Client Benefits and Eligibility

CSHCN Services Program Provider Manual

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TEXAS
Health and Human
Services

CLIENT BENEFITS AND ELIGIBILITY

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3.1 Client Benefits

The CSHCN Services Program is a comprehensive health-care program. Clients must see providers who are enrolled in the CSHCN Services Program, and they can go to specialists without a referral. Benefits include, but are not limited to, the items in the list below. Consult the specific chapter or section for more details about coverage and authorization requirements.

- Ambulance
- Ambulatory or day surgery
- Augmentative communication devices (ACDs)
- Behavioral health
- Dental and orthodontia
- Drug copayments (except Children's Health Insurance Program [CHIP] drug copayments)
- Durable medical equipment and expendable medical supplies
- Eye prostheses
- Gastrostomy devices
- Genetic services
- Hearing services
- Hemophilia blood factor products
- Home health services
- Hospice care
- Inpatient services
- Laboratory services
- Insurance Premium Payment Assistance (IPPA) (reimburses health insurance premiums)
- Medical foods and nutritional services
- Orthotics and prosthetics
- Outpatient services
- Physical and occupational therapy (outpatient only)
- Physical medicine
- Prescription drugs
- Primary and preventive care
- Physician services, including services performed by advanced practice registered nurses (APRNs)
- Podiatry
- Prescription shoes
- Radiology and radiation therapy services
- Rehabilitation (inpatient and outpatient)
- Renal dialysis
- Renal transplants
- Respiratory care and equipment

- Speech-language pathology (outpatient only)
- Sleep studies
- Stem cell transplants ($200,000 maximum)
- Surgery
- Telemedicine
- Vision care

3.1.1 Prescription Drug Benefits

Prior Authorization requests for prescription drug claims are submitted to the CSHCN Services Program and approved internally by CSHCN.

Providers do not need prior authorization for the following drugs and products:

- Insulin/insulin syringes
- Medications for home use

For the CSHCN Services Program, providers must obtain prior authorization for the following drugs and products by submitting the specified form:

- Aerosolized tobramycin (TOBI) (HHS Form 1143)
- Cayston (HHS Form 1143)
- Kalydeco (HHS Form 1143)
- Pulmozyme (HHS Form 1143)
- Growth hormone products (HHS Form 1312)
- Synagis (HHS Form 1055)

Prior authorization request forms are available on the CSHCN Services Program Prior Authorization Forms page of the Texas Vendor Drug Program website at www.txvendordrug.com/about/manuals/pharmacy-provider-procedure-manual/p-18-forms/prior-authorization-requests-cshcn-services-program. The forms must be faxed to 1-512-776-7238.

An approved prescribing physician must submit a completed and signed CSHCN Authorization Request Form to certify that the client continues to require these medications. The CSHCN Services Program generally grants authorizations for one year. Regardless of how long the authorization lasts, the client must be eligible for and enrolled in the CSHCN Services Program.

Pulmozyme and Kalydeco may not require an annual review if initial prior authorization criteria is established. Kalydeco will be approved for clients with cystic fibrosis who meet current CF Foundation and FDA indications and prescribing guidelines.

Coordination with primary payer insurance must be used when applicable.

Providers must obtain approval from the CSHCN Services Program for HIV products, family planning, and pulmonary hypertension drugs.

To obtain approval, the prescribing physician must compose a letter of medical necessity on office stationery and fax it to the CSHCN Services Program at 1-512-776-7238. The CSHCN Services Program generally grants approval for one year. Regardless of how long the approval lasts, the client must be eligible for and enrolled in the CSHCN Services Program.

HIV/AIDS drugs are a benefit of the CSHCN Services Program for 60 days. The CSHCN Services Program can extend the benefit beyond 60 days if the provider submits a denial from the Texas HIV Medicaid program or any other third-party payer.

The CSHCN Services Program does not reimburse providers for drug waste.

3.1.2 Respiratory Syncytial Virus (RSV) Prophylaxis

Prior authorization for the RSV prophylaxis drug Palivizumab (Synagis) must be obtained through the CSHCN Services Program.

To request prior authorization, a completed Children with Special Health Care Needs (CSHCN) Services Program Synagis® (Palivizumab) Prior Authorization Request & Prescription Form 1055 must be faxed to the CSHCN Services Program at 1-512-776-7238.

Providers may refer to the Texas Health and Human Services Commission Texas Medicaid/CHIP Vendor Drug Program website at https://www.txvendordrug.com/formulary/respiratory-syncytial-virus-treatment for a copy of the prior authorization form and more information about obtaining palivizumab for CSHCN Services Program clients.

For additional information about RSV criteria, refer to Section 31.2.25.13, "Respiratory Syncytial Virus (RSV) Prophylaxis" in Chapter 31, "Physician."

3.1.3 Medical Transportation Program (MTP) Benefits

The MTP makes travel arrangements for CSHCN Services Program clients to get to their medical or dental appointments, or to the pharmacy. Clients must call MTP in advance to request travel assistance. To contact MTP, call 1-877-633-8747.

3.1.4 Services Provided Outside of Texas

CSHCN Services Program policies and procedures apply to all enrolled providers outside of the state of Texas. Out-of-state providers must be enrolled and remain enrolled as Title XIX Medicaid providers for to claims to be considered for reimbursement by the CSHCN Services Program.

Refer to: Section 2.1.9, "Out-of-State Providers" in Chapter 2, "Provider Enrollment and Responsibilities."

3.1.5 CSHCN Services Program Services and Supplies Limitations and Exclusions

The following are not CSHCN Services Program benefits (this list is not all-inclusive):

- Abortions
- Allergy treatment services, except antibiotic desensitization
- Ambulatory blood pressure monitoring
- Attendant care services
- Augmentation mammoplasty or breast reconstruction (except following a medically necessary mastectomy)
- Autopsies
- Neurofeedback (i.e., EEG biofeedback)
- Care and treatment related to any condition for which benefits are provided or available under worker's compensation laws
- Chemolase injection (chymodiactin and chymopapain)
- Chiropractic treatment
- Circumcisions (routine)
- Color vision and dark adaption exams
- Craniotomy for lobotomy

- Custodial care
- Dermabrasion or chemical peels
- Donor search for kidney transplants
- Donor search for stem cell transplants
- Dressings and supplies billed in physician's office
- Ear piercing or repair of ear piercing
- Experimental or investigational procedures
- Extracorporeal membrane oxygenation (ECMO)
- Extracorporeal photophoresis
- Fees for completing or filing a CSHCN Services Program claim form, the CSHCN Services Program Physician/Dentist Assessment Form, or other documentation
- Fertility services
- Fetal medical and surgical services
- Implantation of anti-esophageal reflux device
- More than 60 days of inpatient hospitalization per calendar year

  Note: *An additional 60-day hospital stay begins on the date of hospital admission for an approved stem cell transplant (refer to Section 24.3.1.6, "Transplants - Nonsolid Organ" in Chapter 24, "Hospital").*
- Inpatient rehabilitation of more than 90 days per calendar year
- Intermittent positive pressure breathing (IPPB) (physician services)
- Intersex surgery (except to repair or treat congenital defects)
- Intestinal bypass surgery and gastric stapling for the treatment of morbid obesity
- Lipectomies and rhytidectomies
- Manipulation of chest wall, including percussion
- Newborn services (routine)
- Obsolete diagnostic tests
- Obstetrical tests
- Outpatient cardiac rehabilitation
- Penile plethysmography or nocturnal tumescence test
- Peripheral and thermal angioplasty
- Portable X-ray services
- Prostate treatment (massage and surgery)
- Recreational therapy
- Routine blood drawing for specimens
- Salivary gland and duct diversion or ligation
- Services or supplies:
  - For which benefits are available under any other contract, policy, or insurance

  - For which claims were not submitted within the filing deadline
  - That are not reasonable and necessary for diagnosis or treatment
  - That are not specifically a benefit of the CSHCN Services Program
  - Provided before or after the eligibility time period of the client
  - Provided to clients on the CSHCN Services Program waiting list
  - Provided to a client after a finding was made during utilization review procedures that these services or supplies were not medically necessary
  - Payable by any health, accident, or other insurance coverage; by any private or other governmental benefit system; or by any legally liable third party
  - Provided by ineligible, suspended, or excluded providers
- Silicone or collagen injections (cosmetic)
- Single photon emission computerized tomography (SPECT) imaging
- Social and educational counseling
- Speech prosthesis insertion
- Sterilizations, sterilization reversals, infertility, obstetrics, and family-planning services
- Substance use treatment
- Tattooing
- Telephone calls, computer calculations, reports, and medical testimony
- Transplants of the heart, intestines, liver, lung or pancreas
- Travel allowance for specimen collection for homebound clients

3.2 Client Eligibility

3.2.1 CSHCN Services Program Application Criteria

Applicants who may be eligible for coverage under Medicare, Medicaid, Medicaid Buy-In (MBI), Medicaid Buy-In for Children (MBIC), or CHIP by reason of citizenship, residency status, age, or medical condition must apply for coverage. A written Medicaid and CHIP determination must be sent with the application for the CSHCN Services Program. Applicants who are not citizens or legal residents of the United States or who are currently enrolled in CHIP or Texas Medicaid are exempt from this requirement. Proof of exempt status must be sent with the application for the CSHCN Services Program.

If the CSHCN Services Program does not receive the Medicaid or CHIP determination or evidence of exemption from this requirement with the application, the applicant is given 60 days to submit the requested information. During this 60-day period, the applicant may send in any additional information that the CSHCN Services Program requires to process the application. If all information is received before the end of the 60 days, the CSHCN Services Program may grant eligibility for CSHCN Services Program health-care benefits or place the client on the waiting list. The eligibility effective date will be established as the date the application was made complete.

If the client or applicant has submitted all of the documentation required to approve his or her case for CSHCN Services Program health-care benefits, except for the Medicaid and CHIP determinations, the program may approve the case for 60 days until the Medicaid and CHIP determinations are received. Services are suspended if the Medicaid or CHIP determinations are not received on or before the end of 60 days. The suspension remains until the requested information is received. Once all of the required information is received, eligibility is granted. Eligibility is suspended between the 60-day cutoff date and the date on which the requested information is received.

An extension of 30 days may be granted for exceptional circumstances when requested.

The CSHCN Services Program does not pay for any services until the client's application is approved and the client is eligible to receive CSHCN Services Program health-care benefits.

If the CSHCN Services Program denies eligibility to a program applicant, the program shall give the applicant written notice of the denial and of the applicant's right to request an administrative review of the denial within 30 days of the date of the notification.

If the CSHCN Services Program proposes to modify, suspend, or terminate a client's eligibility for health-care benefits (unless such program actions are authorized by the CSHCN Services Program Rules Title 26 Part I TAC §351.16 relating to Procedures to Address Program Budget Alignment), the CSHCN Services Program shall give the client written notice of the proposed action and of the client's right to request an administrative review of the proposed action within 30 days of the date of notification.

Any questions concerning a client's eligibility for benefits of the CSHCN Services Program must be directed to the CSHCN Services Program Central Office at 1-800-252-8023.

3.2.2 Eligibility Criteria

A person may be eligible for health-care benefits under the CSHCN Services Program if the following conditions are met:

- The applicant must be a Texas resident.
- The applicant is 20 years of age or younger. Persons diagnosed with cystic fibrosis are exempt from this requirement.
- The applicant's family meets the CSHCN Services Program financial eligibility criteria.
- The applicant's physician or dentist attests to the program's medical certification definition and provides a diagnosis that meets the definition on the CSHCN Services Program Physician/Dentist Assessment Form located in the CSHCN Services Program Application.

The applicant must be eligible for medical assistance at the time the service is provided. Having an application for CSHCN Services Program eligibility in process is not a guarantee that the applicant can become eligible. Services and supplies are not paid by the CSHCN Services Program if they are provided to a client before the effective date of his or her eligibility or after the effective date of his or her denial of eligibility.

3.2.3 Prematurity

Applicants who meet the definition of prematurity are not medically eligible for CSHCN Services Program health care benefits until they have been discharged from the hospital and remain out of the hospital for at least 14 consecutive days.

3.2.4 Program Applicants and Clients Residing in Long-Term Care

Applicants and clients who are residing in skilled nursing facilities (SNF), intermediate care facilities for individuals with intellectual disabilities (ICF/IID), state hospitals (court-ordered and not considered a public institution), or community group homes may apply for CSHCN Services Program health care benefits.

Long-term care services provided by the facilities described above are not a covered health care benefit. If an ongoing CSHCN Services Program client is admitted to any of the above-mentioned facilities, his or her eligibility for covered health care benefits remains unchanged; however, the client may qualify for Medicaid or CHIP services and must maintain that coverage to continue eligibility for covered CSHCN Services Program health care benefits.

3.2.5 Program Applicants and Clients That Are Incarcerated

If an applicant or client meets the financial, medical, age, residency, and other criteria for eligibility for CSHCN Services Program health care benefits, eligibility may be granted; however, the applicant or client is not eligible for CSHCN Services Program health care benefits until released from custody. Services provided while the client is in the custody of, or incarcerated by, any municipal, county, state, or federal governmental entity are not covered.

Exception: *Case management or prior-approved FSS not provided by the governmental entity, that are needed during the time when a client is making a transition from custody or incarceration into a community-living setting, may be covered*

3.2.6 Sporadic Medicaid, MBIC, MBI, or CHIP Coverage

If the CSHCN Services Program client loses Medicaid coverage for longer than one month, reapplication to Medicaid is required. The client is notified that reapplication is required and is given 60 days to submit the Medicaid determination. CSHCN Services Program coverage for health care benefits may be granted during the 60 day period. If the determination is not received within the 60 day period the client's eligibility may be suspended. The CSHCN Services Program may grant a 30-day extension, at the client's request, to obtain the determination for Medicaid.

If a client is disenrolled by MBIC or MBI during the coverage period, the client or family must submit written notification to the CSHCN Services Program stating the reason for disenrollment.

Acceptable reasons to end MBIC or MBI coverage include, but are not limited to:

- Age limitations
- Has Medicaid coverage
- Lost private insurance coverage
- Found not to be a U. S. citizen

3.2.7 Eligibility Date for Program Health Care Benefits

The effective date of eligibility for CSHCN Services Program health care benefits is the date of receipt of the application, except in the following circumstances:

- *Newborn*. The effective date of eligibility for newborns that are not born prematurely is the date of birth. Newborn means a child 30 days old or younger.
- *Spend down*. The effective date of eligibility for applicants with spend down is the day after the earliest DOS on which the cumulative bills are sufficient to meet the spend-down amount. Only medical bills having a DOS within the 12 months prior to the date of receipt of the application denial date may be included to satisfy spend-down requirements. Medical bills from any member of the household for which the applicant, parents, guardian, or managing conservator of the applicant is responsible and that are not payable by another entity may be included. All spend-down documentation must be received within 60 days of receipt of the application denial. Medical bills that are used to meet spend down are not payable by the CSHCN Services Program.
- *Waiting List Exception.* If an ongoing client (not on the waiting list) reapplies on or before the day that CSHCN Services Program financial and medical eligibility expires and the income is over scale, his or her name is not placed on the waiting list. Eligibility is denied until bills are received that are sufficient to meet spend down. Eligibility then begins according to the spend-down criteria above.
- *Prematurity*. The effective date of eligibility for an applicant that is born prematurely is the day after the applicant has been out of the hospital for 14 consecutive days.
- *Trauma*. The effective date of eligibility following traumatic injury is the day after the acute phase of the treatment ends, the date of transfer to the rehabilitation facility, or the date discharged to home.

- The Trauma and Accident Section of the CSHCN Services Program Physician and Dentist Assessment Form in the CSHCN Services Program Application must be completed for all first time applicants. Applicants who are currently ongoing clients and are reapplying to establish continuing eligibility, or applicants who have had CSHCN Services Program eligibility in the past are exempt from this requirement. This exemption pertains even if the returning applicant has sustained a traumatic injury or accident during any time following the submission of an original application that included this information.
- The received date is the date the application is received by the CSHCN Services Program.

3.2.8 Financial Eligibility Criteria

Prospective CSHCN Services Program clients must meet financial eligibility requirements. Additional information about CSHCN Services Program financial eligibility is available at the toll free CSHCN Services Program Inquiry Line at 1-800-252-8023 or online at www.dshs.texas.gov. CSHCN Services Program inquires may also be mailed to:

CSHCN Services Program
MC 1938
PO Box 149030
Austin, TX 78714-9947

Important: *All client eligibility information must be kept up to date. CSHCN Services Program financial eligibility must be updated annually. Medical eligibility must be updated annually; however, medical information may be updated whenever there is a change in the client's condition.*

3.2.9 Medical Eligibility Criteria and the Physician/Dentist Assessment Form (PAF)

An important element of determining client eligibility is the CSHCN Services Program Physician/Dentist Assessment Form. The PAF provides the CSHCN Services Program with vital information about the client's medical condition, qualifies the client as medically eligible for benefits, and is used when clients are considered for removal from the waiting list. The PAF also provides a medical certification for a diagnosis that meets the CSHCN Services Program's definition of a child with special health-care needs and also allows for identification and explanation of an urgent need for medical care.

CSHCN Services Program applicants and clients are required to submit proof of their medical condition with the initial application, notify the CSHCN Services Program of any changes in the client's condition, and certify at least once annually that the client is medically eligible. This information is completed and submitted on the CSHCN Services Program Physician/Dentist Assessment Form.

Copies of the form are included with the application packet, and clients or their families must ensure that a physician or dentist provides the information necessary to meet the medical eligibility requirements of the CSHCN Services Program.

3.2.9.1 Medical Certification Definition

The CSHCN Services Program rules state that the following medical criteria should be used when referring clients to the program:

- A chronic developmental condition must include physical manifest and may not be solely a delay in intellectual, mental, behavioral, or emotional development.

CSHCN Services Program rules state the following for a chronic physical condition:

- Such a condition may exist with accompanying developmental, mental, behavioral, or emotional conditions, but is not solely a delay in intellectual development or solely a mental, behavioral, or emotional condition.

A diagnosis of intellectual disability, autism, or attention deficit hyperactivity disorder (ADHD) does not indicate a physical disability by itself. If the client also has cerebral palsy or another condition causing physical disability, use that diagnosis on the PAF to expedite the processing of the application.

The physician or dentist who completes the PAF must also certify that the applicant meets the CSHCN Services Program's definition of a person with special health-care needs outlined below:

- 21 years of age or younger
- Must have a chronic physical or developmental condition that will last or is expected to last for at least 12 months and may result in limits to one or more major life activities or result in death if not treated
- Must have a chronic physical or developmental condition that requires health and related services of a type or amount beyond those generally required by children
- Must have a physical (body, bodily tissue, or organ) manifestation
- May have an accompanying developmental, mental, behavioral, or emotional condition(s) that is not solely a delay in intellectual development or solely a mental, behavioral, or emotional condition
- A person of any age who has cystic fibrosis

3.2.9.2 Primary and Secondary Diagnoses

The CSHCN Services Program is not diagnosis-restricted; however, a valid *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM) code, or its successor, that indicates an applicant's chronic physical condition is required on the PAF. This information is important for program data purposes and to ensure that the applicant meets the program's definition of a child with special health-care needs.

The primary diagnosis on the PAF must be medical in nature and meet CSHCN Services Program criteria. Any additional diagnoses may be listed in the Other Diagnoses section located below the Primary Diagnosis line.

For example, if a CSHCN Services Program client has a diagnosis of autism and cerebral palsy, use cerebral palsy as the primary diagnosis because it indicates a physical disability, and autism does not.

To facilitate applications to the CSHCN Services Program for certain applicants, the CSHCN Services Program medical director may accept written documentation of medical criteria certification submitted by a physician or dentist who is licensed to practice in a state or jurisdiction of the United States of America other than Texas.

The CSHCN Services Program does not reimburse providers for written documentation of medical criteria certification. In addition, providers may not request or accept payment from the client or applicant, or the client or applicant's family, for completing any CSHCN Services Program forms.

3.2.9.3 Important Considerations When Completing the PAF

- Use as the primary diagnosis, a medical diagnosis that indicates the client's chronic condition that meets the CSHCN Services Program's definition of a child with special health-care needs, and/or identifies the urgent need for care.
- Use the full diagnosis code, including any suffixes (e.g., "D51.2" rather than "D51").
- If YES is noted in the Determination of Urgent Need for Services section, an explanation must be entered to justify the YES answer. If this section is incomplete, the PAF will be rejected.

- A physician or dentist must complete the Physician/Dentist Data section of the form, sign it, and date it. The signature must be an original signature. Electronic or stamped signatures are not accepted. The form can only be signed by a physician (doctor of medicine [MD], doctor of osteopathy [DO], doctor of dental surgery [DDS], or doctor of dental medicine [DMD]) who has seen the client in the previous 12 months.
- An original signature is required. Electronic or stamped signatures are not accepted.
- Instructions for updating the PAF are also available on the Texas Health and Human Services website.
- The CSHCN Services Program Physician/Dentist Assessment Form instructions

Important: *Providers can photocopy this form but should retain the original for future use.*

3.3 CSHCN Services Program Notice of Eligibility

The CSHCN Services Program Notice of Eligibility gives clients, parents, and providers a quick way to verify CSHCN Services Program eligibility. The Notice is designed to convey all of the information necessary to document identification information.

Refer to: Section 3.3.2, "CSHCN Services Program Notice of Eligibility Sample" in this chapter.

CSHCN Services Program Notices of Eligibility are valid for a 12-month coverage period. Clients must reapply for CSHCN Services Program health-care benefits annually. A new application and all proof of financial eligibility must be submitted each time a client reapplies for the CSHCN Services Program. This notice is one way to verify client eligibility.

The client's notice of eligibility shows:

- The client's case number (also called the client ID number). The case number for the CSHCN Services Program will always begin with a 9 and end with 00.
- The client's name, date of birth, and gender.
- The 12 months of the client's eligibility.

Providers should ask for the notice when scheduling a client for an appointment. Under certain circumstances, the notice may not be valid at the time the provider sees the client.

Providers can also verify client eligibility by using the following options:

- CSHCN Services Program Automated Inquiry System (AIS) at 1-800-568-2413.
- CSHCN Services Program at 1-800-252-8023.
- TMHP Electronic Data Interchange (EDI) Gateway.
- TMHP website at www.tmhp.com.

If the client is not eligible when they arrive for an appointment, the provider must advise the client that they are being accepted as a private-pay client at the time the service is provided. The client will be responsible for paying for all services received. Providers are encouraged to ensure that the client signs written notification indicating that the client is being accepted as a private-pay client.

Refer to: The "Client Eligibility" computer-based training on www.tmhp.com.

The CSHCN Services Program Notice of Eligibility provides the reapplication deadlines that are specific to each client. It identifies the date on which they can start the reapplication process and lets them know that they must submit a renewal application before their eligibility ends.

Approximately 60 days before the eligibility renewal date, the CSHCN Services Program mails a letter and a reapplication packet containing the CSHCN Services Program Application (T-3) to clients. Clients who have not received the packet within 30 days prior to the renewal date can request one from their local CSHCN Services Program Regional Office (refer to the listing in Section 1.3.2, "Regional Offices" in Chapter 1, "TMHP and HHSC Contact Information" of this manual), or by calling the CSHCN Services Program Central Office at 1-800-252-8023, or downloading the booklet from the CSHCN Services Program website at www.dshs.texas.gov/cshcn/clapplforms.shtm.

3.3.1 Eligibility Restrictions

Under certain circumstances, the client eligibility notice may not be valid at the time of the client's appointment. For example, restrictions are sometimes placed on clients' cases after they receive their eligibility notice. Some reasons for restrictions are:

- The CSHCN Services Program needs a Medicaid or CHIP determination.
- The client or family has moved.
- The family circumstances have changed, possibly making the client ineligible for the CSHCN Services Program.
- The client or family must apply to the Medically Needy Program.

The restriction period usually lasts 60 days. A 30-day extension may be granted when requested.

The client can continue to receive CSHCN Services Program benefits while there is a pending restriction on the case. However, there are a few important conditions to keep in mind.

- If the CSHCN Services Program receives the requested information or documentation before the end of the 60-day restriction period, the restriction ends, and there is no lapse in the client's eligibility.
- If the CSHCN Services Program receives the information or documentation after the end of the 60-day period (and the added 30-day extension, if requested), but before the end of the client's eligibility, their eligibility will lapse from the time the restriction period deadline until the time the CSHCN Services Program received the information.
- If the CSHCN Services Program receives the information after the client's eligibility expires, the client's name is placed on the program's waiting list. Clients on the waiting list are not eligible for health benefits.

3.3.2 CSHCN Services Program Notice of Eligibility Sample

TEXAS
Health and Human Services

Charles Smith
Executive Commissioner

Children with Special Health Care Needs (CSHCN) Services Program
Notice of Eligibility

John Client
123 Texas Street
City, TX 12345-0001

Client: John Client
Client ID: 123456789

This is your CSHCN Services Program Notice of Eligibility. Your Notice cannot be used for anyone else and can only be used for services between the current approval periods: **12/11/2017 - 12/10/2018**. Please bring this Notice with you when you visit your program providers. You are eligible for benefits as shown below.

Benefit Category	Approved	Start Date	End Date
Drugs	Yes	12/11/2017	12/10/2018
Medical/Dental	Yes	12/11/2017	12/10/2018
Medical Transportation	Yes	12/11/2017	12/10/2018
Insurance Premium Payment Assistance (IPPA)	No		
Family Support Services (FSS)	Yes*	12/11/2017	12/10/2018

***FSS requires prior authorization.** *This means that the program must make sure that you are eligible for each service before approving it. To learn more, please refer to your Client Handbook or call your case manager at your local health services regional office.*

To apply to continue receiving services after the Benefit End Date, the program must receive your new application no later than **12/10/2018**, but not sooner than **10/11/2018**.

To request a new copy of this Notice, get a new application, contact Eligibility Services, or for any other questions, please call **1-800-252-8023** or visit **dshs.texas.gov/cshcn**.

CSHCN Services Program • MC 1938 • PO Box 149347 • Austin, Texas 78714-9347
1-800-252-8023 • dshs.texas.gov/cshcn

3.4 Clients Eligible for Medicaid and CSHCN Services Program Benefits

The CSHCN Services Program requires all applicants to apply for Medicaid and include the determination or exemption letter in their program application. The CSHCN Services Program will not pay for services until the client's Medicaid eligibility is determined. The CSHCN Services Program also does not pay for services provided to children who are also eligible for Medicaid, with the exception of the transportation of a deceased client's body.

If the CSHCN Services Program pays benefits that also were paid by Medicaid, providers are responsible for refunding the full CSHCN Services Program payment. Providers must make the refund check payable to TMHP and send it to the attention of the TMHP Financial Unit. Send the refund check along with the CHSCN Services Program Refund Information Form to the following address:

Texas Medicaid & Healthcare Partnership
Attn: Financial Unit
12365-A Riata Trace Parkway, Suite 100
Austin, TX 78727

Include the following information:

- Client name and CSHCN Services Program client number
- Copies of the Remittance and Status (R&S) Reports from both Texas Medicaid and the CSHCN Services Program that show the claims were paid
- Date of service
- Provider name
- National Provider Identifier (NPI)

Note: *If the Medicaid claims administrator (TMHP) denies a claim with the explanation of benefits (EOB) code 00182 (client not eligible), but the family has evidence that the client is eligible for Medicaid, providers must appeal or resubmit the claim to TMHP. Client Medicaid eligibility information may not have been available at the time of the first claim submission.*

3.5 Clients Eligible for CHIP and CSHCN Services Program Benefits

CHIP offers comprehensive health-care coverage to thousands of Texas children who are uninsured. CHIP provides services such as physician care, medications, medical equipment, therapies, hospitalization, and much more.

Many children in the CSHCN Services Program are eligible for CHIP. Children may receive CHIP and CSHCN Services Program benefits at the same time. The CSHCN Services Program may pay for meals, transportation, lodging, other services not available from CHIP, or services beyond the CHIP maximum benefit. The CSHCN Services Program is the payer of last resort for medical services.

CHIP benefits apply to all children in the family, including the child who is also eligible for the CSHCN Services Program. For more information about CHIP (children and perinatal coverage), contact CHIP/Children's Medicaid at 1-877-KIDS-NOW (1-877-543-7669) or visit the CHIP website at www.insurekidsnow.gov.

3.6 Clients Eligible for Medicaid and Comprehensive Care Program (CCP) Benefits

The Texas Comprehensive Care Program (CCP) and Texas Medicaid (Title XIX) Home Health Services cover medically necessary services for enrolled clients who are 20 years of age or younger.

The CSHCN Services Program does not pay claims for its clients who are eligible for CCP and whose claims were denied by Medicaid for any reason, including late filing, limited client, duplicate services, incorrect claim form, or additional information required.

Additional information about CCP is available toll free at 1-800-846-7470, Monday through Friday, from 7 a.m. to 7 p.m, Central Time.

3.7 Medically Needy Program (MNP)

MNP provides access to Medicaid benefits for children who are 18 years of age or younger and whose family income exceeds the eligibility limits under Temporary Assistance to Needy Families (TANF) or one of the medical-assistance-only programs for children, but whose income and assets are not sufficient to meet their medical expenses.

The CSHCN Services Program requires all applicants to include a Medicaid determination or exemption along with their application. No services are paid by the CSHCN Services Program until Medicaid eligibility is determined.

Once eligibility is established, the client can receive the same care and services available to all other Medicaid clients.

The CSHCN Services Program may ask clients to apply to MNP if $2,000 or more in medical bills were paid or are expected to be paid by the CSHCN Services Program. Clients are given 60 days to apply to MNP and send the determination to the CSHCN Services Program.

CSHCN Services Program client benefits are not limited during this 60-day period; however, the Program will suspend a client's eligibility if he or she does not comply with the request to apply to MNP.

3.7.1 MNP Spend Down Processing

MNP applicants must meet basic TANF eligibility requirements. Eligibility may be determined with or without spend down (the difference between the applicant's net income and the MNP income limits). When the applicant is eligible without spend down (income is below MNP income limits), the applicant is certified to be Medicaid-eligible.

Prospective MNP clients who do not qualify for Medicaid must participate in the "Spend Down" program which is based on income and health-care expenses. The spend-down amount and duration of Medicaid coverage is determined by HHSC. The client is issued a Medical Bills Transmittal (Form H1120 or H1122) that indicates the spend-down amount and the months of potential coverage (limited to the month of application and any of the 3 months before the application month).

During spend down, program participants are responsible for paying a portion of their health-care bills and submitting those bills or completed claim forms, also referred to as invoices, to the Medically Needy Clearinghouse (MNC). All medical bills (for all family members) must be submitted to the TMHP-MNC, along with the Form H1120 or H1122 for application toward the spend-down amount.

Texas Medicaid & Healthcare Partnership Medically Needy Clearinghouse
PO Box 202947
Austin, TX 78720-2947

Charges from the bills are applied in date-of-service order to the spend-down amount. The spend down is met when the accumulated charges equal the spend-down amount.

Once the client has met the total spend-down amount and becomes eligible for Medicaid, MNC will return the invoices to the client, and the client will receive a Medicaid Identification form. Spend down program participants are required to notify their providers once their Medicaid eligibility has been

established. Providers are expected to submit claims to Medicaid for those clients after that time. MNC will also mail notification letters to providers who have not yet submitted claims for clients who have become eligible for Medicaid by meeting their spend-down amount.

Note: *Providers must include the CSHCN Services Program client number and the CSHCN Services Program client name on all of the documentation sent to the CSHCN Services Program or TMHP-MNC.*

The CSHCN Services Program can assist with the submission of medical bills to apply for Medicaid coverage through the spend down process. TMHP MNC accepts paid or unpaid medical bills from the CSHCN Services Program for application toward the spend-down amount regardless of the date of service. This process enables TMHP MNC to expedite the conclusion of the case and inform DSHS when the spend down is met.

When the spend down is met and the client is certified as Medicaid-eligible, the CSHCN Services Program may consider whether any of the services used to meet the spend-down amount (client liability) may be considered for CSHCN Services Program health-care benefits coverage.

3.7.2 Provider Assistance to Clients with Spend Down

Providers may assist clients in meeting their spend-down amount by:

- Submitting bills to TMHP MNC for the CSHCN Services Program client that are not payable by the program.
- Submitting bills to TMHP MNC for services provided to any other member of the family.
- Providing clients and families with current itemized statements.
- Encouraging clients to submit all of the medical bills they incurred from all of their providers.

Only medical bills having a date of service (DOS) within the 12 months preceding the date of receipt of the application denial date may be included to satisfy spend-down requirements. Medical bills from any member of the household for which the applicant, parents, foster parents, guardian, or managing conservator of the CSHCN Services Program applicant is responsible and which are not payable by another entity may be included. All spend-down documentation must be received within 60 days of receipt of the application denial Medical bills used to meet spend down are not payable by the CSHCN Services Program.

Submitted bills must be itemized and must show the provider's name, client's name, CSHCN Services Program client number, MNP client number, dates of service, services provided, charge for each service, total charges, amounts of payments, dates of payments, and total due.

Bills for past accounts must be itemized statements dated in the last 60 days from the provider and must verify the outstanding status of the account and the current balance due. Accounts with payments made by an insurance carrier, including Medicare, must be accompanied by the carrier's EOB or a Medicare Summary Notice (formerly known as a Medicare Explanation of Benefits) that shows the specific services covered and amounts paid.

When additional information is requested by TMHP MNC, the applicant has 30 days from the date of the letter to respond. The provider may assist the client by furnishing the additional information to the applicant or sending it directly to TMHP MNC in a timely manner.

Note: *TMHP MNC does not pay bills; it only applies the charges toward the spend-down amount. The provider must file a Medicaid claim after the client's Medicaid eligibility is established so that Medicaid can consider the claim. During the spend-down period, the client does not have Medicaid coverage, and providers cannot send claims to Medicaid. Any claim filed at that time is denied due to client ineligibility.*

Providers may make inquiries regarding status, months of potential eligibility, Medicaid or case number, and general client information by contacting the TMHP Contact Center at 1-800-925-9126, from 7 a.m. to 7 p.m., Central Time, Monday through Friday.

3.7.3 Claims Filing Involving a Medicaid Spend Down

TMHP MNC will mail notification letters to providers whenever clients meet spend down and TMHP has not yet received any claim for the client's bills. The notification letter will state that an invoice was submitted for the spend down and that the provider should submit claims for any bills that fall within the indicated spend-down month.

Clients are also responsible for informing their medical providers of their Medicaid eligibility and making arrangements to pay the charges used to meet the spend-down amount. For CSHCN Services Program clients, the CSHCN Services Program may consider paying the charges used to meet the spend down for covered services.

TMHP MNC notifies the client of:

- Bills or charges that were used to meet the spend down.
- Bills or charges that the client is financially responsible to pay.
- Bills or charges that the provider should submit to Texas Medicaid for consideration of payment.

Bills or charges not applied toward spend down or not previously submitted to the CSHCN Services Program, must be received by TMHP for Medicaid consideration. These claims must be received within 95 days from the date the client's eligibility was added to the TMHP file (add date) and must be on the appropriate claim form (such as CMS-1500 and UB-04 CMS-1450).

The client's payment responsibilities are as follows:

- When a portion of the entire bill was used to meet spend down, the client is responsible for the payment of the specific portion or the entire bill. For CSHCN Services Program clients, submit the bill to the CSHCN Services Program for payment consideration.

Claims are subject to the following:

- The claim must show the total billed amount for the services provided. Charges for ineligible days or spend-down amounts must not be deducted or included on the claim.
- A client's payment toward spend down must not be reflected on the claim submitted to TMHP.

  Note: *Payments made by the client for services that were not used in the spend down but that were incurred during an eligible period must be reimbursed to the client before the provider files a claim with TMHP.*

Once eligibility is established, the client is eligible to receive the same care and services available to all other Medicaid clients.

3.8 Renal Dialysis

Eligibility for clients needing renal dialysis begins with the initial date of eligibility or the first dialysis treatment date, whichever is later, and may continue for a period of three months. All CSHCN Services Program clients who need dialysis due to end-stage renal disease (ESRD) are referred to the Kidney Health Care (KHC) program and to Medicare for coverage. These clients are notified that they must apply to KHC and Medicare and are given 60 days to submit the determinations to the CSHCN Services Program. Coverage for health care benefits continues for ongoing clients and waiting list clients may receive eligibility during the 60-day period. A 30-day extension may be granted to obtain the determinations. If the client is not eligible for KHC or Medicare, eligibility for CSHCN Services Program coverage continues.

3.9 Waiting List Information

The CSHCN Services Program may establish a waiting list when budgetary limitations exist. The waiting list is maintained continually from one fiscal year to the next.

Clients are placed on the waiting list for one of two reasons:

1) They are new applicants to the program.
2) They are current clients who did not renew on time.

Clients placed on the waiting list are notified of their status. The CSHCN Services Program periodically contacts waiting list clients to confirm their eligibility for CSHCN Services Program services.

Clients on the waiting list do not receive a CSHCN Services Program Notice of Eligibility Form. The CSHCN Services Program sends information about the waiting list process to adult clients, the parent, guardian, caretaker, or managing conservator of a minor child, the DSHS Regional Office, and the client's physician or dentist. Applicants are not placed on the waiting list until it is determined that they meet all of the eligibility criteria for the program.

If all of the documentation necessary to complete the application has been received except the Medicaid or CHIP determinations, the client is placed on the waiting list. The Medicaid or CHIP determinations must be received before the client is removed from the waiting list.

Each month the CSHCN Services Program reviews its funds to see if it can take people off the list. The Program can only take a group of clients off the list and does not take one person off at a time. Clients are removed from the list when funds become available.

Funding decisions concerning the waiting list are based both on the amount of program funds available and the anticipated amounts required to provide health-care benefits. The order in which clients are removed is not purely sequential; it depends on a combination of factors, including the urgent medical need of the condition as reported by a physician or dentist on the CSHCN Services Program Physician/Dentist Assessment Form, the availability of other health insurance, the client's age, and the date and time of the latest uninterrupted eligibility period.

When a client is removed from the waiting list, the client receives a new program approval letter and a CSHCN Services Program Notice of Eligibility Form with the active eligibility dates and information regarding the range of services. If there is a change in the client's condition, the client's medical information must be updated. It is important that all client eligibility information is current.

Clients' placement on the waiting list is also based on the date and time their application is processed and approved for the program. Clients must maintain program eligibility to remain on the waiting list. A lapse in eligibility changes their placement on the waiting list.

Waiting list clients who wish to remain eligible to be considered for program health-care benefits must reapply for eligibility before their eligibility is scheduled to end. The eligibility coverage period is 12 months (i.e., 365 days from the first day of the client's current eligibility period, or 366 days during a Leap Year). Clients are notified of program deadlines to re-establish eligibility. Within 60 days of the client's eligibility end date, the CSHCN Services Program mails the client a CSHCN Services Program Application and a letter advising that it is time to reapply.

If a waiting list client submits an application without all of the required documentation, the application is considered incomplete, and the client is given 60 days to complete it. If the reapplication process is not completed within the 60-day period, the client's place on the waiting list is forfeited. When the CSHCN Services Program receives a complete reapplication after the 60-day period, the client is placed at the end of the waiting list according to the approval date of his or her complete application.

3.10 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.