Provider

ANNUAL COMMUNICATION

December 2022

Information and updates for Texas Children's Health Plan members and their families.

Texas Children's Health Plan

TEXAS CHILDREN'S HEALTH PLAN PHONE NUMBERS

Provider Relations
Monday – Friday 8:00 a.m. – 5:00 p.m.
Contact us for:

- Inquiries regarding Texas Children's Health Plan policies and procedures
- Contract clarification
- Claim Process and Status
- Fee schedule inquiries
- Change of address/phone number notification
- Requests for provider directories
- Information on provider education training
- Requests for information on accessing Texas Children's Health Plan's web-based provider portal, Texas Children's Link

Phone: 832-828-1004 | **Fax:** 832-825-8750
Toll-Free: 1-800-731-8527
Email: providerrelations@texaschildrens.org

Member Services
STAR: 832-828-1001 or 1-866-959-2555
CHIP: 832-828-1002 or 1-866-959-6555
STAR Kids: 832-828-1003 or 1-800-659-5764

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

Utilization Management
Phone: 1-800-731-8527
Provider Portal:
https://epiccarelink.texaschildrens.org/EpicCareLink/common/epic_login.asp

Prior Authorization Fax Lines

- Medical Inpatient Admissions and Discharge Notifications - 832-825-8462 or Toll-Free 844-663-7071
- Medical Services Fax Line - 832-825-8760 or Toll-Free 1-844-473-6860
- Behavioral Health Services Fax Line - 832-825-8767 or Toll-Free 1-844-291-7505
- LTSS and Private Duty Nursing Fax Line - 346-232-4757 or Toll-Free 1-844-248-1567

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

- Prior authorization request
- Concurrent review
- Notification of admissions

Care Management
Phone: 832-828-1430 | **Fax:** 832-825-8745
For members with chronic or complex conditions, pregnant members, and members with a behavioral health condition.

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

Dental Services

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

Texas Children's Health Plan Nurse Help Line
Phone: 1-800-686-3831

Electronic Funds Transfer (EFT)
Change Healthcare: 1-800-956-5190

Pharmacy Hotline
Navitus: 1-877-908-6023

Behavioral Health Hotline and Referral Line
STAR: 1-800-731-8529
CHIP: 1-800-731-8528
STAR Kids: 1-844-818-0125

MK-1911-660 12/22

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CLINICAL PRACTICE GUIDELINES

Texas Children's Health Plan, with the guidance of its Clinical & Administrative Advisory Committees, develops or adopts evidence-based clinical practice guidelines. These practice guidelines: (1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; and (2) Consider the needs of Texas Children's Health Plan enrollees. Texas Children's Health Plan has Clinical Practice Guidelines in place including, but not limited to the following:

Allergy Guidelines:
- Allergy Diagnostic Testing
- Allergen Immunotherapy

Asthma Guidelines:
- Global Initiative for Asthma (GINA) Guide for Management and Prevention
- 2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group | NHLBI, NIH
- 2020 Focused Updates to the Asthma Management Guidelines: Clinician's Guide | NHLBI, NIH
- 2020 Focused Updates to the Asthma Management Guidelines | NHLBI, NIH

Behavioral Health Guidelines

ADHD
- Clinical Practice Guideline: Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder | Pediatrics | American Academy of Pediatrics (aap.org)

Addiction Medicine
- Clinical Guidelines (asam.org)
- Texas Health and Human Services - Substance Abuse Outpatient Care

Depression
- American Psychiatric Association Practice Guidelines
- APA - Practice Guideline Major Depressive Disorder
- Institute for Clinical Systems Improvement, Health Care Guideline: Major Depression in Adults in Primary Care

Anxiety
- AACAP Clinical Practice Guideline - Anxiety

State Guidelines – Screening and Drug Formulary:
- Texas Health and Human Services Child and Adolescent Needs and Strength Assessment (CANS)
- Texas Health and Human Services Adult Needs and Strength Assessment (ANSA)
- Texas Health and Human Services Psychiatric Drug Formulary

Diabetes Guidelines:
- Professional Practice Committee: Standards of Medical Care in Diabetes—2021 | Diabetes Care | American Diabetes Association (diabetesjournals.org)
- Diabetes Standards of Care Change Summary
- Diabetes Care for Transition to Adult Diabetes Care Systems

Neuropsychology Guidelines
- Neuropsychological Testing Guidelines

Otitis Guidelines:
- AAP Otitis Media with Effusion

Obesity Guidelines:
- National Heart, Lung, and Blood Institute (NHLBI) Obesity Guidelines for Adults
- American Academy of Pediatrics
- Endocrine Society
- NIH Pediatric Obesity Algorithm

Pharyngitis:
- Group A Pharyngitis, IDSA

Preventative Care Guidelines:
- Texas Health Steps Periodicity Schedule
- Recommended Immunization Schedule Age 0-18
- Catch-up Immunization Schedule Age 0-18
- AAP Bright Futures Periodicity Schedule
- Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older - United States, 2022 - PubMed (nih.gov)
- Adult Preventative Services
- Developmental Screening - Texas Children's Health Plan

Tonsillectomy:
- Tonsillectomy in Children

The clinical practice guidelines are updated at least once every two years. These guidelines are adapted

from national guidelines for practice. All are reviewed, modified if appropriate and approved by participating providers and the Texas Children's Health Plan Medical Advisory Committees and Quality Committee, which are composed of primary care physicians and a variety of specialists. Clinical practice guidelines can be found as follows:

Provider Portal: texaschildrenshealthplan.org/for-providers

Website: http://www. tchp.us/for-providers/provider-resources/practiceguidelines.

We will fax or mail the clinical practice guidelines to providers without internet access upon request. Please contact Provider Relations at 832-828-1004 or toll free at 800-731-8527.

PHARMACY

Formulary

TCHP is required to follow the formulary selected by the Texas Vendor Drug Program (VDP) at the Texas Health and Human Services (HHSC). The formulary contains brand and generic drugs. Only medications on the formulary are covered as a pharmacy benefit. This includes generic drugs, therapeutic interchange, and step therapy protocols as determined by HHSC. The Texas Medicaid and CHIP Formularies can be accessed multiple ways:

1. The VDP website with a formulary search tool: txvendordrug.com/formulary
2. The Navitus Medicaid website with a full list of covered products: https://txstarchip.navitus.com/pages/formulary.aspx
3. The Epocrates mobile application

Preferred Drug List (PDL)

The formulary also contains a preferred drug list (PDL). Medications that are non-preferred will require a prior authorization (in addition to any clinical prior authorization edits). Preferred drugs are medications recommended by the DUR Board for their efficaciousness, clinical significance, cost effectiveness, and safety. The PDL is updated every January and July. TCHP makes best efforts to notify providers of PDL changes, and especially those that may negatively impact access to care. The Preferred Drug List (PDL) is available at: https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs

Epocrates

The Texas Medicaid Formulary and the corresponding Preferred Drug List (PDL) are available on the Epocrates drug information system. The service is free and provides instant access to information through the internet or smart phone.

Clinical Prior Authorization Edits

Clinical prior authorization criteria is determined by the DUR Board and VDP. Some medications may require both non-preferred prior authorization and clinical prior authorization. Clinical criteria may change throughout the year. TCHP makes best efforts to notify providers of changes. Updates can be found on the Checkup Blog: http://www.thecheckup.org/. The most recent clinical prior authorization criteria and forms can be found here: https://txstarchip.navitus.com/pages/prior-authorization-forms.aspx.

Requesting Exceptions

Providers can appeal prior authorization denial decisions using the Navitus 'Exception to Coverage Request' form. To download the form, access the website www.navitus.com > Providers> Texas Medicaid STAR/CHIP. The form describes the supporting documentation required and the fax information where to submit the request. A TCHP pharmacist and Medical Director will review exceptions for medical necessity. This includes exception requests for non-formulary or non-preferred medications.

Texas Drug Utilization Review (DUR) Board

Texas Children's Health Plan highly encourages our network practicing prescribing practitioners and pharmacists to provide expert commentary regarding the Texas Medicaid and CHIP formulary, PDL, or clinical prior authorization edits. Please submit comments or suggestions to: TCHPPharmacy@texaschildrens.org. Alternatively, providers can submit comments directly to the DUR Board. Information about the DUR Board including instructions for submitting public comments can be found here: https://www.txvendordrug.com/resources/drug-utilization-review-board

Pharmacy Access

Texas Children's Health Plan (TCHP) partners with Navitus, a pharmacy benefits manager, to administer pharmacy benefits to our members. This includes managing the pharmacy network. Members and providers can find participating pharmacies by visiting the TCHP website and selecting "Find a Pharmacy."

Providers may call Navitus at 1-866-333-2757 to inquire about or conduct telephonic prior authorizations. Providers can also ask about quantity limits or alternative choices on the PDL.

AUTHORIZATION FOR HEALTH SERVICES

The following services require authorization effective September 1, 2022.

Medical Authorizations

- Adaptive Aids
- Adult Day Care/Day Activity and Health Services (more than 1 unit per day)
- Augmentative Communication Device and accessories
- Autism Services
- Bariatric Surgery
- Case by Case Added Services (Codes not listed in the TMHP Fee Schedule)
- Cerebral Seizure Monitoring (EEG) – Inpatient ONLY
- Circumcision (members one year of age and older)
- Clinician Administered Drugs that Require Authorization
- Continuous Glucose Monitoring
- Cosmetic Surgery
- Cranial Molding Orthosis
- DME/ Equipment/Supplies (In excess of benefit limitations for members 20 years of age and under)
- Electrical Bone Growth Stimulator
- Employment Services
- Emergency Response Services (Community First Choice)
- Fetal Magnetic Resonance Imaging
- Flexible Family Support Services
- Functional Endoscopic Sinus Surgery – Inpatient/Outpatient
- Financial Management Services
- General Anesthesia for Dental Procedures (Facility and Physician) 6 years and under
- Genetic Testing
- Habilitation (Community First Choice)
- Home Health Care
- Home Modifications Maintenance
- Home Telemonitoring Services
- Hospital Beds and accessories
- Hospital Inpatient care
- Hearing Devices (excluding batteries)
- Incontinence Supplies (For ages 0-3)
- Minor Home Modifications
- Miscellaneous DME (E1399) for billed amount >$500
- Mobility Aids
- Non-Emergency Ambulance Transport
- Non-Invasive Prenatal Testing
- Nutritional Supplements for oral nutrition
- Oral Surgery and Medically Necessary Dental Procedures
- Out of Network Services (excluding emergency services, family planning for STAR/STAR Kids only, and well child exams for all plans)
- Personal Care Services or Personal Assistance (Community First Choice)
- Positron Emission Tomography Scans
- Positive Airway Pressure Device (CPAP/BiPAP)
- Prescribed Pediatric Extended Care Centers
- Private Duty Nursing
- Prosthetics
- Respite Care MDCP
- Secretion and Mucous Clearance Devices
- Sleep Studies
- Single Photon Emission Computed Tomography Scans
- Supported Employment
- Therapy-Occupational (excluding Early Childhood Intervention (ECI) Programs, Reevaluations, and Initial Evaluations for network providers)
- Therapy-Physical (excluding Early Childhood Intervention (ECI) Programs, Reevaluations and Initial Evaluations for in network providers)
- Therapy-Speech (excluding Early Childhood Intervention (ECI) Programs, Reevaluations and Initial Evaluations for in network providers)

- Therapeutic and Reconstructive Breast Procedures (including breast prosthesis)
- Transition Assistance Services
- Transplants including Solid Organ and Bone Marrow
- Wheelchairs and accessories

Behavioral Health Authorizations

- Psychological/Neuropsychological Testing
- Out of Network Services
- Mental Health
  - Inpatient Care
  - Residential Treatment
  - Partial Hospitalization Program
  - Intensive Outpatient Program (Chemical Dependency Treatment Facility)
  - Outpatient Psychotherapy Visits (Greater than 30 Visits per year)

Substance Abuse Disorder Treatment

- Inpatient Detoxification
- Residential Treatment
- Partial Hospitalization Program
- Intensive Outpatient Program
- Outpatient Services

HOW TO CONTACT UTILIZATION MANAGEMENT

Texas Children's Health Plan Utilization Management (UM) staff is available from 8 a.m. to 6 p.m. Monday through Friday for inbound calls regarding UM issues. Messages left for UM staff after hours by phone are returned the next business day.

Inbound messages may be left at any time. Providers may contact Texas Children's Health Plan Utilization Management Services at 1-800-731-8527.

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

All medical necessity appeals regarding services that have not been rendered or have already been delivered should be directed to the addresses below:

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

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

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

AUTHORIZATION AND APPEALS PROCESS

Providers are encouraged to submit authorization requests on Texas Children's Link since this is the most efficient way for our team to process authorizations. Important benefits of using the new portal to submit authorizations include:

- Faster Authorization Processing – Prior Authorization requests received in the portal are assessed by the UM team faster than any other method
- Real-time Access to Authorization Status Information – Authorization Status Update and Status History are immediately available and determinations can be reviewed on the portal in real-time
- Auto Authorizations for Certain Services – Certain services and supplies such as medically necessary nutritional supplements, general anesthesia for dental procedures and targeted case management can be submitted for auto authorizations
- Easy Access for Providers and Staff – In addition to providers, both clinical staff and non-clinical staff may submit and review authorization requests on the portal on behalf of a requesting provider. For more information on the ease of using our new portal, watch the how-to videos on the portal linked at the bottom of the page under "Quick Links"

Non-clinical Users can submit Prior Authorizations requests and/or claims. This functionality can be accessed by all non-clinical portal users.

When a UM Specialist is unable to approve the requested service based on Texas Children's Health Plan criteria, the Medical Director/Associate Medical Director/Physician Reviewer will review the authorization request and any available clinical information, prior to issuance of any denial based on lack of medical necessity.

Before a denial is issued by Texas Children's Health Plan regarding the medical necessity or appropriateness, or the experimental or investigational nature, of a healthcare service, Texas Children's Health Plan provides the requesting provider a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis prior to the adverse determination. A decision to deny a service authorization based on medical necessity can only be made by a physician.

If a request for services is denied by Texas Children's Health Plan, the ordering provider, rendering provider, and member will receive a letter indicating the reason why services are being denied. The member, member designee, practitioner, or provider has the right to appeal a denial of services. Members may represent themselves or be represented by the health care provider, a friend, a relative, legal counsel, or another spokesperson. Texas Children's Health Plan will make a decision within 30 days of receiving the request for appeal. An expedited appeal may be placed when Texas Children's Health Plan determines or the provider indicates to Texas Children's Health Plan that routine appeal time frames could jeopardize the member's life, health, or ability to recover a function. Texas Children's Health Plan will make a decision within 72 hours of receiving the request.

Phone: 1-800-731-8527

Provider Portal:
https://epiccarelink.texaschildrens.org/EpicCareLink/common/epic_login.asp

Prior Authorization Fax Lines:

- Medical Inpatient Admissions and Discharge Notifications - 832-825-8462 or Toll-Free 844-663-7071
- Medical Services Fax Line - 832-825-8760 or Toll-Free 1-844-473-6860
- Behavioral Health Services Fax Line - 832-825-8767 or Toll-Free 1-844-291-7505
- LTSS and Private Duty Nursing Fax Line - 346-232-4757 or Toll-Free 1-844-248-1567

Hours of Operation: 8 a.m. to 6 p.m. Monday - Friday

FIND OUT A MEMBER'S RIGHTS AND RESPONSIBLITIES

It's important that members know and understand your rights and responsibilities. You can see the full text of them under the "Members Rights and Responsibilities" section in the member handbook, which was mailed to each member when you joined. They can be accessed using the links below:

- CHIP AND CHIP PERINATE NEWBORN MEMBERS
  - **www.texaschildrenshealthplan.com/CHIPHandbook**
- STAR KIDS Members
  - **www.texaschildrenshealthplan.com/STARKidsHandbook**
- STAR MEMBERS
  - **www.texaschildrenshealthplan.com/STARHandbook**

PREVENTIVE HEALTH SERVICE RESPONSIBILITIES

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

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

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

To access the guidelines providers may log in to the Provider Portal at **texaschildrenshealthplan.org/forproviders** or contact Texas Children's Health Plan Provider Relations Department at 832-828-1004 or toll-free at 1-800-731-8527.

AVAILABILITY OF CRITERIA TO PRACTITIONERS AFFIRMATIVE STATEMENT

Texas Children's Health Plan uses written criteria (Utilization Management Guidelines) based on clinical evidence in addition to a review of individual circumstances and local health system structure when determining medical appropriateness of health care services that require prior authorization. The goal of our UM Guidelines is to encourage the highest quality care from the right provider in the right setting.

Providers may access the guidelines and medical necessity criteria in any of the following methods:

- Provider Portal: texaschildrenshealthplan.org/for-providers
- Website: https://www.texaschildrenshealthplan.org/for-providers/provider-resources/prior-authorization-information
- Contact Texas Children's Health Plan Provider Relations Department at 832-828-1004 or toll-free at 1-800-731-8527.

TEXAS HEALTH STEPS

- Quick Reference Guide
- Checkup Periodicity Schedule

26027.pdf

THSteps_QRG.pdf

HEALTH AND HUMAN SERVICES', HEALTHY TEXAS WOMEN PROGRAM

The Healthy Texas Women program offers women's health and family planning services to eligible, low-income women.as a transition from the Medicaid for Pregnant Women program coverage. Eligible women will receive a letter from the Texas Health and Human Services confirming their enrollment in the Healthy Texas women program. If you have questions about a member's enrollment visit https://www.healthytexaswomen.org/healthcare-programs/healthy-texas-women/htw-benefits.

The services help women plan their families, whether they want to achieve, postpone or prevent pregnancy. These services may also have a positive effect on future pregnancy planning and general health. Healthy Texas Women provides a wide variety of women's health and core family planning services, including:

- Pregnancy testing
- Pelvic examinations
- Sexually transmitted infection services
- Breast and cervical cancer screenings
- Clinical breast examination
- Mammograms
- Screening and treatment for cholesterol, diabetes and high blood pressure
- HIV screening
- Long-acting reversible contraceptives
- Oral contraceptive pills
- Permanent sterilization
- Other contraceptive methods such as condoms, diaphragm, vaginal spermicide, and injections
- Screening and treatment for postpartum depression

Resources:
HTW Benefits:
https://www.healthytexaswomen.org/healthcare-programs/healthy-texas-women/htw-benefits

HTW Eligibility Information:
https://www.healthytexaswomen.org/healthcare-programs/healthy-texas-women/htw-who-can-apply
HTW Provider Resources:
https://www.healthytexaswomen.org/provider-resources/healthy-texas-women-provider-resources
PEMS Instructions for HTW Certification and Attestation:
https://www.tmhp.com/sites/default/files/file-library/topics/provider-enrollment/PEMS-instructions-for-htw-certification.pdf
The Texas Long-Acting Reversible Contraception Toolkit:
https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/health/women/texas-larc-toolkit.pdf

HEALTHY TEXAS WOMEN PLUS PROGRAM FEATURES ENHANCED POSTPARTUM CARE SERVICES

To qualify for Healthy Texas Women Plus benefits, HTW clients must have been pregnant within the last 12 months. Other qualifications include:

- are age 15 through 44 (women age 15 through 17 must have parental or legal guardian consent to apply and receive services);
- are U.S. citizens or qualified immigrants;
- reside in Texas;
- do not have private health insurance, Medicaid, or CHIP coverage; and
- are not currently pregnant.

Benefits available through HTW Plus focus on treating health conditions that contribute to maternal morbidity and mortality, including the following:

- Postpartum depression and other mental health conditions
  - Services include individual, family and group psychotherapy services; and peer specialist services
- Cardiovascular and coronary conditions
  - Services include imaging studies; blood pressure monitoring; and anticoagulant, antiplatelet, and antihypertensive medications.
- Substance use disorders, including drug, alcohol and tobacco use
  - Services include screening, brief intervention, and referral for treatment (SBIRT), outpatient substance use counseling, smoking cessation services, medication-assisted treatment (MAT), and peer specialist services.

Resource:
Healthy Texas Women Plus Services Available September 1, 2020 HHSC Notice

CULTURAL COMPETENCY

For more information, please visit this website: https://www.texaschildrenshealthplan.org/for-providers/provider-resources/cultural-competency

What is Cultural Competency in health care?
The ability of systems to provide effective care to people of various cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individuals.

TCHP's Cultural Competency Plan

We invite you to review our Cultural Competency Plan detailing the Culturally and Linguistically Appropriate Services (CLAS) that are provided for TCHP staff, members and providers. Link to Texas Children's Health Plan's plan: https://www.texaschildrenshealthplan.org/sites/default/files/pdf/GA-2111-003%20Cultural%20Competency%20Plan_V2.pdf

Provider Training

To support TCHP's Cultural Competency Plan, we strongly encourage providers to complete the Health and Human Services, Texas Health Steps, Culturally Effective Health Care online course.

https://www.txhealthsteps.com/500-culturally-effective-health-care

COMPLEX CASE AND DISEASE MANAGEMENT PROGRAM

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

Health Plan care managers enroll members into both disease management and/or case management programs. Members can be identified for disease and/or case management programs through multiple avenues, including provider referrals. An assessment and care plan are completed on the patient and referrals are provided to the parent/member. The primary care provider or member may request the provider be given a copy of the care plan for members enrolled in case/disease management programs. With the member's permission, the providers can also access the care plan through the provider portal. Providers should include the care plans in the patient's medical record. Follow-up calls with phone coaching are done based on the assessment level of care to monitor the patient/parent progress with the plan of care. The care manager collaborates closely with the member's primary care provider to share relevant health information. The objective is to positively impact the member's adherence to the treatment plan.

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

Providers may request these services by calling the Care Management Department at 832-828-1430. Referral forms are available for download at texaschildrenshealthplan.org/for-providers and on the homepage of the Texas Children's Link, provider portal under TCHP Provider Resources/Physician forms. Once completed, the forms may be faxed to 832-825-8745.

QUALITY CARE COORDINATION

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

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

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

Care coordination has 3 primary focus areas:

1. Support of self-management through education, advocacy (specialist access, school nurse), shared decision making, and flexibility with individuals and families by connecting members with prevention and wellness services.
2. Coordination of assessment data and health information.

3. Promoting connections to care delivery and transition support from pediatrics into adult care. Comprehensive care coordination develops a plan of care including clinical (medical and behavioral) and social service needs and wellness goals.

Comprehensive care coordination:

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

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

You can find a referral form for case management on the Texas Children's Health Plan website. For more information: Fax:832-825-8745, call 832-828-1430 or email: casemanagementphysicianreferral@texaschildrens.org

UNDERSTANDING FRAUD, WASTE AND ABUSE

The Office of Inspector General (OIG) is continuously monitoring the populations served by the Health and Human Services Program, for instances of fraud, waste and abuse. In order to provide a better understanding of the OIG's efforts in detecting, deterring and correcting incidents of fraud, waste and abuse, please refer to their website: oig.hhsc.texas.gov. Incidences of fraud, waste and abuse can also be reported through the OIG's website.
If there is a particular topic you would like to have addressed, please contact the OIG at oig.hhsc.texas.gov/contact.

To report potential fraud directly to Texas Children's Health Plan:
The Texas Children's Health Plan Fraud Hotline: 832-828-1320
Fax number: 832-825-8722
Email: TCHPSIU@texaschildrens.org
Mail:
Texas Children's Health Plan
Fraud and Abuse Investigations
PO Box 301011, WLS 8360
Houston, TX 77230-1011

REPORTING CHANGES TO THE HEALTH PLAN

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

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

The following demographic information must be maintained:

- Name
- Address (both physical and billing)
- Telephone number
- Office hours
- Coverage procedures
- Corporate Number (if applicable)
- Specialty change
- Tax ID Number
- Medicaid Provider Number
- National Provider Identifier Number
- Permit to Practice
- Professional liability
- insurance coverage
- Change in hospital affiliation
- Contract status change
- Open or closure of panel
- Patient age limitations
- Practice limitations

- Whether the following is
- offered with the practice:
- Telehealth
- Telemedicine
- Languages spoken by the provider and/or office staff PCP Providers: Texas Health Steps Provider
- distinction
- Other information that may affect current contracting relationship

*Hours of operation that practitioners offer to Medicaid members should be no less than those offered to commercial members.

Please contact Provider Network Management with reported changes at **832-828-1004 or toll-free at 1-800-731-8527.**

Reporting Changes to Texas Medicaid healthcare Partnership

Network providers must also maintain their enrollment and demographic information with Texas Medicaid Healthcare Partnership (TMHP). Provider Medicaid enrollment functions are available through Provider Enrollment and Management System (PEMS). Updates to provider's current enrollment, new practice locations or change of ownership updates, can be made on this site titled "Provider Enrollment and Management System (PEMS)", accessible here: https://www.tmhp.com/topics/provider-enrollment/pems/start-application

For instructions on how to make other demographic updates to your current enrollment, access the site titled "Provider Enrollment Help", accessible here: https://www.tmhp.com/topics/provider-enrollment/provider-enrollment-help

LEARN MORE INFORMATION ON OUR PROVIDER PORTAL, TEXAS CHILDREN'S LINK

Texas Children's Health Plan launched Texas Children's® Link platform in August 2022. A single, robust and powerful system that consolidates communications between Texas Children's® Health Plan staff, members and providers. From the portal, providers have access to evidence-based shared decision-making (SDM) aids, such as clinical practice guidelines. Clinical Practice Guidelines are developed based on TCHP member population-based needs, adopted from current national guidelines for practice and updated at least every two years. They are reviewed and approved by participating providers on our TCHP Clinical Advisory Committees and Quality Committee, which are composed of primary care physicians and a variety of specialists.

Our provider portal is available at:
texaschildrenshealthplan.org/for-providers.

As Texas Children's Link users, providers and staff can:

Verify Eligibility and Benefits
- View Texas Children's® Health Plan member eligibility and benefits

Manage Claims
- Submit, review and appeal claims
- Ability to check claim status by individual or batch claims
- Claims appeal report
- Claims processing for both batch claims and single claim submission

Manage Prior Authorization
- Submit prior authorization requests, referrals, and orders
- Authorization criteria and utilization management guidelines

Improve Quality of Care
- Access up to date Clinical practice guidelines
- Tools to Manage your Population
- For Primary Care Physicians and OB/GYNs, access to Healthcare Effectiveness Data and Information Set (HEDIS®) data through Inovalon Population Management software
- Access reports, including member rosters with improved descriptions and instructions in the portal training guide

Communicate with us
- Provider's ability to update demographic information by accessing the necessary forms
- Access patient clinical activity provided at Texas Children's

CREDENTIALING

TCHP uses various credentialing criteria and guidelines to verify the provider meets and maintains the standards for network participation. Credentialing with TCHP begins after the provider or group has started the contracting process with TCHP via the Provider Relations Department (tchpnetworkmanagement@texaschildrens.org).

During the credentialing process TCHP utilizes Verisys where Verisys shall collect applications and/or documentation from the practitioner/provider via the Council for Affordable Quality Healthcare ("CAQH") ProView as is necessary to perform primary source verifications. Verisys will also accept applications submitted via Availity's portal, which should be consistent with the Texas Standardized Credentialing Application. Practitioner applications received on forms other than the described above will be rejected by Verisys and the provider will be redirected to apply with one of the approved application forms.

During the credentialing process TCHP verifies the following items where applicable:

- Demographic Information
- Credentials - All state professional license(s), permits and registrations, including Drug Enforcement Administration
- Board Certification (if applicable)
- Training and Education
- Acceptable professional liability (malpractice) insurance coverage and malpractice history
    - Copy of current malpractice insurance declaration sheet, including amounts and dates of coverage
- Hospital Affiliation
- Curriculum vitae and/or past five (5) years of work history
    - Explanations of gaps greater than six (6) months
- Fully answered questionnaire with explanations for unfavorable answers
- The absence of negative actions taken by any State board and/or governing entity
- Provider's signature and date on consent and release/attestation form
- Laboratory Improvement Amendments (CLIA) Certificate (If Applicable)
- An Accreditation Certificate from a recognized accrediting body, Centers for Medicare and Medicaid Services (CMS) State Survey, or any applicable State Survey (For Facility Applicants).

Interested practitioner's should complete an application through CAQH at https://proview.caqh.org/Login/Index?ReturnUrl=%2f or contact the CAQH Help Desk at 1-888-599-1771.

If you do not see the information you need, visit the Council for Affordable Quality Healthcare (CAQH) website for more information.

Most commonly asked questions are:

1. **What is CAQH?**
   CAQH is a national 3rd party vendor used to collect provider data for credentialing purposes. Any participating health plan with CAQH may use the application. This streamlines the credentialing process for practitioners by reducing paperwork.

2. **What if I do not have a CAQH ID?**
   Contact CAQH to begin the process of creating yours.

3. **How long does the credentialing process take?**
   On average, complete applications are processed within 60-90 days.

4. **What can cause a delay in the credentialing process?**
   When an application is not complete in CAQH, this will cause a delay in the credentialing process. If you intend to become a provider, please be sure to:
   - Review your CAQH application.
   - Check for expiring documents.
   - Sign and date the Attestation.
   - Update all material as needed.

5. **Can I become credentialed before I have a contract with TCHP?**
   No. You must obtain a contract before being credentialed.

6. **The following are a list of common mistakes made on the CAQH application:**
   - Name changes not updated.
   - Expired attestation.
   - Provider NPI number is missing.
   - Provider NPI is not enrolled with PEMS.
   - Last 5 years of work history missing: an explanation of gaps over five months not provided.
   - Incomplete group practice and service location(s) on application.
   - Liability coverage policy must be 1 million occurrences and 3 million in aggregate.
   - If the liability is under the group's insurance policy (attach a letterhead or roster stating that the provider is covered under the group's insurance policy).
   - Required documents must be successfully uploaded and approved by CAQH before the CAQH ProView profile is considered complete and accessible to TCHP. Documents typically take 2-5 days for CAQH's approval.
   - Complete application status is indicated as Initial Profile Complete and Re-Attestation. Any other status indicates the application is incomplete.
   - View the Provider Documentation page for the missing required documents.

7. **If I do not have a complete CAQH application, will my credentialing start?**
   No. Primary source verification and/or data collection will not start until a complete application is submitted by the provider via CAQH. Facilities can submit their credentialing applications through www.availity.com.

Re-Credentialing Information:
Verisys will notify providers due for re-credentialing via letter the timeframe in which the provider must submit its re-credentialing application for processing. Notification letters will be sent to providers six (6) months prior to the end of the provider's thirty-six (36) month re-credentialing cycle.

Practitioner's Right's:
The practitioner has the right to:
- Review information submitted by outside sources (malpractice insurance carriers, state licensing boards, etc.) to support their credentialing application. TCHP is not required to make available references, recommendations or peer review protected information.
- Give written notification of any substantial variance in the information submitted in the application and obtained from primary sources during the credentialing process
- Correct or explain any inconsistent or erroneous information obtained from primary sources and/or identified in their credentialing application.
- Receive the status of their credentialing or re-credentialing application upon request. To request, provide or correct any information in your credentialing file, send an email to TCHPCredentialing@texaschildrens.org. If a practitioner inquires about the status of their credentialing application, the credentialing staff will review the practitioner's CAQH application and the status of the credentialing file, including pending and/or completed primary source verifications with Verisys. Once the staff determines the completeness and anticipation of credentialing committee review timeframe, the provider will be notified of their credentialing status via email.

Credentialing status inquiries received via the provider hotline, will be forwarded by member services to the credentialing department.

When a practitioner's prepared credentialing file contains a variance in the information that the practitioner submitted, and that which was obtained through primary source verification; such as actions on a license, malpractice claims history or board certification, the Credentialing staff will, under the direction of the CMO, Designated Medical Director, or Associate Medical Director, notify the practitioner in writing via letter regarding the variance. The notice will also inform the practitioner of his/her right to correct or explain, in writing, within ten (10) calendar days of receipt of the notice, any inconsistent or erroneous primary source information to the Credentialing Manager. The Credentialing Manager notifies the practitioner via letter when the correction has been received.