the complaint cannot be resolved within 30 business days, the provider is notified in writing or by phone of the status of the complaint.

If the provider feels he or she did not receive due process from the Texas Health Network, the provider may file a complaint to HHSC. However, providers must exhaust the appeals/grievance process with the Texas Health Network before filing a complaint with the HHSC.

Complaints to the HHSC must be received in writing and sent to the following address:

Texas Health & Human Services Commission  
Resolution Services H-610  
1100 West 49th Street  
Austin, TX 78756

Complaints must be received by the HHSC within 60 calendar days from the Texas Health Network’s written notification of the final action.
Under the complaint process, the HHSC works with the Texas Health Network and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program/contract issues. Please refer to the Texas Medicaid Provider Procedures Manual, section 5.4, Complaints to the HHSC - Managed Care Providers, for more information.

**Utilization Management Appeals**
A denial is issued when a precertification, authorization, or extension of stay request by a physician or a facility is not approved. A Texas Health Network Medical Director may issue a medical necessity or technical denial.

**Medical Necessity Denials**
- Documentation provided fails to support the need for requested service.
- The member's condition/service requested does not warrant the level or location of care the provider requested.

**Technical Denials**
- The provider has failed to comply with Texas Health Network policies and procedures. These include failure to:
  - notify of an inpatient stay
  - provide concurrent review during an inpatient admission
  - obtain precertification for an elective/scheduled service prior to the delivery of service

A denial may also be issued if:
- The provider or the location of service is not within the network.
- The patient is no longer eligible for coverage.
- Texas Medicaid does not cover the service.

The appeals process affords the provider the opportunity to dispute a denial and explain or justify the original request.

To file an appeal with the Texas Health Network, send a written request stating the reason the decision by the Texas Health Network is in question, a copy of the denial letter you received, a copy of the remittance and status report on which the denied claim appears, an explanation of the appeal, and clinical documentation to support approval of the service(s) within 180 days of the determination. Appeals may be mailed or faxed to the Texas Health Network Complaint and Appeals Resolution Unit.

**Appeal Procedures for Technical Denials**
**Level I: Review by the Texas Health Network Complaint and Appeals Resolution Unit**
The provider may appeal a technical denial if the provider has evidence that he or she complied with policy and/or did not receive proper notification of the technical denial.
All requests for provider appeals must be submitted in writing to the following address:

Texas Health Network
ATTN: Complaints and Appeals Resolution Unit
P.O. Box 14685
Austin, TX 78761
or faxed to 1-888-235-8399

Level II: Review by the Texas Health and Human Services Commission (HHSC)
If a provider believes they did not receive full consideration under the appeals process, he or she may file a complaint with the HHSC. Providers must exhaust the appeals process with the Texas Health Network before filing a complaint with the HHSC. Complaints (Level II appeals to the HHSC) must be in writing and include copies of all documentation from the provider to the Texas Health Network, and from the contractor to the provider. The Texas Health Network’s decision letters, specifically, the final decision letter, should be included as part of the documentation.

Complaints must be received at the HHSC within 60 calendar days from the date of the contractor’s final decision letter. Provider complaints (Level II appeals to the HHSC) may be mailed to the following address:

Texas Health and Human Services Commission
Resolution Services H-610
1100 West 49th Street
Austin, TX 78756-3172

Providers may request the Texas Health Network forward the complaint to the HHSC on his or her behalf. All of the necessary information must be received by the HHSC in order for the complaint to be reviewed.

If the HHSC determines that the provider did not receive full consideration, the HHSC will work with the provider and the Texas Health Network to ensure that a proper review is conducted.

Appeal Procedures for Medical Necessity Denials
Level I: Review by the Texas Health Network Medical Directors
A request for appeal based on medical necessity should be forwarded to the Texas Health Network’s Complaint and Appeals Resolution Unit. The HHSC defines Medical appeals as disputes regarding medical necessity and level of care.

• Upon receipt of the request, the Complaint and Appeals Resolution Unit Specialist will document the request to ensure that all information necessary to complete the appeal is in order. The information is forwarded to the Utilization Manager or designee.

• The Utilization Manager or designee reviews the information and directs the appeal to a Medical Director.

• The Medical Director reviews the information and makes a determination.

• After a determination is made, the Medical Director forwards the determination to the Utilization Manager or designee who sends the resolution letter to the appealing provider.

• The appealing provider has 90 days from the receipt of this notification to request a Level II Review.
Level II: Review by the Texas Health Network Grievance Committee
If dissatisfied with the Level I medical necessity denial decision, a provider can request a Level II appeal by sending the request in writing to the Texas Health Network Complaint and Appeals Resolution Unit within 90 days from receipt of the Level I determination.

Upon receipt of the Level II medical necessity denial request:

• The Utilization Manager and the Member Services Manager convene the Grievance Committee.
• The provider is notified of the Grievance Committee hearing at least 10 working days prior to the date of the hearing.
• If desired, the provider may appear before the Grievance Committee at the hearing or participate by telephone.
• A quorum of at least five Grievance Committee members must be present for the hearing.

The Grievance Committee is comprised of the following individuals:

• The Texas Health Network Health Services Director or designee
• The Texas Health Network CQI Director or designee
• The PCP Contract Compliance designee
• The Texas Health Network Provider/Member Services Director and/or designee.
• The Texas Health Network Project Director is an ad hoc member of the Grievance Committee and may participate.
• The Texas Health Network Medical Director or Associate Medical Director (not included in Level I review).

The appealing provider is allowed a maximum of 30 minutes for his or her presentation. The provider may also be questioned by the Committee if clarification is required.

All Committee action is by a majority vote if a quorum of at least five members is present.

The provider is notified in writing of the Grievance Committee's decision within 30 days from the date the Level II appeal was filed.

The Member Services Manager is responsible for maintaining appropriate documentation to ensure that written details of each level of appeal as well as the outcome of each appeal decision are accurately captured.

Level III: Review by HHSC
If a provider believes they did not receive full consideration under the appeals process, he or she may file a complaint with HHSC. Providers must exhaust the appeals process with the Texas Health Network before filing a complaint with the HHSC. Complaints (Level II appeals to HHSC) must be in writing and include copies of all documentation from the provider to the Texas Health Network, and from the Texas Health Network to the provider. The Texas Health Network’s decision letters, specifically, the final decision letter, should be included as part of the documentation.
Complaints must be received at HHSC within 60 calendar days from the date of the Texas Health Network’s final decision letter. Providers may request the Texas Health Network forward the complaint to HHSC on his or her behalf. All of the necessary information must be received by HHSC in order for the complaint to be reviewed.

If HHSC determines that the provider did not receive full consideration, HHSC will work with the provider and the contractor (Texas Health Network) to ensure that a proper review is conducted. Otherwise, the final decision will be upheld.
CHAPTER V
MEMBER ELIGIBILITY AND ENROLLMENT

Overview

The Texas Department of Human Services is responsible for determining a client’s Medicaid eligibility. The enrollment broker identifies Medicaid clients who are eligible for or are required to enroll in the Texas STAR Program and assists these clients in the selection of a health plan. A client who chooses or is assigned to the Texas Health Network becomes a member of the plan and selects a PCP to manage his or her medical care. This chapter details member eligibility, the enrollment process, and member rights and responsibilities.

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Client Eligibility

The HHSC has targeted the following client groups in the Texas Medicaid population in designated counties as eligible members of the Texas STAR Program:

- Individuals receiving TANF benefits
- Individuals receiving TANF-related benefits
- Individuals receiving Blind and Disabled benefits who live in the community (residing in any Texas STAR Program county except Harris County)

Beginning December 1, 1997, aged, blind, and disabled clients residing in Harris County were required to enroll in a new Medicaid managed care demonstration pilot known as STAR+PLUS. See STAR+PLUS later in this chapter.

The TANF and TANF-related client groups are composed primarily of women and their dependent children under the age of 21. These groups comprise nearly 70 percent of the entire Medicaid population. Program goals will best be achieved by improving the health care delivery system for clients in the TANF and TANF-related groups. Eligible clients in the TANF and TANF-related groups must enroll in one of the Medicaid Managed Care Plans. The third group, the blind and disabled, may choose to enroll in the Texas STAR Program but their enrollment is not required. The tables below list those program types required to enroll in managed care and those that may enroll voluntarily.

### TABLE 5.1 Medicaid Program Types:
Mandatory Enrollment in Managed Care
Category 02 (TANF and TANF-Related)

<table>
<thead>
<tr>
<th>Program Code</th>
<th>Program Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Regular TANF</td>
</tr>
<tr>
<td>07</td>
<td>12 month Medicaid - TANF denied due to earnings</td>
</tr>
<tr>
<td>20</td>
<td>4 month Medicaid - TANF denied due to child support income</td>
</tr>
<tr>
<td>29</td>
<td>12 or 18 month Medicaid – TANF denied due to time limited benefits</td>
</tr>
<tr>
<td>37</td>
<td>12 month Medicaid - TANF denied due to earned income—disregards ending</td>
</tr>
<tr>
<td>40</td>
<td>Pregnant women at 185% of poverty level</td>
</tr>
<tr>
<td>43</td>
<td>Children under age 1 at 185% of poverty level</td>
</tr>
<tr>
<td>44</td>
<td>Children age 6 or older born on or after 10-01-83 at 100% of poverty level</td>
</tr>
<tr>
<td>45</td>
<td>Newborns of Medicaid-eligible mothers</td>
</tr>
<tr>
<td>47</td>
<td>Medicaid for deprived children with stepparent or grandparent income</td>
</tr>
<tr>
<td>48</td>
<td>Children under the age of 6 at 133% of poverty level</td>
</tr>
<tr>
<td>61</td>
<td>TANF-UP (unemployed parent)</td>
</tr>
</tbody>
</table>

Texas STAR enrollment, for clients in the programs listed above, with category code 02 is mandatory.
### TABLE 5.2 Medicaid Program Types: Voluntary Enrollment in Managed Care Categories 03 (Blind) And 04 (Disabled)

<table>
<thead>
<tr>
<th>Program Code</th>
<th>Program Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>TANF grant below $10</td>
</tr>
<tr>
<td>12</td>
<td>SSI</td>
</tr>
<tr>
<td>13</td>
<td>SSI</td>
</tr>
<tr>
<td>14</td>
<td>SSI</td>
</tr>
<tr>
<td>18</td>
<td>Disabled</td>
</tr>
<tr>
<td>19</td>
<td>Disabled under 18 years of age</td>
</tr>
<tr>
<td>22</td>
<td>Disabled from age 60-65</td>
</tr>
</tbody>
</table>

**NOTE:** Texas STAR enrollment for clients in the above programs, with category codes 03 and 04 and a base plan 13 (meaning the client lives in the community) is **voluntary** in all service areas except Harris County. Harris county STAR-eligible clients must enroll in STAR+Plus.

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**Clients Not Eligible for Texas STAR Program Enrollment**

Texas Medicaid clients who are **excluded** from the Texas STAR Program are those who:

- Have Medicare eligibility (except for clients residing in Harris County)
- Are residing in a nursing facility, intermediate care facility, or MR facility (except for those residing in Harris County)
- Have an eligibility period that is retroactive only
- Are eligible through the Medically Needy Program
- Live in an area excluded from the Texas STAR Program service area
- Are refugees
- Are foster children
- Are blind and disabled individuals residing in the Southeast Region service area (Chambers, Hardin, Jefferson, Liberty and Orange Counties)

**NOTE:** The PCP is responsible for coordinating care for children placed in the conservatorship of the Texas Department of Protective and Regulatory Services (TDPRS) until the child is placed in foster care and is no longer eligible for Texas STAR Program enrollment.
Member Enrollment

Once identified as eligible for the Texas STAR Program, clients select a plan and primary care provider. Benefits under the STAR Program begin on the first day of the month following selection of a PCP and plan (dual eligible members in STAR+PLUS do not choose a PCP). For example, a client who has become eligible for traditional Medicaid benefits for the first time, may be certified and begin to receive benefits under the Texas Medicaid program on the same day. If the client is also determined to be eligible for the Texas STAR Program, or STAR+PLUS Program, a second and separate enrollment process will take place.

The client will not begin to receive services under the Texas STAR or STAR+PLUS Program until the first day of the following month. Enrollments and disenrollments become effective on the first day of the month (see examples below).

<table>
<thead>
<tr>
<th>Client Certified For Texas Medicaid</th>
<th>January 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Benefits Begin</td>
<td>January 1</td>
</tr>
<tr>
<td>Client Selects STAR or STAR+PLUS Plan and PCP</td>
<td>January 1</td>
</tr>
<tr>
<td>STAR Program Services Begin</td>
<td>February 1</td>
</tr>
</tbody>
</table>

In the example above, the client would have traditional Medicaid coverage until Texas STAR Program benefits begin.

Texas STAR Program and STAR+PLUS Program eligibilities are not retroactive except for some pregnant (TP40) members.

For children under the age of 19, eligibility is guaranteed for 6 months, regardless of changes in household composition, income, or resources.

Expedited Pregnant Women Process

The Medicaid program has streamlined the eligibility and enrollment process for pregnant women. House Bill 2896, adopted by the Texas Legislature, directed the Texas Department of Health and Human Services and Texas Department of Health to devise new policies to promote early access to prenatal care.

Expedited Eligibility (Applies to Medicaid-eligible women throughout the state)
Within 15 days of receipt, DHS will process Medicaid applications for pregnant women. Once certified, a Medicaid ID card (Form 3037) will be issued to verify eligibility and to facilitate provider reimbursement.

Expedited Medicaid Managed Care enrollment (Applies to STAR Program service areas)
The enrollment broker, MAXIMUS, will contact the member to begin the enrollment process. The member may also contact MAXIMUS directly at 1-800-964-2777 (STAR Help line). Members may select a Medicaid HMO or, where available, the PCCM model. To protect continuity of care and member choice, MAXIMUS will work with each pregnant woman to select a health plan that includes her current prenatal care provider or to choose an obstetrical care provider that meets her needs.

Until coverage begins in a Medicaid managed care health plan, members will be covered under traditional Medicaid fee-for-service. Members may initially receive a Medicaid ID card (Form 3087) that shows them to be a member of a STAR health plan but does not list the plan name. To ensure proper billing, providers should call MAXIMUS at 800-964-2777 (STAR helpline) to obtain the name of the member’s plan.
The plan name should appear on the Medicaid ID card the following month. However, member eligibility should always be verified.

Within 14 days of enrolling in a new health plan, a plan representative will contact the new member to help arrange the first prenatal appointment. Physicians should also expect contact from the health plans to facilitate prenatal appointments for new health plan members. Physicians and other prenatal care providers are encouraged to make prenatal appointments within 2 weeks or as soon as possible.

**Newborns**

Newborns are eligible for Texas STAR Program benefits from the date of birth (DOB) if the baby is born to a mother who is enrolled in the Texas STAR Program and the baby is Medicaid eligible at the time of the birth. The baby will be enrolled in the same plan as the mother at the time of birth.

As with the traditional Medicaid Program, there may be a delay of up to several months from the DOB for a newborn to receive a Medicaid client number. If you provide care to a newborn who is eligible for the Texas Health Network based on the mother’s eligibility, you should wait to submit your claim until the newborn has a Medicaid number. Claims submitted with no Medicaid number or using the mother’s Medicaid number will be denied until the baby is assigned a Medicaid number. However, you may submit claims to the Texas Medicaid Claims Administrator before the baby has an assigned PCP.

If the newborn has not yet been assigned a PCP, the Texas Health Network ID card will indicate to providers that the client is “Newborn” and instruct them to “Call Plan” to inquire about filing a claim. Claims submitted to the Texas Medicaid Claims Administrator should show PCCNEWB01 as the referring provider identifier. Once the baby is assigned a PCP and a Medicaid number, normal billing and referral procedures will be in effect.

Generally, the answer to the following question determines eligibility:

“Is the mother Texas Health Network eligible on the newborn's date of birth?”

- **If Yes:** Newborn is a Texas Health Network member as of the DOB.
- **If No:** Newborn is regular Medicaid from DOB until enrolled in the Texas STAR Program with a plan and PCP.
Member Disenrollment

PCP Changes
A member may change his or her PCP without cause four times annually. A member may request a change of PCP more often with cause:

- The member is dissatisfied with the care or treatment they have received.
- The member’s condition or illness would be better treated by another provider type.
- The member’s new address is no longer convenient to the PCP’s location.
- The provider leaves the program (e.g. moves, no longer accepts Medicaid, is removed from Medicaid enrollment, or is deceased).
- The member/provider relationship is not mutually agreeable.

A provider may request a member be reassigned to another PCP for any of the following reasons:

- The member is not included in PCP’s scope of practice.
- The member is noncompliant with medical advice.
- The member consistently displays unacceptable office decorum.
- The member/PCP relationship is not mutually agreeable.

Any request by a provider to reassign a member to another PCP must be processed through the Texas Health Network. Before a request for reassignment can be initiated, reasonable measures must be taken to correct the member’s behavior. Reasonable measures may include education or counseling. The Texas Health Network will notify the member of the reassignment if all attempts to remedy the situation have failed. The Texas Health Network requests that providers also notify the member about the reassignment in writing and send a copy of the notification to the Texas Health Network.

In addition, the Texas Health Network may reassign a member to another PCP for any of these reasons:

- The PCP is no longer a Texas Health Network provider.
- The PCP exhibits a documented pattern of unacceptable quality of care.
- The PCP is sanctioned by the Texas Health Network.
- The PCP inappropriately limits the member’s access to covered specialty services.

Member and PCP requests for PCP changes received prior to the middle of the month usually become effective on the first day of the following month. PCP and member requests for PCP changes received after the middle of the month usually become effective on the first day of the second month following the request, as shown below:

<table>
<thead>
<tr>
<th>Request Receipt Date</th>
<th>Change Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>On or before mid-May</td>
<td>June 1</td>
</tr>
<tr>
<td>After mid-May</td>
<td>July 1</td>
</tr>
</tbody>
</table>

The Enrollment Broker is responsible for documenting these changes.
Plan Changes
Members have the right to change plans once a month. Members must call the Enrollment Broker to initiate a plan change. If a plan change request is received before the middle of the month, the plan change is effective on the first day of the following month. If the request is received after the middle of the month, the plan change will be effective on the first day of the second month following the request, as shown below:

<table>
<thead>
<tr>
<th>Request Receipt Date</th>
<th>Change Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>On or before mid-May</td>
<td>June 1</td>
</tr>
<tr>
<td>After mid-May</td>
<td>July 1</td>
</tr>
</tbody>
</table>

All plan change requests must be processed by the Enrollment Broker.

Request For Disenrollment From the Texas Health Network
The Texas Health Network has a limited right to request that a member be disenrolled from the Texas Health Network without the member’s consent. HHSC must approve any request for such disenrollment.

The Texas Health Network may request that a member be disenrolled for the following reasons:

- The member loans their Texas Health Network Identification Card to another person to obtain services.
- The member continually disregards the advice of his or her PCP.
- The member repeatedly uses the emergency room inappropriately.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the member’s behavior. Reasonable measures may include education or counseling conducted by Texas Health Network Member Outreach staff. The HHSC will notify the member of the disenrollment if all attempts to remedy the situation have failed. The HHSC will also notify the member of the availability of appeal procedures and the HHSC fair hearing process. These procedures are discussed in greater detail in Chapter IV.

Neither the Texas Health Network nor a Texas Health Network provider may request a disenrollment based on an adverse change in the member’s health or the utilization of services which are medically necessary for the treatment of a member’s condition.

Automatic Re-enrollment
If a client loses Medicaid eligibility and then regains eligibility within 6 months, the member is automatically reassigned his or her previous plan and PCP.

Eligibility Verification
All health care providers are responsible for verifying eligibility before medical care is provided to Texas Health Network members, except in cases of emergency. In an emergency, eligibility should be determined as soon as possible.

Each Texas Health Network PCP receives a monthly panel report of members assigned to them for the current month. Each member will have a Medicaid Identification Form 3087 that indicates eligibility for
Medicaid and participation in the Texas Health Network. Also, each member will receive a Texas Health Network Identification Card which indicates the PCP assigned.

You should ask to see the Medicaid Identification Form 3087 (or the Temporary Identification Form 1027-A) and the Texas Health Network Identification Card when determining whether the patient is a Texas Health Network member.

The Medicaid Identification Form 3087 indicates Medicaid eligibility for the current month. There is no end date on the Texas Health Network card.

**Steps to Determine Eligibility**

When a patient identifies himself or herself as a Texas Health Network member, you should verify eligibility through *one or more* of the following steps:

- Request the Texas Health Network Identification Card and the Medicaid Identification Form 3087, or the Temporary Identification Form 1027-A.
- Photocopy the patient’s eligibility identification and retain copies in his or her file.
- PCPs only—Check the current monthly panel report of patients assigned to your practice to determine whether the patient’s name and Medicaid number appear on the list. If the patient’s name and Medicaid number are shown, eligibility is guaranteed for that month only.
- If the patient does not have either form of identification:
  - Inquire using TDHconnect (TexMedNet if your vendor supports eligibility inquiries)
  - Call the AIS 24-hour telephone service to confirm eligibility

  **AIS Phone Numbers**

  1-800-925-9126
  1-512-345-5949

  *(See the Texas Medicaid Provider Procedures Manual - AIS User’s Guide)*

**Medicaid Identification Form 3087**

The Medicaid Identification Form 3087 verifies Medicaid eligibility. This form has been amended by the TDHS for clients who participate in the Texas STAR Program. These changes include the following:

- A Texas STAR Program logo has been added to the form for easy recognition.
- The name and telephone number of the plan in which the client is enrolled is shown below the client’s name.
- For Texas Health Network members, the Form 3087 also identifies the member’s PCP and whether the member is due for a THSteps exam.

In addition, a watermark (an image of the State Seal) has been added to both traditional Medicaid and Texas STAR Program 3087 forms for authentication purposes.

**NOTE:** The member’s Medicaid Identification Form 3087 may continue to indicate that member’s age 21 years and older are eligible for hearing aid and vision services for dates of service on or after September 1, 2003 and October 16, 2003, respectively. Regardless
of this indicator on the Form 3087, services rendered to member’s age 21 years or older are no longer eligible for vision or hearing aid benefits

Temporary Identification Form 1027-A
In the event a member’s Medicaid Identification Form 3087 is lost or stolen, the TDHS will issue a temporary Identification Form 1027-A. This temporary form should be accepted as evidence of eligibility during the eligibility period noted on the form unless the form contains limitations that affect the eligibility of the intended service. Please see the Texas Medicaid Provider Procedures Manual for more information.

Texas Health Network ID Card
All Texas Health Network members are issued an identification card that displays the member’s name, member number, date of birth and enrollment date, as well as an indicator of any other insurance the member may have. The designated PCP name, address, and daytime phone number are also displayed. The card also lists telephone numbers of the Texas Health Network member and clinical helplines.

The Texas Health Network ID Card alone does not guarantee eligibility for services.

A sample of the Texas Health Network ID card is in Appendix B.

Monthly Member Panel Report
Each month the PCP will receive from the Texas Health Network a member panel report that lists all Texas Health Network members who have either selected or who have been assigned to them. This report verifies member assignments for the current month and identifies those who have been defaulted to your practice and those that may be eligible for THSteps services. An example of this report can be found in Appendix A.

Members appearing on the monthly Panel Report are eligible for services for the entire calendar month.

Based on the number of members appearing on the monthly member panel report, the PCP receives a monthly case management fee. This check is issued by the Texas Medicaid Claims Administrator.

Panel Closings
You may choose to close your panel to new assignments. To close your panel, you should contact the Texas Health Network’s Contracting/Credentialing Department in writing (by mail or fax) to request a suspension of new enrollments or assignments to your practice. Please include your contracted Texas Provider Identifier (TPI) on signed letterhead or contact the Contracting/Credentialing Department for a Provider Information Change Form (see Appendix C). Should you choose to re-open your panel, contact the Texas Health Network’s Contracting/Credentialing Department to request your panel be re-opened to new assignments. Please notify the Texas Health Network at least 30 days before you expect to reopen your panel.
Member Rights

Members of the Texas Health Network have defined rights and responsibilities. The Texas Health Network and primary care providers share the responsibility to ensure and protect member rights and to assist members in understanding and fulfilling their responsibilities as plan members.

A Texas Health Network member has the right to:

• respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
  — be treated fairly and with respect; and
  — know that their medical records and discussions with their providers will be kept private and confidential.

• a reasonable opportunity to choose a health care plan and primary care provider (the doctor or health care provider they will see most of the time and who will coordinate their care) and to change to another plan or provider in a reasonably easy manner. That includes the right to:
  — be informed of how to choose and change health plans and primary care provider;
  — choose any health plan that is available in their area and choose a primary care provider from that plan;
  — change their primary care provider (see below);
  — change health plans without penalty (see below); and
  — be educated about how to change their health plan or their primary care provider.

• ask questions and get answers about anything they don’t understand. That includes the right to:
  — have their provider explain their health care needs to them and talk to them about the different ways their health care problems can be treated; and
  — be told why care or services were denied and not given.

• consent to or refuse treatment and actively participate in treatment decisions. That includes the right to:
  — work as part of a team with their provider in deciding what health care is best for them; and
  — say yes or no to the care recommended by their provider.

• utilize each available complaint process through the managed care organization and through Medicaid, receive a timely response to complaints and receive a fair hearing. That includes the right to:
  — make a complaint to their health plan or to the state Medicaid program about their health care, provider or health plan;
  — get a timely answer to their complaint; and
  — request a fair hearing from the state Medicaid program about their complaint.

• timely access to care that does not have any communication or physical access barriers. That includes the right to:
  — have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care;
— get medical care in a timely manner,
— be able to get in and out of a health care provider’s office, including barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act;
— have interpreters, if needed, during appointments with their providers and when talking to their health plan. Interpreters include people who can speak in their native language, assist with a disability, or help them understand the information; and
— be given an explanation they can understand about their health plan rules, including the health care services they can get and how to get them.

• not be restrained or secluded when doing so is for someone else’s convenience, or is meant to force them to do something they do not want to do, or to punish them.

**Member Responsibilities**

Both the Texas Health Network and PCPs should help Texas Health Network members understand their responsibilities. These include the responsibility to:

• learn and understand each right they have under the Medicaid program. That includes the responsibility to:
  — learn and understand their rights under the Medicaid program;
  — ask questions if they don’t understand their rights; and
  — learn what choices of health plans are available in their area.

• abide by the health plan and Medicaid policies and procedures. That includes the responsibility to:
  — learn and follow their health plan rules and Medicaid rules;
  — choose their health plan and a primary care provider quickly;
  — make any changes in their health plan and primary care provider in the ways established by Medicaid and by the health plan;
  — keep their scheduled appointments;
  — cancel appointments in advance when they can’t keep them;
  — always contact their primary care provider first for non-emergency medical needs;
  — be sure they have approval from their primary care provider before going to a specialist; and
  — understand when they should and shouldn’t go to the emergency room.

• share information relating to their health status with their primary care provider and become fully informed about service and treatment options. That includes the responsibility to:
  — tell their primary care provider about their health;
  — talk to their providers about their health care needs and ask questions about the different ways their health care problems can be treated; and
  — help their providers get their medical records.
• actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility:
  — work as a team with their provider in deciding what health care is best for them;
  — understand how the things they do can affect their health;
  — do the best they can to stay healthy; and
  — treat providers and staff with respect.

**STAR+PLUS Demonstration Pilot**  
**Harris County Only**

STAR+PLUS is a demonstration pilot that integrates acute care, long term care, and primary care into one managed care delivery system. The HHSC is the operating agency for STAR+PLUS. It is designed to improve access to care, emphasize community-based care, and provide more accountability and cost control.

**Mandatory Enrollment**
The State has mandated that the following clients residing in Harris County enroll with a STAR+PLUS HMO:

• SSI clients 21 and older who are living in the community.
• Clients denied SSI benefits because of cost of living adjustments, but retain their Medicaid eligibility.
• Clients entering a Title XIX nursing facility after the implementation date of STAR+PLUS.
• Clients who qualify for nursing facility care but elect to receive services in the community (community-based alternative waiver clients).
• Adults in nursing facilities who spend down to Medicaid eligibility in less than 12 months after implementation of STAR+PLUS.
• Medical Assistance only clients who qualify for nursing facility level of care.

STAR+PLUS-eligible clients residing in Harris County who must enroll with either a STAR+PLUS participating HMO or the Texas Health Network are:

• SSI clients with Severe and Persistent Mental Illness (SPMI).
• SSI-eligible children younger than age 21.
• Children and adolescents younger than age 21 with serious emotional disturbances (SED) who are receiving Medicaid-funded rehabilitation services for mental illness through the local mental health authority.
• ICF-MR/HCS waiting list clients (SSI clients with mental retardation who are on the MHMR list to be considered for the Home And Community-Based Services [HCS] waiver program).
Clients in Harris County eligible for STAR+PLUS who may voluntarily enroll with a STAR+PLUS participating HMO or remain in the traditional Medicaid Program are:

- Residents of nursing facilities who are eligible for SSI/MAO
- Residents of nursing facilities who spend down to MAO after 12 months or more in a nursing facility

**Ineligible Clients**

Harris County clients *not eligible* for Texas STAR or STAR+PLUS include those clients who:

- Participate in the CLASS (Community Living Assistance and Support Services) Waiver Program
- Participate in the MDCP (Medically Dependent Children’s Waiver Program)
- Participate in the HCS (Home and Community Services) Waiver Program
- Participate in the HCS-OBRA (Home and Community Based Services-OBRA) Waiver Program
- Participate in the Deaf Blind Multiple Disabled Waiver Program
- ICF-MR residents
- Residents of State hospitals or institutions for mental diseases
- Frail Elderly (or 1929B) Program recipients
- Recipients of In-Home and Family Support Program Services
- Qualified Medicare Beneficiaries
- Undocumented aliens
- Foster children
- Clients eligible for Medicaid through the Medically Needy Program
CHAPTER VI
REIMBURSEMENT AND CLAIMS SUBMISSION

Overview

This chapter provides information on reimbursement for PCPs, THSteps and Family Planning Providers, specialists, and in-network and Out-of-Network Hospitals. It also provides basic information on claims submission, remittance and status reports, provider certifications of compliance with various State and Federal laws and regulations, and the limited circumstances under which a provider may bill members for services.

Note: The Texas Medicaid Claims Administrator processes and adjudicates all claims. Medicaid claims submission requirements specified in the Texas Medicaid Provider Procedures Manual apply to Texas Health Network claims.

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Medicaid Reimbursement Policy

The Medicaid policy governing reimbursement for services rendered to Medicaid clients does not change for Texas Health Network services. Reimbursement is made by the Texas Medicaid Claims Administrator in accordance with the limitations and procedures of the Texas Medicaid Program, the HHSC, and the Texas Health Network. Providers who receive payment for services agree that the endorsement or deposit of check issued by the Texas Medicaid Claims Administrator is the acceptance of money from Federal and State funds and that any falsification or concealment of a material fact related to payment may be grounds for prosecution under Federal and State laws.

PCP Reimbursement

In addition to a case management fee, PCPs receive Medicaid fee-for-service payments for services they provide to Texas Health Network members. The fee-for-service reimbursement for the Texas Health Network is based on the Texas Medicaid Reimbursement Methodology (TMRM) structure.

Case Management Fee

The case management fee is compensation for managing the medical care of Texas Health Network members who have either selected or who have been assigned to the PCP’s practice as their “medical home.” The fee:

- is paid to the PCP whether or not the member is seen that month.
- is paid to the PCP in a separate check no later than the tenth State business day of each month.

Two reports are mailed to PCPs on a monthly basis. The member panel report lists the Texas Health Network members who have selected or who have been assigned to each PCP’s practice. This report is provided in hard copy at the beginning of each month. The second report, a case management summary, is produced by the Texas Medicaid Claims Administrator and accompanies the case management check.

If there are any discrepancies in either report, contact your Texas Health Network Provider Relations Representative. Please call the Provider Helpline (1-888-834-7226) prior to returning a check; this allows the Texas Health Network to do necessary research and provide assistance.

THSteps and Family Planning Services

THSteps and family planning services will continue to be reimbursed at their current rates. If a provider other than the member’s PCP furnishes THSteps and/or family planning services to a Texas Health Network member, he or she should contact the PCP listed on the member’s Texas Health Network Identification Card and/or Medicaid ID Form 3087 to:

- Discuss the patient’s general health
- Share information about the services furnished
- Discuss the nature and results of tests performed
- Review any recommendations for follow-up care
Communication between and among providers is essential to maintain continuity of care for the patient and to ensure that the patient’s medical record in the PCP’s office is complete.

**Specialists**

Specialists may bill for health care services provided to Texas Health Network members if the patient was referred by the member’s PCP. Reimbursement for specialists is based on the current Medicaid fee-for-service rates. The PCP’s name and Texas Provider Identifier (TPI) must be shown in the referring physician field of the electronic submission (Boxes 17 and 17A on the HCFA-1500 claim form), indicating referral from the PCP.

The following services are exempt from the referral requirement:

- THSteps (medical screenings and dental services)
- Family Planning
- Case Management for High-Risk Pregnant Women and Infants (PWI) and Early Childhood Intervention (ECI) services
- School Health and Related Services (SHARS)
- Behavioral Health Services provided by psychiatrists, psychologists, LMSW-ACPs, and LPCs*
- Mental health case management, case management for mental retardation diagnosis and assessment services, and mental health rehabilitative services provided through MHMR
- Routine Vision Services
- School-based Clinic Services
- Emergency Services

*These services were affected by recent changes made to the Medicaid Program. Please refer to *Texas Medicaid Bulletin number 174, HIPAA Special Bulletin Update* for specific benefit limitations.

**Hospitals**

**Network Hospitals**

A network hospital is one that is contracted to provide services to Texas Health Network members. Individual reimbursement arrangements are negotiated for the HHSC by the Texas Health Network Administrator.

All services, including inpatient services, provided to Texas Health Network members receiving SSI benefits are reimbursed at the traditional fee-for-service Medicaid rate.

**Out-of-Network Hospitals**

An out-of-network hospital is one that is not contracted to provide services to Texas Health Network members:

- Out-of-network hospitals are reimbursed only for inpatient services provided to Texas Health Network members as the result of an emergency admission, and then only until the patient is stabilized. Inpatient services are reimbursed at the rate paid by the traditional Medicaid program.
• Reimbursement for emergency treatment will be made at the current Medicaid rates.

Hospitals that are not contracted with the Texas Health Network but are contracted with the LoneSTAR Select Program are reimbursed under the selective contracting method.

After a patient in an out-of-network hospital is stabilized, additional services are considered non-covered benefits. The out-of-network hospital may, however, request an exception to the stabilization policy by contacting the Texas Health Network Utilization Management Department at 1-888-302-6167.

• The hospital must state the circumstances surrounding the emergency admission and provide an estimate of the additional number of days required until the patient is discharged.

• The Texas Health Network grants exceptions based on the information provided by the non-contracted hospital and issues a precertification for billing purposes if an exception is granted.

• Although in some cases, the Texas Health Network Utilization Management Department may require additional time to review the circumstances of the request for exception, it normally reviews the request and contacts the out-of-network hospital within 36 hours of its request. The UM Department will either provide the non-contracted hospital with a precertification or deny the exception request.

• Should a stabilization exception be denied, any inpatient services provided to the Texas Health Network member at the out-of-network hospital will cease to be a covered benefit 24 hours after the hospital is notified.

Non-emergency inpatient admissions are not a covered benefit at out-of-network hospitals and are considered for reimbursement only if precertification has been received from the Texas Health Network or the member would experience an undue burden traveling to a network hospital. In this case, a “hardship exemption” may be granted. This exemption permits reimbursement of a non-emergency admission at an out-of-network hospital.

To obtain a hardship exemption, the attending physician or designee must contact the Texas Health Network Utilization Management Department at 1-888-302-6167 before any non-emergency admission to an out-of-network hospital and provide details to substantiate why the member would experience an undue burden traveling to a network hospital.

If the details substantiate undue burden, the Utilization Management Department will grant the exemption and issue a precertification. The physician can then admit the patient to the out-of-network hospital.

NOTE: Under no circumstances will authorization for an undue travel burden be granted after a patient has been admitted for a non-emergency condition to an out-of-network hospital.

Fees for Network Hospitals

Emergency Services
Hospitals are eligible to bill for any services required in the medical screening examination and stabilization of a Texas Health Network member. All services must be supported by the clinical record.

When treatment is provided to a Texas Health Network member, “professional” and “facility” services must be billed separately.
Reimbursement of emergency facility and ancillary charges for diagnostic tests, monitoring, and treatment is based on the actual services rendered. The hospital is paid at its current Medicaid reimbursement rate.

**Emergency Inpatient Admissions**

If an emergent admission is necessary, the hospital must notify the Texas Health Network in accordance with the policies detailed in Chapter III of this manual. Failure to notify the Utilization Management Department of the admission will result in denial for non-notification.

All inpatient services will be subject to concurrent and retrospective review for appropriateness of services and level of care provided.

Notification of emergency admissions can be telephoned or faxed to:

Texas Health Network Utilization Management Helpline
1-888-302-6167
Fax: 1-512-302-5039

**Emergency Outpatient Services**

If the member presents at a hospital emergency outpatient facility, the physician should provide the medically necessary medical screening examination and stabilization services immediately, and the member should be referred back to the PCP for follow-up care. Reimbursement for emergency outpatient services requires that the medical record document the medically necessary services.

The hospital should contact the Texas Health Network Utilization Management Department and the member’s PCP within 24 hours or the next business day to advise that emergency treatment has been provided. Reimbursement in cases of emergency treatment will be based on the actual services rendered. The hospital will be reimbursed at its current Medicaid reimbursement rate.

**Non-Emergency Outpatient Clinic Services**

All hospitals are reimbursed for outpatient clinic services at their current Medicaid outpatient reimbursement rate.

**Claims Submission Details**

All claims for services provided to Texas Health Network members must be submitted to the Texas Medicaid Claims Administrator either electronically or at the claims addresses listed in the current *Texas Medicaid Provider Procedures Manual*.

If the provider of the services is not the member’s assigned PCP, the PCP’s name and Texas Provider Identifier (TPI) must be entered in the referring provider field of your electronic claim submission (boxes 17 and 17A on the HCFA-1500) indicating a referral from the PCP.

If this information is missing or if the treating provider is not the assigned PCP on the date of service, the claim will be denied.

For services requiring precertification, enter the precertification number in the prior authorization field. It is not necessary to send the Precertification Request Form with the claims submission.
Remittance and Status Report

Claims filed under the same Medicaid TPI and program ready for disposition at the end of each week are paid by a single check sent to the provider. Each check issued by the Texas Medicaid Claims Administrator for Texas Health Network members will be mailed with a Texas Health Network Remittance and Status (R&S) Report. Providers will receive two R&S Reports, a Texas Health Network R&S, and a traditional Medicaid R&S:

- The Texas Health Network R&S Report provides the same information as the Medicaid R&S Report. (Refer to the Texas Medicaid Provider Procedures Manual for information on the R&S Report.)
- The Texas Health Network R&S Report has the Texas STAR Program logo in the upper left hand corner to differentiate it from the traditional Medicaid R&S.

If no claim activity or outstanding account receivable exists during the time period, the provider will not receive an R&S for the week.

TexMedNet Electronic Claims Submission

Providers who currently have TexMedNet filing capability for the traditional Texas Medicaid Program may continue to submit claims to the Texas Medicaid Claims Administrator through the same means, i.e., current software or vendor.

Providers who currently do not file electronically but are interested in more information about electronic filing should contact their Provider Relations Representative or the TexMedNet Help Desk for assistance with technical consultation services and software installation at 1-888-863-3638.

These services are available at no charge to the provider.

Provider Certification of Compliance

Providers who submit claims for services to Texas Health Network members are required to certify compliance with various provisions of State and Federal laws and regulations.

By submitting a claim, the provider certifies that:

- Services were personally rendered by the billing provider or under the personal supervision of the billing provider.
- The information contained on the claim is true, accurate, and complete.
- All services, supplies, or items billed were medically necessary for the diagnosis and/or treatment of the patient, with the exception of routine check-ups.
- Medical records document all services that have been billed.
- Billed charges are usual and customary and are not higher than the fees charged to private-pay patients.
- Services were provided without regard to race, color, sex, national origin, age or handicap.

The provider of medical care and services agrees to accept Medicaid reimbursement as payment in full for services covered under the Texas Health Network.
Furthermore, the provider understands that endorsing or depositing a Medicaid check is accepting money from Federal and State funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under Federal and State laws.

Billing Members

A provider may not bill, or take recourse against, a member for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the Medicaid program.

A provider who elects to furnish services not covered by the Medicaid program, including services that have been determined as not medically necessary, may bill a member only if both of the following conditions are met:

- The service or item is provided at the patient’s request.
- The provider has obtained the member’s signature on the Member Acknowledgment Statement or the Private Pay Agreement (see below) specifying that the member will be held responsible for payment of services.

All services, including hospital admissions, that are denied by the Texas Health Network are included in this policy.

Texas Health Network members, or others on their behalf, must not be “balance-billed” for the amount above that which is paid by the Texas Health Network for covered services. Texas Health Network members must not be billed for claims denied by the Texas Medicaid Claims Administrator for any of the following reasons:

- Failure to submit a claim, including claims not received by the Texas Medicaid Claims Administrator.
- Failure to submit a claim to the Texas Medicaid Claims Administrator for initial processing within the 95-day filing deadline.
- Failure to appeal a claim within the 180-day appeal period.
- Failure to submit a claim to the Texas Medicaid Claims Administrator within 95 days of denial by Title XX for Family Planning services.
- Submission of an unsigned or otherwise incomplete claim, such as the omission of the Hysterectomy Acknowledgement Statement or Sterilization Consent Form with claims for these procedures. Refer to the Physician Section of the Texas Medicaid Provider Procedures Manual for more information.
- Errors made in claims preparation, claims submission, or the appeal process.
- Failure to obtain a signed Member Acknowledgment Statement or Private Pay Agreement.

A provider attempting to bill or recover money from a Texas Health Network member in violation of the above conditions may be subject to exclusion from the Texas Health Network and the Texas Medicaid Program.

Federal regulations prohibit providers from charging clients or the Texas Medicaid Claims Administrator a fee for completing or filing Medicaid claim forms. The cost of claims filing is considered a part of the usual and customary charges to all clients.
Providers appealing a claim denied for any of the above reasons must follow the procedures in the Appeals Section of the *Texas Medicaid Provider Procedures Manual*.

**Member Acknowledgment Statement**

A provider may bill a Texas Health Network member for a service that is not medically necessary or not a covered benefit if both of the following conditions are met:

- The patient requests a specific service or item that in the opinion of the provider may not be reasonable and medically necessary.
- The provider must obtain and keep a written acknowledgment statement verifying that the provider has notified the Medicaid member of financial responsibility for services rendered. This acknowledgment must be signed by the member. If the service the member requested is determined not to be medically necessary by the Texas Health Network, HHSC or the Texas Medicaid Claims Administrator, the signed acknowledgment statement must indicate that the member has been notified of the responsibility of paying the bill. The acknowledgment must state:

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

  “Comprendo que, según la opinión del (nombre del proveedor), es posible que Texas Health Network no cubra los servicios o las provisiones que solicité el (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que la Comisión de Salud y Servicios Humanos de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o las provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no fueron o son razonables ni médicamente necesarios para mi salud.”

A provider may bill a member without a signed acknowledgment statement if:

- The service received is not a benefit of the Medicaid Program. The provider must inform the member that the service in question is not a benefit of the Texas Medicaid Program and notifies the member of financial responsibility, and

- The provider accepts the member as a private pay patient. Providers must advise members that they are accepted as private pay patients at the time of service and will be responsible for paying for all services received. In this situation, HHSC strongly encourages that notification be in writing with the member’s signature so there is no question how the member was accepted. Without written, signed documentation that the Medicaid member has been properly notified of the private pay status, the provider should not
seek payment from an eligible member. The following “Private Pay Agreement” is an example of written documentation.

I understand (provider name) is accepting me as a private pay patient for the period of ____ ________, and I will be responsible for paying for any services I receive. The provider will not file a claim to the Texas Health Network or Medicaid for services provided to me.

Signed:__________________________
Date:____________________________

• The member is accepted as a private pay patient pending Medicaid eligibility determination and does not become eligible for Medicaid retrospectively. The provider is allowed to bill the member as a private pay patient if retroactive eligibility is not granted. If the member does become eligible retroactively, the member should notify the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the member becomes eligible, the provider must refund any money paid by the member if a Medicaid claim is filed.
Texas Health Steps (THSteps) is the State’s federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The Texas Health Network considers full PCP participation in this program as the most important investment the plan makes in the health of the infants, children, and adolescents under its care. In collaboration with the Texas Health and Human Services Commission and the Texas Department of Health, the Texas Health Network has established extensive support and educational programs for PCPs and plan members to achieve the highest possible level of compliance with the THSteps periodicity and screening schedules.
Objectives and Outreach

The Texas Health Network seeks to significantly improve the screening rate for THSteps and to exceed the federally mandated 80 percent screening rate. The key to meeting this objective is direct outreach to Medicaid clients. Outreach should be centered around a consistent and ongoing emphasis on preventive care.

The Texas Health Network encourages its members to use THSteps preventive medical check-up services and the adolescent preventive service visits when they first enroll and each time they are periodically due for their next medical check-up.

Providers are encouraged to perform check-ups on Texas Health Network members they identify as eligible for medical check-ups and adolescent preventive service visits. They are encouraged also to notify the client when he or she is due for the next check-up according to the periodicity schedule. Providers should also remind parents/caretakers of the need to receive dental check-ups.

A sample message from PCPs to members might include the following text:

“Your children can get check-ups. In addition to these check-ups, there are shots and tests that may keep your child from getting sick. These services are important for your children to stay well. Find out what services your children can get by calling my office, or by calling 1-877-THSTEPS (1-877-847-8377).”

The Texas Health Network’s approach to THSteps is focused and effective:

- The member outreach program is interactive and positive.
- Materials are appropriate for various segments of the member population.
- Available services are described in easy-to-understand terms.
- Access to services is made simple.
- PCP enrollment in THSteps is facilitated by the Texas Health Network.
- PCP training in THSteps services is facilitated by the Texas Health Network.
- Feedback to PCPs is used to achieve high rates of screening compliance.

Several channels of communication are opened to send messages to parents and guardians about these services, especially check-ups that identify health problems early and the follow-up services available for complete diagnoses and treatments.

THSteps Outreach

The Texas Health Network conducts the following activities to help PCPs with THSteps outreach for on their panels:

- Works with the enrollment broker to ensure that eligible Medicaid clients are informed about THSteps services during the managed care plan selection process.
- Provides THSteps education to members during New Member Orientations.
• Sends a letter to each new family enrolled in the Texas Health Network indicating that an appointment with their PCP should be scheduled within 30 days for THSteps eligible children to receive an initial screening examination. The letter includes a brochure describing:
  — THSteps benefits, e.g., routine screening, diagnostic testing, and treatment
  — The availability of services that are beyond the normal scope of the Medicaid Program (CCP services)
  — The importance of immunizations, health screenings and follow-up treatment
  — How to obtain services
  — The role of the PCP in THSteps

• The letter explains that clients may choose any qualified provider to perform THSteps services, pointing out the advantage of using their PCP (as a positive step that will lead to the development of a trusting, ongoing relationship with their PCP) and explains the benefits of having a “medical home” and establishing a baseline of basic health information for their medical record.

• Sends a birthday card to remind eligible members to obtain their Texas Health Steps screen.

• Indicates on the PCPs monthly panel report which members are due for a Texas Health Steps screen.

• Develops simple, attractive, and culturally sensitive materials for use throughout the service area in PCP offices.

**Member Eligibility**

THSteps services are covered for members under the age of 21. The screening examinations and periodicity schedule are age specific. Client eligibility for a medical check-up is determined by the client’s age on the first day of the month. If a client has a birthday on any day except the first day during the month, the new eligibility period begins on the first of the following month. If a client turns 21 during a month, the client continues to be eligible for THSteps services through the end of that month.

**NOTE:** The THSteps periodicity schedules for children and adolescents and the schedule for routine immunizations can be found in the *Texas Medicaid Provider Procedures Manual* and the *Texas Medicaid Service Delivery Guide*.

**Provider Enrollment**

The Texas Health Network’s goal is to ensure that each PCP views THSteps as an important and integral part of his or her practice and understands fully how to properly provide THSteps services. The Texas Health Network identifies those PCPs who are not enrolled as THSteps providers and assists interested PCPs in the enrollment process—ensuring they receive the proper materials and training (if needed) to perform THSteps screenings.

• Currently enrolled Medicaid providers can contact the Texas Medicaid Claims Administrator at 1-800-925-9126, to enroll in the THSteps Program, or contact the Texas Health Network for assistance.

• Providers do not have to enroll separately with each Texas STAR Program health plan to be reimbursed for THSteps services.
• A registered nurse (RN) or licensed physician assistant (PA) may perform the THSteps medical check-up under the supervision of a THSteps-enrolled physician.

In addition, the Texas Health Network provides:

• Knowledgeable technical assistance through trained Provider Helpline staff.
• Workshops and in-services to provide tools and information to your office or clinic.
• Information gathering and sharing to ensure that you have access to information you need to coordinate, monitor, and document THSteps services to your members.

THSteps Screening Protocol

Medical check-up services are covered for eligible Texas Health Network members under 21 when delivered in accordance with the State of Texas, Texas Health Steps Program 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 medical check-up services are reimbursable. The periodicity schedule incorporates an annual comprehensive exam for adolescents consistent with American Academy of Pediatrics recommendations.

Major components of the THSteps screening examination are:

• A comprehensive health and developmental history, including assessment of both physical and mental development
• A comprehensive, unclothed physical examination
• Dental screening and referral to a primary care dentist, beginning at age one
• Nutritional assessment
• Developmental assessment (Denver II or other appropriate observation screening tool)
• Mental health assessment
• Vision screening
• Hearing screening
• Tuberculosis testing
• Laboratory screening procedures
• Age specific routine immunization
• Health education and anticipatory guidance

Newborn Screening

The required components of the initial THSteps checkup must meet AAP recommendations and must include the following documentation:

• History and physical examination
• Length, height, weight, and head circumference
• Sensory screening (vision and hearing appropriate to age)
• Hepatitis B immunization
• Neonatal genetic/metabolic screen
• Health education with the parents or a responsible adult who is familiar with the child’s medical history. Health education by the nursing staff, individually or in a class, is acceptable.

Physicians and hospital staff are encouraged to inform parents eligible for Medicaid that the next THSteps checkup on the periodicity schedule should be scheduled at one to two weeks of age and that regular check-ups should be scheduled during the first year.

Exceptions to Periodicity

The Texas Medicaid Claims Administrator reimburses for medical check-ups that are exceptions to the periodicity schedule to allow for services that include the following categories:

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

Immunizations

Children must be immunized during medical check-ups according to the Texas Department of Health (TDH) routine immunization schedule. The screening provider is responsible for administration of immunizations and should not refer children to local health departments to receive the immunizations. However, vaccines are available free of charge to THSteps providers through the local health departments and regional offices of TDH.

Providers interested in enrolling in the Texas Vaccines for Children Program should contact 1-800-252-9152, for more information.

In addition, the TDH provides necessary laboratory supplies, forms, and instructions for collection of required specimens. All newly enrolled providers receive a start-up package of forms and supplies. Supply requests can be faxed to the TDH laboratory at 1-512-458-7672. The TDH laboratory processes the specimen and reports the results to the submitting provider.

For children not previously immunized, the State of Texas requires immunizations be given unless medically contraindicated or against parental religious beliefs.
Referrals for Diagnosis and Treatment

After the check-up, PCPs may make referrals as needed for any diagnostic and treatment procedures not provided directly by the PCP’s office or clinic.

The Texas Health Network assists PCPs in ensuring that this service is performed in accordance with plan guidelines. With this assistance, PCPs can:

• Identify potential specialty diagnosis and treatment providers in the area.
• Remind members of scheduled appointments for diagnosis and treatment.
• Monitor missed diagnosis and treatment appointments; follow-up with family/caretakers.
• Make arrangements for transportation.

The PCP should request, and the referral provider should deliver, a summary of findings from the referral visit and recommendations for follow-up. This information should be incorporated into the member’s medical record in the PCP’s office. See Chapter II for additional details.

Coordination of Comprehensive Care Program (CCP) Services

THSteps-CCP is an expansion of the THSteps-EPSDT program as mandated by the Omnibus Budget Reconciliation Act (OBRA) of 1989, which requires all states to provide treatment for correction of physical or mental problems to THSteps eligible clients for any medically necessary services for which Federal Financial Participation (FFP) is available even if the services are not covered under the state’s Medicaid plan. This expansion of services is provided only for those clients who are younger than age 21 and eligible to receive THSteps services. Refer to the Texas Medicaid Provider Procedures Manual for a complete list of CCP covered services.

Your office or clinic should receive information and education from the Texas Health Network to help you and your staff identify, provide, and coordinate care for children with special health needs and complex diseases or illnesses. These children may require treatment and support from a multidisciplinary team of providers. The Texas Health Network uses a variety of sources to identify these children and works with you, specialists, TDH, HHSC, community and advocacy organizations to ensure that an appropriate treatment plan is developed to meet the member’s health needs.

PCP Responsibilities

With assistance from the Texas Health Network, PCPs have the responsibility to coordinate, monitor, and document medical care to children with special needs. Necessary activities include:

• Obtaining and recording diagnoses, treatment results, and aftercare plans
• Referring members for specialty medical care
• Ensuring continuity of care
• Preventing the duplication of services

Provider/Member Services and Health Services staff can assist PCPs in these efforts.
THSteps Medical Case Management

The mission of THSteps Medical Case Management is to provide equal access to all services necessary for each THSteps recipient to have an opportunity to develop and maintain his or her maximum progress toward age-appropriate development, health, wellness, and educational pursuits.

Children eligible for THSteps Medical Case Management must be:

- One year of age up to 21 years of age
- Medicaid eligible
- Children with special health care needs
- Children who have a health condition/health risk
- Medically complex children
- Medically Fragile

TDH Regional THSteps Telephone Numbers

Region 1 (Northwest Texas/Lubbock, Amarillo, Canyon)
1-806-655-7151

Region 5S/6 (Houston, Galveston, Beaumont, Port Arthur)
1-713-767-3110

Region 8 (San Antonio, Victoria, Del Rio)
1-210-949-2000

Region 2/3 (Arlington, Dallas, Fort Worth, Richardson)
1-817-264-4000

Region 9/10 (El Paso, Van Horn)
1-915-783-1129
CHAPTER VIII
SUPPORT SERVICES

Overview

The Texas Health Network provides services and support to PCPs to achieve Texas STAR Program objectives and address provider concerns. As a PCP, you have the challenge and the opportunity to improve health outcomes for Medicaid members and to achieve the goals of the Texas Health Network. The Texas Health Network recognizes that this challenge requires the cooperation of plan members who will be asked to change the way they have accessed Medicaid services in the past. The Texas Health Network provides a broad range of services to guide and assist members in making this change.

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Provider Support and Education

Texas Health Network Provider Relations Representatives in each service area support participating providers. These representatives also are available to contact providers who are considering participation as well as those who are unfamiliar with the program. Texas Health Network core support services to primary care providers include:

Provider Helpline — Knowledgeable Provider Helpline Agents are available to assist you with a broad range of Medicaid and Texas Health Network issues. Toll-free customer service lines are available Monday through Friday, from 7:00 a.m. to 6:00 p.m., and are answered directly by Provider Helpline Agents.

Texas Health Network Provider Helpline
1-888-834-7226

Texas Health Network Medical Director's Office
1-512-506-7008

Provider Information and Educational Services — Provider Relations Representatives conduct informational and educational workshops, group meetings, and training sessions for office practices and groups when requested, as well as on a regularly scheduled basis. On at least an annual basis, the Texas Health Network sponsors a provider informational and educational workshop in each Texas STAR Program region. Topics for the workshops are selected based on provider interests and suggestions. The Texas Health Network structures these workshops at times and places most convenient to providers.

Enrollment and Recruitment Assistance — Texas Health Network Provider Relations Representatives recruit and enroll new PCPs in the Texas Health Network. Providers who desire to enroll as a PCP must first enroll in the Texas Medicaid Program, then submit a Texas Health Network application. PCPs must be approved by the HHSC and enter into a contractual agreement with the HHSC. The Texas Health Network can also assist you in enrollment as a THSteps provider.

Medical Director Services — The Texas Health Network Medical Director maintains overall responsibility for utilization management procedures, quality improvement activities and reporting, health education for both members and providers, precertification requirements, and claim appeals related to the appropriateness of specific medical procedures or services. Texas Health Network providers may contact the Texas Health Network Medical Director for specific professional information related to standards of practice. To contact the Medical Director, call 1-512-506-7008.

Provider Directory — The Texas Health Network prepares and distributes to members a directory of all providers. This directory identifies those providers who are accepting new patients, those whose panels are closed, and those who provide THSteps services. This directory is updated on a quarterly basis. To request a copy of the directory, please contact the Provider Helpline at 1-888-834-7226.

Provider Manual — The Texas Health Network develops and distributes this provider manual, which contains significant HHSC policies and procedures specific to the Texas Health Network. As indicated previously, this manual complements and supplements the official Texas Medicaid Provider Procedures Manual. This manual will be updated on at least an annual basis. Texas Health Network providers are invited and encouraged to suggest changes and improvements to this working document.
**Monthly Panel Report** — The Texas Health Network provides to PCPs a list of members who have selected or who have been assigned to the PCP for management and coordination of their health care. This list is mailed to providers in hard copy at the beginning of every month. Members on this list are eligible for Texas Health Network services throughout the entire month. See Chapter VI for more information on the monthly member panel report.

**Practice Profiling Information** — The Texas Health Network collects and processes data so that each PCP may be given periodic practice profiling reports and practice pattern analyses. Specifically, the Texas Health Network prepares reports periodically that describe each PCP’s practice and referral patterns and compare the PCP’s practice with that of comparable peer groups. Peer group data are blinded and providers are not identified as individuals. The intent of these reports and analyses is to give providers information that will enable them to discuss and identify “best practices” to improve health outcomes for plan members. Currently, only those providers with more than 100 members on their panels receive these reports.

**Member Support and Education**

The Texas Health Network provides educational services available to its members. The most significant of these are two Helplines:

- The nurse line is a clinical helpline (1-800-304-5468) available 24 hours a day, 7 days a week to Texas Health Network members.

- A non-clinical Member Helpline (1-888-302-6688) is also available to Texas Health Network members. The purpose of this helpline is to respond to members’ non-clinical questions and concerns and provide information on how to access health care services appropriately. This number is also used to request PCP changes and to register complaints and grievances.

**The Nurse Line** — The Texas Health Network provides a toll-free clinical nurse line for its members. The nurse line is staffed (nationally) by registered nurses who use physician-developed, symptom-based algorithms and 1,200 sets of self-care instructions to provide information, triage, and clinical assessment services for health plan members 24 hours a day, 7 days a week. The nurse line nurses do not diagnose; they assess the member’s symptoms and guide the member to the most appropriate care setting.

The toll-free telephone number (1-800-304-5468) is widely publicized to Texas Health Network members. The nurse line can:

- Provide triage, assistance, and reassurance to members.
- Direct members to the most appropriate care setting.

If a nurse determines that a member needs emergency care, the nurse will direct the member to the nearest emergency facility or contact 911 on the member’s behalf.

**Member Helpline** — The non-clinical Member Helpline (1-888-302-6688) staffed by Member Services Agents is the principal resource for members seeking information or answers to questions. The helpline also is a resource for members to express their concerns and file complaints concerning the operation and management of the Texas Health Network. This helpline operates with Member Services staff from 7:00 a.m. to 6:00 p.m. Central Standard Time, Monday through Friday, and is connected to an answering service after hours that instructs members on reaching help in case of urgent or emergent situations. After hours, for
clinical issues, members are referred to nurse line. For urgent, non-clinical issues, members are referred to a Texas Health Network staff member who is on call.

**Member Outreach** — Texas Health Network Member Outreach Representatives are available to educate Texas Health Network members on how to access health care services appropriately. Outreach staff offer education on the following topics:

- THSteps
- Family Planning
- Case Management
- ECI
- Emergency Room Protocol
- Behavioral Health
- WIC

Outreach Representatives can provide this education in members’ homes, hospital emergency rooms, and providers’ waiting rooms.

The goal of the outreach staff is to facilitate a mutually beneficial relationship between the member, the provider, and the Texas Health Network. To contact a Member Outreach Representative in your area, please call the Member Helpline and they will provide you with the appropriate contact number.

The Texas Health Network also identifies the health education needs of members and tailors health education programs to meet those needs. Health education needs are identified through:

- Member and provider surveys
- Claims records for members who have not sought or who have not complied with treatment
- Medical record reviews of health education activities and unmet health education needs

The Texas Health Network also offers a variety of classes designed to fit the needs of its members. These include classes on self-esteem, prenatal education, HIV, parenting programs, new parent classes, first aid, nutrition, survival skills, self care and wellness education. One-on-one classes are available if needed. The Member Services Department Outreach Representatives work with Texas Health Network Health Educators and Wellness Coordinators by holding orientations in and around the communities to meet and educate Texas Health Network members. All health education initiatives include a systematic feedback method for assessing the impact of the initiative.

Priority health education efforts address these topics:

- Reducing emergency room visits
- Increasing family planning visits
- Increasing THSteps screening rates

The Texas Health Network provides a number of educational and support services to ensure that members eligible for THSteps receive all appropriate screening and follow-up diagnosis and treatment services. More information on THSteps is provided in Chapter VII of this manual.

In addition, the Texas Health Network publishes a quarterly newsletter in both English and Spanish for member heads of household. The focus of the newsletter is health-related (such as dates of upcoming health fairs, the importance of well child care, and the significance of early entry into prenatal care), but it also
provides useful information about services to improve members’ access to health care, such as non-emergent medical transportation, community child care resources, and clinical services offered during nontraditional hours of operation.
CHAPTER IX
CONTINUOUS QUALITY IMPROVEMENT

Overview

The Texas Health Network operates a comprehensive quality management and improvement program to assess a variety of factors, e.g., adequacy, appropriateness, and timeliness of care. The Continuous Quality Improvement Program (CQIP) uses systematic activities to monitor and evaluate medical services according to predetermined objective standards, including the means to develop and implement corrective actions. The Texas Health Network Medical Director retains ultimate responsibility and authority for the CQI program and executes this responsibility through routine review and approval of the program.

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Definition of Quality

The Texas Health Network defines quality as “a degree of excellence or superiority.” Quality medical care is defined as “medical services that are acceptable, accessible, available, appropriate, timely, effective, and of a reasonable cost.”

CQI Philosophy

The Texas Health Network is built around a Continuous Quality Improvement (CQI) process that ensures that medically necessary care is delivered in a manner that is:

• Appropriate
• Delivered at the highest level of quality possible
• Provided in the least amount of time and in the most effective manner and setting
• Provided at a reasonable cost

CQI is an important element of any managed care program:

• It consists of an assessment of the appropriateness of medical care and treatment in a specific case or in a profile of cases.
• The CQI process is kept separate and distinct from utilization management to preserve the integrity of the process.
• CQI encompasses and complements all activities of the health care delivery system.
• The CQI process is designed to identify adverse patient outcomes as well as to establish a regular, ongoing program to communicate quality-related information to all professionals involved in treatment and review functions within the Texas Health Network.
• CQI identifies quality of care and quality of service problems, collects information, analyzes performance, and initiates corrective action with joint efforts of the Texas Health Network staff and the QMIC.
• Continued monitoring of corrective actions is essential to determine whether further corrective action is needed.

Provider Relations staff also reviews credentialing systems used for verifying professional, recredentialing, recontracting, and/or annual performance evaluations and educational credentials of Texas Health Network providers. (See Chapter XI of this Manual for more information.)

The Scope of CQI

The scope of quality improvement is broad. It spans the spectrum of health care delivery services provided to Medicaid clients:

• All health care delivery settings
  — Inpatient
  — Outpatient
— Ambulatory

• Outcomes – The Texas Health Network cooperates with the external quality review organization in evaluations of Texas Health Network activities and focuses on priorities defined by HHSC

• All types of services provided
  — Preventive
  — Primary
  — Specialty and ancillary care
  — Acute care

**The CQI Process**

The CQI process encompasses the following areas:

• Provider accessibility and availability
• Adequacy of the provider network and PCP turnover rates
• Member and provider satisfaction
• Continuity and coordination of care
• Member and provider education
• Member and provider complaints
• Appropriate utilization of health care services

**Centers for Medicare and Medicaid Services (CMS)**

**QARI Guidelines**

The recommended CQI standards for managed care organizations issued by CMS are based on 16 guidelines developed by a group of managed care medical directors. These standards help ensure the provision of quality health care to patients in managed care plans. Corresponding procedures are implemented at the same time to monitor compliance with these standards.

The CMS guidelines are similar to those of the National Committee for Quality Assurance (NCQA). Childhood immunizations and prenatal care are among the health care services recommended for continuous monitoring.

Texas Health Network CQI Program is based on the 16 standards detailed below. These standards are the Quality Assurance Reform Initiative (QARI) guidelines. The basis for maternal and child health care quality assessment was developed from practice guidelines established by the American Academy of Pediatrics and the American Academy of Obstetrics and Gynecology.
QARI Standards Outline

Presented below is an overview outline of the QARI standards, and the Texas Health Network’s application of each:

STANDARD I - Written Quality Improvement Plan (QIP) Description
QARI identifies the following components of a QIP:

• Goals and Objectives — Written description containing detailed set of Quality Improvement objectives.
• Scope — Comprehensive description of scope, addressing both clinical and non-clinical aspects of services such as availability, accessibility, coordination and continuity of care.
• Specific Activities — Quality of care studies and other activities to be undertaken over a prescribed period of time; the methodologies used to accomplish these and the individuals responsible.
• Continuous Activity — Continuous performance of activities including tracking of issues over time.
• Provider Review — Review by physicians and other health professionals of the process followed in the provision of health services; also feedback to managed care organization (MCO) health care professionals regarding performance and patient results.
• Focus on Health Outcomes — The QIP methodology addresses health outcomes to the extent consistent with existing technology.

STANDARD II - Systematic Process of Quality Improvement Description
The process of systematic quality improvement objectively monitors and evaluates the quality and appropriateness of care and service to members and is accomplished through specific quality of care studies and related activities. The process is intended to be one of continuous improvement.

• Guidelines for Quality of Care Studies — The first step is to identify the clinical or health services delivery areas to be monitored. Studies which monitor and evaluate care reflect the population served by the MCO or health plan in terms of age groups, disease categories, and special risk status. For the Medicaid population, the QIP monitors care and services in certain priority areas selected by the State.
• Use of Quality Indicators — Quality indicators are measurable variables relating to a specified clinical or health services delivery area.
• Use of Clinical Standards/Practice Guidelines — The QIP studies and other activities monitor quality of care against clinical care, health service delivery standards or practice guidelines specified for each area identified. Standards or guidelines:
  — Are based on reasonable scientific evidence and are developed or reviewed by the plan providers.
  — Focus on the process and outcomes of health care delivery, as well as access to care.
  — Need to be combined with a mechanism that can continuously update the standards/guidelines.
  — Will address preventive health services and will encompass the full spectrum of all populations enrolled in the plan.
• Analysis of Clinical Care and Related Services — Appropriate clinicians monitor and evaluate quality through review of individual cases where there are questions about care. For quality issues identified
and targeted in clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines.

- **Implementation of Remedial/Corrective Actions** — The QIP includes written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written remedial/corrective action procedures include:
  - Specifications of the type of problems requiring corrective action.
  - Specifications of the person(s) responsible for making final determination
  - Specific action to be taken
  - Provision of feedback to appropriate health professionals
  - Schedule of accountability for implementing corrective actions.
  - The approach to modifying the corrective action plan if no improvement occurs
  - Procedures for terminating affiliation with the specific provider

- **Assessment of Effectiveness of Corrective Actions** — Monitoring and evaluation of corrective actions will take place to ensure appropriate changes have been made. In addition, changes in practice patterns are tracked. The managed care organization follows up on issues to ensure that actions for improvement have been effective.

- **Evaluation of Continuity and Effectiveness of the QIP** — The managed care organization conducts periodic examinations of the scope and content of the QIP to ensure that it covers all types of services in all settings. At the end of each year, a written report on the QIP is prepared which addresses QI studies and other activities completed. Evidence is collected to determine whether QI activities have contributed to significant improvements in the care delivered to members.

An external quality review organization performs clinical studies on behalf of the Texas Health Network. Addressing both physical and behavioral health needs of the population, these studies are conducted annually. Examples include ADHD, pregnancy, well child, major depression, diabetes, asthma, and substance abuse in pregnancy. Please see Appendix E for data collection tools similar to those used by the external quality review organization.

**STANDARD III — Accountability of the Governing Body**

The governing body of the organization is the Board of Directors or a designated committee. Responsibilities include:

- Serving as the oversight entity
- Creating QIP progress reports
- Performing annual QIP review
- Modifying the program as necessary
STANDARD IV — Active QI Committee
The QIP delineates an identifiable structure responsible for performing QI functions within the managed care organization. Responsibilities include:

- Regular meetings
- Established parameters for operation
- Documentation
- Accountability
- Membership

STANDARD V — QIP Supervision
A designated senior executive is responsible for program implementation. The organization’s Medical Director has substantial involvement in QI activities.

STANDARD VI — Adequate Resources
The QIP has sufficient material, resources and staff with the necessary education and training experience to carry out its activities.

STANDARD VII — Provider Participation in the QIP
Participating physicians and other providers are kept informed about the written QIP. All providers are required to cooperate with the QIP. Contracts specify that all providers will allow the managed care organization access to the medical records of its members.

STANDARD VIII — Delegation of QIP Activities
The managed care organization remains accountable for all QIP functions, even if certain functions are delegated to other entities. If the managed care organization delegates any QI activities to contractors:

- There must be written procedures for monitoring
- There must be evidence of continuous and ongoing evaluation of delegated activities

STANDARD IX — Credentialing and Recredentialing (See Chapter XI)
The QIP includes provisions to determine whether physicians and other health care professionals, who are licensed by the State and who are under contract to the managed care organization, are qualified to perform their services. Provisions include:

- Written policies and procedures
- Oversight by the governing body
- Credentialing agent
- Scope
- Process

An initial visit is made to each potential PCP’s office, including documentation of a structured review of the site and medical record keeping practices, to ensure conformance with the HHSC’s standards.
Recredentialing — A process for the periodic reverification of clinical credentials (recredentialing, re-appointment, or re-certification) is described in the organization’s policies and procedures. The recredentialing, re-certification or re-appointment process also includes review of the data from:

- Member complaints
- Results of quality reviews
- Utilization management
- Member satisfaction surveys
- Reverification of hospital privileges and current licensure

STANDARD X — Enrollee Rights and Responsibilities
The organization must demonstrate a commitment to treat members in a manner that acknowledges their rights and responsibilities. The organization must ensure that the confidentiality of client information and records is protected. At a minimum, the information provided to members must include:

- Written policy on member rights
- Written policy on member responsibilities
- Communication of all policies to providers by copying policies to all participating providers.
- Communication of the following policies to members upon enrollment:
  - Benefits and services included and excluded as a condition of membership and how to obtain them, including a description of any special benefit provision that may apply to services obtained outside the network, and the procedures for obtaining out-of-area coverage
  - Provision for after-hours and emergency coverage
  - The policy on referrals for specialty care
  - Charges to members, if applicable
  - Procedures for notifying members affected by termination of or change in any benefits, services, or delivery office/site
  - Procedures for appealing decisions adversely affecting a member’s coverage, benefits, or relationship with the organization
  - Procedures for changing practitioners
  - Procedures for disenrollment
  - Procedures for complaints and/or grievances and for recommending changes in policies and services
  - Member complaint procedures
  - Procedures for accommodating member suggestions
  - Policies and procedures to ensure access to care
  - Written information for members in easily understandable form
  - Policies for ensuring confidentiality
STANDARD XI — Standards for Availability and Accessibility
The managed care organization or health plan must have written established standards for access to and accessibility of medical care. The State requires the plan to provide care in urgent situations the same day the client calls; for routine care within 2 weeks; and for physical exams within 4-8 weeks of the initial request. Providers must have regular office hours and a designated on-call provider when they are not available. The PCP or his/her designee should be available by telephone to clients at all times.

STANDARD XII — Medical Records Standards
The managed care organization or health plan must provide access to client’s medical records for reviews by CMS, the State Medicaid Agency or agents thereof. Medical records must be available and accessible, and there must be both written medical record keeping standards and a medical record review process.

STANDARD XIII — Utilization Management
Managed care organizations are required to have a written utilization management program that includes procedures for precertification and concurrent review.

STANDARD XIV — Continuity of Care System
Managed care organizations must have a system developed and implemented that promotes continuity of care and case management.

STANDARD XV — QIP Documentation
Managed care organizations must have a written Annual Quality Improvement Plan, which includes a process for quality monitoring.

STANDARD XVI — Coordination of QI Activity with Other Management Activities
The findings, conclusions, recommendations, actions taken, and results of the actions are documented and reported to appropriate individuals within the organization and through the established QI channels.

• CQI information is used in recredentialing, re-contracting, and/or annual performance evaluations.
• CQI activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.
• There is linkage between QI and other functions, such as:
  — Network changes
  — Benefits redesign
  — Medical management systems
  — Practice feedback to physicians
  — Patient education
  — Member services
Quality Management & Improvement Committee (QMIC)

The QMIC provides oversight for the Texas Health Network Quality Improvement Program. Representatives from the HHSC Medicaid Program, and Texas Health Network leadership staff comprise the core of the committee. The Texas Health Network Medical Director chairs the QMIC. Other committee members include three participating providers, two non-participating providers, two Texas Health Network enrolled members from different geographic regions, and a non-PCCM Medicaid client.

Responsibilities of the QMIC
The QMIC meets at least quarterly to review current operations and resolve quality-of-care problems, monitor corrective actions, and follow-up on study findings. The committee’s function is to:

- Oversee and assist in the formulation of Continuous Quality Improvement (CQI) measures and the development and revision of CQI protocols.
- Evaluate and monitor the appropriateness, availability, accessibility and medical necessity of services.
- Maintain familiarity with current medical practices and ensure their incorporation into precertification, concurrent and retrospective review criteria and into practice guidelines and clinical indicator development.
- Implement outcome measures and document member health outcomes.
- Review corrective action plans and monitor their implementation.

Other Quality Considerations of the QMIC
A number of Texas Health Network activities provide the QMIC with quality-related information that will assist the committee in fulfilling its responsibilities. Most of these activities are described in other chapters of this manual. These activities include:

- Provider satisfaction surveys
- Information from the complaints and appeals process for providers (Chapter IV)
- 24-hour access monitoring findings
- Monitoring of THSteps screening rates and compliance (Chapter VIII)
- Contract compliance site visits and medical record reviews (Chapter XI)
- Information from the Utilization Management Staff (Chapter I)
- Information from the credentialing and recredentialing processes (Chapter XI)
- Practice pattern analysis from provider profiling activities.
CHAPTER X
OFFICE AND MEDICAL RECORDS STANDARDS

Overview

The Texas Health Network has a responsibility to its members to ensure that network providers deliver high quality health services in safe, accessible, and well-equipped offices. The Texas Health Network employs a variety of techniques to monitor provider performance and implement quality-of-care indicators. Each provider agrees to meet minimum operational requirements for continued participation in the Texas Health Network provider network.

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Office and Facility Requirements

To ensure that each on-site office or facility used to deliver health care to Texas Health Network members is safe, sanitary, and accessible, the Texas Health Network has defined standards for offices and other facilities:

- A site visit is conducted for each location as part of the evaluation process.
- An office compliance audit ensures that the facility meets defined standards.
- Evaluators use the visit as an opportunity to interact with the provider and his or her staff.
- Evaluators are prepared to explain the program and promote a strong network relationship.

For a provider to be considered for Texas Health Network participation, all office sites must be in compliance with the “conditions of participation” stipulated in the provider contract. Texas Health Network staff conduct an office on-site review at each primary care site prior to the acceptance of the provider into the Texas Health Network. Subsequently, Provider Relations staff perform routine audits at primary care office sites every two years.

Staff use the on-site review form presented in Appendix C to evaluate a provider’s office:

- Offices that are found to be marginally acceptable receive a follow-up visit within 90 days.
- The Texas Health Network may recommend that HHSC cancel a provider’s contract if office conditions do not meet defined standards after notice of required corrective action has been provided, and time to make changes has been made available.

Medical Records Standards

A Texas Health Network provider is required to maintain comprehensive and accurate medical records to ensure the quality and continuity of care of his or her patients. Each provider must maintain and make available medical records in accordance with the applicable provider agreement.

Content of Medical Record

Each patient’s medical record must include patient identification information, progress notes, and laboratory, referral, and consultation notes. Data to be maintained include:

- Patient identification information
  - Patient’s full name, address, and phone number
  - Patient’s history, including:
    - Past and present medical condition of patient and family
    - Past illnesses and surgeries
    - X-ray and lab tests
    - Immunizations
    - Documentation of discussion of Advance Directives (patients 21 and older)
• Present physiological condition:
  — Drug or allergy sensitivities
  — Current medications

• Progress notes:
  — Patient’s complaint or reason for visit
  — Results of physical examinations
  — Tests, procedures, and medications ordered by physician
  — Diagnoses and problems identified
  — Health education/preventive services performed

• Laboratory, referral, and consultation notes:
  — Laboratory and X-ray reports
  — Consultation and referral consultation reports

• Copies of reports concerning hospital admissions including:
  — Authorizations
  — Surgical reports
  — Discharge summaries

**Characteristics of Entries**
Provider entries in a Texas Health Network member’s medical record should comply with State requirements:

• Entries in the medical record should be legible and compiled systematically.
• Entries should be dated and signed by the appropriate practitioner(s).
• Entries should be made in a timely manner (that is, as soon as possible after the patient encounter).
• Medical data and clinical information should be integrated into one record.
• Referral and consultation reports should be included in the member’s medical record.
• Reports concerning hospital admissions, including surgical reports and discharge summaries, should be included.
• Requests for release of medical records information should be handled only by individuals who are guided by the Texas Health Network’s confidentiality policy and in accord with applicable law.
• Records should be stored and filed so that they are readily available for use.
• Only authorized personnel should be permitted access to records.
• Medical records should include retrieval and release information.

**IMPORTANT:** Upon request, a provider will give the Texas Health Network copies of member medical records, as outlined in the provider agreement, so that Texas Health
Network staff can implement utilization management, quality improvement, and grievance programs.

**Confidentiality of Medical Records**

The relationship and all communication between physician and patient are privileged. Accordingly, the medical record containing information about the relationship is confidential.

A physician’s code of ethics, as well as Texas and Federal laws, protect against the disclosure of the contents of medical records to persons or agencies who are not properly authorized to receive such information.

For a provider to release the contents of a patient’s medical record to a third party, the patient must first authorize the disclosure by signing and dating an authorization form. If the record is for a deceased individual, the executor of the estate must authorize the release.

The Texas Health Network’s policy is to allow only medical personnel and health professionals who are directly involved in the delivery or evaluation of a patient’s records to access the medical record. All requests for medical record information must be handled according to policy and law.

An authorization from the patient for release of medical information is not required when the release is requested by and made to the Texas Health Network, the Texas Medicaid Claims Administrator, HHSC, the EQRO, or the Texas Attorney General’s Medicaid Fraud Control Unit.

**Medical Records Audits**

Texas Health Network Provider Relations staff perform a general medical record review of the PCP’s practice as part of the credentialing and recredentialing process and as part of the quality improvement program. The medical record evaluation tool presented in Appendix C is used to evaluate provider medical records as part of the credentialing and recredentialing process. Other audit tools similar to those used by the external quality review organization collect data for focused studies are located in Appendix E.

Medical record audit results are submitted to the Medical Director and, if necessary, to the Credentialing Committee for review. Depending upon review findings, the Credentialing Committee will assist the Medical Director in concluding the audit in one of three ways:

- Recommending that HHSC accept the provider
- Recommending that HHSC reject the provider on the basis of poor medical record documentation and procedures
- Recommending that HHSC accept the provider conditionally with the provision that certain changes must be made and standards must be met within a specified timeframe

These recommendations apply to audits of an initial review of a provider as well as those of subsequent reviews.

If a provider has been found to be marginally in compliance with requirements, he or she will be given training and education directed at correcting the deficiency. The Texas Health Network will establish a system to audit this provider every 90 days for a maximum of three follow-up audits:
• Each audit must show substantial improvement over the previous audit.
• Following the third follow-up audit, if no improvement has been noted, the Texas Health Network will work with HHSC to apply sanctions and monitor performance closely.
• Subsequent to these measures, if the provider is still not in full compliance, the Texas Health Network will recommend to HHSC that the provider be terminated from the plan.

Medical Records may also be reviewed in conjunction with provider profiling to identify opportunities to improve care and services.

**Access and Availability Standards**

The Texas Health Network requires that participating PCPs maintain coverage 24 hours a day, 7 days a week.

On-call coverage is a contractual obligation for any participating primary care site.

A PCP must ensure that his or her scheduling practices adhere to the standards listed below:

- **Urgent Care**: within 24 hours after the request
- **Routine Care**: within two weeks after the request
- **Physical/Wellness Exams**: within four to eight weeks after the request
- **Prenatal Care**: initial visit within 14 calendar days of the request or by the 12th week of gestation

Texas Health Network staff routinely evaluate and monitor provider compliance with scheduling requirements. These scheduling requirements are designed to enhance access to health services and to provide assurance of service availability based on the urgency of need.

**Monitoring Provider Performance**

The Texas Health Network is responsible for monitoring quality of care and, if necessary, recommending that HHSC disenroll providers who do not meet plan requirements.

The health care industry commonly employs a variety of techniques to monitor provider performance and develop quality-of-care indicators. Among the indicators used to monitor Texas Health Network providers’ performance are:

- **Member Comments and Complaints** — The Texas Health Network Member Services staff closely monitor the activities associated with member complaints as they relate to quality assurance and utilization management reviews for specific provider performances. The reports of these activities are used to trigger separate actions and inquiries about performance.
- **Office Site Reviews** — Texas Health Network staff undertake a variety of assessments as part of quality improvement activities and provider service activities. The results of these reviews will be made part of the file of performance factors and indicators assessed during the recredentialing process.
• **Compliance With 24-Hour Access Standards** — Texas Health Network staff conduct surveys to assess the degree of compliance with the access standards described above. Member comments and complaints may trigger reviews of specific providers. The results of these reviews are considered in the recredentialing process.

• **Ability to Perform or Directly Supervise Ambulatory Primary Care Services for Members** — Provider performance is monitored on an ongoing basis through the CQI Program. Texas Health Network staff follow up evidence of poor performance and address identified problems immediately to ensure that high-quality care is delivered to Plan members.

• **Admitting Privileges** — Texas Health Network staff verify that each provider maintains his or her membership on the medical staff with admitting privileges at a minimum of one accredited contracted hospital or has an acceptable (timely and complete transfer of patients and records) arrangement with a PCP who has such admitting privileges.

• **Continuing Medical Education Credits** — Contracting and credentialing staff monitor each provider's activities in the area of continuing medical education credits.

• **Education Sessions** — Provider Relations staff provide UM, CQI, and case management policies and procedures to each Texas Health Network PCP. Staff also provide a series of educational sessions regarding all aspects of UM, CQI, and case management. Provider contracts require that each PCP attend at least one educational session on UM, CQI, and case management policies and procedures each year.

• **Valid DEA Certification** — Proof of Drug Enforcement Administration (DEA) certification must be submitted as part of the application process and will be maintained by the Texas Health Network in its credentialing files.

• **Performance Within Scope of Individual Licensure and Texas Health Network Credentialing** — The Texas Health Network staff includes in each provider application a statement that provides assurance that a certified registered nurse practitioner, nurse midwife, or physician assistant will perform services only within the scope of his or her licensure, and that the individual will be disciplined immediately if this agreement is violated.

• **Compliance with Fraud and Abuse Policy** — The Texas Health Network will recommend to HHSC that a network provider be suspended immediately upon notification from any source that the provider:
  
  — Has been terminated or suspended from participation in the Medicaid or Medicare Program
  
  — Has lost his or her license
  
  — Has been convicted of a criminal act

The Texas Health Network employs the above indicators as part of its oversight function. Findings are cataloged and analyzed for patterns of performance that require special attention. Where warranted, the results are made part of the recredentialing process. Failure to adhere to the above standards of performance will be grounds for suspension or termination.
CHAPTER XI
FRAUD AND ABUSE POLICY

Overview

The Texas Health and Human Services Commission (HHSC), through the Office of Investigations and Enforcement, detects and investigates suspected fraud, abuse, or waste in Health and Human Services programs, including the Medicaid program. This chapter examines the policy governing fraud and abuse, and describes protective measures employed by Texas Health Network to prevent or minimize fraud and abuse in the program.

Fraud and Abuse Policy ........................................................................................................................ XI-2
Provider Deficiencies .............................................................................................................................. XI-3
Provider Sanctions ................................................................................................................................. XI-3
Fraud and Abuse Policy

Federal and State law give authority to HHSC, as the single state agency for Medicaid, to identify, investigate and refer cases of suspected fraud and/or abuse in the Medicaid or social services program.

HHSC takes appropriate action to protect clients and the Medicaid program when providers of services are suspected of fraudulent or abusive activities.

• HHSC is responsible for detecting, preventing, and investigating provider fraud and abuse. HHSC has the responsibility to create a proactive environment that assures the delivery of quality medical services to all Medicaid clients while protecting the financial integrity of the Medicaid program. HHSC, through OIE, establishes criteria for identifying cases of possible fraud and abuse, investigates cases of program abuse, and recoups all overpayments to a provider. HHSC also has the authority to impose administrative sanctions on Medicaid providers, to include civil monetary penalties, payment hold, termination of contract, and/or exclusion from the Medicaid program on a temporary or permanent basis.

• If the investigation conducted by HHSC through OIE shows potential fraud, that is, shows that the provider knew his/her actions would cause losses to the Medicaid program while benefiting him/herself, HHSC will refer the provider’s case to the Texas Attorney General’s Medicaid Fraud Control Unit, which is responsible for criminal investigation of suspected provider fraud. In other circumstances, it could result in administrative sanctions or actions being taken against a provider if deemed appropriate by HHSC through OIE.

Per the regulations, HHSC is required to:

• Exclude from participation and reimbursement, or otherwise sanction, any provider who defrauds or abuses the Medicaid Program

• Exclude from participation any provider receiving reimbursement under the Medicaid Program who has been suspended or excluded from Medicare for conviction of a program-related crime, or who is not eligible to participate in Medicare as a result of the Federal Office of the Inspector General for the Department of Health and Human Services directing such action.

A determination of fraud may result in State penalties being assessed against a provider under the State Civil Monetary Penalty Law. A provider may be assessed a penalty of up to $15,000 per item or service identified as false. Additionally, a provider who has been assessed civil monetary penalties may be barred from participation in Medicare, Medicaid, or both.

Cases of fraud and/or abuse may also be referred to the United States Department of Health and Human Services for consideration and assessment of penalties under the Federal Civil Monetary Penalty Law of the Social Security Act. The provisions of this law allow the Federal government to apply damages and penalties against a provider for violations in the Medicaid and/or Medicare programs.

Individuals having knowledge regarding suspected Medicaid fraud or abuse should report this information to the Medicaid Fraud Hotline:

Recipient Fraud: 1-800-436-6184
Provider Fraud: 1-512-424-6519
Provider Deficiencies

The Texas Health Network Provider Relations staff provides support and guidance in the identification and resolution of provider problems or deficiencies. They are responsible for reviewing problems and working with the provider or HHSC to initiate action to resolve the problem or correct the deficiency. Providers who fail to correct deficiencies in their operations may be subject to prepayment review, fraud or abuse referral, and administrative sanctions.

Provider Sanctions

HHSC may impose sanctions against a provider or a provider’s employee who permits, or causes any of the following, or commits any other fraud or abuse defined by law:

- Submitting a false statement or misrepresentation, or omitting pertinent facts, when claiming payment under Medicaid or when supplying information used to determine the right to payment under Medicaid.
- Submitting a false statement, information, or misrepresentation, or omitting pertinent facts to obtain greater compensation than that to which the provider is legally entitled.
- Submitting a false statement, information or misrepresentation, or omitting pertinent facts to meet pre-certification requirements.
- Failing to disclose or make available upon request to HHSC or its authorized agents, representatives of the United States Department of Health and Human Services (DHHS), or the Attorney General’s Medicaid Fraud Control Unit any records the provider is required to maintain. This also includes records of services provided to Medicaid recipients and payments made for those services, including but not limited to, documents related to diagnosis, treatment, service, lab results, and X-rays.
- Failing to provide and maintain quality services to Medicaid recipients within accepted medical community standards or standards required by statute, regulation or contract.
- Failing to comply with the terms of the Medicaid contract or provider agreement, assignment agreement, the provider certification on the Medicaid claim form, or other rule published by HHSC.
- Furnishing or ordering services to patients (whether or not eligible for benefits) under Title XVIII or a state health care program that substantially exceed the recipient’s needs, are not medically necessary, are not provided economically, or are of a quality that fails to meet professionally recognized standards of health care.
- Rebating or accepting a fee, or part of a fee or charge, for a Medicaid patient referral.
- Violating any provision of the Human Resources Code, Chapter 32, or any rule published under it.
- Submitting a false statement or misrepresentation or omitting pertinent facts on any application, or any documents requested as a prerequisite for Medicaid participation.
- Failing to meet standards required for licensure as required by State or Federal law, HHSC rule, provider agreement, or provider manuals for participation in the Medicaid Program.
- Being excluded from Medicare because of fraudulent or abusive practices.
- Charging recipients for allowable services that exceed the amount HHSC or its agents pay for except when specifically allowed by HHSC.
- Refusing to execute or comply with a provider agreement or amendments when requested.
• Failing to correct deficiencies in provider operations after receiving written notice of them from HHSC or its authorized agents.

• Engaging in any negligent practice resulting in death, injury, or substantial probability of death or injury to the provider's Medicaid patients or to persons who receive or benefit from the provider's services.

• Pleading guilty or no contest, agreeing to an order of probation without adjudication, or being a defendant in a court judgment or finding of guilt for a violation relating to performance of a provider agreement or program violation of Medicare, the Texas Medicaid Program, or any other state's Medicaid Program.

• Failing to repay or make arrangements that are satisfactory to HHSC to repay identified overpayments or other erroneous payments.

• Failing to abide by applicable statutes regarding handicapped individuals or civil rights.

• Being terminated, suspended, or excluded from participation in any Federal program, having an unpaid debt under any Federal program or being otherwise sanctioned under any Federal program involving the provision of health care, including the Department of Defense, the Veterans Administration and any other state health care program for actions or failure to act that would be considered abusive or fraudulent. This includes any reasons related to the person's professional competence, performance or financial integrity. Any appeal by the provider for an action taken against him under this item does not consider the validity of a sanction or action taken by Medicare or any other state's Medicaid Program.

• Submitting or causing to be submitted under Title XVIII or a state health care program claims or requests for payment containing unjustified charges or costs for items or services that substantially exceed the person's usual and customary charges or costs for those items or services to the public or private pay patients.

• Failing to comply with Medicaid policies, published Medicaid bulletins, policy notification letters, provider policy or procedure manuals, contracts, statutes, rules, regulations, or interpretations for any of the items listed previously sent to the provider.

• Submitting claims with a pattern of inappropriate coding or billing that results in excessive costs to the Medicaid Program.

• Billing for services or merchandise that were not provided to the recipient.

• Submitting to the Medicaid Program a cost report containing costs not associated with the Medicaid Program or not permitted by Medicaid Program policies.

• Submitting a false statement or misrepresentation that, if used, has the potential of increasing any individual or state provider payment rate or fee.

• Charging recipients for services when payment for the services was recouped by Medicaid because of any of the reasons stated in 25 Texas Administration Code (TAC) Section 79.2303 (relating to Recovery from Providers).

• Failing to notify and reimburse HHSC or its agents for services paid by Medicaid if the provider also received reimbursement from a liable third party.

• Misapplying, misusing, embezzling, failing to release promptly upon a valid request, or failing to keep detailed receipts of expenditures relating to any funds or other property in trust for a Medicaid recipient.

• Having an outstanding debt with the State or Federal government.
• Pleading guilty or being convicted of a violation of state or federal statutes relating to dangerous drugs, controlled substances, or other drug-related offense.

• Pleading guilty of, being convicted of, or engaging in conduct involving moral turpitude.

• Having a voluntary or involuntary action taken by a licensing agency or board to require the provider or employee to comply with professional practice requirements of the board after the board receives evidence of noncompliance with licensing requirements.

• Pleading guilty to or being convicted of a violation of any State or Federal statutes relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct relating to the delivery of a health care item or service relating to any act or omission in a program operated or financed by any federal, state or local government agency.

• Being convicted in connection with the interference with or obstruction of any investigation into any criminal offense described in 25 TAC Subsection 79.2112 (f) (relating to Administrative Sanctions or Actions) or paragraphs (16), (29), (30), or (32) of 25 TAC Subsection 79.2105.

• Having its license to provide health care revoked or suspended by any state licensing authority, or losing this license because of an action based on assessment of the person's professional competence, professional performance, or financial integrity, or surrendering this license while a formal disciplinary proceeding is pending before licensing authorities and the proceeding concerns the person's professional competence, professional performance, or financial integrity.

• Substantially failing, as a health maintenance organization under Title XIX or any entity furnishing services under waiver granted by the DHHS under that title, to provide medically necessary items or services that are required under law or under contract, if the failure has adversely affected or is substantially likely to affect adversely the Medicaid recipient of these items or services.

• Committing an act as described in the Social Security Act, Subsections 1128A or 1128B.

• Meeting any of the conditions specified in 25 TAC 79.2112(f) or (g), (relating to Administrative Sanctions or Actions).

• Failing to fully and accurately make any disclosure required by the Social Security Act, Section 1124 or Section 1126.

• Failing to disclose information about the ownership of a subcontractor with whom the person has had business transactions in an amount exceeding $25,000 during the previous 12 months or about any significant business transactions (as defined by DHHS) with any wholly owned supplier or subcontractor during the previous five years.

• Failing, as a hospital, to comply substantially with a corrective action required under the Social Security Act, Subsection 1886(f)(2)(B).

• Defaulting on repayments of scholarship obligations or items related to health professional education made or secured, in whole or in part, by DHHS when DHHS has taken all reasonable steps available to DHSS to secure payment.

• Developing false source documents or failing to sign source documents, to retain supporting documentation, or to comply with the provisions or requirements of HHSC pertaining to electronic claims submission.

• Failing to comply with the Texas Family Code and being delinquent in child support payments.
• Substantially failing, as an eligible organization under a risk-sharing contract as defined in 42 USCA 1359mm, to provide medically necessary items or services that are required under a law or contract, if the failure has adversely affected or has the potential to affect the patient adversely.

   Involvement in any of the aforementioned items could result in exclusion or suspension from the Texas Medicaid Program.

If an administrative sanction is warranted, providers are notified in writing of the proposed sanction, and procedures for informal resolution and/or administrative appeal. Full investigation of criminal Medicaid fraud is the responsibility of the Texas Attorney General’s Medicaid Fraud Control Unit and may result in a felony or misdemeanor criminal conviction. Persons who solicit, receive, offer, or pay any remuneration (including bribes, kickbacks, or rebates) directly or indirectly in relation to referrals, purchases, leases, or arrangements of services covered by Medicare or Medicaid may be guilty of a Federal felony offense. Current legislation allows for suspension of providers convicted of a criminal offense related to Medicare or Medicaid.

Under the Social Security Act, Section 1909, the penalty for a Medicare/Medicaid felony is a maximum fine of $25,000, maximum imprisonment of five years, or both.
# APPENDICES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
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<tbody>
<tr>
<td>Appendix A</td>
<td>Panel Report</td>
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<tr>
<td>Appendix B</td>
<td>Member ID Card</td>
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<td>Appendix C</td>
<td><strong>Forms</strong></td>
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<td>Referral Form</td>
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<td>Precertification Form</td>
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<td>Notification of Inpatient Admission</td>
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<td>Office Site Review and Medical Record Evaluation Form</td>
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<td>Behavioral Health Consent Form</td>
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<td>Provider Information Change Form</td>
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<td>Member Education Request Form</td>
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<td>Authorization to Release Confidential Information (NorthSTAR)</td>
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<td>Appendix D</td>
<td>Primary Care Provider Application</td>
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<td>Appendix E</td>
<td>Focused Studies</td>
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<td>Appendix F</td>
<td>Frequently Asked Questions</td>
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<tr>
<td>Appendix G</td>
<td>Holiday Schedule</td>
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Members on this panel report are Texas Health Network eligible for entire month indicated on report. You do not need to call the Texas Health Network to verify eligibility.

<table>
<thead>
<tr>
<th>Medicaid ID</th>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Birth Date</th>
<th>Sex</th>
<th>SSN</th>
<th>Address</th>
<th>City</th>
<th>Zip Code</th>
<th>Case Number</th>
<th>De-</th>
<th>Voluntary</th>
<th>NMO Comp</th>
<th>Check for THSteps</th>
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<tr>
<td>123456789</td>
<td>DOE</td>
<td>JON</td>
<td>M</td>
<td>7/1/1968</td>
<td>F</td>
<td>123-56-470</td>
<td>123 BONITA</td>
<td>HITCHCOCK</td>
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<td>RAYME</td>
<td>L</td>
<td>11/3/1965</td>
<td>F</td>
<td>123-35-128</td>
<td>123 TANGLEWOOD</td>
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<td>R</td>
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<td>N</td>
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Total Members Enrolled with Provider 999999999: 5

☆ This member may be due for THSteps screening. Please continue to verify eligibility with the member’s Medicaid ID Form 3087 and through the AIS line at 1-800-925-9126.

Retain this report in your files. It can be used to appeal inappropriate claim denials related to eligibility.
Appendix C
Forms

Referral Form

Precertification Form

Notification of Inpatient Admission

Office Site Review and Medical Record Evaluation Form

Behavioral Health Consent Form

Provider Information Change Form

Member Education Request Form

Authorization to Release Confidential Information (NorthSTAR)
### Referral Form

#### PCP Information
- **Provider Name**
- **Medicaid Provider Number**
- **Contact Name and Phone Number**

#### Member Information
- **Member Name**
- **Date of Birth**
- **Member's Medicaid Number**
- **Phone**

#### Referring Provider Information (If Different from PCP)
- **Provider Name**
- **Medicaid Provider Number**
- **Contact Name and Phone Number**
- **Referral Date**
- **Provider Signature**

#### Consulting Provider/Facility
- **Provider/Facility Name**
- **Medicaid Provider # (if known)**
- **Appointment Time and Date**
- **Address**
- **Phone**

#### Reason for Referral:

### TO THE CONSULTANT

This notice authorizes the following care:

- **Evaluation Only**
- **Evaluation and Single Treatment**
- **Evaluation and Treatment**

Number of Treatments ___

Other (Specify) ____________________________

Initial consultations are for one visit only for evaluation and development of a treatment plan unless otherwise specified. All consultations require a written report (preferably typed and attached to this form) to the PCP and phone conferences as necessary to assure continuity of care. Referrals are valid for 30 days from the time of issue and it is the consulting provider's responsibility to verify eligibility prior to delivering services. Consulting providers may not authorize secondary referrals. All requests for additional services or visits to other providers must come through the PCP. All claims are subject to retrospective review for purposes of determining eligibility, benefit coverage, appropriateness, and medical necessity. Claims payment may be affected by review findings.

Consultant Comments: ____________________________

___________________________

Consultant Signature

Date

Fax to Health Services at (512) 302-0318

Revised January 2001
**Precertification Request**

**PHONE:** (888) 302-6167   **Fax:** (512) 302-5039  
Please print all information on this form.

<table>
<thead>
<tr>
<th>Date: ___________________________</th>
<th>Name of Person Completing Form: ___________________________</th>
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<tr>
<td>Time ___________________________</td>
<td>Office Number: ___________________________</td>
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<td>(for phone requests only)</td>
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<tr>
<th>Member Name: ___________________________</th>
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<th>Sex: M or F</th>
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<tr>
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<tr>
<th>Primary Care Provider: ___________________________</th>
<th>Requesting Provider Name: ___________________________</th>
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<td>Facility: ___________________________</td>
<td>Fax ___________________________</td>
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<th>Diagnosis: ___________________________</th>
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<tr>
<th>Service(s)/Procedure(s) You are Requesting: ___________________________</th>
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<tr>
<td>CPT 4 Codes: ___________________________</td>
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<th>Estimated LOS Required: ___________________________</th>
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<td>(number of days requesting) ___________________________</td>
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**Medical History** (Please attach all documentation relevant to the requested procedure) Required for review.

*NOTE: Transplant requests require the following information be forwarded: history and physical, current status, expected prognosis, and patient management plan/protocol.

Precertification is a condition of reimbursement. It is not a guarantee of payment. It is the responsibility of each provider to verify the member’s eligibility prior to rendering services. Processing time is at least four business days after requested information is complete. An incomplete Precertification Request Form will delay processing of your request.

**BEBELOW THIS LINE FOR TEXAS HEALTH NETWORK USE ONLY**

<table>
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<tr>
<th>Approved</th>
<th>Denied</th>
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<tr>
<th>Authorization Dates:</th>
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| Services authorized (if different than requested): ___________________________ |

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<th>Precertification Nurse: ___________________________</th>
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Revised September 2002
# TEXAS HEALTH NETWORK
## Notification of Hospital Admissions

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<tr>
<th>Client Name (last, first, middle)</th>
<th>Client Medicaid # (PCN)</th>
<th>Date of Birth</th>
<th>Admit Date</th>
<th>Attending MD and Phone #</th>
<th>Diagnosis</th>
<th>Precertification / Certification Number (BDHMC Use Only)</th>
<th>Reference Number (BDHMC Use Only)</th>
<th>COMMENTS</th>
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Please fax form to: Texas Health Network    Fax: (512) 302-5039    Phone: (888) 302-6167

Birch & Davis Health Management Corporation
**OFFICE APPEARANCE:**

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<th>1) Appears Clean</th>
<th>Meets Criteria</th>
<th>Comments (include provider’s comments regarding any criteria not met)</th>
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<td>Y</td>
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<td>COP</td>
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<tr>
<th>2) Signage Clearly Visible</th>
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<th>3) In Good Repair</th>
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<th>5) Adequate Seating</th>
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<th>6) Good Visibility from Reception Area</th>
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**OFFICE SPACE:**

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<thead>
<tr>
<th>11) Exam Rooms Well-Equipped</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

**EMERGENCY PREPAREDNESS:**

<table>
<thead>
<tr>
<th>12) Emergency Equipment Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13) What Types of Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14) Staff Knowledgeable of Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15) Staff Trained in CPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16) Emergency Numbers Posted</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
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</table>

**SAFETY:**

<table>
<thead>
<tr>
<th>17) Smoke Alarms</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
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<table>
<thead>
<tr>
<th>18) Fire Extinguisher</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
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<table>
<thead>
<tr>
<th>19) Exit Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
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<table>
<thead>
<tr>
<th>20) Passageways Clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
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</table>

**HANDICAPPED ACCESS:**

<table>
<thead>
<tr>
<th>21) Wheelchair Ramp</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>22) Wide Doors</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
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</table>

<table>
<thead>
<tr>
<th>23) Elevators (N/A if Single Story)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
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</table>

**STAFF:**

<table>
<thead>
<tr>
<th>24) Courteous</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>25) Answer Phones Promptly</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>26) Appear Knowledgeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
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</table>

<table>
<thead>
<tr>
<th>27) Neat/Well Groomed</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

**MEDICAL RECORDS:**

<table>
<thead>
<tr>
<th>28) Individual Charts for Each Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>29) Stored in Dedicated Space</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>30) Personal/Biographical Data Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>31) Provider Identification &amp; Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>32) Legible</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>33) Allergies Noted Prominently</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>34) Health Ed/Preventive SvS Noted</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>35) Advance Directives Offered (Adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>36) Confidentiality Maintained</th>
</tr>
</thead>
<tbody>
<tr>
<td>COP</td>
</tr>
</tbody>
</table>

**ADDENDUM LEP QUESTION:** Do you have access to translation services if needed for members with limited English language skills?

***Offer phone #s for translation services if needed***
PLEASE FILL OUT THE INFORMATION BELOW:

I, ________________________________________________________________

Name

Address

(   )

City, State

Phone

authorize: __________________________________________________________

Provider Name

to disclose to: ______________________________________________________

Provider Name

Address

(   )

City, State

Phone

from (date) __________________________ to (date) __________________________ the following information:

Please indicate what, if any, information you would like to release.

☐ Total Medical Records to be released to primary care provider

☐ Medication Information Only to be released to primary care provider

☐ Medical Records to health plan

I understand that my records are protected under Federal (42 CFR Part 2) and/or State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. File copy is considered equivalent to the original. This release of information expires in thirty (30) days or sixty (60) days following completion or termination of treatment, whichever is later.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

EXECUTED THIS ___________ DAY OF ______________

(Witness) __________________________________________ (Patient) __________________________________________

(Parent, Guardian, or Authorized Representative, if required)

The person signing this authorization is entitled to a copy.

TO THE INDIVIDUAL FILLING THIS OUT:

You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method for asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact the Texas Health Network Member Helpline. You can call the Texas Health Network Member Helpline at P.O. Box 14685, Austin, TX 78761. You can also call the Texas Health Network Member Helpline at 1-888-302-6688.

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION:

PROHIBITION ON DISCLOSURE

If the information disclosed to you is related to substance abuse treatment, these records’ confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient’s records.
INSTRUCCIONES. Esta es una autorización para la divulgación de información para su Proveedor de Cuidado Primario.

POR FAVOR, DÉ LA SIGUIENTE INFORMACIÓN:

Yo, ____________________________________________
Nombre

Dirección

(___________)

Ciudad, Estado

Teléfono

autorizo a: ____________________________________________
Nombre del proveedor

para que le dé a: ____________________________________________
Nombre del proveedor

Dirección

(___________)

Ciudad, Estado

Teléfono

la siguiente información de (fecha) ___________ a (fecha) ___________: 

Por favor, indique qué información quiere divulgar, si es que quiere divulgar alguna.

☐ Todos los expedientes médicos se pueden divulgar al Proveedor de Cuidado Primario
☐ Sólo la información sobre medicamentos se puede divulgar al Proveedor de Cuidado Primario
☐ Los expedientes médicos se pueden divulgar al plan de salud

Entiendo que mis expedientes están protegidos bajo Normas de Confidencialidad Estatales y Federales (42 CFR Parte 2). Esta autorización puede revocarse por escrito en cualquier momento, excepto en el caso en que el programa o la persona que hará la divulgación haya dependido de ella para tomar una acción. Al revocar la autorización, la divulgación adicional de información se detendrá inmediatamente. Las copias de archivo se consideran equivalentes al original. Esta autorización para divulgar información se vence en treinta (30) o sesenta (60) días después de que se termine o se suspenda el tratamiento, el que se llegue después.

También reconozco que se me explicó detalladamente la información que se divulgará y que doy este consentimiento por mi propia voluntad.

FIRMADO ESTE DÍA ______ DE ____________________

___________________________________________

(Paciente)

___________________________________________

(Padre, Tutor o Representante Autorizado, si se exige)

La persona que firma esta autorización tiene derecho a una copia.

PARA LA PERSONA QUE LLENA ESTE FORMULARIO:

Tiene el derecho de hacernos preguntas sobre este formulario. También tiene el derecho de revisar la información que nos da en el formulario. (Hay algunas excepciones). Si la información está incorrecta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Puede encontrarlo en el Título 1 del Código Administrativo de Texas, Secciones 351.17 a 351.23. Para hablar con alguien acerca de esta forma, o para pedir correcciones, haga el favor de comunicarse con la Línea de Ayuda para Miembros de Texas Health Network. Puede comunicarse con el personal de la Línea de Ayuda para Miembros de Texas Health Network escribiendo a P.O. Box 14685, Austin, TX 78761 o llamando al 1-888-302-6688.

PARA LA PERSONA QUE RECIBE LA INFORMACIÓN CONFIDENCIAL: PROHIBICIÓN SOBRE LA DIVULGACIÓN
Si la información que usted ha recibido tiene que ver con el tratamiento para el abuso de sustancias, la ley federal protege la confidencialidad de estos expedientes. Las normas federales (42 CFR Parte 2) le prohíben a usted hacer cualquier otra divulgación de estos expedientes sin el consentimiento escrito específico de la persona de quien se trata, o de otra manera permitida por dichas normas. Una autorización general para la divulgación de información médica o de otro tipo no es suficiente para divulgar expedientes relacionados con el abuso de sustancias. Las reglas federales limitan el uso de la información a investigar o enjuiciar penalmente a algún paciente de abuso de sustancias. Es posible que las leyes estatales también protejan la confidencialidad de los expedientes del paciente.
Provider Information Change Form

Complete this form and submit to update your provider files. Mail or fax the completed form to the appropriate entity.

PLEASE PRINT OR TYPE THE INFORMATION SUBMITTED ON THIS FORM.

Date: __________________ Nine-Character Texas Provider Identifier (TPI): ____________________

If you have more than one TPI that will also use this same information, list the other TPIs:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Physical Address Accounting/Mailing Address Secondary Address
(Cannot be a P.O. Box) (W-9 Form Required) (Plan Use Only)

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Telephone Telephone Telephone

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Fax Fax Fax

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**Type of Change:** (please check the appropriate box below)

☑ Change of Physical Address, telephone and/or fax number
☑ Change of Billing/Mailing Address, telephone and/or fax number
☑ Change/Add Secondary Address, telephone and/or fax number
☑ Change of Provider Status (i.e., termination from plan, moved out of area, specialist, etc.), Please Explain:
☑ Other (i.e., panel closing, capacity changes, age acceptance, etc.)

**Explanation Required:**

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Tax Information: IRS ID Number (attach W-9) ______________________________

Effective Date: _________________

List the exact name reported to the IRS for the above Tax ID number:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**Must be signed and dated or changes cannot be completed:**

Provider Signature: ___________________________ Date: ______________________

E-mail Address: ______________________________

Send your completed change forms to:

Texas Health Network Provider Enrollment
Attn: Credentialing/Contracting Department NHIC
P.O. Box 14685 PO Box 200795
Austin, TX 78761 Austin, TX 78720-0795
Fax: 1-888-235-8399 FAX: 512-514-4214

**ACS/BDHMC representative ** **Date** **NHIC representative ** **Date**

TO THE INDIVIDUAL FILLING THIS OUT:

You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method for asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section §351.17 through §351.23. To talk to someone about this form or ask for corrections, please contact the Texas Health Network Provider Helpline. You can write to the Texas Health Network Provider Helpline at P.O. Box 14685, Austin, TX. 78761. You can also call the Texas Health Network Provider Helpline at 1-888-834-7226.

If Managed Care, please send this form via mail or fax to NHIC c/o your respective plan.
INSTRUCTIONS FOR COMPLETING
PROVIDER INFORMATION CHANGE FORM

SIGNATURES:
♦ The provider’s signature is required on the attached document for any/all changes requested for individual practitioner provider numbers.
♦ Signature by the authorized representative of a group or facility is acceptable for changes requested for group/facility provider numbers.

ADDRESS:
♦ Performing providers* may NOT change accounting information.
   (* a physician performing services within a group)

TAX IDENTIFICATION NUMBER:
♦ T.I.N. changes for individual practitioner provider numbers can only be made by the individual to which the number is assigned.
♦ Performing providers CANNOT change T.I.N.

GENERAL:
♦ Forms will be returned unprocessed if the nine-digit provider number is not indicated on the attached form.
♦ W-9 form is required for all name and T.I.N. changes.
Please fax completed form to the Texas Health Network Member Services Department at 1-866-254-2963.

**Provider Information**

Provider Name: ___________________________ Phone Number: (______) ________
Contact name: _____________________________ Date: ________________________

<table>
<thead>
<tr>
<th>Member Information</th>
<th>Reason for Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Name</strong></td>
<td><strong>Member ID Number</strong></td>
</tr>
<tr>
<td>(Please include parent’s name if member is a child)</td>
<td></td>
</tr>
<tr>
<td><strong>Area Code/Phone Number</strong></td>
<td><strong>Appointment No Show</strong></td>
</tr>
<tr>
<td><strong>Education of Referral Process</strong></td>
<td><strong>ER without PCP Notification</strong></td>
</tr>
<tr>
<td><strong>Non-compliance w/ medical treatment</strong></td>
<td><strong>Abusive w/ Doctor and/or staff</strong></td>
</tr>
<tr>
<td><strong>Newborn Education</strong></td>
<td><strong>Other (please specify)</strong></td>
</tr>
</tbody>
</table>

*For Texas Health Network members only

Revised 09/2002
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

PATIENT’S NAME ______________________________________________________

I authorize ____________________________________________________________, and/or
(Name of HMO) (Name of BHO)

the following person/agency/group:

<table>
<thead>
<tr>
<th>Provider/Agency/Group</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
</table>

To disclose information and records regarding my treatment, medical and/or behavioral health condition to the following professional person/agency, physician and/or facility;

<table>
<thead>
<tr>
<th>Provider/Agency/Group</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
</table>

Information to be released or exchanged include (check all that apply):

_______ History and physical
_______ Discharge and Summary
_______ Behavioral Health Treatment Records
_______ Laboratory Reports
_______ Physical Health Treatment Records
_______ Medication Records
_______ Information on HIV or communicable disease treatment
_______ Other (specify) ______________________________________________

The authorized purpose(s) for this release are:

_______ Diagnosis and Treatment
_______ Coordination of Care
_______ Insurance Payment Purposes
_______ Other (specify) ______________________________________________
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. I may revoke this authorization. This authorization is valid until I revoke it or sixty (60) days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

This authorization was explained to me as I signed it of my own free will on:

The _____________ day of ________________, 20____.

_________________________________ _______________________________ ____________
Signature of Client Signature of Witness

Signature of Parent, Guardian, or Authorized Representative, if required

NOTICE OF CLIENT’S REFUSAL TO RELEASE INFORMATION:

I have reviewed the above release of information form and refuse to authorize release of health and behavioral health information to mental health and/or alcohol and/or drug abuse treatment providers and/or physical health providers.

Executed this ______________ day of ________________, 20____.

________________________________  ___________________________________________
Signature of Client     Signature of Witness

Signature of Parent, Guardian, or Authorized Representative, if required

The person signing this authorization is entitled to a copy.

TO PERSON RECEIVING THE CONFIDENTIAL INFORMATION: PROHIBITION OF REDISCLOSURE

Federal and state law protects the confidentiality of the information disclosed to you related to the individual’s alcohol and drug abuse treatment. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Disclosure is limited to the purpose and persons included on the authorization form. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. State laws may also protect the confidentiality of the client’s records.

TO THE INDIVIDUAL FILLING THIS OUT:

You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method of asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact NorthSTAR. You can write to NorthSTAR at 1199 S. Beltline Rd., Coppell, Texas 75019. You can also call the NorthSTAR Helpline at 1-972-906-2500.
AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN CONFIDENCIAL

NOMBRE DEL PACIENTE ___________________________________________________________

Autorizo a ____________________, a _____________________ y a la siguiente persona, agencia o grupo:

(Nombre de la HMO) (Nombre de la BHO)

Proveedor/Agencia/Grupo Dirección Ciudad Estado ZIP
________________________________________________________

para que divulgue información y expedientes relacionados con mi tratamiento y estado de salud física, mental o de abuso de sustancias a las siguientes personas, agencias, doctores y centros profesionales:

Proveedor/Agencia/Grupo Dirección Ciudad Estado ZIP
________________________________________________________

La información que se divulgará o intercambiara es, entre otra (marque toda la que sea pertinente):

_____ Historia clínica y física
_____ Documentos de alta y resumen
_____ Documentos del tratamiento de la salud mental y abuso de sustancias
_____ Informes de laboratorio
_____ Documentos del tratamiento de la salud física
_____ Documentos de medicamentos
_____ Información del tratamiento del VIH o de las enfermedades transmisibles
_____ Otra (especifique) ____________________________________________

Esta divulgación se ha autorizado con el siguiente propósito (marque todos los que sean pertinentes):

_____ Diagnóstico y tratamiento
_____ Coordinación de la atención médica
_____ Pagos del seguro
_____ Otro (especifique) ____________________________________________
AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN CONFIDENCIAL

Entiendo que mis expedientes de salud mental y abuso de sustancias están protegidos contra la divulgación bajo la ley federal o estatal. Puedo revocar esta autorización. Esta autorización tiene vigencia hasta que yo la revoque o sesenta (60) días después de que yo haya terminado el tratamiento, lo que suceda primero. Una vez que revoque esta autorización, no se podrá divulgar ninguna información, excepto como lo autorice o lo permita la ley. La copia de archivo se considera equivalente al original.

Se me explicó esta autorización y la firmé por mi propia voluntad:

El día __________ del mes de ___________________ de 20____.

_________________________ ________________________________
Firma del cliente Firma del testigo

_________________________ ________________________________
Firma del padre, tutor o representante autorizado, si es necesario

AVISO SOBRE LA DECISIÓN DEL CLIENTE DE NO AUTORIZAR LA DIVULGACIÓN DE INFORMACIÓN:

He revisado el formulario anterior para la divulgación de información y me he negado a autorizar la divulgación de información de salud mental y abuso de sustancias a los proveedores de salud física o de tratamiento de salud mental o contra el abuso de alcohol o drogas.

Firmado este día __________ del mes de ___________________ de 20____.

_________________________ ________________________________
Firma del cliente Firma del testigo

_________________________ ________________________________
Firma del padre, tutor o representante autorizado, si es necesario

La persona que firma esta autorización tiene derecho a una copia.

PARA LA PERSONA QUE RECIBE LA INFORMACIÓN CONFIDENCIAL: PROHIBICIÓN SOBRE LA DIVULGACIÓN

Las leyes federales y estatales protegen la confidencialidad de la información que usted recibió sobre el tratamiento del abuso de alcohol y drogas de la persona. Las normas federales (42 CFR Parte 2) le prohiben a usted dar esta información a otra persona a menos que se haya permitido expresamente en un consentimiento escrito de la persona de quien se trata, o de otra manera permitida por dichas normas. La divulgación se limita al propósito y a la persona anotados en el formulario de autorización. Las reglas federales limitan el uso de la información a investigar o enjuiciar penalmente a algún paciente que tiene problemas de abuso de alcohol o drogas. Es posible que las leyes estatales también protejan la confidencialidad de los expedientes del paciente.

PARA LA PERSONA QUE LLENA ESTE FORMULARIO:

Tiene el derecho de hacernos preguntas sobre este formulario. También tiene el derecho de revisar la información que nos da en el formulario. (Hay algunas excepciones). Si la información está incorrecta, puede pedir que la corrijamos. La Comisión de Salud y Servicios Humanos tiene un método para pedir correcciones. Puede encontrarlo en el Título 1 del Código Administrativo de Texas, Secciones 351.17 a 351.23. Para hablar con alguien acerca de esta forma, o para pedir correcciones, haga el favor de comunicarse con NorthSTAR. Puede comunicarse con NorthSTAR escribiendo a 1199 S. Beltline Rd., Coppell, Texas 75019 ó llamando a la Línea de Ayuda de NorthSTAR al 1-972-906-2500.
Section I  Capacity Verification

Please identify Service Area(s) provider participates in or the Service Area(s) the members in which the provider is providing services for?

[ ] Harris  [ ] Harris STAR+PLUS  [ ] Harris Expansion Service Area  [ ] Bexar
(Brazoria, Ft.Bend, Galveston, Waller, Montgomery)

[ ] Dallas  [ ] El Paso  [ ] Southeast Region  [ ] Lubbock
(Orange, Jefferson, Hardin, Chambers, Liberty)

Texas Health Network total capacity _________________________

Capacity for Texas Health Network in: (please distribute total capacity among the SDA(s) you are participating with)

Harris ________  Harris Expansion Service Area _________  Harris STAR+PLUS _____________
El Paso _______  Southeast Region __________  Bexar __________
Lubbock _____  Dallas __________

Section II  Provider Practice Information

If you have more than one office location in which you provide primary care services, please complete the Provider Practice Information for each location below.

Provider Last Name    _________________________    First Name    ___________________________    MI

AGE RANGE OF PATIENTS SEEN: From__________ To___________

DO YOU PROVIDE ANY OF THE FOLLOWING SPECIALIZED SERVICES?

___ AIDS    ___ Children w/ Disabilities    ___ High Risk OB/GYN    Other__________

PRACTICE LIMITED TO:  _____ Male only    _____ Female only    _____ Current/Established Patients only

(No new patients will be accepted)

Accepting New Patients:  ___ Yes    ____ No

PRACTICE LOCATION #2

AGE RANGE OF PATIENTS SEEN: From__________ To___________

DO YOU PROVIDE ANY OF THE FOLLOWING SPECIALIZED SERVICES?

___ AIDS    ___ Children w/ Disabilities    ___ High Risk OB/GYN    Other__________

PRACTICE LIMITED TO:  _____ Male only    _____ Female only    _____ Current/Established Patients only

(No new patients

Accepting New Patients ___ Yes ____ No

Section III  Ethnicity

___ White    ___ Black    ___ Hispanic    ___ American Indian/Alaskan    ___ Asian/Pacific Islander

___ Unknown/Other    ___ Provider chose not to indicate

TO THE INDIVIDUAL FILLING THIS OUT:
You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method for asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section §351.17 through §351.23. To talk to someone about this form or ask for corrections, please contact the Texas Health Network Provider Helpline. You can write to the Texas Health Network Provider Helpline at P.O. Box 14685, Austin, TX. 78761. You can also call the Texas Health Network Provider Helpline at 1-888-834-7226.
Texas Standardized Credentialing Application

Section I - Individual Information

**TYPE OF PROFESSIONAL**

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST</th>
<th>MIDDLE</th>
<th>(J.R., SR., ETC.)</th>
</tr>
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<table>
<thead>
<tr>
<th>MAIDEN NAME</th>
<th>YEARS ASSOCIATED (YYYY-YYYY)</th>
<th>OTHER NAME</th>
<th>YEARS ASSOCIATED (YYYY-YYYY)</th>
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<table>
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<th>HOME MAILING ADDRESS</th>
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<tr>
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<table>
<thead>
<tr>
<th>HOME PHONE NUMBER</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>Female</th>
<th>Male</th>
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**CORRESPONDENCE ADDRESS**

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<th>CITY</th>
<th>STATE/COUNTRY</th>
<th>POSTAL CODE</th>
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<table>
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<tr>
<th>DATE OF BIRTH (MM/DD/YYYY)</th>
<th>PLACE OF BIRTH</th>
<th>CITIZENSHIP</th>
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**IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS**

<table>
<thead>
<tr>
<th>ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES?</th>
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<tr>
<td>Yes</td>
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**U.S. MILITARY SERVICE/PUBLIC HEALTH**

<table>
<thead>
<tr>
<th>BRANCH OF SERVICE</th>
<th>ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY?</th>
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<tbody>
<tr>
<td></td>
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**EDUCATION**

**PROFESSIONAL DEGREE** (MEDICAL, DENTAL, CHIROPRACTIC, ETC.)

<table>
<thead>
<tr>
<th>Issuing Institution:</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>ADDRESS</th>
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<tbody>
<tr>
<td>CITY</td>
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<table>
<thead>
<tr>
<th>DEGREE</th>
<th>ATTENDANCE DATES (MM/YYYY TO MM/YYYY)</th>
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<table>
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<th>SPECIALTY</th>
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<tbody>
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<table>
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<tr>
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<table>
<thead>
<tr>
<th>ADDRESS</th>
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<td>CITY</td>
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<table>
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<tr>
<th>Program successfully completed</th>
<th>ATTNEDANCE DATES (MM/YYYY TO MM/YYYY)</th>
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<th>SPECIALTY</th>
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<table>
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<tr>
<th>INSTITUTION</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
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<table>
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<tr>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CITY</td>
</tr>
<tr>
<td></td>
</tr>
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</table>

LHL234 Eff. 08/02 Texas Department of Insurance
### Postgraduate Education

- **Program successfully completed**
- **Current Program Director (if known)**
- **Attendance Dates (MM/YYYY to MM/YYYY)**

If you received additional postgraduate training, please check this box and complete and submit Attachment B.

### Other Graduate-Level Education

- **Issuing Institution:**
- **Address:**
- **City, State/Country, Postal Code:**

### Licenses and Certificates

- **Please include all license(s) and certifications in all States where you are currently or have previously been licensed.**

<table>
<thead>
<tr>
<th>License Type</th>
<th>License Number</th>
<th>State of Registration</th>
<th>Original Date of Issue (MM/DD/YYYY)</th>
<th>Expiration Date (MM/DD/YYYY)</th>
<th>Do You Currently Practice in This State?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>License Type</th>
<th>License Number</th>
<th>State of Registration</th>
<th>Original Date of Issue (MM/DD/YYYY)</th>
<th>Expiration Date (MM/DD/YYYY)</th>
<th>Do You Currently Practice in This State?</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>Yes □ No</td>
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- **DEA Number:**

- **DPS Number:**

### Other CDS (Please Specify)

<table>
<thead>
<tr>
<th>License Type</th>
<th>License Number</th>
<th>State of Registration</th>
<th>Original Date of Issue (MM/DD/YYYY)</th>
<th>Expiration Date (MM/DD/YYYY)</th>
<th>Do You Currently Practice in This State?</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes □ No</td>
</tr>
</tbody>
</table>

### UPIN

- **National Provider Identifier (When Available):**
- **Are you a participating Medicare provider?** Yes □ No
- **Are you a participating Medicaid provider?** Yes □ No

### Educational Council for Foreign Medical Graduates (ECFMG)

- **ECFMG Number:**
- **ECFMG Issue Date (MM/DD/YYYY):**

### Professional/Specialty Information

- **Primary Specialty**
  - **Board Certified?** Yes □ No
  - **Name of Certifying Board:**
  - **Initial Certification Date (MM/YYYY):**
  - **Recertification Date(s), If Applicable (MM/YYYY):**
  - **Expiration Date, If Applicable (MM/YYYY):**

- **If not board certified, indicate any of the following that apply.**
  - I have taken exam, results pending for ___________________________ Board.
  - I have taken Part I and am eligible for Part II of the ___________________________ Exam.
  - I am intending to sit for the Boards on ___________________________ (date)
  - I am not planning to take Boards.

- **Do you wish to be listed in the directory under this specialty?**
  - HMO: Yes □ No
  - PPO: Yes □ No
  - POS: Yes □ No

- **Secondary Specialty**
  - **Board Certified?** Yes □ No
  - **Name of Certifying Board:**
  - **Initial Certification Date (MM/YYYY):**
  - **Recertification Date(s), If Applicable (MM/YYYY):**
  - **Expiration Date, If Applicable (MM/YYYY):**
**Professional/Specialty Information -continued**

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.
- [ ] I have taken exam, results pending for __________________________ ______ Board.
- [ ] I have taken Part I and am eligible for Part II of the __________________________ ______ Exam.
- [ ] I am intending to sit for the Boards on __________________________ ______ (date)
- [ ] I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
- [ ] HMO: Yes [ ] No
- [ ] PPO: Yes [ ] No
- [ ] POS: Yes [ ] No

ADDITIONAL SPECIALTY BOARD CERTIFIED?
- [ ] Yes [ ] No

Name of Certifying Board:

INITIAL CERTIFICATION DATE (M/M/YYYY) RECERTIFICATION DATE(S), IF APPLICABLE (M/M/YYYY) EXPIRATION DATE, IF APPLICABLE (M/M/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.
- [ ] I have taken exam, results pending for __________________________ ______ Board.
- [ ] I have taken Part I and am eligible for Part II of the __________________________ ______ Exam.
- [ ] I am intending to sit for the Boards on __________________________ ______ (date)
- [ ] I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
- [ ] HMO: Yes [ ] No
- [ ] PPO: Yes [ ] No
- [ ] POS: Yes [ ] No

PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.)

**Work History** - Please provide a chronological work history for the past 5 years. You may submit a Curriculum Vitae as a supplement. Please explain all gaps in employment that lasted more than six months.

<table>
<thead>
<tr>
<th>CURRENT PRACTICE/EMPLOYER NAME</th>
<th>START DATE/END DATE (M/M/YYYY TO M/M/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>STATE/COUNTRY POSTAL CODE</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PREVIOUS PRACTICE/EMPLOYER NAME</th>
<th>START DATE/END DATE (M/M/YYYY TO M/M/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>STATE/COUNTRY POSTAL CODE</td>
</tr>
<tr>
<td>REASON FOR DISCONTINUANCE</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PREVIOUS PRACTICE/EMPLOYER NAME</th>
<th>START DATE/END DATE (M/M/YYYY TO M/M/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>STATE/COUNTRY POSTAL CODE</td>
</tr>
<tr>
<td>REASON FOR DISCONTINUANCE</td>
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</table>

<table>
<thead>
<tr>
<th>PREVIOUS PRACTICE/EMPLOYER NAME</th>
<th>START DATE/END DATE (M/M/YYYY TO M/M/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>STATE/COUNTRY POSTAL CODE</td>
</tr>
<tr>
<td>REASON FOR DISCONTINUANCE</td>
<td></td>
</tr>
</tbody>
</table>

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (M/M/YYYY TO M/M/YYYY) IN WORK HISTORY.

Gap Dates: Explanation:

Gap Dates: Explanation:
### Work History – continued

**Gap Dates:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Explanation</th>
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</thead>
</table>

**Gap Dates:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Explanation</th>
</tr>
</thead>
</table>

- Please check this box and complete and submit Attachment C if you have additional work history.

### Hospital Affiliations

Please include all hospitals where you currently have or have previously had privileges.

<table>
<thead>
<tr>
<th>Hospital Affiliation</th>
<th>Type of Privileges</th>
<th>Privilege Temporality</th>
<th>Start Date (MM/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Do you have hospital privileges?
  - Yes
  - No

- If you do not have admitting privileges, what admitting arrangements do you have?

- Primary Hospital Where You Have Admitting Privileges
  - Address
  - City
  - State/Country
  - Postal Code
  - Phone Number
  - Fax
  - E-mail
  - Full Unrestricted Privileges?
    - Yes
    - No
  - Types of Privileges (Provisional, Limited, Conditional, etc.)
  - Are privileges temporary?
    - Yes
    - No

- Of the total number of admissions to all hospitals in the past year, what percentage is to primary hospital?

- Other Hospital Where You Have Privileges
  - Address
  - City
  - State/Country
  - Postal Code
  - Phone Number
  - Fax
  - E-mail
  - Full Unrestricted Privileges?
    - Yes
    - No
  - Types of Privileges (Provisional, Limited, Conditional, etc.)
  - Are privileges temporary?
    - Yes
    - No

- Of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital?

- Please check this box and complete and submit Attachment D if you have additional current hospital affiliations.

### Previous Hospital Where You Have Had Privileges

<table>
<thead>
<tr>
<th>Hospital Affiliation</th>
<th>Privileged Dates (MM/YYYY to MM/YYYY)</th>
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<tbody>
<tr>
<td>Hospital 3</td>
<td></td>
</tr>
</tbody>
</table>

- Address
- City
- State/Country
- Postal Code
- Full Unrestricted Privileges?
  - Yes
  - No
- Types of Privileges (Provisional, Limited, Conditional, etc.)
- Were privileges temporary?
  - Yes
  - No
- Reason for discontinuance

- Please check this box and complete and submit Attachment E if you have additional previous hospital affiliations.

### References

- Please provide three peer references from the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of your abilities.

<table>
<thead>
<tr>
<th>Name/Title</th>
<th>Phone Number</th>
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<table>
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<tr>
<th>City</th>
<th>State/Country</th>
<th>Postal Code</th>
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</thead>
<tbody>
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<td>CITY</td>
<td>STATE/COUNTRY</td>
<td>POSTAL CODE</td>
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<td>3 NAME/TITLE</td>
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<tr>
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<td>STATE/COUNTRY</td>
<td>POSTAL CODE</td>
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<td><strong>Professional Liability Insurance Coverage</strong></td>
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<tr>
<td>SELF-INSURED?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY</td>
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<td></td>
</tr>
<tr>
<td>ADDRESS</td>
<td></td>
<td></td>
</tr>
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<td>STATE/COUNTRY</td>
<td>POSTAL CODE</td>
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<tr>
<td>PHONE NUMBER</td>
<td>POLICY NUMBER</td>
<td>EFFECTIVE DATE (MM/DD/YYYY)</td>
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<td>AMOUNT OF COVERAGE PER OCCURRENCE</td>
<td>AMOUNT OF COVERAGE AGGREGATE</td>
<td>TYPE OF COVERAGE</td>
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<tr>
<td>Individual</td>
<td>Shared</td>
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<tr>
<td>LENGTH OF TIME WITH CARRIER</td>
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<td></td>
</tr>
<tr>
<td>NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS</td>
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<td></td>
</tr>
<tr>
<td>ADDRESS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>STATE/COUNTRY</td>
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<td>PHONE NUMBER</td>
<td>POLICY NUMBER</td>
<td>EFFECTIVE DATE (MM/DD/YYYY)</td>
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<td>AMOUNT OF COVERAGE PER OCCURRENCE</td>
<td>AMOUNT OF COVERAGE AGGREGATE</td>
<td>TYPE OF COVERAGE</td>
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<td>Shared</td>
<td></td>
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<tr>
<td>LENGTH OF TIME WITH CARRIER</td>
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<tr>
<td><strong>Call Coverage</strong></td>
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<td></td>
</tr>
<tr>
<td>See attached list of hospital staff within my department I utilize for call coverage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLEASE LIST NAMES OF COLLEAGUE(S) PROVIDING REGULAR COVERAGE AND HIS OR HER SPECIALTIES.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name: Specialty:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name: Specialty:</td>
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<td>Name: Specialty:</td>
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<td></td>
</tr>
<tr>
<td>Name: Specialty:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLEASE LIST FULL NAMES OF ALL PARTNERS IN YOUR PRACTICE.</td>
<td>CHECK THIS BOX AND ATTACH LIST FOR LARGE GROUP.</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
<td></td>
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<tr>
<td>Name:</td>
<td></td>
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</tr>
<tr>
<td>Name:</td>
<td></td>
<td></td>
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</table>
### Practice Location Information

- **Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.**

#### Practice Location of

<table>
<thead>
<tr>
<th>TYPE OF SERVICE PROVIDED</th>
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<tbody>
<tr>
<td>Solo Primary Care</td>
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<tr>
<td>Solo Specialty Care</td>
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<tr>
<td>Group Primary Care</td>
</tr>
<tr>
<td>Group Single Specialty</td>
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<tr>
<td>Group Multi-Specialty</td>
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</table>

<table>
<thead>
<tr>
<th>GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9</td>
</tr>
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### Practice Location Address

- **Primary**

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE/COUNTRY</th>
<th>POSTAL CODE</th>
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<table>
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<tr>
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<th>FAX NUMBER</th>
<th>E-MAIL</th>
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<table>
<thead>
<tr>
<th>BACK OFFICE PHONE NUMBER</th>
<th>SITE-SPECIFIC MEDICAID NUMBER</th>
<th>TAX ID NUMBER</th>
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</table>

<table>
<thead>
<tr>
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<th>GROUP NAME CORRESPONDING TO TAX ID NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Are you currently practicing at this location?**
  - Yes
  - No

- **If no, expected start date? (MM/DD/YYYY)**

- **Do you want this location listed in the directory?**
  - Yes
  - No

#### Credentialing Contact

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#### Billing Company's Name (If Applicable)

- **Billing Representative**

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#### Billing Company's Name

- **Department Name if Hospital-Based**

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<th>CAN YOU BILL ELECTRONICALLY?</th>
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#### Hours Patients Are Seen

- **Monday**
  - No Office Hours
  - Morning: Afternoon: Evening:
- **Tuesday**
  - No Office Hours
  - Morning: Afternoon: Evening:
- **Wednesday**
  - No Office Hours
  - Morning: Afternoon: Evening:
- **Thursday**
  - No Office Hours
  - Morning: Afternoon: Evening:
- **Friday**
  - No Office Hours
  - Morning: Afternoon: Evening:
- **Saturday**
  - No Office Hours
  - Morning: Afternoon: Evening:
- **Sunday**
  - No Office Hours
  - Morning: Afternoon: Evening:

- **Does this location provide 24 hour/7 day a week phone coverage?**
  - Answering Service
  - Voice mail with instructions to call answering service
  - Voice mail with other instructions
  - None

#### This Practice Location Accepts

- **All new patients**
- **Existing patients with change of payor**
- **New patients with referral**
- **New Medicare patients**
- **New Medicaid patients**

- **If new patient acceptance varies by health plan, please provide explanation.**

#### Practice Limitations

- **Male only**
- **Female only**
- **Age:**
- **Other:**

- **Do nurse practitioners, physician assistants, midwives, social workers or other non-physician providers care for patients at this practice location?**
  - Yes
  - No

#### Professional Designation

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# Practice Location Information - continued

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### Non-English Languages Spoken by Healthcare Providers

### Non-English Languages Spoken by Office Personnel

### Are Interpreters Available?

- [ ] Yes
- [ ] No

### Does This Practice Location Meet ADA Accessibility Standards?

- [ ] Yes
- [ ] No

### Which of the Following Facilities Are Handicapped Accessible?

- Building
- Parking
- Restroom
- Other:

### Are Interpreters Available?

- [ ] Yes
- [ ] No

### Does This Location Have Other Services for the Disabled?

- Text Telephony
- Sign Language
- Mental/Physical Impairment Services
- Other:

### Is This Location Accessible by Public Transportation?

- Bus
- Subway
- Regional Train
- Other:

### Does This Location Provide Childcare Services?

- [ ] Yes
- [ ] No

### Does This Location Qualify as a Minority Business Enterprise?

- [ ] Yes
- [ ] No

### Who at this Location Have the Following Current Certifications? (Please list only the applicant's certification expiration dates.)

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<tr>
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<tr>
<td>Advanced Cardiac Life Support</td>
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<tr>
<td>Neonatal Advanced Life Support</td>
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<tr>
<td>Advanced Life Support in OB</td>
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<td>Cardio-Pulmonary Resuscitation</td>
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<tr>
<td>Pediatric Advanced Life Support</td>
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<tr>
<td>Other (please specify)</td>
<td>Staff</td>
<td>Provider Exp:</td>
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### Does This Location Provide Any of the Following Services on Site?

- [ ] Laboratory Services: please list all certificates of participation (CLIA, AAFP, COLA, CAP, MLE):

- X-ray: please list all certifications:

### Other Services

- [ ] Radiology Services
- [ ] EKG
- [ ] Allergy Skin Tests
- [ ] Care of Minor Lacerations
- [ ] Pulmonary Function Tests
- [ ] Allergy Injections
- [ ] Routine Office Gynecology
- [ ] Drawing Blood
- [ ] Age Appropriate Immunizations
- [ ] Tymanometry/Audiometry Tests
- [ ] Asthma Treatments
- [ ] Osteopathic Manipulations
- [ ] Cardiac Stress Tests
- [ ] Physical Therapies
- [ ] Other:

### Please List Any Additional Office Procedures Provided (Including Surgical Procedures)

- [ ] Flexible Sigmoidoscopy
- [ ] Iv Hydration/Treatments
- [ ] Physical Therapies

### Is Anesthesia Administered at This Practice Location?

- [ ] Yes
- [ ] No

### Who Administers It?

- Please specify the classes or categories:

### Please check this box and complete and submit Attachment F if you have other practice locations.
Section II-Disclosure Questions - Please provide an explanation for any question answered yes-except 19-on page on page 10.

Licensure
1  Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?
   □ Yes □ No

2  Have you ever received a reprimand or been fined by any state licensing board?
   □ Yes □ No

Hospital Privileges and Other Affiliations
3  Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?
   □ Yes □ No

4  Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?
   □ Yes □ No

5  Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?
   □ Yes □ No

Education, Training and Board Certification
6  Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?
   □ Yes □ No

7  Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?
   □ Yes □ No

8  Have any of your board certifications or eligibility ever been revoked?
   □ Yes □ No

9  Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?
   □ Yes □ No

DEA or DPS
10 Have your Federal IDEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?
    □ Yes □ No

Medicare, Medicaid or other Governmental Program Participation
11 Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?
    □ Yes □ No

Other Sanctions or Investigations
12 Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, IDEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?
    □ Yes □ No
Section II - Disclosure Questions - continued

Other Sanctions or Investigations

13 To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?

☐ Yes  ☐ No

14 Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

☐ Yes  ☐ No

15 Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?

☐ Yes  ☐ No

Malpractice Claims History

16 Have you ever had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated?)

☐ If yes, please check this box and complete and submit Attachment G.

☐ Yes  ☐ No

Criminal

17 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?

☐ Yes  ☐ No

18 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?

☐ Yes  ☐ No

19 Have you been court-martialed for actions related to your duties as a medical professional?

☐ Yes  ☐ No

Ability to Perform Job

20 Are you currently engaged in the illegal use of drugs? (“Currently” means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one’s ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It “does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law.” The term does include, however, the unlawful use of prescription controlled substances.)

☐ Yes  ☐ No

21 Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

☐ Yes  ☐ No

Ability to Perform Job

22 Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?

☐ Yes  ☐ No

23 Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation?

☐ Yes  ☐ No

Please use the space on page 10 to explain yes answers to any question except 16.
Section II - Disclosure Questions continued
Please use the space below to explain yes answers to any question except 16.

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Section III - Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as “Participation”) at or with

(Please indicate managed care company(s) or hospital(s) to which you are applying) (hereinafter, individually referred to as the “Entity”)

and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. Further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

For Hospital Credentialing. I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as “Agents”), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release “Disciplinary Information,” as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, “Disciplinary Information” means information concerning: (I) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third

Applicant's initials and date (MM/DD/YYYY)
Section III - Standard Authorization, Attestation and Release - continued

party for their acts, defamation or any other claim based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retain the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity’s medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Required Attachments or Supplemental Information - Please attach hard copy or scanned documents of the following:
- Copy of DEA or state DPS Controlled Substances Registration Certificate
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant’s name
- Copy of workers compensation certificate of coverage, if applicable
- Copies of IRS W-9s for verification of each tax identification number used
- Copies of radiology certifications, if applicable
- Copy of CLIA certifications, if applicable
- Copy of DD214, record of military service, if applicable

Reproduction of this form without any changes is allowed.

Notice About Certain Information Laws and Practices Pertaining to State Governmental Bodies (i.e. State Hospitals)

With few exceptions, you are entitled to be informed about the information that a state governmental body collects about you (i.e. a state hospital). Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However, the state governmental body may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that the state governmental body correct information that it has about you that is incorrect. For information about the procedure and costs for obtaining information, please contact the appropriate state governmental body to which you have submitted this application.
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- Program successfully completed
- ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
- PROGRAM DIRECTOR
- CURRENT PROGRAM DIRECTOR (IF KNOWN)

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- Program successfully completed
- ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
- PROGRAM DIRECTOR
- CURRENT PROGRAM DIRECTOR (IF KNOWN)

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<td>Types of Privileges (Provisional, Limited, Conditional, etc.)</td>
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### Practice Location Information
- **Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.**

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<th>TYPE OF SERVICE PROVIDED</th>
<th>Solo Primary Care</th>
<th>Solo Specialty Care</th>
<th>Group Primary Care</th>
<th>Group Single Specialty</th>
<th>Group Multi-Specialty</th>
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<table>
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<th>GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY</th>
<th>GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9</th>
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**PRACTICE LOCATION ADDRESS**
- **Primary**
  - CITY
  - STATE/COUNTRY
  - POSTAL CODE
  - PHONE NUMBER
  - FAX NUMBER
  - E-MAIL

**BACK OFFICE PHONE NUMBER**
- SITE-SPECIFIC MEDICAID NUMBER
- TAX ID NUMBER

<table>
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<tr>
<th>GROUP NUMBER CORRESPONDING TO TAX ID NUMBER</th>
<th>GROUP NAME CORRESPONDING TO TAX ID NUMBER</th>
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</thead>
</table>

- **ARE YOU CURRENTLY PRACTICING AT THIS LOCATION?**
  - Yes
  - No

- **IF NO, EXPECTED START DATE? (MM/DD/YYYY)**

- **DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY?**
  - Yes
  - No

**CREDENTIALING CONTACT**
- ADDRESS
  - CITY
  - STATE/COUNTRY
  - POSTAL CODE
  - PHONE NUMBER
  - FAX NUMBER
  - E-MAIL

**BILLING COMPANY’S NAME (IF APPLICABLE)**
- BILLING REPRESENTATIVE

- ADDRESS
  - CITY
  - STATE/COUNTRY
  - POSTAL CODE
  - PHONE NUMBER
  - FAX NUMBER
  - E-MAIL

**DEPARTMENT NAME IF HOSPITAL-BASED**
- CHECK PAYABLE TO
  - CAN YOU BILL ELECTRONICALLY?
  - Yes
  - No

**HOURS PATIENTS ARE SEEN**
- Monday
  - No Office Hours
  - Morning: 
  - Afternoon: 
  - Evening: 

- Tuesday
  - No Office Hours
  - Morning: 
  - Afternoon: 
  - Evening: 

- Wednesday
  - No Office Hours
  - Morning: 
  - Afternoon: 
  - Evening: 

- Thursday
  - No Office Hours
  - Morning: 
  - Afternoon: 
  - Evening: 

- Friday
  - No Office Hours
  - Morning: 
  - Afternoon: 
  - Evening: 

- Saturday
  - No Office Hours
  - Morning: 
  - Afternoon: 
  - Evening: 

- Sunday
  - No Office Hours
  - Morning: 
  - Afternoon: 

**DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?**
- Answering Service
- Voice mail with instructions to call answering service
- Voice mail with other instructions
- None

**THIS PRACTICE LOCATION ACCEPTS**
- all new patients
- existing patients with change of payor
- new patients with referral
- new Medicare patients
- new Medicaid patients

**IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.**

**PRACTICE LIMITATIONS**
- Male only
- Female only
- Other

**DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?**
- Yes
- No

**If yes, provide the following information for each staff member:**
- NAME
  - PROFESSIONAL DESIGNATION
  - STATE & LICENSE NUMBER

**NAME**
- PROFESSIONAL DESIGNATION
- STATE & LICENSE NUMBER

LHL234F Eff.08/02 Texas Department of Insurance
Practice Location Information - continued

NAME | PROFESSIONAL DESIGNATION | STATE & LICENSE NUMBER
--- | --- | ---

NAME | PROFESSIONAL DESIGNATION | STATE & LICENSE NUMBER
--- | --- | ---

NAME | PROFESSIONAL DESIGNATION | STATE & LICENSE NUMBER
--- | --- | ---

NAME | PROFESSIONAL DESIGNATION | STATE & LICENSE NUMBER
--- | --- | ---

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS | NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL
--- | ---

ARE INTERPRETERS AVAILABLE?
☐ Yes ☐ No If yes, please specify languages.

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?
☐ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
☐ Building ☐ Parking ☐ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☒ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☐ Bus ☐ Subway ☐ Regional Train ☐ Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?
☐ Yes ☐ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☐ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT’S CERTIFICATION EXPIRATION DATES.)

Basic Life Support ☐ Staff ☐ Provider Exp: Advanced Life Support in OB ☐ Staff ☐ Provider Exp:
Advanced Trauma Life Support ☐ Staff ☐ Provider Exp: Cardio-Pulmonary Resuscitation ☐ Staff ☐ Provider Exp:
Advanced Cardiac Life Support ☐ Staff ☐ Provider Exp: Pediatric Advanced Life Support ☐ Staff ☐ Provider Exp:
Neonatal Advanced Life Support ☐ Staff ☐ Provider Exp: Other (please specify) ☐ Staff ☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE?
☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

☐ X-ray; please list all certifications:

OTHER SERVICES
☐ Radiology Services ☐ EKG ☐ Care of Minor Lacerations ☐ Pulmonary Function Tests
☐ Allergy Injections ☐ Allergy Skin Tests ☐ Routine Office Gynecology ☐ Drawing Blood
☐ Age Appropriate Immunizations ☐ Flexible Sigmoidoscopy ☐ Tymanometry/Audiometry Tests ☐ Asthma Treatments
☐ Osteopathic Manipulations ☐ IV Hydration / Treatments ☐ Cardiac Stress Tests ☐ Physical Therapies
☐ Other:

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?
☐ Yes ☐ No Please specify the classes or categories:

WHO ADMINISTERS IT?

☐ Please check this box and complete and submit Attachment F if you have other practice locations.
<table>
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<tr>
<th>INCIDENT DATE (MM/DD/YYYY)</th>
<th>DATE CLAIM WAS FILED (MM/DD/YYYY)</th>
<th>CLAIM/CASE STATUS</th>
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**PROFESSIONAL LIABILITY CARRIER INVOLVED**

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<tr>
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<th>POLICY NUMBER</th>
<th>AMOUNT OF AWARD OR SETTLEMENT &amp; AMOUNT PAID</th>
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**METHOD OF RESOLUTION**

- [] Dismissed
- [] Settled (with prejudice)
- [] Settled (without prejudice)
- [] Judgment for Defendant(s)
- [] Judgment for Plaintiff(s)
- [] Mediation or Arbitration

**DESCRIPTION OF ALLEGATIONS**

**WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?**

- [] Yes
- [] No

**NUMBER OF OTHER CO-DEFENDANTS**

**YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)**

**DESCRIPTION OF ALLEGED INJURY TO THE PATIENT**

**TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?**

- [] Yes
- [] No
Appendix E
Focused Studies

Physical Health Focused Studies:

Well Child Medical Record Audit Tool

Asthma In Children Medical Record Audit Tool

Diabetes In Adults Medical Record Audit Tool

Behavioral Health Focused Studies:

ADHD Treatment Practices For Children (Under Age 21) Medical Record Audit Tool

Pregnancy/Substance Use In Pregnancy Medical Record Audit Tool

Major Depression In Adults Medical Record Audit Tool
MEDICAID MANAGED CARE PHYSICAL HEALTH FOCUS STUDY
WELL CHILD
MEDICAL RECORD AUDIT TOOL

Reviewer __________________________ Date of Audit ___________ Study Period ________________________________

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<td>Race</td>
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<td>Medicaid #</td>
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<td>Date of Birth</td>
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</table>

Answer all questions by checking the appropriate boxes or filling in the blanks.

Record excluded?  
☐ yes  ☐ no

Reason for exclusion

a. not produced
b. wrong age

c. other----specify __________________________

If excluded, stop—do not continue

Comments:

Definition:

Eligibility: Random sample is based on all enrollees with six (6) months of continuous eligibility. The child must have reached the age of 28 months at any time during the reporting period.
## THSTEPS MEDICAL CHECKUPS

<table>
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<tr>
<th>Documentation Elements</th>
<th>TH Steps Medical Checkups in the First 24 Months of Life</th>
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<tbody>
<tr>
<td>Date of Visit</td>
<td>#1 #2 #3 #4 #5 #6 #7 #8 #9 #10</td>
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### NEWBORN

#### 5 Proxy Elements
- Neonatal History
- Physical Exam Including Vital Signs
- Newborn Screening Laboratory Tests
- Height/Weight/Circumference Recorded and Graphed
- Nutrition Evaluation – Breast or Bottle Feeding Mentioned

### 2 TO 24 MONTHS

#### 5 Proxy Elements
- Health History/Parental Concerns
- Physical Exam Including Vital Signs
- Developmental Screening
- Height/Weight/Circumference Recorded and Graphed
- Immunizations

#### Supplemental Elements
- Lab: i.e., Hemoglobin/Hematocrit and Lead Screening
- Health Education/Parenting – 2-12 mo. (e.g. Nutrition, Safety), 15-48 mo. (e.g. Environmental Tobacco Exposure, Safety)
- Environmental Tobacco Exposure (2-12 mo.), Dental Referral (15-48 mo.)
- No evidence of required elements

No THSteps Medical Checkups in the First 24 Months of Life

### Comments

### Definitions

**Newborn Screening Laboratory Tests**: Newborn screening [hereditary/metabolic testing (hypothyroidism, PKU, Galactosemia, sickle hemoglobin, congenital adrenal hyperplasia)] is required by Texas law at hospital discharge and between one and two weeks old. Date of second screen should be documented during first office THSteps medical checkup first year of life. If Hemoglobin Type has been done and results are documented in chart, it does not need to be repeated. Hgb type also part of the newborn screening. (Taken from the TDH 1998 Texas Medicaid Service Delivery Guide, page 3-5.)

**THSteps Medical Checkups**: THSteps medical checkups are required in accordance with the THSteps Medical Checkups Periodicity Schedule. Includes newborn office visits and inter-periodicity well child visits and office visits done by PPC or other PCPs outside of plan. To count as a THSteps medical checkup, medical record documentation must include a note indicating a visit with a primary care provider, the date on which the well-child visit occurred, and at a minimum, the 5 required elements listed above. A child is considered to have received a well-child visit if he or she had a claim/encounter from a PCP that meets the coding definition on page 5 of the Well Child Focus Study Instructions. Inpatient, emergency room, mental health, chemical dependency and specialist visits should not be counted as a well-child visit. Preventative services may be rendered on the occasion of visits other than well-child visits. If the specified codes are present, these services may be counted regardless of the primary intent of the visit.
## IMMUNIZATIONS

<table>
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<tr>
<th>Immunization</th>
<th>Date Received</th>
<th>Name of Antigen</th>
<th>Vaccine Lot Number</th>
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*Vaccine Lot Number:* Name(s) of the specific antigen OR vaccine lot number(s) can be counted for entries made in the medical record at the time the immunization was given.

### Comments

### Definitions

**Immunizations:** Children must be immunized during medical checkups according to the TDH Routine Immunization Schedule by age and immunizing agent. The checkup provider is responsible for administration of immunizations (do not refer to local health departments). For children not previously immunized, TDH requires that immunizations be done unless medically contraindicated or against parental religious beliefs. (Taken from the TDH 1998 Texas Medicaid Service Delivery Guide, page 4-1.)

Refer to “Recommended Ages for Administration of Currently Licensed Childhood Vaccines” in the TDH Texas Medicaid Service Delivery Guide, page 4-2. According to this guide, a 2-year-old is considered to be up to date if he/she has received the following:

- 4 Diphtheria, Tetanus, Pertussis Vaccinations (DPT or DTaP)
- 3 Oral Polio Vaccinations (IPV/OPV)
- 1 Measles/Mumps/Rubella (MMR)
- 3 Hepatitis B Vaccinations (HBV)
- 4 Hemophilus Influenza B Vaccinations (HiB)

For immunization information obtained from the patient history, plans may count the immunization if the medical record contains the following information: a dated immunization history or a note indicating the name(s) of the specific antigen and the date the immunization(s) was given.

Entries made in the medical record at the time the immunization(s) was given must include a note indicating the name(s) of the specific antigen and the date the immunization(s) was given or the vaccine lot number(s) of the specific antigen and the date the immunization(s) was given. A certificate of immunization prepared by an authorized health provider or agent must include the specific dates and types of immunizations administered. All medical record entries must be dated by the child’s second birthday (i.e., entries made retroactively may not be counted). A note that the “member is up-to-date” with immunizations without a listing of the dates all immunizations were given and the names of the immunization agents does not constitute sufficient evidence of immunization.

**Look for all immunizations documented on or before the second birthday.** Look as far back as possible in the medical record for contraindications for immunizations, for evidence that a child is immunocompromised, or for evidence that immunizations are against parental religious beliefs. These cases may be excluded. See Table 1 of Well Child Focus Study Instructions for Contraindications for Childhood Immunizations.

9/14/98 draft
## LEAD SCREENING

<table>
<thead>
<tr>
<th>Lead Screening Date</th>
<th>Lead Level</th>
<th>Follow-up plan documented in the medical record (follow-up lead screen, treatment) for Abnormal Lead Screening Results (≥ 10 ug/dL)</th>
<th>Follow-up (follow-up lead screen, treatment) for Abnormal Lead Screening Results (≥ 10 ug/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- -</td>
<td>- - ug/dL</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>- -</td>
<td>- - ug/dL</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
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<td>- - ug/dL</td>
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<td>- - ug/dL</td>
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<td>□ Yes □ No</td>
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</tr>
<tr>
<td>- -</td>
<td>- - ug/dL</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
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</table>

### Lead Exposure Questionnaire

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>- -</td>
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<td>- -</td>
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</tbody>
</table>

### Comments

#### Definitions

**Lead Screening**: It is mandatory that children be tested in accordance with the THSteps Medical Checkups Periodicity Schedule. A lead concentration of greater than or equal to 10ug/dL are reflected as above the acceptable limit and follow-up activities are to be implemented.

To identify lead screening, look for laboratory reports that involve actual blood level analysis on or before the second birthday.

To identify a follow-up plan for lead screening results greater than or equal to 10 ug/dL, documentation must address repeat testing and/or medical treatment. This could be noted in the progress notes, physical exam, or other physician documentation.

To identify follow-up for lead screening results greater than or equal to 10 ug/dL, documentation should reflect that repeat testing and/or medical treatment occurred. This could be noted in the progress notes, physical exam, laboratory reports, or other physician documentation.

**Lead Exposure Questionnaire**: Lead screening involves actual blood lead analysis or completion of a parent questionnaire (with appropriate action taken depending on the answers). Blood lead analyses are mandatory at ages 12 and 24 months. At certain THSteps periodic visits, the parent questionnaire may be administered. The parent questionnaire is found in the TDH Texas Medicaid Service Delivery Guide. There is also an abbreviated questionnaire that may be used for children with previously recorded normal blood level. **Look for all questionnaires dated on or before the second birthday.**
MEDICAID MANAGED CARE PHYSICAL HEALTH FOCUS STUDY
ASTHMA IN CHILDREN
MEDICAL RECORD AUDIT TOOL

Reviewer________________________________ Date of Audit____________ Study Period_______________________________

<table>
<thead>
<tr>
<th>PCP Number:</th>
<th>Asthma Specialist Number:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member name</th>
<th>Last:</th>
<th>First:</th>
<th>MI:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
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<th>Female</th>
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</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>White</th>
<th>African Am</th>
<th>Hispanic</th>
<th>Am Indian</th>
<th>Asian</th>
<th>Other/Unknown</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>County of Service</th>
<th>Medicaid #</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
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</tbody>
</table>

**Answer all questions by checking the appropriate box or filling in the blanks.**

**Record excluded?**
- [ ] Yes
- [ ] No

**Reason for exclusion**
- [ ] Record not available
- [ ] Wrong age
- [ ] No asthma
- [ ] Enrolled< 6 mo.
- [ ] Other----specify_____________________________________________________

**If excluded, stop—do not continue**

**Definitions**

**Eligibility:** Members eligible for the study must meet the following criteria:
(a) The member must be a child between the ages of 2 to 19 years for at least three months during the study period.
(b) The member must have been enrolled continuously in the MCO for at least 6 consecutive months during the study period.
(c) The member must have at least two asthma encounters (493xx) during the study period.

**Comments:**
### PCP and SPECIALIST VISITS

<table>
<thead>
<tr>
<th>1. Date of asthma-related visit(s)</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
<th>#5</th>
<th>#6</th>
<th>#7</th>
<th>#8</th>
<th>#9</th>
<th>#10</th>
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</thead>
<tbody>
<tr>
<td>Specialist visit? (check if “yes”)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### Documentation Elements

1. Severity of asthma
2. Peak flow meter use
3. Nebulizer treatments and/or spacers (at home)
4. Referred to formal asthma education program
5. Education/instruction in asthma disease management
6. Demonstrated understanding of asthma disease management
7. Medications prescribed or utilized:
   - No medications documented
   - Illegible
   - Long-term inhaled anti-inflammatories
     - Inhaled Corticosteroids (Beclamethasone, Budesonide, Flunisolide, Fluticasone, Triamcinolone acetonide)
     - Cromoly Sodium or Nedocromil
     - Leukotriene Modifiers (Zafirlukast, Zileuton)
   - Quick-relief Medications
     - Short-acting beta2 agonists (Albuterol MDI, DPI, or nebulizer or Albuterol HFA, Bitolterol MDI or nebulizer, Pirbuterol, Terbutaline)
     - Anticholenergics
     - Ipratropium MDI or nebulizer
   - Oral Steroids ≥ 1 month
     - Methylprednisolone, prednisolone, prednisone
   - Short Burst Oral Steroids (< 1 month)
     - Methylprednisolone, prednisolone, prednisone
8. Flu Immunization
9. Symptoms:
   - Documentation addressing physical activity and/or exacerbations in relation to asthma

#### Comments

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MEDICAID MANAGED CARE BEHAVIORAL HEALTH FOCUS STUDY
ADHD Treatment Practices for Children (under age 21)
MEDICAL RECORD AUDIT TOOL

Reviewer __________________________________ Date of Audit ___________ Study Period __________________________

<table>
<thead>
<tr>
<th>PCP Number:</th>
<th>Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member name</td>
<td>Last:</td>
</tr>
<tr>
<td></td>
<td>First:</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
</tr>
<tr>
<td>Race</td>
<td>White</td>
</tr>
<tr>
<td>County of Service</td>
<td></td>
</tr>
<tr>
<td>Medicaid #</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
</tbody>
</table>

ADHD diagnosis (member diagnosed during the study period)

<table>
<thead>
<tr>
<th>DSM IV/ICD9CM Codes (circle)</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>314.0</td>
<td>ADHD: Attention Deficit/Hyperactivity Disorder – ADHD is defined according to the current US standard diagnostic system in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).</td>
</tr>
<tr>
<td>314.00</td>
<td>This study focuses on ADHD. The DSM-IV Codes are:</td>
</tr>
<tr>
<td>314.01</td>
<td>314.01 ADHD, Combined Type OR Predominantly Hyperactive-Impulsive Type</td>
</tr>
<tr>
<td>314.09</td>
<td>314.00 ADHD, Predominantly Inattentive Type</td>
</tr>
<tr>
<td>314.1</td>
<td>314.09 ADHD Not Otherwise Specified</td>
</tr>
<tr>
<td>314.2</td>
<td>The ICD-9-CM codes are:</td>
</tr>
<tr>
<td>314.8</td>
<td>314.0 Attention Deficit Disorder</td>
</tr>
<tr>
<td>314.9</td>
<td>314.00 Without mention of hyperactivity</td>
</tr>
<tr>
<td></td>
<td>314.01 With hyperactivity</td>
</tr>
<tr>
<td></td>
<td>314.1 Hyperkinesis with developmental delay</td>
</tr>
<tr>
<td></td>
<td>314.2 Hyperkinetic conduct disorder</td>
</tr>
<tr>
<td></td>
<td>314.8 Other specified manifestations of hyperkinetic syndrome</td>
</tr>
<tr>
<td></td>
<td>314.9 Unspecified hyperkinetic syndrome</td>
</tr>
</tbody>
</table>

The study does not include Other Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence such as Conduct Disorder (DSM-IV Code 312.8), Learning Disorders (DSM-IV Codes 315.00-315.9), or Mental Retardation (DSM-IV Codes 317-319).

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Response</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated by PCP with medication for ADHD during study period</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Referred to a BH provider OR there is evidence that the member was receiving services from a BH provider during study period</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Referred for social intervention OR there is evidence that the member was receiving services for social intervention during the study period</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Notes:______________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

11/06/98
Parent Questionnaire (ADHD Focus Study)

Date:_____/_____/_____ Who answered the Questions: _____Mother _____Father _____Both _____Other: Please Specify:____________________

Please check your answers to the following questions:

1. How did you feel about the services your child received for ADHD?
   _____1) Very Pleased.
   _____2) Pleased.
   _____3) Mixed Feelings.
   _____4) Displeased.
   _____5) Very Displeased.

2. How did you feel about the information you received about your child’s ADHD?
   _____1) Very Pleased.
   _____2) Pleased.
   _____3) Mixed Feelings.
   _____4) Displeased.
   _____5) Very Displeased.

3. How did you feel about how much information the doctor asked you to give about your child’s problems?
   _____1) Very Pleased.
   _____2) Pleased.
   _____3) Mixed Feelings.
   _____4) Displeased.
   _____5) Very Displeased.

4. How did you feel about the amount of time the doctor spent with you and your child?
   _____1) Very Pleased.
   _____2) Pleased.
   _____3) Mixed Feelings.
   _____4) Displeased.
   _____5) Very Displeased.
5. The doctor who worked with your family was:
   _____1) Very Helpful.
   _____2) Helpful.
   _____3) Sometimes Helpful.
   _____4) Not Helpful.
   _____5) Made Things Worse.

6. Since receiving services, how is your child doing?
   _____1) Much Better.
   _____2) Better.
   _____3) About the Same.
   _____4) Worse.
   _____5) Much Worse.

7. Since receiving services, how are you able to manage your child’s behavior?
   _____1) Much Better.
   _____2) Better.
   _____3) About the Same.
   _____4) Worse.
   _____5) Much Worse.

8. Since receiving services, how pleased are you with your child’s progress?
   _____1) Very Pleased.
   _____2) Pleased.
   _____3) Mixed Feelings.
   _____4) Displeased.
   _____5) Very Displeased.
PREGNANCY/SUBSTANCE USE IN PREGNANCY MEDICAID MANAGED CARE FOCUSED STUDIES
MEDICAL RECORD AUDIT TOOL

Reviewer________________________________ Date of Audit____________ Study Period______________

<table>
<thead>
<tr>
<th>Member name</th>
<th>Last:</th>
<th>First:</th>
<th>MI:</th>
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</thead>
<tbody>
<tr>
<td>Medicaid #</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>Race (if not in admin data)</td>
<td>□ Caucasian</td>
<td>□ African Am</td>
<td>□ Hispanic</td>
</tr>
<tr>
<td>Provider</td>
<td>Name</td>
<td>Number:</td>
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</tr>
<tr>
<td>County of service</td>
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<tr>
<td>Enrollment dates</td>
<td>/</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>Delivery date</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>Pregnancy outcome</td>
<td>□ Live birth(s) ______ (Number)</td>
<td>□ Stillborn ______ (Number)</td>
<td>□ Maternal death</td>
</tr>
<tr>
<td>Pregnancy complication</td>
<td>DRG code ___________</td>
<td>ICD-9 code ___________</td>
<td></td>
</tr>
</tbody>
</table>

Please answer all questions by checking the appropriate boxes or filling in the blanks.

Eligible population:
STAR members eligible for the study must meet the following criteria:
1. The member must have delivered during the study period live or stillborn fetus(es) 20 weeks gestation or greater.
2. The member must have been enrolled 42 days after delivery.

Note: Abstractor should include all services provided by other providers outside of plan, if the service and its results are well documented in the medical record. If member enrolled in plan multiple times, use all available data. For instance, if member dis-enrolled after receiving 1st prenatal visit, then re-enrolled, include data from first enrollment date and any subsequent visits that are documented in the record.

1. Record excluded?
   □ 1. Yes
   □ 2. No
2. Reason for exclusion
   □ 1. Unable to locate record
   □ 2. Birth outside study period
   □ 3. Not enrolled 42 days after birth
   □ 4. Birth less than 20 weeks gestational age
   □ 5. Other please explain ________________________________

If excluded, stop—do not continue
Comments:
**Prenatal Care**

Enter dates of prenatal and postpartum visits in column.

<table>
<thead>
<tr>
<th>Element</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Estimated Date of Confinement (EDC)</td>
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<tr>
<td>Last Menstrual Period (LMP)</td>
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</tr>
<tr>
<td>Visit No.</td>
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</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
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<td>Additional visits</td>
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</tr>
<tr>
<td>Post-partum visit</td>
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<tr>
<td><strong>Screened prenatally for:</strong></td>
<td><strong>Screening method(s):</strong></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Alcohol □ Yes □ No</td>
<td>□ ACOG or another standardized visit summary form or Patient history</td>
</tr>
<tr>
<td>Tobacco □ Yes □ No</td>
<td>□ Lab</td>
</tr>
<tr>
<td>Drugs □ Yes □ No</td>
<td>□ Other (includes Hollister, Oregon, or undocumented screen with documented treatment plan or diagnosis, or other documented screening method)</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Screened at delivery for:</strong></th>
<th><strong>Screening method(s):</strong></th>
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</thead>
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<tr>
<td>Alcohol □ Yes □ No</td>
<td>□ ACOG or another standardized visit summary or Patient history</td>
</tr>
<tr>
<td>Tobacco □ Yes □ No</td>
<td>□ Lab</td>
</tr>
<tr>
<td>Drugs □ Yes □ No</td>
<td>□ Other (includes Hollister, Oregon, or undocumented screen with documented treatment plan or diagnosis, or other documented screening method)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Positive Screen or Diagnosis for:</strong></th>
<th><strong>If positive screen or diagnosis, amount of self-reported usage or lab level:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol</strong></td>
<td><strong>Amount:</strong></td>
</tr>
<tr>
<td>□ prior to realizing she was pregnant/prior to visit—has discontinued use</td>
<td></td>
</tr>
<tr>
<td>□ present use</td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco</strong></td>
<td><strong>Amount:</strong></td>
</tr>
<tr>
<td>□ prior to realizing she was pregnant/prior to visit—has discontinued use</td>
<td></td>
</tr>
<tr>
<td>□ present use</td>
<td></td>
</tr>
<tr>
<td><strong>Drugs</strong></td>
<td><strong>Type:</strong></td>
</tr>
<tr>
<td>□ prior to realizing she was pregnant/prior to visit—has discontinued use</td>
<td></td>
</tr>
<tr>
<td>□ present use</td>
<td></td>
</tr>
<tr>
<td><strong>Amount:</strong></td>
<td></td>
</tr>
<tr>
<td>If member had positive screen or substance use diagnosis, documented evidence that she received education regarding substance use during pregnancy and/or treatment options</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

| If member had positive screen or substance use diagnosis, documented evidence that she was referred to BH provider during study period | □ Yes □ No | **Behavioral Health Provider**: An individual clinician licensed to provide mental health or chemical dependency services. Provider types include: Psychiatrists, Psychologists, Licensed Professional Counselors, Chemical Dependency counselors, and Licensed Master’s Social Workers-Advances Clinical Practitioners. **Behavioral Health Referral**: An attempt, documented in the member’s medical record, to refer a member to a behavioral health provider for the specific purpose of substance use treatment. A behavioral health referral may be documented with one or both of the following:
- Clinician/provider documentation that an attempt was made to make a referral by giving the member information to make the connection with a behavioral health provider; and/or
- Assisting the member in making the connection with a behavioral health provider (i.e. phone call, FAX, letter). |

| If member received education or referral (yes to either above questions), documented evidence that the prenatal provider followed up concerning The member’s decision or understanding on behavior change/treatment options, OR the referral to BH provider | □ Yes □ No | **Follow Up**: Documentation in the member’s medical record, that prenatal provider questioned the member concerning understanding of effects of substance use on fetal development and/or treatment options OR had been informed of member receiving referral to BH provider. |

| Comments |
## Information on Newborn

<table>
<thead>
<tr>
<th>Member name</th>
<th>Last:</th>
<th>First:</th>
<th>MI:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn#1 name</td>
<td>Last:</td>
<td>First:</td>
<td>MI:</td>
</tr>
<tr>
<td>Newborn#2 name</td>
<td>Last:</td>
<td>First:</td>
<td>MI:</td>
</tr>
<tr>
<td>Newborn#3 name</td>
<td>Last:</td>
<td>First:</td>
<td>MI:</td>
</tr>
</tbody>
</table>

### Newborn Outcome(s)
- [ ] Livebirth: Number
- [ ] Stillborn: Number
- [ ] Died within 28 days after birth

<table>
<thead>
<tr>
<th>Newborn#1 Birth weight</th>
<th>grams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn#2 Birth weight</td>
<td>grams</td>
</tr>
<tr>
<td>Newborn#3 Birth weight</td>
<td>grams</td>
</tr>
</tbody>
</table>

Newborn complications code: DRG code _____________ ICD-9 code _____________

### Pounds to grams

1 pound = 453.6 grams

Comments:
### MEDICAID MANAGED CARE BEHAVIORAL HEALTH FOCUS STUDY

**MAJOR DEPRESSION IN ADULTS**

**MEDICAL RECORD AUDIT TOOL (10-12-98)**

<table>
<thead>
<tr>
<th>PCP Number</th>
<th>Type</th>
<th>Member name</th>
<th>Last</th>
<th>First</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th></th>
<th>Race</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td>White</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>African Am</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hispanic</td>
<td></td>
<td>Am Indian</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td>Other/Not documented</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County of Service</th>
<th>Medicaid #</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

### Medical diagnosis (any current diagnosis identified during the study period)

<table>
<thead>
<tr>
<th>ICD9-CM Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Depression diagnosis (member diagnosed during the study period)

<table>
<thead>
<tr>
<th>DSM IV/ICD9CM Codes (circle)</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.20 293.83 300.4 311</td>
<td>Depression: Depression is defined according to the current US standard diagnostic system in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). This study focuses on Major Depression but also includes: Mood Disorder Due to General Medical Condition, Dysthymic Disorder, and Depressive Disorders NOS. The DSM-IV Codes are as follows: Major Depression (Single Episode 296.2x/Recurrent 296.3x): 296.20 296.22 296.24 296.26 296.31 296.33 296.35 296.21 296.23 296.25 296.30 296.32 296.34 296.36 Mood Disorder Due to General Medical Condition 300.4, Dysthymic Disorder 293.83, Depressive Disorder NOS: 296.30</td>
</tr>
<tr>
<td></td>
<td>The International Classification of Disease, 9th Edition (ICD-9-CM) codes for Major Depression, Dysthymic Disorder, Depressive Disorders NOS, and Mood Disorder Due to a General Medical Condition are the same as the DSM-IV codes listed here. The study does not include Other Mood Disorders such as Bipolar Disorders (DSM-IV Codes 296.4-296.89), or Bereavement (DSM-IV Code V62.82).</td>
</tr>
</tbody>
</table>

### Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Response</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated by PCP with medication targeted for depressive symptoms during study period</td>
<td>☐ Yes ☐ No</td>
<td>See Focus Study Instructions, Table 1: List of Medications That Could be Used to Treat Depression</td>
</tr>
<tr>
<td>Referred to or were receiving services from BH provider during study period</td>
<td>☐ Yes ☐ No</td>
<td>Behavioral Health Provider: An individual clinician licensed to provide mental health services. Provider types include: Psychiatrists, Psychologists, Licensed Professional Counselors, and Licensed Master’s Social Workers-Advances Clinical Practitioners. Behavioral Health Referral: An attempt, documented in the member’s medical record, to refer a member to a behavioral health provider for the specific purpose of alleviating the symptoms of depression. A behavioral health referral may be documented with one or both of the following: \• Clinician/provider documentation that an attempt was made to make a referral by giving the member information to make the connection with a behavioral health provider; and/or \• Assisting the member in making the connection with a behavioral health provider (i.e. phone call, FAX, letter).</td>
</tr>
<tr>
<td>Received education regarding depression and treatment during study period</td>
<td>☐ Yes ☐ No</td>
<td>Education Regarding Depression and Treatment: An attempt by the clinician/provider to provide the member education for depression and/or its treatment. The attempt is to be documented in the member’s medical record and includes information that is given either verbally or by giving the member a brochure, pamphlet, or other literature.</td>
</tr>
</tbody>
</table>

### Notes:

______________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________
# MEDICAID MANAGED CARE FOCUSED STUDY
## DIABETES IN ADULTS
### MEDICAL RECORD AUDIT TOOL

**Reviewer___________________________ Date of Audit___________ Reporting period___________________________**

<table>
<thead>
<tr>
<th>1. PCP</th>
<th>Number:</th>
<th>Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Member name</td>
<td>Last:</td>
<td>First:</td>
</tr>
<tr>
<td>3. Gender</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>4. Race</td>
<td>White</td>
<td>African Am</td>
</tr>
<tr>
<td>5. County of Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Medicaid #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Date of Birth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Answer all questions by checking the appropriate box or filling in the blanks.**

**Record excluded?**
- [ ] Yes
- [ ] No

**Reason for exclusion**
- [ ] Wrong age
- [ ] No diabetes
- [ ] Enrolled< 5 mo.
- [ ] Both Medicare and Medicaid recipient

**If excluded, stop—do not continue**

**Definitions**

Eligibility: Members eligible for the study must meet the following criteria:

(a) The member must be a diabetic between the ages of 18 and 64 years as of December 31 of the reporting period.
(b) The member must have been enrolled on December 31 and have been continuously in the MCO for at least 5 consecutive months during the study period.
(c) The member must have been prescribed insulin and/or oral hypoglycemics/antihyperglycemics during the reporting period on an ambulatory basis, or
(d) Must have had **two** face-to-face encounters with different dates of service in an ambulatory setting or non-acute inpatient setting or **one** face-to-face encounter in an acute inpatient or emergency room setting during the reporting period with a diagnosis of diabetes.
(e) The member must **not** be dually-eligible (receiving both Medicaid and Medicare benefits). The member must only receive Medicaid benefits.

**Comments:**
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Response</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8. Documented HbA1C performed during January, 1998 to December, 1998?</strong></td>
<td>□ Yes □ No</td>
<td>Documentation must include date of exam and result.</td>
</tr>
<tr>
<td><strong>9. Documented eye screening for diabetic retinal disease?</strong>&lt;br&gt;If no,&lt;br&gt;a) Did member NOT take insulin during January—December, 1998?&lt;br&gt;b) Was the most recent documented HbA1C less than 8.0%?&lt;br&gt;c) Does the record indicate an exam by eye-care professional without evidence of retinopathy during January, 1997 to December, 1997?</td>
<td>□ Yes □ No □ Yes □ No □ Yes □ No</td>
<td>• Documentation from an ophthalmologist, optometrist, or other eye-care professional summarizing the date and results of the procedure, OR&lt;br&gt;• A chart or photograph of retinal abnormalities with the date and signature of an eye-care professional, OR&lt;br&gt;• Documentation by PCP summarizing the date and results of an exam by an eye-care professional&lt;br&gt;(If the member meets at least two of the three criteria, then this member may be included as meeting the criteria for retinal disease screening.)</td>
</tr>
<tr>
<td><strong>10. Documented LDL test performed during the 24-month period January, 1997 to December, 1998?</strong></td>
<td>□ Yes □ No</td>
<td>Documentation must include date of exam and result of one of the following: Lipid panel; Lipoprotein, Cholesterol Fractionation Calculation; or Lipoprotein, LDL, Cholesterol</td>
</tr>
<tr>
<td><strong>11. Documented nephropathy screening during the 12-month period January 1—December 31, 1998?</strong>&lt;br&gt;If no,&lt;br&gt;a) evidence of pre-existing nephropathy?&lt;br&gt;b) Did member NOT take insulin during January—December, 1998?&lt;br&gt;c) Was the most recent documented HbA1C less than 8.0%?&lt;br&gt;d) Does the record indicate a nephropathy screening without evidence of nephropathy during January 1 to December 31, 1997?</td>
<td>□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No</td>
<td>Documentation of screening must include date of exam and result of one of the following: Albumin, Urine, Quantitative; Albumin Urine, Microalbumin Quantitative; Albumin Urine, Microalbumin Semiquantitative, e.g. Reagent strip assay; or a positive dipstick for microalbuminuria.&lt;br&gt;Documentation of pre-existing nephropathy must include reference to: Diabetic nephropathy, proteinuria/microalbuminuria/urine protein+, end-stage renal disease/ESRD, chronic renal failure/CRF, renal insufficiency, acute renal failure/ARF, dialysis, hemodialysis, or peritoneal dialysis. (If documented pre-existing nephropathy, member qualifies as having met the criteria for nephropathy screening.)&lt;br&gt;(If the member has pre-existing nephropathy or meets at least two of the criteria in items b, c, d, then this member may be included as meeting the criteria for nephropathy screening.)</td>
</tr>
<tr>
<td><strong>12. Documented foot exam during the reporting period?</strong></td>
<td>□ Yes □ No</td>
<td>Documentation of screening must include date of exam and at least one of the following findings: Pedal pulses present/absent, sensation in feet present/absent, description of skin integrity on feet, appearance of feet</td>
</tr>
</tbody>
</table>

**COMMENTS:**
Appendix F
Frequently Asked Questions

Q: May I participate in one or more HMOs and the Texas Health Network?
A. Yes. A provider may choose to participate in the Texas Health Network and any HMOs available in his or her service area. In addition, there is no limitation to the number of Texas STAR Program members a provider may be assigned. However, the Texas Health and Human Services Commission (HHSC) will continue to conduct oversight to ensure accessibility and quality of care.

Q: Where do I file my claims?
A. For Texas Health Network members, please file your claims with the Texas Medicaid Claims Administrator, as you always have. The Texas Medicaid Claims Administrator processes all claims for services provided to Texas Health Network members.

Q: How will I know which members are on my panel?
A. The Texas Health Network sends you a panel report every month that lists members who have selected you or been assigned to you. Each member listed is eligible for services throughout the entire month.

Q: What services and procedures require precertification, if any?
A. It’s a short list:

- All non-emergent inpatient admissions (excluding routine deliveries/routine newborn care and inpatient chemotherapy)
- All non-emergent surgical procedures, including those performed during authorized hospital admissions
- Some office and/or outpatient procedures (see Chapter III for the list)

Q: Am I limited to certain specialists for referrals?
A. The Texas Health Network has an open specialty referral network. You may refer to any Texas Medicaid-approved specialist for covered services you do not provide. Certain limitations may apply. See Chapter II for more information.

Q: Is it true that I have to be on call 24 hours a day, 7 days a week?
A. You must make continuous coverage available to your Texas Health Network members 24 hours a day, 7 days a week, but on-call arrangements are acceptable. See Chapter II for details.

Q: Do I have to authorize emergency services?
A. No, members may self-refer for emergency care, family planning services, Texas Health Steps (EPSDT), vision services, behavioral health services, certain case management services, and certain school health services (please refer to pages I-2 and I-3). Each member is encouraged to communicate self-referred services back to his or her primary care provider (PCP). As a PCP, you may be called by the ER. In this situation your timely response is required. See Chapter I for more information.

Q: Which clients are eligible for STAR Program enrollment?
A. In designated counties, the State has mandated that clients receiving Temporary Assistance to Needy Families (TANF) benefits or TANF-related benefits enroll with a health plan in the STAR Program, which includes the Texas Health Network. Clients who do not enroll are auto-assigned to a health plan. Individuals receiving Blind and Disabled ben-
benefits may voluntarily enroll with a STAR health plan (HMO or Texas Health Network), except in Harris County, where it is mandatory that these individuals select a plan (the STAR+PLUS demonstration pilot project).

Q: Must I provide services to all members who choose me as their PCP?

A. Yes, but an exception may be made if you have been assigned a member who is outside your scope of practice, e.g., outside the age range of pediatric patients you serve.

Q: What if one of my members wants to dis-enroll from my panel or I want to remove a member from my panel?

A. The Texas Health Network realizes these situations may occur. Please refer to Chapter V.
Appendix G
Texas Health Network Holiday Schedule

The Texas Health Network recognizes the following holidays:

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Date</th>
<th>Day of Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor Day</td>
<td>09/01/2003</td>
<td>Monday</td>
</tr>
<tr>
<td>Thanksgiving Day</td>
<td>11/27/2003</td>
<td>Thursday</td>
</tr>
<tr>
<td>Christmas Day</td>
<td>12/25/2003</td>
<td>Thursday</td>
</tr>
<tr>
<td>New Year's Day</td>
<td>01/01/2004</td>
<td>Thursday</td>
</tr>
<tr>
<td>Memorial Day</td>
<td>05/31/2004</td>
<td>Monday</td>
</tr>
<tr>
<td>Independence Day</td>
<td>07/04/2004</td>
<td>Sunday</td>
</tr>
<tr>
<td>Labor Day</td>
<td>09/06/2004</td>
<td>Monday</td>
</tr>
<tr>
<td>Thanksgiving Day</td>
<td>11/25/2004</td>
<td>Thursday</td>
</tr>
<tr>
<td>Christmas Day</td>
<td>12/25/2004</td>
<td>Saturday</td>
</tr>
<tr>
<td>New Year's Day</td>
<td>01/01/2005</td>
<td>Saturday</td>
</tr>
</tbody>
</table>

If a hospital admission notification deadline falls on any of the above listed Texas Health Network-recognized holidays, notification is due to the Texas Health Network by COB the following business day. See Chapter III for information on notification guidelines.
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