Lubbock Service Area
Medicaid Rural Service Area (MRSA West)

2025 Provider Manual

STAR and CHIP

FirstCare™
HEALTH PLANS
PART OF BAYLOR SCOTT & WHITE HEALTH

FirstCare.com
1.800.431.7798

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

FC-P001 1024

FirstCare STAR and CHIP Provider Manual

FirstCare prepared this manual, which is an extension of the contract, for use by FirstCare STAR and/or CHIP contracted providers and FirstCare. Please ensure this manual is made available to your contracted off site billing departments and/or billing services used by the provider.

We have included an address and telephone guide in the introduction section of this manual for your reference.

We welcome your suggestions for future editions of our manual. Please send any comments or suggestions to the following address:

FirstCare Health Plans
Attention: Contracts Administration
1206 West Campus Drive
Temple, TX 76502
Fax: 1-512-257-6043

When writing to us about the manual, please include your name, phone number with area code and your return address and tax ID number.

Thank you.

The Staff of FirstCare Health Plans

Table of Contents

SECTION 1: Introduction

Welcome to the FirstCare STAR and CHIP provider network a network of hospitals, physicians, and ancillary health care providers that have agreed to work together to provide a complete network of services to FirstCare STAR and CHIP members. We are genuinely pleased that you have agreed to participate in the FirstCare STAR and CHIP provider network.

FirstCare is a National Committee for Quality Assurance (NCQA) accredited licensed Health Maintenance Organization (HMO) contracted by the Texas Health and Human Services Commission (HHSC) to provide managed care health services for members who are participating in either the STAR (State of Texas Access Reform) program in the Lubbock and the Medicaid Rural Service Area (MRSA) West or CHIP (Children's Health Insurance Program) in the Lubbock service area.

1.1 - About the Manual

This manual has been prepared to help you understand the FirstCare STAR and CHIP (hereinafter referred to as "FirstCare") network and its procedures. The CHIP Perinatal Program is a subprogram of CHIP, therefore, CHIP requirements also apply to the CHIP Perinatal program unless the FirstCare STAR and CHIP Provider Manual states differently. The information in this manual offers general guidelines that are applicable to both the FirstCare CHIP and STAR network, except where noted. Language provided by the State of Texas in regards to certain STAR/CHIP policies are also included and noted within this manual. For additional information on the STAR program, please refer to the current Texas Medicaid Provider Procedures Manual.

In the event any discrepancies arise between this manual and a provider agreement, with respect to FirstCare policies and procedures, the language in the more current of the two documents will prevail. In all other cases of discrepancies, the provider agreement shall prevail, unless the differences are caused by the actions of state or federal regulatory bodies or any of the health benefit programs operated by these entities.

This manual is for the benefit of participating providers. FirstCare policies include, but are not limited to, what is identified in the manual. The policies described in this manual are subject to modification, addition, and/or deletion. Any updates that may occur will be communicated in the form of newsletters, mailings from FirstCare, and/or manual revisions that will be incorporated into the online manual.

1.2 - Background

The LoneSTAR (State of Texas Access Reform) Health Initiative was the result of the 72nd Legislature, House Bill 7 that mandated the State of Texas to implement an innovative and cost-effective program for delivering health care to Medicaid clients. The LoneSTAR Health Initiative, now referred to as the STAR program, was originally implemented in Travis County. With the passing of Senate Bill 10 by the 74th Legislature, the STAR program was expanded to include the Lubbock service area.

Medicaid clients who receive Temporary Assistance for Needy Families (TAN F) or TANF-related benefits are enrolled into the STAR program on a mandatory basis while Social Security Income (SSI) and the blind and disabled clients may enroll on a voluntary basis or are enrolled in the STAR+PLUS program.

The State Children's Health Insurance Program (SCHIP) was created under Title XXI of the Social Security Act to expand health coverage to uninsured children, ages 0 through 18, whose families earn too much to qualify for Medicaid but too little to afford private coverage. With the passing of Senate Bill 445 by the 76th Texas Legislature, the Texas Children's Health Insurance Program (CHIP) was introduced in Texas. CHIP enrollment is voluntary.

1.3 - Objectives of the Programs

STAR

By placing Medicaid eligible clients in a managed care setting, the State of Texas hopes to achieve the following objectives:

- Increase health care access by enhancing provider participation and providing each member with a Primary Care Provider (PCP), thereby giving Medicaid members a "medical home";
- Improve the quality of health care by creating continuity in the overall program of care managed by the PCP;
- Promote appropriate utilization of health care by requiring each member to go first to their PCP for treatment or referral rather than to the local emergency room for non-emergent care; and
- Improve cost-effectiveness of Medicaid in the targeted area by emphasizing preventive care and the coordination of health services received by each member.

CHIP

By expanding health insurance coverage for uninsured children, the State of Texas hopes to achieve the following objectives:

- Provision of quality, accessible, and comprehensive health care, which are tailored to meet the health care needs of Texas children;
- Responsiveness to the special circumstances of children with special health care needs; and
- Provision of health care to all persons who are eligible for and enrolled in CHIP in an efficient, cost-effective manner.

1.4 - Confidentiality of Information

Confidentiality is the responsibility of every FirstCare employee and FirstCare provider. FirstCare and the provider are "Covered Entities" under the Privacy Regulations in the 1996 Health Insurance Affordability and Accountability Act (HIPAA) and the 2009 Health Information Technology for Economic and Clinical Health Act (HITECH). All of the normal transfers of confidential patient information between us are allowed under HIPAA, within the prescribed security limits of the Act. There is a FirstCare corporate policy of zero-tolerance for any infraction of the policy by FirstCare employees. All new FirstCare employees are informed during the orientation process that any breach of confidentiality may result in termination. This policy is also highlighted in the employee handbook. Additionally, access to all files (manual and computerized) is provided with security clearance at the time of employment with FirstCare and revoked formally at the time of termination. Providers are to comply with FirstCare policies regarding confidentiality to the extent that confidential treatment is provided for, under state and federal laws and regulations. All records and other documents deemed confidential by law, and disclosure or transfer of confidential information will be in accordance with applicable law.

For more information about how FirstCare maintains the privacy of the member's health information, please visit the FirstCare website and refer to www.FirstCare.com/ImportantInformation

1.5 - Provider Roles

Primary Care Provider (PCP) - A Primary Care Provider (PCP) should serve as the "Medical Home" and is the focal point of all care management for STAR, CHIP, and CHIP Perinate newborn members. The PCP is responsible for providing, arranging, and coordinating all aspects of the member's health care and for directing and managing appropriate utilization of health care resources.

Specialty Care Provider Role - The role of an in-network FirstCare specialist is to provide consulting expertise, as well as specialty diagnostic, surgical and other medical care for STAR, CHIP and CHIP Perinate newborn members. Specialist focus on specific disciplines of health care and work in conjunction with a member's PCP, ensuring all aspects of a member's health needs are met.

CHIP Perinatal Provider Role - The role of an in-network FirstCare CHIP Perinatal provider is to provide prenatal, delivery, and postpartum care for CHIP Perinatal members. CHIP Perinatal providers ensure care for the unborn child and refer CHIP Perinatal members to community resources to receive services that are non-covered benefits.

Role of the Pharmacy - The role of a pharmacy is to dispense medications prescribed by providers. The pharmacy is responsible for educating members on the use of the prescription medications and advising prescribers regarding composition of drugs, drug interactions, and drug decisions.

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

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

1.6 - Network Limitations

FirstCare STAR members are allowed access to all in-network providers participating in the FirstCare STAR product. STAR members are also allowed access to any Texas Health Steps (THSteps) Provider in the FirstCare service area for immunizations and Texas Health Steps checkups.
In addition, FirstCare STAR members have freedom of choice when selecting a physician to provide Family Planning Services and may seek services from any family planning provider in the FirstCare service area. Female members may elect to designate an OB/GYN in addition to their PCP.

FirstCare CHIP/CHIP Perinatal newborn members are allowed access to all in-network providers participating in the FirstCare CHIP program. FirstCare CHIP Perinatal members are allowed access to all in-network providers participating in FirstCare CHIP Perinatal.

Please refer to the "FirstCare STAR and CHIP Service Area" on the following page to view a listing of counties wherein the FirstCare STAR and CHIP products are available.

1.7 - Service Area

Lubbock Service Area (STAR and CHIP/CHIP Perinate):
Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher and Terry counties.

Medicaid Rural Service Area (MRSA) West (STAR Only):
Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Yoakum, Young and Zavala counties.

1.8 – Service Area Maps

1.9 - FirstCare Contact Information

FirstCare Website	www.FirstCare.com
FirstCare STAR	www.FirstCare.com/STAR
FirstCare CHIP	www.FirstCare.com/CHIP
Customer Service Department (Member Eligibility and Benefit Questions)	
STAR	1-800-431-7798
CHIP and CHIP Perinatal	1-877-639-CHIP(2447)
STAR, CHIP and CHIP Perinatal Claims	1-806-784-4300
Claim Inquiries	1-800-431-7798
Claims Mailing Address (Please use this address for all claim-related correspondence including original claim submissions, adjustment requests and recovery correspondence).	FirstCare Health Plans P.O. Box 211342 Eagan, MN 55121-1342
FirstCare Electronic Claim Clearinghouses	
Availity (formerly THIN)	1-800-282-4548 1-800-884-4905
Healthsmart (formerly CareVu)	1-888-744-6638
Claim Shuttle	1-800-718-5103
Medical Prior Authorization Department	1-800-718-5103 1-800-248-1852 (fax)
Behavioral Health Prior Authorization Department	1-800-327-6943
Provider Relations	1-800-431-7798
Case Management	1-800-431-7798
Non-Emergency Medical Transportation (NEMT)	1-833-779-3105
Pharmacy	
Providers/Pharmacies (Navitus)	1-877-908-6023
Members (STAR)	1-800-431-7798
Members (CHIP)	1-877-639-CHIP(2447)
Behavioral Health	1-800-327-6934
Ombudsman Managed Care Assistance Team(OMCAT)	1-866-566-8989
Medicaid Hotline (HHSC)	1-800-252-8263
CHIP Help Line	1-800-647-6558
Texas Health Steps (THSteps)	1-877-847-8377
TMHP Contact Center	1-800-925-9126
Relay Texas	7-1-1
HHSC Administrative Contractor	1-800-964-2777
FirstCare Interpreter Services	STAR 1-800-431-7798 CHIP 1-877-639-2447

1.10 - Provider Service Guide

FirstCare Health Plans provider self-service area is a secure location for providers to access personal information, member benefit information and claims information. You may access this site by visiting www.FirstCare.com and clicking on "Providers."

From this website, you will also be able to verify and/or update:

- Provider Information
- Demographic information
- Claim Information
  - Check claim status
  - Submit a claim redetermination or additional information for a previously processed claim
- Authorizations
  - Request a referral or authorization
  - Update an existing referral or authorization
  - Check the status of a referral or authorization
- Member Eligibility
  - Verify member eligibility
  - Verify member benefit information
- Disease Management
  - Refer a member to Disease Management

NOTE: If you need to obtain an activation code to create a new account, please contact PR Support at PRSupport@BSWHealth.org, call Customer Service at 1-800-431-7798, or go to my.firstcare.com

SECTION 2: Provider ID Numbers and Automated Services

2.1 - National Provider Identifier (NPI)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The Centers for Medicare and Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

The National Provider Identifier (NPI) is a unique, ten-digit numeric identifier assigned to covered health care providers by the National Plan and Provider Enumeration System (NPPES). This identifying number does not carry any information about health care providers, such as the state in which they practice or their provider type or specialization.

The intent of the NPI is to improve the efficiency and effectiveness of electronic transmission by allowing providers and business entities to submit the same identification number(s) to all payors, such as insurance plans, clearinghouses, systems vendors, and billing services.

Individual health care providers are eligible to obtain the Type 1 permanent identifier that will identify the provider for their lifetime. This identifier does not change for this provider regardless of group affiliation, regional location, or licensure changes.

Business entities, which include incorporated individuals, groups, and facilities, are eligible for a Type 2 NPI. With few exceptions identified by CMS, business entities are able to define and obtain one or more NPI to represent their business as they choose.

For more information about NPI and how to obtain an NPI, please visit the NPPES Website at https://nppes.cms.hhs.gov/NPPES or contact NPPES directly by phone at 1-800-465-3203.

2.2 - Texas Provider Identifier (TPI)

All Providers must comply with State of Texas licensure requirements and all state and federal laws governing the provision of Covered Services. Providers may not be under sanction or exclusion from the Medicaid program. All Acute Care Providers serving Medicaid and/or CHIP members must be enrolled as Medicaid providers and have an active nine (9) digit Texas Provider Identification Number (TPI) in order to receive payment. This includes Medicaid and CHIP, as of January 1, 2018. To obtain a TPI Number, or if a Provider's TPI number is inactive, please outreach to the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126, option 2.

2.3 - FirstCare Provider ID Numbers

FirstCare assigns unique provider ID numbers to each contracted provider, which includes physicians, ancillaries, and facilities. This nine (9) digit number is used by FirstCare to identify providers in all areas of interaction between the provider and FirstCare, such as accessing of FirstCare's provider services web portal. Providers are reminded that their provider ID numbers should be made available to all appropriate office and billing services staff that require access to FirstCare's provider portal.

Providers who have not received their nine (9) digit FirstCare unique provider ID number should contact the FirstCare customer service department.

2.4 - FirstCare Provider Portal

FirstCare's provider web portal gives providers confidential, 24-hour access to information and services such as:

- Member eligibility and benefit verification - including quick access to copayment information, if applicable;
- Submission and updating of specialist referrals and authorization requests;
- Status checks on previously submitted claims, referrals and authorization requests;
- Prevent and appeal claim denials by submitting corrected or additional information on-line;
- Use of a secure message center mailbox feature to send a message to FirstCare. You can also check status of a message. Each message will have its own unique ID number for reference.

FirstCare Health Plans provider portal is a secure location for providers to access personal information, member benefit information and claims information. You may access this site by visiting my.FirstCare.com. From this website you will also be able to verify and/or update:

- Provider Information
  - View provider demographic information
- Claims
  - Update demographic information
  - Claim Information
  - Check claim status
  - Submit a claim redetermination or additional information for a previously processed claim
- Authorizations
  - Request a referral or authorization
  - Update an existing referral or authorization
  - Check the status of a referral or authorization
- Member Information
  - Verify member demographic information
  - Verify member eligibility
  - Verify member benefit information
  - Other insurance
- Renounces/Documents
  - Payment discrepancy report
  - Panel reports
  - Texas Health Steps report
  - General documents
  - Policy changes
  - Provider manual

If you do not know your FirstCare ID or password, please contact Customer Service at 1-800-4317798

SECTION 3: Customer Service

FirstCare is committed to providing exceptional customer service to all of our participating providers. In order to ensure continued optimal operation with its health care partners, FirstCare has established convenient and easily accessible channels for its participating providers to utilize. FirstCare offers secured online customer service through its provider services web portal, which can be accessed 24 hours a day, 7 days a week at my.FirstCare.com.

Through the provider services self-service portal, participating providers can access or request the following information or action:

- View member's benefits and eligibility information;
- Request referrals and authorizations; and
- Check claim status.

If further assistance is required, providers may call FirstCare's customer service department. Customer service representatives are available between the hours of 8 a.m. and 5 p.m. Monday through Friday.

FirstCare Customer Service

STAR	1-800-431-7798
CHIP/CHIP Perinatal	1-877-639-CHIP (2447)

Additional phone numbers can be found on the "Address and Telephone Guide" in the Introduction section of this manual.

3.1 - Eligibility and Benefits

Member Eligibility Statements

Participating providers may access a member's eligibility statement from FirstCare to determine if the member is eligible for health services at the time of visit. Such eligibility statements are available for view and print through FirstCare's provider services web portal, and will include the following information:

- Member's FirstCare ID number (Medicaid or CHIP ID Number);
- Member's name, birth date, and gender;
- Member's current enrollment and eligibility status with FirstCare;
- Description of member's benefits and excluded benefits or limitations; and
- Copayment requirements, if any.

For more details on how to view and print member eligibility statements from the provider services web portal, please contact your local FirstCare office.

3.2 - Member ID Card

FirstCare members receive a member identification (ID) card. Members should present these ID cards when they are seeking services from FirstCare network providers. If the patient does not have his/her ID card or enrollment form for new members, the provider's office can call Customer Service to verify member eligibility or through the provider web portal using the members full name and DOB.

Members that have possession of an ID card are not guaranteed eligibility. Providers are encouraged to verify the effective date of benefit coverage as well as member identity prior to rendering services to the member.

This ID card will contain the following information:

Member Number - The FirstCare member ID (Medicaid or CHIP ID) number of the member
Effective Date - The initial date of eligibility
Name of Member - This is the name that should be used for claims filing and preauthorization requests
Group Number - The number assigned to the member's employer or payor
Member Date of Birth
Benefit Description and Copayments - CHIP copayment amounts are due at the time of service for the following services or benefits rendered to the member
Name, telephone number, and effective date of the member's PCP

Emergency numbers and important notices are located on the back of the card.

Note: An example member ID card is shown in Section 4.

IMPORTANT

- Each physician or provider is responsible for verifying eligibility each time services are rendered.
- Copayments are to be paid by the member at the time of service.
- Notify FirstCare immediately if an ID card has been used fraudulently.
- For specific plan design or coverage information, contact the customer service department.
- Copy the member's ID card on the first visit and keep it in the member's file.
- Note the effective date of eligibility and update this information.

SECTION 4: Member Enrollment and Disenrollment

4.1 - FirstCare STAR Eligibility and Enrollment

The Health and Human Services Commission (HHSC) is the state agency that administers the Medicaid and CHIP programs in Texas. HHSC will make eligibility determination for the STAR Medicaid programs. STAR stands for State of Texas Access and Reform. The HHSC Administrative Services Contractor will enroll and disenroll eligible individuals in the STAR program. To enroll in FirstCare STAR the member's permanent residence must be located within the FirstCare STAR Service Area.

Pregnant Women and Newborns
The HHSC Administrative Services Contractor will retroactively enroll some pregnant members in FirstCare STAR based on their date of eligibility. Newborns will be retroactively enrolled to their date of birth. Newborns born to Medicaid eligible mothers who are enrolled in FirstCare STAR will be enrolled in FirstCare STAR for at least 90 days following the date of birth, unless the mother requests a plan change as a special exception.

Upon enrollment in FirstCare STAR, FirstCare will send the member an ID card, a member handbook and a new member packet.

There are rare cases when FirstCare does not receive enrollment for newborns whose mothers enrolled in FirstCare STAR. When FirstCare does not receive these enrollments, claims cannot be paid. Coverage for newborns not enrolled in FirstCare can be researched in TexMedConnect at www.TMHP.com or at www.yourtexasbenefitscard.com (1-800-925-9126). Please contact the Customer Service phone number on the back of the member ID card with questions

FirstCare STAR Automatic Re-Enrollment

Members who are disenrolled because they are temporarily ineligible for Medicaid will be automatically re-enrolled into the health plan of their last enrollment or the member may choose to change to a different health plan. Temporary loss of eligibility is defined as a period of 6 months or less. Members may choose to switch plans.

4.2 - FirstCare CHIP and CHIP Perinatal Eligibility and Enrollment

CHIP members will have up to 12 months of coverage and must submit a re-enrollment application at the end of the 12 months coverage. Members are allowed to make health plan changes under the following circumstances:

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

HHSC will make the final decisions on enrollment, re-enrollment, and plan changes. The HHSC Administrative Services Contractor will enroll and disenroll eligible individuals in the CHIP and CHIP Perinatal programs.

Pregnant Teen Member Process *(not applicable to CHIP Perinatal Members)*
Teen CHIP members who become pregnant will be referred to HHSC for eligibility determinations. Those who are determined eligible for Medicaid will be disenrolled from CHIP. In the event FirstCare is unaware of a FirstCare CHIP member's pregnancy until delivery, the delivery will be covered by CHIP. The baby will be automatically enrolled in FirstCare CHIP at birth. Upon determination of pregnancy of a CHIP member, Providers should complete the FirstCare CHIP Pregnancy Notification Fax Form and fax the form to the FirstCare OB Case Manager as indicated on the form.

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

CHIP Perinatal member at or below 198% of the FPL
A CHIP Perinate (unborn child) who lives in a family with an income at or below 198% of the FPL will be deemed eligible for Medicaid and moved to Newborn Medicaid coverage for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker.

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

A CHIP Perinate mother in a family with an income at or below 198% of the FPL should be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under 198% of the FPL will receive a Form H3038 with their enrollment confirmation. Form H3038P must be filled out by the delivering provider at the time of birth and faxed to HHSC at 1-877-447-2839 or by mail to:

Texas Health and Human Services Commission P.O.
Box 15100
Midland, TX 79711

For more information, please see the CHIP Perinatal FAQs on the HHSC website at: https://hhs.texas.gov/services/health/medicaid-chip/provider-information/chip-perinatal-coverage/chipperinatal-faqs.

CHIP Perinate newborns of Perinatal members at or below 198% of the FPL will receive fee-for-service (Traditional) Medicaid for the first three months. By month three, the mother will be sent a packet to select a Managed Care Organization (MCO) in their service area. They will have 15 days to return their selection to the Enrollment Broker.

CHIP Perinate member and newborn member between 198% and 202% of FPL
A CHIP Perinate newborn will continue to receive coverage through the CHIP program if born to a family with an income above 198 % to 202% FPL and the birth is reported to HHSC's enrollment broker.

CHIP Perinatal coverage lasts 12 months. If HHSC determines eligibility when the CHIP Perinatal member is three months pregnant and the child is born 6 months later, the CHIP Perinate member will have six months of CHIP prenatal care, and the baby will have six months of full CHIP coverage after it's born.

Plan Changes *(applicable to CHIP Perinatal Members)*
A CHIP Perinate (unborn child) who lives in a family with an income at or below 198% of the FPL will, at birth, be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC.

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

- At any time or;
- If the member moves into a different service delivery area.

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

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

4.3 - FirstCare STAR Disenrollment

Members have a right to disenroll from FirstCare STAR at any time except during an inpatient hospital stay. FirstCare is not allowed to accept disenrollment from a member. Members must contact the HHSC Administrative Services Contractor to request disenrollment and HHSC will make the final decision on the disenrollment request. A member's disenrollment request from managed care will require medical documentation from the primary care provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment. Providers may not take any retaliatory action against a member for his/her request for disenrollment.

FirstCare cannot request disenrollment based on adverse change in the member's health status or utilization of services that are medically necessary for treatment of a member's condition.

If a disenrollment request is received on or before the monthly HHSC "cut off" date for the month, disenrollment is effective on the first day of the next month. If a disenrollment request is received after the HHSC "cut off" date for the month, disenrollment will be effective the first day of the month after next.

4.4 - FirstCare CHIP Disenrollment

A member is considered disenrolled on the final day of the month in which notification occurs, if notification is received by FirstCare before the cut-off date. When notification occurs after the cut-off date, the member will remain eligible until the following cut-off date. HHSC will make the final decision on disenrollment requests. Disenrollment due to loss of eligibility includes, but is not limited to:

- "Aging-out" when a member turns nineteen;
- Failure to re-enroll at the conclusion 12-month eligibility period
- Change in health insurance status, such as member participating in an employer-sponsored health plan;
- Failure to meet monthly cost-sharing obligation (not applicable to CHIP Perinate members);
- Death of a child;
- The member permanently moves out of the state; and
- Data match with the Medicaid system indicates dual enrollment in Medicaid and CHIP.

Providers may not take any retaliatory action against a member for his/her request for disenrollment.

4.5 - FirstCare CHIP Perinate Disenrollment

CHIP Perinatal members may request disenrollment from FirstCare. HHSC will make the final decision on the disenrollment request. Providers may not take retaliatory action against a member for his/her request for disenrollment.

4.6 - Member Non-Compliance

FirstCare has a limited right to request that a member be disenrolled from the FirstCare STAR or CHIP/CHIP Perinatal plan without the member's consent. HHSC must approve any request for disenrollment of a member for cause. Disenrollment of a member may be permitted under the following circumstances:

- Member misuses or loans his/her FirstCare member identification card to another person to obtain services;
- Member is disruptive, unruly, threatening or uncooperative to the extent that the Member's membership seriously impairs FirstCare's or FirstCare provider's ability to provide services to the member or to obtain new members, and the member's behavior is not caused by a physical or behavioral health condition; and/or
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow FirstCare or FirstCare's providers to treat the underlying medical condition.)

Before a provider or FirstCare can request a member to be disenrolled, FirstCare must take reasonable measures to correct the member's behavior. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors. HHSC is to notify the member of its decision to disenroll the member if all reasonable measures have failed to remedy the problem.

If a provider requests disenrollment of a member, the provider is to notify, in writing, both FirstCare and the member. The provider is to give the member 30 days to select a new PCP. FirstCare will also contact the member and assist with selection of a new PCP that can meet their medical needs. For assistance with member non-compliance, contact the FirstCare outreach department at 1-866-787-0663

FirstCare nor a FirstCare STAR/CHIP/CHIP Perinatal provider can request a disenrollment based on adverse change in the member's health status or utilization of services, which are medically necessary for the treatment of a member's condition.
If the member disagrees with the decision for disenrollment by FirstCare, the member may submit a complaint with FirstCare or with the Texas Department of Insurance (MI) for CHIP. A FirstCare STAR member may also request a State Fair Hearing with HHSC.

4.7 - Forms of Identification

For STAR Members:

Your Texas Benefits Medicaid Card

HHSC issues a Your Texas Benefits Medicaid card to all Medicaid members. The card will include the member's name and ID number. Additional information will be contained on the magnetic strip. Providers should use the card to verify eligibility. A card reader is not required for accessing information, the members number can be entered on the website. For more information visit www.YourTexasBenefitsCard.com. A copy of the card is listed below.

FirstCare STAR Identification Card

Members participating in the FirstCare STAR program are issued a FirstCare STAR member identification card. See following page for a sample FirstCare STAR member identification card. The member ID card will contain the following information:

- Name of member;
- FirstCare STAR member ID number (Medicaid ID number);
- Effective date;
- Date of birth of member;
- Group number;
- Name, telephone number, and effective date of the member's PCP,
- Claims addresses information, and
- Pharmacy Information

The FirstCare STAR member ID number is comprised of the member's unique nine (9) digit Medicaid number. Dependents are treated as separate subscribers with their own member identification number. Newborns will receive a separate card once they are enrolled with FirstCare.

For CHIP/CHIP Perinatal Members:

FirstCare CHIP/CHIP Perinatal Enrollment Letter

CHIP/CHIP Perinatal eligible children are enrolled in the health plan chosen by their parent or guardian. Following receipt of the enrollment information, HHSC Administrative Service Contractor will mail the family a confirmation enrollment letter that indicates the health plan and PCP chosen, the applicable copayment amount, each insured child's identification number, and the initial date of coverage. This letter serves as the Evidence of Coverage until the permanent member ID cards are received from FirstCare. FirstCare must attach benefit information from the EOC/COC.

FirstCare CHIP/CHIP Perinatal Identification Card

Members participating in FirstCare CHIP/CHIP Perinatal program are issued a FirstCare CHIP/ CHIP Perinatal member identification card. A sample FirstCare CHIP/CHIP Perinatal member identification card is included. The CHIP member ID card will contain the following information:

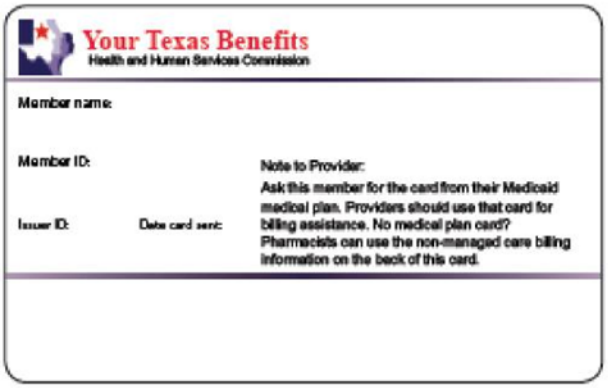
- Name of member;
- Member ID number (CHIP ID Number);
- Effective date;
- Date of birth of member;
- Group number;
- Name, phone number, and effective date of the member's PCP,
- Pharmacy Information, and
- Benefit description and copayment amounts.

The FirstCare CHIP/CHIP Perinatal member ID number is comprised of a unique nine digit CHIP Perinatal number.

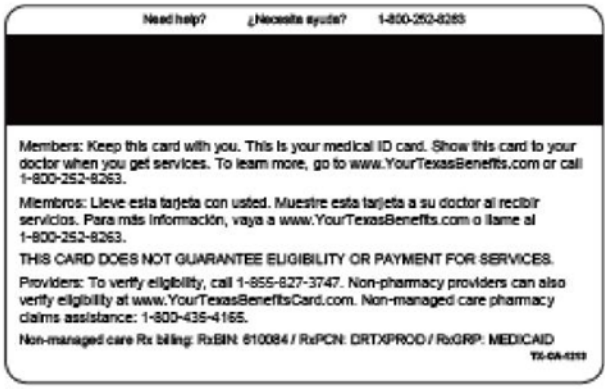
4.8 - Card Samples

Your Texas Benefits Card

Front of Card



Back of Card



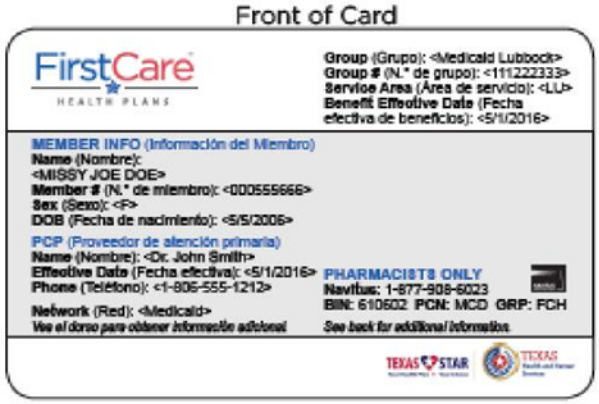
FirstCare STAR Member ID Card (Lubbock)

Front of Card

Back of Card

FirstCare STAR Member ID Card (MRSA)

Front of Card



Back of Card

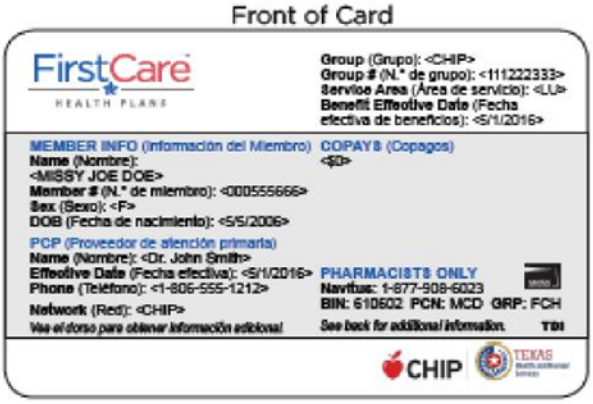
FirstCare CHIP Member ID Card

Front of Card

Back of Card

FirstCare CHIP Perinate Newborn Member ID Card

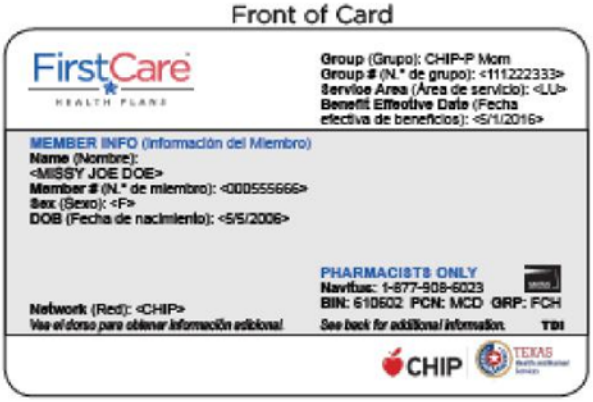
Front of Card



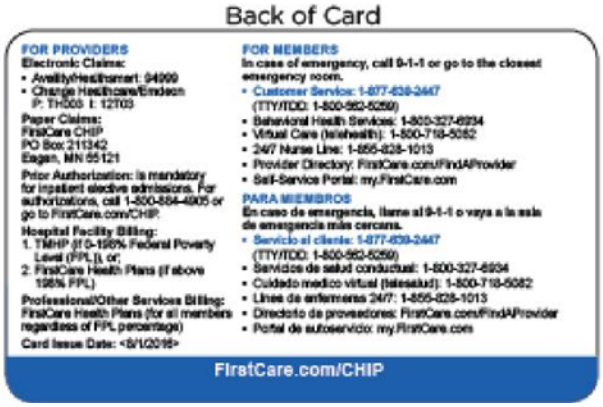
Back of Card

FirstCare CHIP Perinate Member ID Card

Front of Card



Back of Card



4.9 - Verifying Member Eligibility

When a member is seeking services from a FirstCare participating provider, the provider should verify eligibility through one or more of the following steps:

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

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

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

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

Verifying Member CHIP/CHIP Perinatal Eligibility

- Request the FirstCare CHIP/CHIP Perinatal member identification card. If the member does not have his/her member ID card, providers may visit FirstCare's web portal at www.FirstCare.com or call FirstCare's customer service department to verify member eligibility.
- You can verify eligibility by calling FirstCare at 1-877-639-2447.
- For Pharmacies Only - You can verify eligibility through electronic eligibility verification e.g., NCPDP E1 transaction.
    - **Providers are reminded that the presence of the FirstCare CHIP/CHIP Perinatal member ID card alone does not guarantee eligibility and are advised to confirm eligibility through the FirstCare's web portal or customer service department.**

4.10 - MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:

    a. Be treated fairly and with respect.

    b. Know that your medical records and discussions with your providers will be kept private and confidential.

2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:

    a. Be told how to choose and change your health plan and your primary care provider.

    b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.

    c. Change your primary care provider.

    d. Change your health plan without penalty.

    e. Be told how to change your health plan or your primary care provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:

    a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.

    b. Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:

    a. Work as part of a team with your provider in deciding what health care is best for you.

    b. Say yes or no to the care recommended by your provider.

5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:

    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.

    b. Get a timely answer to your complaint.

    c. Use the plan’s appeal process and be told how to use it.

    d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.

e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.

    b. Get medical care in a timely manner.

    c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.

    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.

    e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

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

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

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

MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:

    a. Learn and understand your rights under the Medicaid program.

    b. Ask questions if you do not understand your rights.

    c. Learn what choices of health plans are available in your area.

2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:

    a. Learn and follow your health plan's rules and Medicaid rules.

    b. Choose your health plan and a primary care provider quickly.

    c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.

d. Keep your scheduled appointments.

e. Cancel appointments in advance when you cannot keep them.

f. Always contact your primary care provider first for your non-emergency medical needs.

g. Be sure you have approval from your primary care provider before going to a specialist.

h. Understand when you should and should not go to the emergency room.

3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:

    a. Tell your primary care provider about your health.

    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.

    c. Help your providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:

    a. Work as a team with your provider in deciding what health care is best for you.

    b. Understand how the things you do can affect your health.

    c. Do the best you can to stay healthy.

    d. Treat providers and staff with respect.

    e. Talk to your provider about all of your medications.

Additional Member Responsibilities while using NEMT Services:

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.

2. You must follow all rules and regulations affecting your NEMT services.

3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.

4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.

5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.

6. You must only use NEMT Services to travel to and from your medical appointments.

7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You can also view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

4.11 - CHIP Member Rights and Responsibilities

MEMBER RIGHTS:

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.

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

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You can also view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

MEMBER RESPONSIBILITIES:
You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. Talk to your child's provider about all of your child's medications.

4.12 - CHIP Perinate Member Rights and Responsibilities

Member Rights:
1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide

for your unborn child. You have a right to know about what those payments are and how they work.

3. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
10. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

Member Responsibilities:
You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Perinatal Program Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. You must talk to your provider about your medications that are prescribed.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

MEMBER'S RIGHT TO DESIGNATE AN OB/GYN:
FirstCare allows the Member to pick any OB/GYN, whether that doctor is in the same network as the Member's Primary Care Provider or not.

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

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

4.13 - Advance Directives

(Applicable to STAR Members only)
The availability of initiating Advance Directives is a right of a FirstCare STAR member and is included as part of their FirstCare STAR member handbook.

Each member receives an advanced directive booklet in their enrollment packet. Included in this booklet is the disclosure statement and explanations regarding Durable Power of Attorney and Living Will. Provided for the member's convenience, are Advance Directive Forms in both English and in Spanish, which can assist the member in the formulation of Advance Directives. (See **ATTACHMENTS** section for an English and Spanish version sample of the *"Disclosure Statement for Medical Power of Attorney"* and the *"Directive to Physicians and Family Surrogates").*

It is the responsibility of the physician to discuss health care options with the member and to assist in the initiation of advance directives. Chart documentation of such discussions and the initiated advance directives is required.

4.14 - Special Services

FirstCare and FirstCare providers will coordinate to ensure the following special services are made available to members.

Interpretation Services for the Hearing-Impaired
To ensure that members who are hearing-impaired are able to fully communicate with their PCPs and/or other providers when accessing health care. FirstCare has made arrangements to have an American Sign interpreter available 24 hours a day, 7 days a week, upon request.

To request an interpreter, one of the following numbers:

Relay Texas	
TTY	1-800-RELAYTX or 7-1-1 (1-800-735-2989)
Voice	7-1-1

Voice Carry-Over (VCO)	1-877-826-1798
Hearing Carry-Over (NCO)	1-800-RELAYTX (1-800-735-2989)
Spanish Speaking Users	7-1-1 or 1-800-662-4954
Local Services	
Lubbock Community Services for the Deaf	1-806-795-2233
For the Hearing Impaired (TTY/TDD)	1-806-795-2345
Emergency Pager	1-806-766-9368
Panhandle Counsel for the Deaf - Amarillo (Available Monday through Friday. After hours, this number is answered by pager.)	1-806-359-1506
For the Hearing Impaired (TTY/TDD)	1-800-562-5259
West Texas services for the Deaf - Abilene	1-915-676-4909
Highland Council for the Deaf - Big Spring	1-800-456-5094
TTY	1-800-759-7038
Emergency Pager	1-432-267-0904
Big Country Services for the Deaf and Hard of Hearing	1-325-677-4988

Please submit request as much in advance as possible. Several days' notice is preferred but all requests including short notices and emergencies are accepted.

Interpretation Services for Spanish and/or Non-Threshold Languages
FirstCare is sensitive to the needs of our non-English speaking members. FirstCare interpretive services provider is a service available to all FirstCare providers who do not have staff available to interpret for a patient who is non-English speaking. This line is available to FirstCare providers 24 hours a day, 7 days a week.

FirstCare providers can access this service for both incoming calls from your patients or for patients in your office. To access the FirstCare interpretive services provider line, please call FirstCare Customer Service at one of the numbers below:

STAR: 1-800-431-7798
CHIP: 1-877-639-2447

Language assistance:
"FirstCare offers free interpreter services to answer any questions you may have about our health or drug plan.

For STAR Members: "To get an interpreter, just call us at 1-800-431-7798. Someone who speaks your language can help you."

For CHIP Members: "To get an interpreter, just call us at 1-877-639-2447. Someone who speaks your language can help you."

"TDD/TTY users can contact FirstCare by calling 7-1-1, Monday through Friday, from 8 a.m. to 8 p.m.; during Medicare open enrollment season, Monday through Sunday, from 8a.m. to 8 p.m."

REPORTING ABUSE, NEGLECT, OR EXPLOITATION (ANE)

MEDICAID MANAGED CARE

Report suspected Abuse, Neglect, and Exploitation:
MCOs and providers must report any allegation or suspicion of ANE that occurs within the

delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

The Provider must provide the MCO with a copy of the abuse, neglect, and exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services (DFPS).

Report to the HHSC, Health and Human Services Commission if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (1-ICSSAs) - Providers are required to report allegations of ANE to both DFPS and HHSC;
- Adult day care centers; or
- Licensed adult foster care providers

Contact HHSC at 1-800-458-9858.

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

- An adult who is elderly or has a disability, receiving services from:
    - Home and Community Support Services Agencies (1-ICSSAs) - also required to report any HCSSA allegation to DFPS;
    - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
    - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
    - A person who contracts with a Medicaid managed care organization to provide behavioral health services;
    - A managed care organization;
    - An officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option

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

Report to Local Law Enforcement:

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

Failure to Report or False Reporting:

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

parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Childcare Services
Childcare at the Covenant Child Development Center is free to FirstCare STAR and CHIP members during medical appointments. STAR and CHIP members living in the Lubbock area are eligible to receive the care for their children or siblings when they have a confirmed medical appointment. FirstCare members living in the Lubbock area are eligible to receive free childcare for their children or siblings when they have a confirmed medical appointment.

To request for childcare, contact the Covenant Child Care Center at 806-725-2232.

Requests for childcare are accepted only if the following criteria are met:
- Child must be up to date on Texas Health Steps (EPSDT Shots and checkups);
- Completed registration form with Covenant Child Care Center; and
- Attached copy of an updated immunization record.

The Covenant Child Development Center is a state licensed childcare center and all staff members are trained in CPR and First Aid. The Covenant Child Development Center is located at:

2210 Joliet Avenue
Lubbock, TX 79410

Continuity of Care
It is the responsibility of FirstCare and the PCP to provide continuity of care to all members, pre-existing condition is not imposed. It is especially important to provide continuity to those newly participating members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if care is disrupted or interrupted. Please refer to "Referrals to Out-of-Network Providers" later in this section for protocols on requesting an out-of-network referral.

For members transferring from FFS to a new MCO and who received CPW services whiles in FFS, the new MCO must allow the Member to continue to receive CPW Services from the CPW Provider in the same amount, duration, and scope as provided in FFS, even if the provider is Out-of-Network, until the CPW service plan developed by the CPW Provider has been completed.

Reading/Grade Level Consideration
It is essential that the member fully understands any and all information that is communicated by his/her PCP and/or provider. To minimize potential misinterpretation and to ensure that the member is aware on his/her health status and the service and treatment options available, written and oral communications to a member are not to exceed a 6th grade reading level.

Cultural Competency
In recognition of the cultural diversity of our members and our commitment to serving and assisting those members, FirstCare has developed a comprehensive cultural competency training workshop intended for its employees, providers, and anyone else who has direct contact with FirstCare members when providing medical and/or customer service. The purpose of this training is to enhance an individual's ability to provide services effectively to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Children of Migrant Farmworkers
FirstCare attempts to identify Children of Migrant Farmworkers to ensure that they are receiving the care they need. FirstCare providers should work with FirstCare and other State Agencies to help identify Children of Migrant Farmworkers and accelerate care when needed prior to travel out of the area.

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup. Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

FirstCare will reimburse any Texas Health Steps provider, within or outside of the network, for a Texas Health Steps checkup performed for an active FirstCare member.

Family Planning
FirstCare STAR members have the right to choose any Medicaid family planning provider, within or outside the FirstCare STAR provider Network. FirstCare provides members information about family planning providers and services in the FirstCare STAR member handbook. Prior authorization is not required for family planning services for network and out-of-network providers.

Providers must provide counseling and education to members requesting contraceptive services or family planning services. Providers and family planning agencies cannot require parental consent for minors to receive family planning services. Providers and family planning agencies must ensure member confidentiality for family planning services, including members who are minors.

Providers should refer to the Texas Medicaid Provider Procedures manual for billing requirements for family planning services.

Focused Populations:

- Pregnant Women who will lose insurance eligibility after delivery
- Young pregnant Women who will have aged out of STAR by the time of delivery
- STAR Members ages 15-45.

Programs:

- Healthy Texas Women Program (Including Healthy Texas Women Plus)
- HHSC Family Planning Program
- HHSC Primary Health Care Program

How can Women receive healthcare after delivery (and they are no longer covered by Medicaid)?
After delivery, Women may lose Medicaid coverage. Women may qualify to receive health care services through the Healthy Texas Women Program and Texas Health and Human Services Commission (HHSC). Women must apply for the services.

Healthy Texas Women Program
The Healthy Texas Women Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185 percent of the federal poverty level). Women must submit an application to find out if they can receive services through this program.
Additional information regarding services is available through the Healthy Texas Women Program's website: https://www.healthytexaswomen.org/

Healthy Texas Women Plus
The Healthy Texas Women program also offers a postpartum services package, called Healthy Texas Women Plus. Healthy Texas Women Plus provides benefits for:

- Postpartum depression and other mental health conditions
- Cardiovascular and coronary conditions
- Substance use disorders

If a woman is currently enrolled in Medicaid for Pregnant Women, they may be automatically enrolled in the Healthy Texas Women program after delivery and Medicaid has terminated. If eligible, the woman will receive a letter from Texas Health and Human Services confirming she has been enrolled in the Healthy Texas Women program.

HHSC Family Planning Program
The Family Planning Program has clinic sites across the state that provide quality, low-cost, and easy-to-use birth control for women and men. To find a clinic visit the Family and Community Health Services Clinic Locator at http://txclinics.com/.
Additional information regarding the Family Planning program, is located on the program's Website: https://www.healthytexaswomen.org/healthcare-programs/family-planning-program
Additional Information can be found at : https://www.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/womens-health-services/family-planning

HHSC Primary Health Care Program
The HHSC Primary Health Care Program serves women, children, and men who are unable to access the same care through insurance or other programs. To get services through this program, a person's income must be at or below the program's income limits (200 percent of the federal poverty level). A person approved for services may have to pay a co-payment, but no one is turned down for services because of a lack of money. Primary Health Care focuses on prevention of disease, early detection and early intervention of health problems. The main services provided are:

- Diagnosis and treatment
- Emergency services
- Family planning
- Preventive health services, including vaccines (shots) and health education, as well as laboratory, x-ray, nuclear medicine or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home health care, dental care, rides to medical visits, medicines your doctor orders (prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services), and social services.
Men and Women can apply for Primary Health Care services at certain clinics in their area. To find a clinic where they can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.dshs.texas.gov/chcl/ .
Additional information regarding the Primary Health Care program is located on the program's website: https://www.hhs.texas.gov/services/health/primary-health-care-services-program

4.15 - Heath Education/Promotion

In order to improve the health status of FirstCare members, FirstCare has implemented a health education program. This comprehensive program includes health education services targeted to the needs of our members, distribution of health promotion materials, OB case-management and one-on-one education. Health education services and materials are disseminated through enrollment events, in the member packet, at special events such as health fairs, and in provider offices.

Provider Responsibility

The PCP is responsible for providing age appropriate health care and education to the member while the member is at the PCP's office. The PCP must take advantage of every encounter with the member to provide the necessary health education, as this may be the only opportunity afforded. Utilization of the child health clinical record can assist you in complying with this responsibility. These records are divided into age groups and can be utilized any time the member is in the office. To obtain a copy of the forms, visit the Texas Health Steps website at: http://www.dshs.state.tx.us/thsteps/childhealthrecords.shtm or call Texas Health Steps program. The use of these forms is optional.

Available Health Education Services

When a health education need is identified, FirstCare provides important health education services that help your patient stay healthy and well. The FirstCare health education department has information for members in the following subject areas:

- Texas Health Steps Checkups

- Breastfeeding;
- Pregnancy and Childbirth;
- Health education related to obesity
- HIV and Sexually Transmitted Diseases;
- Immunizations;
- Parenting; and
- Survival Skills;

To learn more call the FirstCare health education department at 1-866-787-0663.

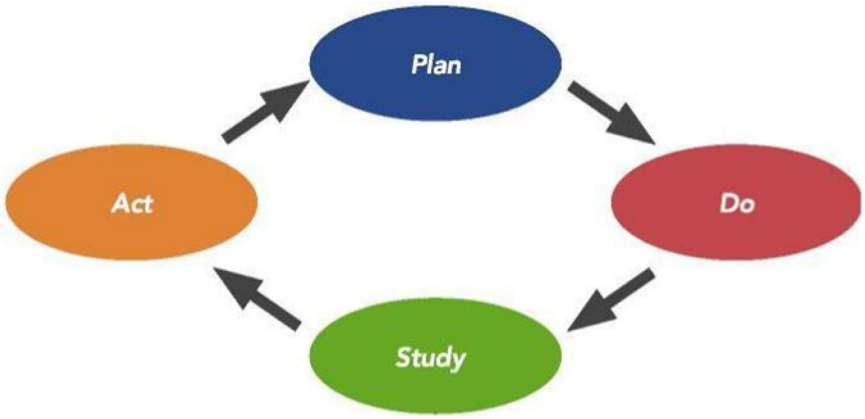
SECTION 5: Quality Improvement Program

5.1 - Introduction

The FirstCare Quality Improvement (QI) Program is a systematic program that involves the entire organization working together at all levels. The Chief Medical Officer, Vice President of Integrated Care Management, Assistant Vice President of Quality Improvement, Regional Medical Directors, providers, managers, and external representatives actively plan, develop, monitor, and adjust quality improvement activities targeting clinical care, service, and organizational efficiency. These individuals manage quality improvement activities as a daily part of FirstCare's operational activities and as leaders within FirstCare's committee structure, which is explained later in this document. In serving on FirstCare's corporate and clinical committees, they establish priorities for FirstCare's QI program, review results of QI monitoring and initiatives, and recommend changes to the program.

Frontline employees participate in the quality improvement program through intradepartmental and interdepartmental quality improvement activities and in serving on QI workgroups. As a part of ongoing quality improvement, when improvement opportunities are identified, FirstCare initiates cross-functional workgroups to analyze problems and develop solutions. Workgroup members may include managers, providers, and front line employees with content knowledge and expertise in the area being addressed. This structure encourages a collaborative multidisciplinary approach to improving quality, which fosters innovation, utilizes available employee knowledge and skills, encourages high employee morale, and results in more effective improvement work.

Quality Improvement Methodology
FirstCare follows the Plan, Do, Study, Act (PDSA) quality improvement model to ensure that performance improvement activities are conducted in a systematic manner. The PDSA cycle is iterative, repeating itself on a continuous basis. This iterative process ensures that FirstCare identifies opportunities for improvement and selects improvement strategies effectively, and ensures success through a feedback loop and continual adjustment. FirstCare completes the following steps using the PDSA model.



Plan: ***Develop a plan for improvement; document the anticipated outcome;*** identify the steps needed to execute the plan. FirstCare designs improvement projects to correct problems and improve performance based on annual goals and objectives. FirstCare also initiates projects when internal surveillance and monitoring identify opportunities for improvement. The various areas of surveillance and monitoring are covered under the 01 program scope and program activities discussed later in this document. FirstCare's planning step includes the following activities:

- Analyze the sources of performance variation and identify root causes of undesirable performance;
- Select interventions to address root causes and improve performance;
- Establish goals/objectives and data indicators to monitor performance; and
- Develop a data collection plan.

Do: ***Execute the plan on a small scale to test the plan: knowledge/research,*** are capable of objectively measuring performance outcomes, e.g., health and functional status, clinical care, customer satisfaction, etc., are defined in clear and unambiguous terms, and include numerator/denominator specifications.

Study: ***Evaluate feedback to determine if the outcome was achieved.*** Immediately after FirstCare has implemented new interventions, the organization uses qualitative data/feedback and process measures to evaluate the initial impact on performance and make any necessary refinements to interventions. Over time, FirstCare uses outcome performance indicators
to evaluate the effectiveness of interventions and ensure that pre-established goals and objectives are met. The organization uses reports of key quantitative performance measures (established during the 01 planning stage) to gauge progress.

Act: ***Take action based on the study.*** Make the plan permanent or start the cycle again to make needed adjustments. FirstCare studies improvement project results over time to determine if interventions have been effective and goals/objectives met. If improvement has
not occurred, FirstCare evaluates whether adjustments to existing initiatives should be made or new improvement projects should be initiated. If a pilot test has been determined to be successful, FirstCare will take steps needed to support full-scale implementation, e.g., system training, policy and procedure development, etc.

The PDSA process is an iterative process, in that when FirstCare identifies that current processes need refinement or new opportunities for performance improvement exist, the PDSA process again enters the planning stage.

5.2 - Program Scope and Objectives

The Quality Improvement (01) program encompasses both clinical care and services provided to members.

Scope of GM Program and Program Activities

The scope of FirstCare's quality improvement activities provides a check and balance of content areas essential to regulatory compliance and desirable performance outcomes. This internal surveillance and monitoring allows FirstCare to identify areas of risk and opportunities for improvement and initiate corrective action and performance improvement timely. These areas include:

- Potential Quality of Care Concerns;
- Coordination with Behavioral Health Care;
- Clinical Practice Guidelines;
- Complaints and Appeals;
- Member education and initiatives;
- Delegation Oversight;

- Provider Involvement and Education;
- Performance Improvement Projects (PIPS)/Quality Improvement Projects (QIPs)
- HEDIS Data Collection and Reporting
- CAHPS Member Satisfaction Survey Data Collection and Reporting; and
- Provider Satisfaction Survey Reporting.

5.3 - HEDIS®

HEDIS is an integral part of the quality improvement program. It monitors member quality of care and service in more than 90% of America's health plans. HEDIS results allow comparison of the performance of health plans on an "apple to apple" basis and helps health plans target their imporvement efforts in quality of care and services. This focus ensure that members get the services and care they need.

FirstCare recognizes the tremendous administrative burden placed on provider offices to retrieve medical records during HEDIS season since multiple health plans are typically asking for records at the same time, and the accrediting body NCQA provides a small window to collect these records.

Providers can use "short cuts" to reduce these administrative burdens on your office, such as:

- Submit claims with the proper ICD-10/CPT codes that count toward the measure
- Report immunizations to state registry: ImmTrac2 (www.dshs.texas.gov/immunize/ Immtrac)
- Electronic Health Records - turn HEDIS "on".
- Example: Have Ht + Wt calculate BMI and BMI percentile for all visits, including GYN visits.
- Provide or refer Members for needed services, e.g., colonoscopy, immunizations, mammograms, etc.
- Take a second Blood Pressure at the end of the visit when patient relaxed and stress is likely lowered- use the right size cuff
- Upper Respiratory Infection- add a second diagnosis code along with URI code so that it won't count against you.

For more information on what you can do, or to schedule individual office training, please contact:

Portia Green
Clinical Quality Lead
portia.green@bswhealth.org

Kathleen Martin
Director QI & Clinical Analytics
kathleen.martin@bswhealth.org

5.4 - Clinical Practice Guidelines

FirstCare's quality improvement committees adopt clinical practice guidelines every two years. These guidelines are generally obtained from professional organizations with expertise in the area, but may be developed internally by designated board certified specialists. The practice guidelines assist providers in standardizing evidence-based care in areas related to preventive screening/ care, care of chronic medical conditions, behavioral health, and medication management.

The practice guidelines are continually updated throughout the year and are available for viewing at the FirstCare provider services web portal. Providers can access a list of guidelines and electronic links on the FirstCare Provider Self-Service Portal at my.FirstCare.com. Click on the Resources/Documents tab, then General Documents, and search for "practice guidelines" to view the guidelines.

FirstCare's approved clinical practice guidelines and their sources are provided below. FirstCare encourages providers to review these guidelines and associated recommendations. FirstCare does monitor provider adherence annually and provides feedback and requests corrective action where appropriate.

To access current guidelines go to my.FirstCare.com and enter your user name/password to log in. If you do not have an account, please create one by contacting your Provider Relations Representative to receive your activation code.

Once you have logged in you can hover over the resources/documents tab to see the options.
The guidelines include:

- Attention Deficit Hyperactivity Disorder
- Asthma
- Depression
- Diabetes
- High cholesterol
- Hypertension
- Prenatal and Postpartum Care
- Preventive Care for Infants, Children, Adolescents and Adults

5.5 - Credentialing

Physician/Physician Group
Credentialing is required for all providers who have an independent physician or medical group contract with FirstCare. Each provider is credentialed separately. As required by NCQA, and Texas Department of Insurance (TDI), FirstCare uses the Texas Standardized Credentialing Application for credentialing and recredentialing of all physicians and physician extenders. Recredentialing is required at least every three years.

FirstCare is currently using the Council for Affordable Quality Healthcare (CAQH), which is a free online service that allows physicians and other professional providers to fill out one application to meet the credentialing requirements of many organizations. This process streamlines the credentialing process and reduces administrative costs. You may access the
CAQH website at http://www.caqh.org or contact the CAQH Help Desk at 1-888-599-1771. You may enroll in CAQH at this website or you may call the help desk for specific answers to your questions.

FirstCare initial credentialing criteria include:

- Graduation from an accredited medical school or training program
- Hold a valid, current professional state license to practice in their designated field
- Possess a valid, current Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable to their practice
- Board certification for MDs, DOs, and DPMs is not required for participation in the FirstCare network but is verified if the provider states board certification on the credentialing application
- Hospital privileges, if applicable based on specialty, in good standing at a FirstCare contracted facility
- Possess and maintain current professional liability insurance that meets or exceeds FirstCare's minimum liability insurance limits
- Detailed explanation of malpractice history and/or Medicare and Medicaid sanctions identified from the provider application and the NPDB search
- Explanation regarding items listed on the C-Tag credentialing criteria list
- Information for unexplained gap in work history of 6 months or more in the last 5 years
- Mid-level providers must have a supervising physician who is a participating provider in the FirstCare network

Verification from the primary source is obtained within 180 days of credentialing for a current state license to

practice, education or training, board certification and hospital privileges. Verification from other sources includes copies of a medical license, DEA or DPS, work history and professional liability coverage. The National Practitioner Data Bank (NPDB) is queried within 180 days of credentialing to verify a provider's history of paid professional liability claims and Medicare and Medicaid sanctions activity.

Practitioners retain the right to:

- Review information submitted to support their credentialing application
- Correct erroneous information by submitting a correction request to the Provider Relations or Credentialing Representative
- Receive the status of their credentialing or recredentialing application, upon request
- Receive notification of these rights

Expedited Credentialing

The expedited credentialing process allows providers to participate in the FirstCare network on a provisional basis. This provisional status is available if:

- Provider is a first time applicant to FirstCare and provisional credentialing request is based on a critical need of the members.
- Provider is joining as a partner, shareholder or employee of a currently contracted and credentialed FirstCare provider in good standing.
- Provider has submitted the appropriate paperwork, including a complete Texas Standard Credentialing Application with current attestation.
- The applicable Regional Medical Director has reviewed the request and determined the application cannot be completed in 30 days or less.
- The required verifications must indicate the file is clean. This includes a state license in good standing with the appropriate medical board, as well as a clean NPDB query.

All provisionally approved providers must agree to comply with the terms of the FirstCare contract currently in force with the applicant physician's established medical group. The full credentialing process must be completed within 60 calendar days of the date a physician is granted provisional status.

Institutional Providers

FirstCare has written policies and procedures for the initial and ongoing quality assessment of the institutional providers with which it intends to contract and with which an ongoing contractual relationship exists. At a minimum, FirstCare confirms before contracting and then every three years thereafter that the institutional provider meets NCQA, TDI and FirstCare standards. Institutional providers credentialed by FirstCare include, but are not limited to: hospitals, nursing homes, skilled nursing facilities, home health agencies, rehabilitation facilities, dialysis centers, free-standing surgical centers, diagnostic imaging centers, laboratories, hospice facilities, infusion service centers, urgent care centers, cancer centers, inpatient behavioral health facilities, residential behavioral health facilities, ambulatory behavioral health facilities, rural health clinics and federally qualified health centers.

Prior to contracting with an institutional provider, FirstCare requires the following:

- A copy of state licensure, if one is required by the State of Texas.
- Documentation of an appropriate Medicare certification as required by state or federal regulations. A copy of the Medicare certificate or provision of the Medicare number will be acceptable proof of participation certification. New facilities awaiting a Medicare number can be considered for participation if they have received accreditation.
- Evidence of applicable state or federal requirements, e.g. Bureau of Radiation Control certification for diagnostic imaging centers, Texas Mental Health and Mental Retardation certification for community mental health centers and CLIA (Clinical Laboratory Improvement Amendments of 1998) certification for laboratories.
- The most recent accreditation certificate, if applicable to the institution. FirstCare accepts certifications from recognized accrediting bodies that assure an independent measure of the quality of services. Recognized accrediting entities include, but may not be limited to, the following:

Institutional Provider	Accrediting Entities
Diagnostic Imaging Center	ACR
Dialysis Centers	ESRD*
Home Health Agencies	TJC, CHAP, or AAAHC
Hospice Facilities	TJC or CHAP
Hospitals	TJC or AOA
Free-Standing Surgical Centers	AAAHC, TJC, AAAAPSF, or AAAASF
Infusion Services Providers	TJC or CHAP
Laboratories	CLIA, CAP
Nursing Homes	State of Texas
Rehabilitation Facilities	CARF
Skilled Nursing Facilities	TJC
Urgent Care Centers	AAAHC

Acronym	Organization
AAAAPSF	American Accreditation Association for Ambulatory Podiatric Surgical Facilities
AAAASF	American Accreditation Association for Ambulatory Surgical Facilities
AAAHC	Accreditation Association for Ambulatory Health Care
ACR	American College of Radiology
AOA	American Osteopathic Association
CARF	Certification of Acute Rehabilitation Facility
CHAP	Community Health Accreditation Program
CLIA	Clinical Laboratory Improvement Amendment
ESRD*	End Stage Renal Disease
TJC	The Joint Commission

**There is no known national accrediting agency but ESRD network participation is encouraged.*

If the institution is not accredited, FirstCare requests a copy of the most recent state or Medicare site survey results. If a national accrediting body does not accredit the institution and if the institution has not had a recent State or Medicare site visit, FirstCare will delay credentialing of the institution pending a Medicare site visit or FirstCare will conduct an on-site evaluation. FirstCare reviews state or Medicare site surveys for the deficiencies found by the accrediting body or Medicare.

Institutional providers provide a current copy of their malpractice liability coverage face sheet showing expiration and coverage amounts.

FirstCare re-credentials institutional providers at least once every three (3) years. The recredentialing process updates the information obtained at initial credentialing including evidence of: state licensure, Medicare certification, applicable state and federal requirements (e.g. Bureau of Radiation Control for

diagnostic imaging centers, Texas Mental Health and Mental Retardation certification for community mental health centers, and CLIA certification for laboratories), accreditation by a national accrediting body, and on-site evaluation if not accredited.

Practitioner Site Visit Evaluation

FirstCare may conduct an office site visit to any provider at any time for cause. The function of the site visit for cause is to gather data to evaluate that network providers are meeting the FirstCare quality standards. The methods by which the deficiencies are identified include, but are not limited to: monitoring member and provider complaints, internal quality reviews, and reports or valid concerns from provider relations department, medical department and/or other internal departments. The survey includes an evaluation of the accessibility, appearance, appointment availability, and space of an office.

On-Going Monitoring

FirstCare monitors network providers to encourage the provision of safe, quality care to FirstCare members between provider credentialing cycles. FirstCare has an on-going monitoring process to determine providers' performance between periods of credentialing.

On a monthly basis, FirstCare reviews the Office of Inspector General's (01G) List of Excluded Individuals/Entities (LEIE), the Office of Personnel Management (OPM), SAM, the state licensing board of each enrolled provider, as well as member and provider complaints, quality reviews, and adverse events.

Credentialing Decisions

All credentialing decisions are made by regional committees defined as peer review bodies and all proceedings are confidential and privileged under the Texas Occupations Code as a medical peer review body. Information obtained or documentation created by FirstCare credentialing staff for credentialing and recredentialing is treated in a confidential manner. First Care complies with HIPAA guidelines regarding the release of credentials information to third parties. Providers or groups are not denied participation with FirstCare or have any such contract terminated on the basis of sex, race, creed, color, national origin, age, or disability. The selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions.

Providers are notified within sixty (60) calendar days of their status in the network according to the determination made by the committee. If initial provider participation is denied or existing participation is altered based on quality of care or quality of service, the provider is notified in writing of the reason for the denial and is given an opportunity for a review process that includes a review panel.

Practitioner Rights

Right to Obtain Credentialing Status —All Practitioners have the right to be informed of the status of their credentialing/recredentialing application. Requests may be submitted in writing via fax or email to the Credentialing department. Upon receipt of the request, the provider will be notified within (10) calendar days in writing by fax, email or letter of

the status of the application with notification to any outstanding information required to complete the application process. Requests to obtain status may be emailed to hpcredentialinggroup@bswhealth.org.

Right to Review Credentialing Information —All practitioners requesting participation with FirstCare Health Plans have the right to review information submitted to and information obtained by FirstCare for the evaluating that practitioner's credentialing or re-credentialing application. This includes non-privileged information obtained from any outside primary source such as the National Practitioner Data Bank, malpractice insurance carriers and state licensing boards. This does not extend to review of information from references, recommendations, peer reviews or otherwise protected by law from disclosure.

Notification of Discrepancy Practitioners will be notified in writing via fax, email or certified letter when information by primary sources varies substantially from the information provided on the practitioner's application. The practitioner will have ten (10) working days to respond and submit corrections after receipt of any discrepancy notification.

Right to Correct Erroneous Information—If a practitioner believes that erroneous information has been supplied to FirstCare from primary sources, the practitioner may submit a written explanation detailing the nature of the error with supporting documents within thirty (30) calendar days to the FirstCare Credentialing department.

FirstCare's Credentialing Committee will include this information in the practitioner's credentialing file and as part of the credentialing/recredentialing process. FirstCare will respond to the practitioner within ten (10) calendar days.

Written requests for information and explanations may be submitted via email to hpcredentialinggroup@bswhealth.org.

SECTION 6: Medical Services

6.1 - FirstCare STAR Scope of Covered Health Services

Members participating in FirstCare STAR will receive all the benefits available to members participating in the traditional Texas Medicaid. Benefits may contain specific requirements and limitations.

Please refer to the current Texas Medicaid Provider Procedures Manual for an inclusive listing of covered health services including limitations and exclusions that apply to each benefit category. It is available online at http://www.TMHP.com. Covered health services listed below are included in the monthly capitation paid to FirstCare by HHSC for the administration of the STAR program. For questions call FirstCare at 1-800-431-7798.

- Ambulance services
- Audiology services, including hearing aids, for adults and children
- Behavioral Health Services*, including:
    - Attention Deficit Hyperactivity Disorder (ADHD) Services:
        - Providers will be reimbursed for the treatment of ADHD in children who are Members and providers may conduct follow-up visits with children for whom they have prescribed ADHD medications.
    - Inpatient mental health services for Children (birth through age 20)
    - Outpatient mental health services
    - Psychiatry services
    - Counseling services for adults (21 years of age and over)
    - Outpatient substance use disorder treatment services including:
        - Assessment
        - Detoxification services
        - Counseling treatment
        - Medication assisted therapy Residential substance use disorder treatment services including:
        - Detoxification services
        - Substance use disorder treatment (including room and board)

    **These services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service Medicaid coverage. The services may be subject to the MCO's non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.*
- Birthing services provided by a physician and certified nurse midwife (CNM) in a licensed
- birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency Services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:

- inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    - all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
    - surgery and reconstruction on the other breast to produce symmetrical appearance;
    - treatment of physical complications from the mastectomy and treatment of lymphedemas; and
    - prophylactic mastectomy to prevent the development of breast cancer.
- external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.

- Medical checkups and Comprehensive Care Program (CCP) Services for children (birth through age 20) through the Texas Health Steps program
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
- Outpatient drugs and biological; including pharmacy-dispensed and provider-administered outpatient drugs and biological
- Drugs and biological provided in an inpatient setting
- Podiatry
- Prenatal care
- Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center.
- Primary care services
- Preventive services including an annual adult well check for patients 21 years of age and older
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies - physical, occupational and speech
- Transplantation of organs and tissues
- Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)
- Telemedicine Telemonitoring (effective October 1, 2013 through August 31, 2015)
- Spell of Illness Eliminated - The 30 day inpatient "spell of illness" limitation has been eliminated for FirstCare STAR members ages 21 and over.
    - Members under the age of 21 already have this benefit through the Comprehensive Care Program (CCP).
- Waiver of the three-prescription per month limit. Unlimited prescriptions for adults.
- $200,000 annual limit on inpatient services does not apply for STAR members.

Added Benefits
FirstCare STAR members are also eligible for the following added benefits.

6.2 - STAR Value-Added Services

FirstCare STAR members are eligible for the following value-added services:

- Up to $150 for Pregnant Members for completing the following:
- My Plan Perks TM' © **$75 gift card** for prenatal visit within the first trimester or within 42 days of FirstCare enrollment.
- My Plan Perks TM' © **$75 gift card** for postpartum within 21 to 56 days after delivery.
- Up to **$500 a year for dental** checkups which includes:
    - cleaning every 6 months
    - x-rays once a year
    - simple extractions
    - limited fillings
    - fluoride treatments

  for Pregnant Members age 21 and older.
- My Plan Perks TM' © **$20 gift card** for Members attending a FirstCare Baby Shower and completing one prenatal visit during the 1st trimester or within 42 days of enrollment with FirstCare.
- My Plan Perks TM' © **$20 gift card** for Members attending a FirstCare Baby Shower and completing a timely postpartum visit between 21 to 56 days after delivery.
- My Plan Perks TM' © **$25 gift card** for having a THSteps checkup on time.
- My Plan Perks TM' © **$20 gift card** for STAR members who have a follow-up doctor visit within 7 days of discharge from a behavioral health hospital stay.
- My Plan Perks TM' © **$25 gift card** for STAR members ages 1-17 taking anti-psychotic medications who receive a blood glucose and a cholesterol test.
- My Plan Perks TM' © **$20 gift card** for timely follow-up after discharge from a behavioral health hospital stay.
- My Plan Perks TM' © **$25 Gift Card** for participation in Asthma Disease Management program for not well controlled or very poorly controlled asthma (Level 2 or 3).
- My Plan Perks TM' © **$20 gift card** who participate in a Diabetes Disease Management program for not well controlled or very poorly controlled diabetes (Level 2 or 3).
- One **sports physical** each year for Members age 19 and younger.
- Eye checkup once a year for Members age 21 and older.
- **Limited to $200** for eyewear, services normally not a covered benefit under the Medicaid program benefits (such as tint, anti-reflective coating, scratch resistant coating, deluxe lens, progressive lenses.) for adults (over 21 years of age).
- FirstCare Members will access to quarterly My Plan Perks TM' © wellness webinars.
- **Talk to a Nurse—Nurse 24TM.** Get answers 24 hours a day, 7 days a week.
- **In-home support** for pregnant Pregnant FirstCare Members in Care Management for high-risk conditions such as diabetes, hypertension, and severe nausea.
    - **"Expecting the Best" ® pregnancy management program:** Early enrollment in Service Coordination support program
    - Access to a nurse 24 hours a day, 7 days a week
    - Educational smart phone app
    - Planning for delivery, including individual support during and after pregnancy Perinatal and Postpartum depression screening during pregnancy and up to one year post delivery Parental education for newborn health
    - Planning for returning to work
- **Baby Shower and Baby Safety program for pregnant members**. . Baby shower includes diaper bag and other small items. One monthly ride for members to go to the grocery store, WIC appointments, health education classes, fitness centers, vocational trainings, job interviews, self-help group meetings, places of worship/religious services, pregnancy/birthing classes, newborn classes, CPR/first aid classes, FirstCare Member Advisory Groups, or FirstCare Baby Showers.
- Grow Well TM' Smart Phone app for trusted health information for you and your family through every age and stage of life. Plus, you can directly connect to resources.
- Online social services resource directory is available on the FirstCare member portal to locate community supports such as food and nutrition, housing, education, and employment services.

6.3 - FirstCare CHIP Scope of Covered Health Services

Covered CHIP services must meet the CHIP definition of medically necessary covered health services as defined in this manual. There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays apply until a family reaches its specific cost-sharing maximum. Covered health services listed below are included in the monthly capitation paid to FirstCare by HHSC for the administration of the CHIP program. For questions call FirstCare at 1-877639-2447.

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

Covered Benefit	Description
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts and splints • Drugs, medications and biologicals • Blood or blood products that are not provided free-of-charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section. □ Hospital, physician and related medical services, such as anesthesia, associated with dental care • Inpatient services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds, and - histological examination of tissue samples. • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and outpatient services and do not count towards the DME 12-month period limit

Covered Benefit	Description
Inpatient General Acute and Inpatient Rehabilitation Hospital Services (continued)	• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; - severe traumatic skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or it's treatment.
Skilled Nursing Facilities (includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints and dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Outpatient services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds, and - histological examination of tissue samples. • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility • Surgical implants • Other artificial aids including surgical implants

Covered Benefit	Description
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center (continued)	• Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: - all stages of reconstruction on the affected breast; - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; - severe traumatic skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.

Covered Benefit	Description
Physician/Physician Extender Professional Services	Services include, but are not limited to, the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations); • Physician office visits, inpatient and outpatient services; • Laboratory, X-rays, imaging and pathology services, including technical component and/or professional interpretation; • Medications, biologicals and materials administered in Physician's office; • Allergy testing, serum and injections; • Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care; - Administration of anesthesia by physician (other than surgeon) or CRNA; - Second surgical opinions; - Same-day surgery performed in a hospital without an over-night stay; and - Invasive diagnostic procedures such as endoscopic examinations. • Hospital-based physician services (including physician-performed technical and interpretive components); • Physician and professional services for a mastectomy and breast reconstruction include: - All stages of reconstruction on the affected breast; - External breast prosthesis for breast(s) on which medically necessary mastectomy procedure(s) have been performed; - Surgery and reconstruction on the other breast to produce symmetrical appearance; and - Treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section; • Physician services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: - Dilation and curettage (D&C) procedures; - Appropriate provider-administered medications; - Ultrasounds; and - Histological examination of tissue samples.

Covered Benefit	Description
Physician/Physician Extender Professional Services (continued)	• Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation; and • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - Cleft lip and/or palate; - Severe traumatic skeletal and/or congenital craniofacial deviations; or - Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
Prenatal Care and Pre-Pregnancy Family Services and Supplies	• Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services. • Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.
Birthing Center Services	• Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) • Limitation: Applies only to CHIP members.
Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center	Covers prenatal services and birthing services rendered in a licensed birthing center.
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.

Covered Benefit	Description
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies • Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: • Neuropsychological and psychological testing • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • Does not require PCP referral
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility: - Neuropsychological and psychological testing - Medication management - Rehabilitative day treatments - Residential treatment services - Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-education skill development) • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination

Covered Benefit	Description
Outpatient Mental Health Services (continued)	• A Qualified Mental Health Provider – Community Services (QMHPCS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services • Does not require PCP referral
Inpatient Substance Abuse Treatment Services	Services include, but are not limited to: • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • Does not require PCP referral
Outpatient Substance Abuse Treatment Services	• Services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized nonresidential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for 4 to 12 weeks, but less than 24hours per day • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training • Does not require PCP referral
Rehabilitation Services	Services include, but are not limited to, the following: • Habilitation (the process of supplying a child with the means to reach age- appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: - Physical, occupational and speech therapy - Developmental assessment
Hospice Care Services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness • Up to a maximum of 120 days with a 6-month life expectancy • Patients electing hospice services may cancel this election at anytime • Services apply to the hospice diagnosis

Covered Benefit	Description
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	HMO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: • Emergency services based on prudent lay person definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by innetwork and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin
Transplants	Services include, but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One (1) pair of non-prosthetic eyewear per 12-month period
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation
Tobacco Cessation Program	Covered up to $100 for a 12- month period limit for a plan–approved program • Health Plan defines plan-approved program • May be subject to formulary requirements
Service Coordination and Care Coordination Services	These services include outreach informing, Service Coordination, care coordination and community referral.
Drug Benefits	Services include, but are not limited to, the following: • Outpatient drugs and biological; including pharmacy-dispensed and provider-administered outpatient drugs and biological; and • Drugs and biological provided in an inpatient setting.

6.4 - CHIP Value Added Services

FirstCare CHIP members are also eligible for the following added benefits":

- One My Plan Perks ™©$25 gift card per year for new or existing CHIP members age 20 and under who get a timely well-child checkup.
- My Plan Perks ™© $20 gift card for timely follow- up after discharge from a behavioral health-hospital stay.
- My Plan Perks ™© $25 gift card for having a well-child checkup on time.
- My Plan Perks ™© $25 Gift Card for participation in Asthma Disease Management for not well controlled or poorly controlled asthma (Level 2 or 3).
- FirstCare Members will have access to quarterly My Plan Perks ™© wellness webinars.
- Talk to a Nurse—Nurse 24™. Get answers 24 hours a day, 7 days a week.
- One sports physical each year for Members age 19 and younger.
    - "Expecting the Best"® pregnancy management program Early enrollment in Service Coordination support program
    - Access to a nurse 24 hours a day, 7 days a week
    - Educational smart phone.
    - Planning for delivery, including individual support during and after pregnancy
    - Perinatal and Postpartum depression screening during pregnancy and up to one year post delivery.Parental education for newborn health
    - Planning for returning to work
- Baby Shower and Baby Safety program for pregnant members. Baby shower includes diaper bag and other small items.
- One monthly ride for members to go to the grocery store, WIC appointments, health education classes, fitness centers, vocational trainings, job interviews, self-help group meetings, places of worship/religious services, pregnancy/birthing classes, newborn classes, CPR/first aid classes, or FirstCare Baby Showers.
- Grow Well ™ Smart Phone app for trusted health information for you and your family through every age and stage of life. Plus, you can directly connect to resources.
- Online social services resource directory is available on the FirstCare member portal to locate community supports such as food and nutrition, housing, education, and employment services.

6.5 - CHIP Exclusions from Covered Health Services

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

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

6.6 - FirstCare CHIP Perinatal Newborn Scope of Covered Health Services

Covered CHIP Perinatal newborn services must meet the CHIP definition of medically necessary covered health services as defined in this manual. FirstCare provides a benefit package that includes the services currently covered in the CHIP, CHIP Perinate, and CHIP Perinate Newborn Evidence of Coverage (EOC) or Certificate of Coverage (COC). There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Copayments do not apply to CHIP Perinatal members. CHIP Perinatal newborns are eligible for 12-months continuous coverage, beginning with the month of enrollment as a CHIP Perinate.

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

Covered Benefit	Description
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free-of-charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section • Hospital, physician and related medical services, such as anesthesia, associated with dental care • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds; and - histological examination of tissue samples. • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas.

Covered Benefit	Description
Inpatient General Acute and Inpatient Rehabilitation Hospital Services (continued)	• Implantable devices are covered under Inpatient and outpatient services and do not count towards the DME 12-month period limit • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; - severe traumatic skeletal and/or congenital craniofacial - deviations; or - severe facial asymmetry secondary to skeletal defects, - congenital syndromal conditions and/or tumor growth or its treatment.
Skilled Nursing Facilities (includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility

Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints and dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Outpatient services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds; and - histological examination of tissue samples. • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility • Surgical implants • Other artificial aids including surgical implants

Covered Benefit	Description
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including Health Center) and Ambulatory Health Care Center (continued)	• Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: - all stages of reconstruction on the affected breast; - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; - surgery and reconstruction on the other breast to produce - symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and Outpatient • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; - severe traumatic skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
Physician/Physician Extender Professional Services	Services include, but are not limited to, the following: • American Academy of Pediatrics recommended well-child exams - and preventive health services (including, but not limited to, vision - and hearing screening and immunizations); • Physician office visits, inpatient and outpatient services; • Laboratory, X-rays, imaging and pathology services, including technical component and/or professional interpretation; • Medications, biologicals and materials administered in Physician's office; • Allergy testing, serum and injections; • Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care; - Administration of anesthesia by physician (other than surgeon) or CRNA; - Second surgical opinions; - Same-day surgery performed in a hospital without an over-night stay; and - Invasive diagnostic procedures such as endoscopic examinations. • Hospital-based physician services (including physician-performed technical and interpretive components);

Covered Benefit	Description
Physician/Physician Extender Professional Services (continued)	• Physician and professional services for a mastectomy and breast reconstruction include: - All stages of reconstruction on the affected breast; - External breast prosthesis for breast(s) on which medically necessary mastectomy procedure(s) have been performed; - Surgery and reconstruction on the other breast to produce symmetrical appearance; and - Treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section; • Physician services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: - Dilation and curettage (D&C) procedures; - Appropriate provider-administered medications; - Ultrasounds; and - Histological examination of tissue samples. • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation; and • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - Cleft lip and/or palate; - Severe traumatic skeletal and/or congenital craniofacial • deviations; or - Severe facial asymmetry secondary to skeletal defects, congenital • syndromal conditions and/or tumor growth or its treatment.
Prenatal Care and Pre-Pregnancy Family Services and Supplies	• Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services. • Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.
Birthing Center Services	• Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) • Limitation: Applies only to CHIP members.
Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center	Covers services rendered to a newborn immediately following delivery.

Covered Benefit	Description
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies • Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: • Neuropsychological and psychological testing. • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • Does not require PCP referral

Covered Benefit	Description
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility: - Neuropsychological and psychological testing - Medication management - Rehabilitative day treatments - Residential treatment services - Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment • Skills training (psycho-education skill development) • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • A Qualified Mental Health Provider - Community Services (QMHPCS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHScontracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services • Does not require PCP referral
Inpatient Substance Abuse Treatment Services	Services include, but are not limited to: • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • Does not require PCP referral
Outpatient Substance Abuse Treatment Services	Services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized nonresidential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training • Does not require PCP referral

Covered Benefit	Description
Rehabilitation Services	Services include, but are not limited to, the following: • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: • Physical, occupational and speech therapy • Developmental assessment
Hospice Care Services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness • Up to a maximum of 120 days with a 6 month life expectancy • Patients electing hospice services may cancel this election at
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	HMO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: • Emergency services based on prudent lay person definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin
Transplants	Services include, but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One (1) pair of non-prosthetic eyewear per 12-month period
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation

Covered Benefit	Description
Tobacco Cessation Program	Covered up to $100 for a 12- month period limit for a plan-approved program: • Health Plan defines plan-approved program • May be subject to formulary requirements
Service Coordination and Care Coordination Services	These services include outreach informing, Service Coordination, care coordination and community referral
Drug Benefits	Services include, but are not limited to, the following: • Outpatient drugs and biological; including pharmacy-dispensed and provider-administered outpatient drugs and biological; and • Drugs and biological provided in an inpatient setting.

Value-Added Services Extra Benefits for Health and Wellness:

- One My Plan Perks ™©$25 gift card per year for new or existing CHIP members age 20 and under who get a timely well-child checkup.
- My Plan Perks ™© $20 gift card for timely follow-up after discharge from a behavioral health-hospital stay.
- My Plan Perks ™© $25 gift card for having a well-child checkup on time.
- My Plan Perks ™© $25 Gift Card for participation in Asthma Disease Management for not well controlled or very poorly controlled asthma (Level 2 or 3).
- FirstCare Members will have access to quarterly My Plan Perks ™©wellness webinars.
- Talk to a Nurse—Nurse 24™. Get answers 24 hours a day, 7 days a week.
- One sports physical each year for Members age 19 and younger.
- "Expecting the Best"® pregnancy management program
  - Early enrollment in Service Coordination support program
  - Access to a nurse 24 hours a day, 7 days a week
  - Educational smart phone app.
  - Planning for delivery, including individual support during and after pregnancy
  - Perinatal and Postpartum depression screening during pregnancy and up to one year post delivery.Parental education for newborn health
  - Planning for returning to work
- Baby Shower and Baby Safety program for pregnant members. Baby shower includes diaper bag and other small items.
- One monthly ride for members to go to the grocery store, WIC appointments, health education classes, fitness centers, vocational trainings, job interviews, self-help group meetings, places of worship/religious services, pregnancy/birthing classes, newborn classes, CPR/first aid classes, or FirstCare Baby Showers.
- Grow Well ™ Smart Phone app for trusted health information for you and your family through every age and stage of life. Plus, you can directly connect to resources.
- Online social services resource directory is available on the FirstCare member portal to locate community supports such as food and nutrition, housing, education, and employment services.

6.7 - CHIP Perinatal Newborn Exclusions from Covered Health Services

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

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Contraceptive medications prescribed only for the purposes of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which

are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by health plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the health plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the health plan
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or Speech therapy services are not covered except when ordered by a Physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)

6.8 - FirstCare CHIP Perinatal Scope of Covered Health Services

Covered CHIP Perinatal (unborn children) services must meet the CHIP definition of medically necessary covered health services as defined in this manual.

Covered Benefit	Description
Inpatient General Acute	For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with income above the Medicaid eligibility threshold (Perinates who do not qualify for Medicaid once born), benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a nonviable pregnancy. Services include: • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: • dilation and curettage (D&C) procedures; • appropriate provider-administered medications; • ultrasounds; and • histological examination of tissue samples.
Skilled Nursing Facilities (includes Rehabilitation Hospitals)	Not a covered benefit.

Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including Health Center) and Ambulatory Health Care Center	Services include, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs

Covered Benefit	Description
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center (continued)	Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds; and - histological examination of tissue samples. 1. Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth. 2. Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or non-viable pregnancy. 3. Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. 4. Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. 5. Surgical services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.
Physician/Physician Extender Professional Services	Services include, but are not limited to the following: - Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth - Physician office visits, in-patient and out-patient services - Laboratory, X-rays, imaging and pathology services including technical component and /or professional interpretation - Medically necessary medications, biologicals and materials administered in physician's office

Covered Benefit	Description
Physician/Physician Extender Professional Services (continued)	• Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. - Administration of anesthesia by physician (other than surgeon) or CRNA - Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. - Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) • Hospital-based physician services (including Physician performed technical and interpretive components) • Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation. • Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT. • Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds; and - histological examination of tissue samples.
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: 1. one visit every four weeks for the first 28 weeks or pregnancy; 2. one visit every two to three weeks from 28 to 36 weeks of pregnancy; and 3. one visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary. Benefits are limited to: • Limit of 20 prenatal visits and 2 postpartum visits (maximum 60 hin days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review.

Covered Benefit	Description
Prenatal Care and Pre-Pregnancy Family Services and Supplies (continued)	Visits after the initial visit must include: - interim history (problems, marital status, fetal status); - physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities); and - laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 2428 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services related to labor with delivery. Applies only to CHIP Perinate members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).
Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center	Covers prenatal services and birthing services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: 1. One visit every four weeks for the first 28 weeks or pregnancy; 2. One visit every two to three weeks from 28 to 36 weeks of pregnancy; and 3. One visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary. Benefits are limited to: • Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: - interim history (problems, marital status, fetal status); - physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities); and - laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).

Covered Benefit	Description
Durable Medical Equipment (DME), Prosthetic Devices	Not a covered benefit.
Home and Community Health S vic s	Not a covered benefit.
Inpatient Mental Health Services	Not a covered benefit.
Outpatient Mental Health Services	Not a covered benefit.
Inpatient Substance Abuse Treatment Services	Not a covered benefit.
Outpatient Substance Abuse Treatment Services	Not a covered benefit.
Rehabilitation Services	Not a covered benefit.
Hospice Care Services	Not a covered benefit.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	MCO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. • Emergency services based on prudent layperson definition of emergency health condition. • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor with delivery of the covered unborn child. • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit. • Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Not a covered benefit.
Vision Benefit	Not a covered benefit.
Chiropractic Services	Not a covered benefit.
Tobacco Cessation Pro ram	Not a covered benefit.

Covered Benefit	Description
Service Coordination and Care Coordination Services	Covered benefit.
Drug Benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting. Services must be medically necessary for the unborn child.

Value-Added Services Extra Benefits for Health and Wellness:

- One My Plan Perks™© $25 gift card per year for new or existing CHIP members age 20 and under who get a timely well-child checkup.
- My Plan Perks ™© $20 gift card timely follow-up after discharge from a behavioral health-hospital stay.
- My Plan Perks ™© $25 gift card for having a well-child checkup on time.
- My Plan Perks ™© $25 Gift Card for participation in Asthma Disease Management for not well controlled or very poorly controlled asthma (Level 2 or 3).
- FirstCare Members will have access to quarterly My Plan Perks ™©wellness webinars.
- Talk to a Nurse—Nurse 24™. Get answers 24 hours a day, 7 days a week.
- One sports physical each year for Members age 19 and younger.
- "Expecting the Best"® pregnancy management program
  - Early enrollment in Service Coordination support program
  - Access to a nurse 24 hours a day, 7 days a week
  - Educational smart phone app
  - Planning for delivery, including individual support during and after pregnancy
  - Perinatal and Postpartum depression screening during pregnancy and up to one year post delivery Parental education for newborn health
  - Planning for returning to work
- Baby Shower and Baby safety program for pregnant members. Baby shower includes diaper bag and other small items.
- One monthly ride for members to go to the grocery store, WIC appointments, health education classes, fitness centers, vocational trainings, job interviews, self-help group meetings, places of worship/religious services, pregnancy/birthing classes, newborn classes, CPR/first aid classes, or FirstCare Baby Showers.
- Grow Well ™ Smart Phone app for trusted health information for you and your family through every age and stage of life. Plus, you can directly connect to resources.
- Online social services resource directory is available on the FirstCare member portal to locate community supports such as food and nutrition, housing, education, and employment services.

6.9 - CHIP Perinatal Unborn Children Exclusions from Covered Health Services

- For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.

- Disposable medical supplies.
- Home and community-based health care.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the labor with delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation programs.
- Chiropractic Services.
- Medical transportation not directly related to labor or threatened labor, miscarriage or non-viable pregnancy, and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or postpartum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Out-of-network services not authorized by the health plan except for emergency care related to the labor with delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care.
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping.

- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, which do not require the skill and training of a nurse.
- Vision training, vision therapy, or vision services.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ.

6.10 - Participating Provider Responsibilities

- Verify the eligibility of the member prior to providing covered health services;
- Maintain hospital privileges, if applicable based on specialty, in good standing at a FirstCare contracted facility or request from the regional 01 department a waiver form to document a FirstCare provider with hospital privileges at a contracted FirstCare facility that will admit and treat hospitalized patients for the contracted provider;
- Prescribe generic pharmaceuticals when appropriate and available;
- Agree to not refer or direct members to hospital emergency rooms for non-emergent medical services at any time. The PCP will make every effort to schedule those urgent cases that could become emergent if left untreated for 24 hours;
- Provider should refer members to other in-network participating providers unless approval is received in advance from FirstCare, or in an emergency situation where, in the prudent medical judgment of the PCP/specialists, physical harm will result if the member is not referred on an emergency basis. In such instances, appropriate medical documentation may be required;
- Assist in the education and instruction of patients on the proper utilization of the provider's office in lieu of the emergency room;
- Coordinate and provide appropriate referrals for members to enable access to second opinions;
- Maintain both general liability and professional liability insurance of $100,000 per occurrence and $300,000 in the aggregate, as specified by HHSC;
- Comply with FirstCare's credentialing and re-credentialing requirements;
- Inform both FirstCare and HHSC's administrative services coordinator of any changes to the provider's address, telephone number, group affiliation, etc.;
- Submit and maintain claims using the appropriate format (CMS-1500/UB-92) with appropriate diagnosis and procedure code designations;
- Document all aspects of patient care, including ancillary services and referrals, in medical records;
- Comply with Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws when using electronic medical records;
- Maintain all medical records relating to FirstCare STAR/CHIP members for a period of at least 5 years (Rural Health Clinics must maintain records for 6 years from the initial date of service);
- Comply with Federal regulations that protect against discrimination and the Americans with Disabilities Act;
- Comply with the requirements of state and federal laws, rules, and regulations relating to advance directives;
- Develop and implement HIV workplace guidelines for direct patient care in accordance with Health and Safety Code, Chapter 85, Subchapter E relating to Duties of State Agencies and State Contractors; and
- Participation in FirstCare's Quality Improvement program, which includes, but is not
- limited to, complaint and/or potential quality review, medical record audits, facility site reviews, access and availability studies, after-hours studies and quality of care studies.
- Provide the same level of care to FirstCare members as provided to all other participants.
- Comply with FirstCare's quality management and utilization management procedures. Use only FirstCare's participating hospital(s), outpatient surgical facilities, laboratories, radiology facilities, and pharmacy provider, except for emergencies and where the member's benefit plan allows for coverage outside of the network.

- Comply with FirstCare's billing procedures and claims submission guidelines.
- Submit clean claims in accordance with state, federal, and/or FirstCare's requirements.
- Comply with all FirstCare claims processing guidelines, including but not limited to any coding edits, coordination of benefits or audit requirements.
- Refund to FirstCare, or the applicable affiliate, any excess or overpayments.
- Comply with all Health Insurance Portability and Accountability Act (HIPPA) regulations.
- Provide an office environment that is protective of the health and safety of their personnel, the FirstCare member, and adheres to the standard set forth by the Texas Department of Health.
- Observe, protect and promote the right of FirstCare members. Respect the cultural and religious concerns of patients.
- Require staff to adhere to FirstCare's confidentiality requirements.

FirstCare Utilization Management (UM) Department staff is available during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a member of the UM staff please call 1-800-884-4905. If the office is closed, please leave a message and someone will contact you the next business day. Staff will identify them salves by FirstCare, name and title when originating or returning calls regarding UM issues.

First Care Health Plans utilization management decision making is based only on appropriateness of care and services and existence of coverage. First care does not specifically reward practitioners or other individual for issuing denials of coverage. First Care does not offer financial incentives to utilization management decision making that encourage decisions that result in underutilization.

PCP Role and Responsibilities

A Primary Care Provider (PCP) is responsible for providing, arranging, and coordinating all aspects of the member's health care and for directing and managing appropriate utilization of health care resources. The PCP is the focal point of all care management for members participating in the FirstCare STAR, CHIP, or CHIP Perinatal newborn product.

FirstCare recognizes General Practice, Family Practice, Internal Medicine, Pediatric, Obstetrics/ Gynecology (OB/GYN), Advance Practice Registered Nurses (APRNs) and Physician Assistants (PAs) (when APRNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology (who also qualify as a PCP), Rural Health Clinics (RHCs), and Federally Qualified Health Center (FQHC), similar community clinics, and specialist physicians who are willing to provide a Medical Home to selected members with special needs and conditions as primary care providers.

However, an internist or other provider who provides primary care to adults only is not considered an age-appropriate PCP choice for members birth through age 20. An internist or other provider who provides primary care to adults and children may be a PCP for children if FirstCare is able to verify that:

1. The provider assumes all MCO PCP responsibilities for such members in a specific age range from birth through age 20;
2. The provider has a history of practicing as a PCP for the specified age range, as evidenced by the provider's primary care practice including an established patient population within the specified age range; and
3. The provider has admitting privileges to a local hospital that includes admissions to pediatric units.

A pediatrician is not considered an age-appropriate choice for a member age 21 and over. The member is requested to select or designate a PCP at the time of enrollment. If a selection is not made, a primary care physician will be assigned by FirstCare. Members may change PCPs upon providing FirstCare notice.

Responsibilities

- Provide or arrange for medically necessary routine, urgent and emergent services within the health care professional's scope of practice and area of expertise for eligible FirstCare STAR/CHIP members;
- Routine Primary Care for STAR/CHIP members should be available to existing members 14 days upon request.
- PCP should be able to accommodate existing STAR/CHIP members with urgent care needs within 24 hours of request.
- PCP for STAR/CHIP members should be able to schedule a preventive medical care appointment for a new adult member, within 90 days of request.
- PCP for STAR/CHIP members should be able to schedule a preventive medical care appointment for a new child member within 90 days of enrollment.
- PCP for STAR/CHIP members should be able to schedule a preventive medical care appointment for a newborn patient within 14 days of enrollment.
- PCP shall provide qualified, consistent, easily accessible on-call coverage 7 days a week, 24 hours a day, either personally or by a reasonable call coverage arrangement with other appropriate individuals;
- PCP shall provide screening and evaluation for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders within the scope of his/her practice;
- Refer members to specialists, network facilities, and other health related service, as needed, and document in medical records the coordination of referrals and services;
- Provide copies of any such records upon the reasonable request of FirstCare, Payor or any authorized representative of a local, state, or federal regulatory agency; and
- Serve as a Medical Home to members.
- For FirstCare STAR members only, provide preventive health services in accordance with FirstCare STAR and related medical policies. The preventive health services shall include, but not be limited to the following:
    1. Periodic health assessments for all adult FirstCare STAR members over 21 years of age in accordance with the U.S. Preventive Task Force requirements, and
    2. Preventive care to children birth through age 20 in accordance with the American Academy of Pediatrics (AAP) recommendations and the Texas Health Steps periodicity schedule published in the Texas Health Steps Manual for Medicaid members.

Designated OBGYN for Female Members

FirstCare allows members to pick an OB/GYN but this doctor must be in part of the FirstCare STAR or CHIP Provider Network.

ATTENTION FEMALE MEMBERS
Members have the right to select an OB/GYN without a referral from their primary care provider. An OB/GYN can give the member:

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

If a female member is 24 weeks or more into her pregnancy, she may remain with her existing OB provider through postpartum, regardless if provider is out-of-network, however an authorization must be obtained. If the PCP is acting as an OB provider, the PCP must also obtain authorization for OB care. Members are allowed to change to an in-network provider if she chooses to do so, and the provider to whom she is changing agrees to accept her late in her pregnancy.

FirstCare will provide or reimburse out-of-network providers who provide medically necessary covered health services to members who move out of the service area through the end of the eligibility period for the member.

Specialty Care Provider Role and Responsibilities

The role of an in-network FirstCare specialist (SPC) is to provide consulting expertise, as well as specialty diagnostic, surgical and other medical care. Specialist focus on specific disciplines of health care and work in conjunction with a member's PCP, ensuring all aspects of a member's health needs are met.

Responsibilities

- Specialists shall provide qualified, consistent, easily accessible on-call coverage 7 days a week, 24 hours a day, either personally or by a reasonable call coverage arrangement with other appropriate individuals;
- Routine Specialty Care for STAR/CHIP members should be available to existing members within 30 days of request.
- Specialists should be able to accommodate existing members with urgent care needs within 24 hours of request.
- Specialists are to submit to the PCP of each member, which specialist is treating, within industry standards after referral and treatment of a member, a report concerning the treatment provided to such member. Such reports may be given verbally initially, provided a written report is submitted within ten (10) calendar days following the verbal report;
- Specialist providers should order all laboratory testing, radiology studies or other diagnostic testing through a contracted, in-network facility unless an emergency situation clearly indicates emergency lab or radiology services are required; and
- Specialists providers are to provide copies of any such records upon the reasonable request of FirstCare, payor or any authorized representative of a local, state, or federal regulatory agency.

Specialists Acting as a PCP
FirstCare provides the opportunity to FirstCare members, with chronic, disabling, or life threatening illnesses that cannot be stabilized/controlled by a PCP, and whose care is centered around decisions made by a specialist, to apply to the FirstCare Medical Director to designate an in-network specialist as the member's PCP

A written request should be directed to FirstCare's Medical Director. Upon receipt of the request, FirstCare will establish that the Specialist meets FirstCare's requirements for PCP designation; including credentialing and contractual obligations.

FirstCare's determination to approve or deny the request along with written notification to the member of that determination will occur within 30 days of FirstCare's receipt of the request. The effective date of the designation of a Specialist as a member's PCP will not be retroactive. If the Medical Director denies the request, the decision may be appealed through the FirstCare complaints and appeal process.

Hospital Role and Responsibilities

The role of the hospital is to provide services to member's admitted by a participating physician in accordance with the physician's orders.

Responsibilities

- Except in cases of emergency care, the hospital agrees to only admit members upon orders of a participating physician, and with prior authorization by FirstCare. FirstCare may deny payment for services that are not appropriately pre-authorized. The hospital may not bill the members for services so denied. In the event that a physician does not provide the hospital an authorization number prior to an admission for the services requested for a member, the hospital is advised to contact FirstCare to verify the existence of such number.
- The hospital agrees to notify FirstCare of all admissions of members during regular working hours, but in no event later than 24 hours or the next working day following the admission of a member.
- FirstCare shall pay for emergency services in the event a member requires medical emergency care. However, the hospital shall obtain prior authorization from FirstCare before providing inpatient Post-Stabilization Care for services originating in a hospital emergency department. FirstCare shall approve or deny such a request within the time appropriate to the circumstances and the condition of the member, but in no case to exceed one (1) hour. If emergency care occurs after business hours, during a holiday, or on a weekend, hospital shall obtain prior authorization of the occurrence on the next business day. Failure to obtain prior authorization may result in payment denial.
- Hospital agrees that it shall not transfer members to another inpatient hospital without prior authorization from FirstCare except in emergency care situations. Such admissions, whenever possible, should only be to an in-network participating hospital.
- Hospital agrees to verify member's eligibility with FirstCare prior to the non emergency admission of, or provision of services to, any member. Failure to verify eligibility as required may subject hospital to a denial of payment with respect to services rendered.

6.11 - Members with Special Health Care Needs (MSHCN)

Identifying MSHCN

FirstCare uses referrals and data from claims and encounters to identify members who have special healthcare needs (MSHCN). These members receive outreach from FirstCare's Service Coordination department to assess the member's needs and create a care and services plan designed to help eliminate care gaps and improve health outcomes for these members.

Members who are identified as MSHCN include but are not limited to:

- Pregnant women identified as high risk
- Members with high-cost catastrophic care needs
- Members with severe and persistent mental illness and/or substance abuse diagnoses
- Members with serious ongoing illness or a chronic complex condition that is anticipated to last for a significant period and requires ongoing therapeutic intervention and evaluation.

FirstCare welcomes and encourages referrals from providers when MSHCN are identified. Referrals may be completed by emailing CaseManagement@BSWHealth.org or by calling FirstCare's Customer Service Department.

Members identified as MSHCN may request to designate a specialist as his/her PCP for the purpose of treating and managing the member's special health care needs. (Refer to previous subsection, SPECIALTY CARE PROVIDER ROLE AND RESPONSIBILITIES, "Specialists Acting as a PCP" for more information on selecting a Specialist as a PCP.)

6.12 - Standards of Access

PCPs/specialists are required to comply with the standards of access established by HHSC and monitored by FirstCare.

FirstCare monitors practitioner compliance with FirstCare standards regarding appointment availability. PCPs and Specialists are to provide member access to care in accordance with the following standards:

- Emergency care services must be provided upon member presentation at the service delivery site, including at non-network and out-of-area facilities;
- Urgent care, including urgent specialty care, must be provided within 24 hours of request;
- Routine primary care must be provided within 14 days of request;
- Initial outpatient behavioral health visits must be provided within 14 days of request;
- Routine specialty care referrals must be provided within 30 days of request;
- Prenatal care must be provided within 14 days of request, except for high-risk pregnancies or new members in the third trimester, for whom an appointment must be offered within 5 days, or immediately, if an emergency exists;
- Preventive health services for adults must be offered to a member within 90 days of request; and
- Preventive health services for children, including well-child checkups should be offered to members in accordance with the American Academy of Pediatrics (AAP) periodicity schedule. For STAR members, provider's should use the Texas Health Steps program modifications to the AAP periodicity schedule. For newly participating members under age 21, overdue or upcoming well-child checkups, including Texas Health Steps medical checkups, should be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 60 days of enrollment for all other eligible child members.

Providers who fail to meet FirstCare standards will be re-audited as per 01 policy. Providers who continue to demonstrate non-compliance will be submitted to the provider relations department for review of contract compliance.

Participating PCPs and specialists shall be available and accessible to FirstCare members 24 hours a day, 7 days a week.

Acceptable After-Hours coverage arrangements include the following:

- Office telephone is answered after-hours by an answering service, which has Spanish translators available 24 hours a day, 7 days a week, and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service are to be returned within 30 minutes;
- Office telephone is answered after normal business hours by a recording in English and Spanish, directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable; and
- Office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within thirty (30) minutes. This location must provide Spanish translation services.

Unacceptable After-Hours coverage arrangements include the following:

- Office telephone is only answered during office hours;
- Office telephone is answered after-hours by a recording that notifies patients to leave a message;
- Office telephone is answered after-hours by a recording that directs patients to go to an emergency room for any services needed;
- Returning after-hours calls outside of thirty (30) minutes; and
- Provider is not able to be reached by Spanish speaking members.

Providers who fail to meet FirstCare standards will be educated and a re-audit will be conducted. Providers who continue to demonstrate non-compliance will be submitted to the provider relations department for review of contract compliance.

FirstCare requires that all practitioners and facilities ensure parity in the provision of services to FirstCare members, regardless of plan type, including hours of operation.

6.13 - On-Call Providers

A participating provider must be available to FirstCare members on a 24-hour-a-day, 7-day-aweek basis. Should a participating provider use an on-call provider to render services in his/ her absence, the provider must arrange such on-call/call coverage with another participating FirstCare provider. Please advise the on-call provider that they must present themselves as an on-call provider.

On-call providers must contact FirstCare for any services that may require prior authorization. The on-call provider should include the prior authorization information on all claims and submit them directly to the FirstCare for consideration. The on-call provider must notify FirstCare of any emergency admissions within 24-hours or the next business day.

The participating provider must ensure that the on-call provider does not balance bill members for covered services under any circumstances (except for copayments). Also, the on-call provider must contact FirstCare for those covered services that require prior authorization, except in emergency situations.

It is the responsibility of the participating provider to ensure that his/her on-call provider understands and agrees to the FirstCare's claims processing guidelines and payment terms, or to make additional reimbursement arrangements with the on-call provider, if necessary.

Who Can Serve as an On-Call/Covering Provider
On-call/covering providers should be of the same or similar specialty type as the physician/ practitioner for whom they cover. Exceptions to this must be approved by a FirstCare Medical Director.

Physician agreements require that physicians/practitioners make appropriate arrangements with other participating FirstCare providers for call coverage to assure availability of care on a 24 hours per day, 7 days per week basis.

> **NOTE:** PCPs are not placed on call for specialists; however, specialists can be on call for PCPs if within the same clinic. Also, physician extenders will be considered on call for physicians but not vice versa.

6.14 - Changes in Provider Status/Information

In order to ensure prompt and accurate payment to providers, it is essential that FirstCare be kept informed of changes in provider information and/or status. Demographic changes, such as those listed below, can be submitted electronically with appropriate documentation (i.e. W9, etc) on our Account Management website section at www.bswhealthplan.com/providers/pages/default.aspx:

- Primary service address changes;
- Billing address changes;
- Telephone number changes;
- Fax number changes; and/or
- Email address changes.
- Name changes;
- Tax ID changes;
- Terminations; and/or
- New or discontinued services.

Network providers must inform both FirstCare and HHSC's administrative services contractor of any changes to the provider's address, telephone number, group affiliation, etc.

Patient Capacity Changes
A PCP may increase or decrease his/her patient capacity from the original contracted capacity. The PCP is to contact the FirstCare by mail or fax to request a change in patient capacity. Increases will become effective immediately. However, decreases will become effective the first day of the second month following the receipt of the notice so as to allow FirstCare sufficient time to arrange for transfer of excess patients to another PCP.

Plan Termination
In-network providers who wish to terminate his/her participation without cause, in FirstCare STAR and/or CHIP should notify FirstCare in writing on group or provider letterhead with reason for termination and requested date of termination. This request will become effective the first of the month following 180 days from receipt of such request.

6.15 - Referrals to Out-Of-Network Providers

Referrals to out-of-network providers for medically necessary and covered health services will require prior authorization by the FirstCare.

Information required for an Out-of-Network Referral

- Clinical rationale or reason for the out-of-network services
- Member's name
- Member ID number
- Member's date of birth
- PCP requesting the referral and NPI and TIN
- Specialist provider requested and NPI and TIN
- Diagnosis (ICD10)
- Visits or services to be performed (if a procedure the procedure code must be included)
- Information about other insurance the member may have

Out-of-Network Approval Requirements
FirstCare may authorize referrals to out-of-network providers when one or more of the following conditions are present:

- Life threatening emergency situation exists and appropriate or timely
- Access to an in-network facility or service is not reasonably practical or possible
- Covered transplant is required and approved
- Covered, medically necessary is not available through an in-network Provider
- Service or care is available in-network, but not accessible
- Service is available in-network, but there is a continuity of care concern for a new member (e.g. any high-risk pregnancy in the second trimester or third trimester) or for a member who is treating provider termed with FirstCare.
- Preexisting condition is not imposed.

Failure to obtain prior authorization for out-of-network referrals may result in denial of payment for services rendered. The provider may not bill the member for services so denied.

Out-of-Network Referral Processing
Out-of-network referral requests are processed in the order received and within 3 working days of receipt of the necessary clinical information. Leave your fax systems on at all times in order to allow FirstCare to return information back to you regarding your request (i.e. request for additional clinical information).

Out-of-Network Services
FirstCare has developed contractual arrangements with a number of specialists, hospitals and centers of excellence throughout the State of Texas and nationally. Before recommending a specific specialist or facility to a member for care, the referring physician should consult with the FirstCare customer service department about providers available through the FirstCare STAR or CHIP network.

The referring physician should discuss with the out-of-network provider any lab or radiology studies expected to be performed prior to the member's visit and have those services performed by an in-network provider or facility before the visit to the out-of-network provider. Lab, X-ray and/or ancillary services performed by, or ordered by, an out-of-network provider not specifically authorized by FirstCare in advance, will not be covered.

When a covered transplant is required, members must have that procedure performed through a FirstCare STAR or CHIP contracted transplant facility. Consult with the FirstCare medical department on available centers and the process of evaluation necessary to make a valid referral for transplants.

Extending a Referral

There may be occasions when a treatment by a specialist or other provider to be extended beyond the initial referral. To extend an out-of-network referral, submit a new prior authorization request specifying the number of additional visits needed for the referral and appropriate medical justification (clinical).

Any follow up care to the out-of-network provider must also be pre-authorized by FirstCare **prior** to care being rendered. Follow-up care is not included in the initial out-of-network pre-authorization.

6.16 - Preauthorization Program and Requirements

Services Requiring Preauthorization

A category authorization list is available on the FirstCare website. Visit the FirstCare website and log in to our Provider Self-Service portal for the Prior Authorization Requirements Code Lookup, which includes a listing of current prior authorization codes, online authorization submissions, and more!

Availability of Criteria

Clinical criteria are available upon request. Clinical criteria are provided to all providers within 10 days of request. A copy of the most recent version of the requested clinical criteria may be faxed, emailed, or mailed to the provider based upon their request.

Preauthorization Program and Requirements

FirstCare defines "preauthorization" as having received FirstCare's approval for a service to be delivered based on evaluation of medical necessity prior to the time the service is rendered. We require that certain medical services, care, or treatments be pre-authorized before we will pay for the covered health services. In order to ensure timely care and services, we encourage

providers to submit requests a minimum of five days prior to the anticipated service date. If you fail to get proper prior authorization, care or treatment may not be covered or you may incur payment penalties. Leave your fax system on at all times in order to allow FirstCare to return information back to the provider (i.e. request for additional clinical information, peer-to-peer notification).

How to Obtain a Preauthorization

Authorization requests are accepted from in network and out-of-network provider. Registered users may log in and submit a prior authorization request electronically via our secure provider portal. Alternatively, complete and fax the FirstCare Prior Authorization request form. Provider Portal log in and the request form are available on our website www.FirstCare.com. In addition, you may contact the preauthorization department by phone at 1-800884-4905.

Information Required for Preauthorization

- Member's name, date of birth, member ID number;
- Ordering provider's name, NPI and TIN;
- Servicing Provider's name, NPI and TIN;
- Date of admission/procedure (if date changes, please notify FirstCare);
- Diagnosis (ICD-10);
- Procedure (CPT/HCPCS) code number;
    - Pertinent clinical information (a clear, concise description of the work-up, pertinent lab, X-ray, or other test data, and any other pertinent information reasonably providing justification for the

requested services);
- Expected length of stay;
- Anticipated discharge needs;
- Treatment plan; and
- Other carrier information.

Preauthorization Department Responsibilities:

- Process authorizations in the order received and within 3 working days of receipt of the necessary clinical information;
- Verify what services will be performed, and if the services are to be performed by a participating, in-network provider;
- Determine if the diagnosis, clinical information and treatment plan are available and request additional clinical information, if needed; and
- Review clincal information against appropriateness criteria and health management guidelines.

Provision of preauthorization by FirstCare for a specific service is not a guarantee of payment. Payment is subject to continuing member's eligibility at the time the service is rendered. Written or verbal "Prior Authorization Not Required" notifications should not be construed to mean a guarantee of payment for services. Payment of services depends on the Member's specific plan benefits and coverage, Member eligibility at the time of service, and on the provider's compliance with claims processing procedures.

Admitting Physician Responsibilities

It is the admitting physician's responsibility to obtain authorization for services specified in this section and to provide the necessary clinical and patient information to process authorization requests. Although any physician participating in an admission, either directly or through consultation, may supply preauthorization information, responsibility for this authorization falls to the admitting physician. Failure to obtain preauthorization for the specified services will result in denial of payment for services rendered. In such cases, providers may not bill members for denied services.

Elective Service Preauthorization Lead Time Requirements

For non-emergent elective admissions and procedures, contact FirstCare at least 2 working days before the planned service or admission. Failure to meet the lead times specified for elective admissions or procedures may result in FirstCare's inability to approve the procedure or admission for the original scheduled date. Late requests for authorization for elective services that do not meet the lead time requirements shall not be given priority nor treated as emergencies, and therefore, shall not be approved on a priority basis.

Emergency Admissions and Direct Admissions
It is the responsibility of the admitting physician to contact FirstCare's preauthorization department within 24 hours or the next business day of any emergency or direct admission. Failure of the physician to contact FirstCare may result in denial of payment or delay of payment for services rendered by the admitting physician and/or other providers involved in the case. Physicians and hospitals may not bill the members for services denied because of failure to contact FirstCare following an emergency or direct admission. (See also "Routine, Urgent, and Emergent Care Services" which appears under a separate heading in this section of the manual).

Inpatient Admission and Length of Stay Authorization
FirstCare uses the nationally recognized standards of MCG as well as direct physician supervision for review of clinical information in determining if inpatient level of care will be authorized. At the time initial clinical and discharge plans is received and reviewed for level of care medical necessity, FirstCare will assign an expected length of stay. Additional days may be authorized based on clinical information supplied by the physician.

If a future scheduled surgery is denied during the preauthorization process, the physician may request a peer-to-peer review of the case with the FirstCare Medical Director. The Medical Director will consult with the requesting physician about the case prior to rendering his or her decision. Please note that many denials during the preauthorization process are a result of
incomplete, absent or inadequate medical information. Specific and accurate clinical information is necessary to process a request for authorization properly. It is essential that the physician or physician's representative submitting the request have the information available at the time of preauthorization in order to avoid possible delay and/or denial of authorization request.

Concurrent Review of Inpatient Admissions
FirstCare will monitor the course of inpatient care services received by a member. The Concurrent Review Nurse may conduct any of the following:

- Review of member's chart;
- Communicate with the patient/guardian/parent;
- Discuss the case with the hospital UM staff;
- Speak directly to the admitting physician regarding the progress of the case;
- Identify discharge or alternative care needs; and
- Assist the facility, physician, and/or member with post-facility care arrangements, coverage information, benefit information, etc.

If, during the course of the review, the Concurrent Review Nurse determines, based on established guidelines, that the available documentation indicates the patient can be transitioned to a lower level of care, the attending physician will be contacted to discuss the justification of any continued services and possible alternatives. The Concurrent Review Nurse, in collaboration with the FirstCare Medical Director, may reduce the authorized level of services and notify the attending Physician of same, and suggest appropriate alternatives to current services.

If the attending physician disagrees with FirstCare's determination regarding denial of continued services, he or she may request a further review by the FirstCare Medical Director (Refer to: COMPLAINT AND MEDICAL APPEAL PROCEDURES section, "Appeals to Adverse Determinations").

Requesting Extensions to the Authorized Length of Stay
If, during the course of hospitalization or other services, the attending physician believes the approval for reimbursement of hospitalization or other services should be extended beyond what has been authorized, he or she should submit a clinical update to the concurrent review nurse to request an extension of the length of stay or other services. Failure to obtain authorization for additional days of inpatient stay or other services may result in denial of payment for services.

The request for extension will be evaluated based on the clinical information provided. If the Medical Director denies the extension, the attending physician may pursue the next level of the appeals process (Refer to:

COMPLAINT AND MEDICAL APPEAL PROCEDURES section, "Appeals to Adverse Determinations").

Availability of Criteria
Providers are notified that Clinical Criteria are available upon request. They are provided to all provides within 10 days of request. A copy of the most recent version of the requested clinical Criteria will be faxed, emailed or mailed to the provider based upon their request.

6.17 - Cancellations, Technical Denials and Adverse Determinations

Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage. FirstCare does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

Technical Denials
A "technical denial" is a denial of reimbursement for requested or provided services based on non-medical issues such as: member ineligibility, non-covered health services, benefit limitations, and/or failure to obtain preauthorization within the required time frame. Technical denials are issued by the preauthorization department.

FirstCare will notify the member or a person acting on behalf of the member and the member's provider of record of a technical denial made during the course of utilization review activities.

The notification of a technical denial will include:

- Principal reason for the technical denial;
- Description or the source of any screening criteria that were utilized as guidelines in making the technical denial; and
- Description of the procedure for the complaint process, including notification of the:
  - Member's right to file a complaint related to a technical denial; and
  - Member's right to contact the Texas Department of Insurance (TDI), including TDI's toll-free telephone number and address.
- You have the right to request an appeal or a State Fair Hearing if you do not agree with the action. An appeal is the process where you ask for a review of the action. Call customer service toll-free at 1-800-431-7798. A customer service advocate can help you file your request. You may file your appeal by phone or in writing. Every phone appeal received must be confirmed by a written, signed appeal by you or your representative unless it is an expedited appeal. Your request for an appeal must be filed within 30 days from when you get notice of the action. To make sure services continue, you must file the appeal on or before the later of: 10 days following the FirstCare's mailing of the notice of the action or the intended effective date of the proposed action. The appeal process may be extended up to 14 calendar days if member request it. Or, it can be extended if FirstCare STAR shows there is a need to learn more and the delay would be best for the member. The member will get written notice if the appeal process is extended. You can request a State Fair Hearing any time during or after FirstCare's appeals process.

Adverse Determinations (Denials Based On Lack of Medical Necessity)
The Medical Director must review all potential denials related to medical necessity. Prior to the issuance of an adverse determination, the requesting/ordering provider will be given the opportunity to discuss the plan of treatment for the member and the clinical basis for

FirstCare's decision with the Medical Director. A verbal notification or a faxed letter will be sent to the provider regarding the option to speak to the Medical Director. The Medical Director may call the provider directly. If the treating practitioner would like to request a peer-to-peer discussion with the Medical Director who rendered the decision, the must notify FirstCare Health Plans within 24-hours of receipt of faxed letter. A non-urgent peer-to-peer review can be scheduled by calling 1-800-844-4905 or faxing 1-806-784-4319 during normal business hours from 8 a.m. to 5 p.m., Monday through Friday, or 24/7 for urgent and post stabilization reconsiderations. If the case results in an adverse determination, all requirements related to an adverse determination will be followed.

FirstCare will notify the member or a person acting on behalf of the member and the member's provider of record of an adverse determination made during the course of utilization review activities. The notification of an adverse determination will include the following:

- The dates, types, and amount of service requested;
- The type of action the MCO has taken or intends to take (e.g. denial or limited authorization of a requested service; reduction, suspension or termination of a previously authorized services, etc.);
- The date the MCO will take the action;
- Principal reason(s) for the adverse determination;
- Clinical basis for the adverse determination;
- Description or the source of the screening criteria that were utilized as guidelines in making the determination;
- Explanation of how the requested service does not meet one or more of the criteria for medical necessity, as set forth in the managed care contract's definition of "Medical Necessary";
- Description of the procedure for the complaint and appeal process, including:
  - Member's right to contact the Texas Department of Insurance (TDI);
  - TDI's toll-free telephone number and address;
  - You have the right to request an appeal or a State Fair Hearing if you do not agree with the action. An appeal is the process where you ask for a review of the action. Call customer service toll-free at 1-800-431-7798. A customer service advocate can help you file your request. You may file your appeal by phone or in writing. Every phone appeal received must be confirmed by a written, signed appeal by you or your representative unless it is an expedited appeal. Your request for an appeal must be filed within 30 days from when you get notice of the action. To make sure services continue, you must file the appeal on or before the later of:10 days following the FirstCare's mailing of the notice of the action or the intended effective date of the proposed action. The appeal process may be extended up to 14 calendar days if member request it. Or, it can be extended if FirstCare STAR shows there is a need to learn more and the delay would be best for the member. The member will get written notice if the appeal process is extended. You can request a State Fair Hearing any time during or after FirstCare's appeals process; and
  - The member may represent himself or herself, or use legal counsel, a relative, friend or other spokesman.
- Determination concerning an acquired brain injury. In addition to the notification required by this section, a URA must comply with this subsection in regard to a determination concerning an acquired brain injury as defined by §21.3102 of this title (relating to Definitions). Not later than three business days after the date an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness, a URA must provide notification of the determination through a direct telephone contact to the individual making the request. This subsection does not apply to a determination made for coverage under a small employer health benefit plan.

FirstCare will provide the notification of the adverse determination:

- Within 1 working day by telephone or electronic transmission to the provider of record in the case of a patient who is hospitalized at the time of the adverse determination, to be followed by a letter notifying the patient and the provider of record of an adverse determination within 3 working days;
- Within 3 working days in writing to the provider of record and the member if the member is not hospitalized at the time of the adverse determination; or
- Within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one (1) hour from notification when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or provider. In such circumstances, notification shall be provided to the treating physician or health care provider.

NOTE *Retroactive reviews of adverse determinations are not subject to an Independent Review Organization (IRO) appeal process.*

6.18 – FirstCare's Service Coordination Program

Our Service Coordination Program is included in health plan coverage as an added benefit for our members. The program is at no cost to our members and completely voluntary. Your patient may opt in or out at any time.

Service Coordination Program provides:

- Coordination to bridge gaps in care for needed treatment, services and/or equipment
- Empowerment towards self-management of chronic diseases/conditions
- Specialized management options based on diagnoses, medications, and health status including pregnancy and behavioral health
- Guidance and advice on the healthcare system and patient benefits
- Assistance with coordination of referrals and authorizations
- Referrals to community resources to alleviate social determinant of health barriers

Referring a patient to Service Coordination:

All health plan members with current coverage are eligible to participate in the Service Coordination Program. Anyone can refer a member to Service Coordination, including providers. Members may even self-refer to Service coordination by calling the number on the back of their insurance card and asking to speak with a member of our team.

Referrals can also be made by sending a secure email to: CaseManagement@BSWHealth.org. Please include the members name, date of birth and information on why you are sending the referral.

What to expect after referring to Service Coordination:

A member of the Service Coordination team will call your patient within four business days, offer Service Coordination and attempt to complete a comprehensive health assessment. Any needs or opportunities for assistance identified during the assessment will be utilized to develop an individualized plan of care with your patient. Our staff will continue to work with you and your patient until the goals are met, the member's coverage terminates, the member remains unreachable, or they decline to continue.

Service Coordination for Children and Pregnant Women (CPW)
Service Coordination for Children and Pregnant Women (CPW) is a program that provides services to high-risk Medicaid children (under age 21) and high-risk Medicaid pregnant women. CPW providers are social workers or Registered Nurses (RNs) working as individuals or employed by schools, health departments, counseling agencies, health clinics, and other agencies. Providers must be approved by Department of State Health Services (DSHS) and enroll with Texas Medicaid and Healthcare Partnership (TMHP) as CPW Medicaid Providers. CPW helps high-risk members get help in the following areas:

- Supplies and equipment;
- Family problems;

- Financial concerns;
- Accesses to medical services;
- Education and school problems; and
- Finding help near the member.

The main difference in services provided by CPW versus and internal FirstCare Service Coordination/Service Coordination services, is CPW:

- Home visits are conducted
- Visits are face to face
- Case manager may attend school meetings with parent to advocate for client
- The whole family is assessed, not just the client
- Services are provided only if client currently has needs related to their health condition or health risk
- CPW Providers cannot provide health education

In most cases, the Member needs can be met by the FirstCare Service Coordination/Service Coordination department. If the Member requires services FirstCare is unable to provide and can be met via a CPW provider, the Health Plan will coordinate with the CPW provider and will issue a referral reference number to indicate the CPW services are not a duplication of FirstCare provided services.

CPW providers should submit a referral for services request to FirstCare prior to providing Member services to confirm services are not a duplication of FirstCare services and assist in claims processing. Referral for services request can be requested verbally by contacting the Member Services Department or via secure email directly to the FirstCare Service Coordination/Service Coordination department.

Required Referral Information (must provide via secure email or telephonically)

- Member Name and Insurance Member Number
- Member phone number
- CPW Provider to Render Services (include NPI and/or Supplier Number claims will be billed to)
- CPW Provider contact information for coordination of services and referral
- Services to be provided (example: CPW)
- Planned start date for services
- Planned end date for services
- How many days/visits expected to be needed
- Reason Services are needed

Send Secure Email Requests to
For Pregnant Women and Birth to 1 Year of Age: hpmaternitycasemanagement@bswhealth.org
For Children 1 to 20 Years: casemanagement@BSWHealth.org
For Behavioral Heath Related Cases: HPBHCaseManagement@BSWHealth.org

*If unknown, all requests can be sent to casemanagement@BSWHealth.org and the request will be directed to the appropriate department.

*Referral completion process dependent on reachable status and coordination engagement of the CPW provider and the Member with the FirstCare Service Coordinator/Case Manager.

For members transferring from FFS to a new MCO and who received CPW services whiles in FFS, the new MCO must allow the Member to continue to receive CPW Services from the CPW Provider in the same amount, duration, and scope as provided in FFS, even if the provider is Out-of-Network, until the CPW service plan developed by the CPW Provider has been completed. The CPW provider must notify FirstCare when requesting a referral to the MCO, confirming the above requirements are met and providing the necessary supporting documentation.

Billing for CPW Services – Individual

- CPW providers will continue billing for G9012 (Other specified Service Coordination service not elsewhere classified) and related modifiers U2, U5, and TS
- HHSC expects the codes used for Service Coordination for children and pregnant women services to remain the same. Refer to the TMPPM Behavioral Health and Service Coordination Services Handbook, Section 3.3
- Service Coordination for children and pregnant women is distinct from Early Childhood Intervention Targeted Service Coordination. Service Coordination for children and pregnant women is not in the Medicaid Children's Handbook. The benefit is defined in the Behavioral Health and Service Coordination Services Handbook.
- Service Coordination for children and pregnant women services are not billed by time increments but by the service encounter.
- T1017 is not a procedure code associated with Service Coordination for Children and Pregnant Women services.

Billing for CPW Services – FQHC

- The FQHC prospective payment system (PPS) wrap payment methodology applies to CPW services delivered.
- FQHCs will bill using G9012 (Other specified Service Coordination service not elsewhere classified) and TS in addition to T1015 and appropriate modifiers.
- Refer to TMPPM Clinics and Other Outpatient Facility Services Handbook, Section 4.1.2 for the most up to date codes.

G9012

- Comprehensive visit G9012 with modifier U5 and U2
- Follow up face-to-face G9012 with modifier U5 and TS
- Follow-Up telephone G9012 with modifier TS

6.19 - Maternity Care

(Refer to: CLAIMS SUBMISSION AND ADMINISTRATION section, "Special Billing Situations" for additional information)

Should any change occur in pregnancy status or the expected date of confinement, it is requested that the provider notify FirstCare. You may use the "Pregnancy Notification Form" and fax it to customer service 1877-878-8422.

Breast Pump Coverage in Medicaid and CHIP

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

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.

CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	
STAR Health	STAR Health	STAR Health	
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

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

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

Ultrasounds/Sonograms

Obstetric Ultrasound, pregnancy ultrasound limit is 3 per pregnancy. The limit applies to the following codes: 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, and 76817. The limit of three obstetric ultrasounds per pregnancy does not apply to obstetric ultrasound procedures that are rendered in the emergency room, outpatient observation, or inpatient hospital setting. Obstetric ultrasounds provided in the emergency department must be submitted with modifier U6 when submitted on the professional claim form in order to be considered for payment. Claims configuration is based on the billed diagnosis and CPT codes.

For example, an over-the-limit ultrasound claim may deny for a diagnosis of routine screening or supervision of pregnancy, but may pay for complications of pregnancy.

FirstCare standard of practice for ultrasounds during normal, uncomplicated pregnancies include 3 ultrasounds for determination of fetal size. Ultrasounds solely for the purpose of sex determination are not covered.

Maternity Care, Inpatient and Delivery
By policy, no authorization is required for inpatient care for delivery, for both mother and newborn, for a minimum of 48 hours following an uncomplicated vaginal delivery, and 96 hours following an uncomplicated delivery by cesarean section.

The member, in consultation with her physician, may choose to be discharged from an inpatient setting prior to the initial length of stay authorized if medically appropriate.

Should a decision be made to discharge the mother or newborn from inpatient care prior to the initially authorized length of stay, FirstCare will cover alternative post-delivery care, if requested. This care can consist of physician services, services of a registered nurse or other appropriate health care provider in the member's home, plan provider's office, or health care facility.

6.20 - Lab Testing and Radiology Services

All laboratory and radiological services are to be performed by a facility contracted and approved with FirstCare for these services. All providers should use the laboratory and radiology providers as recommended by FirstCare.

> ***NOTE:*** *Providers may not order tests from a reference laboratory and re-bill those services to FirstCare as if performed by the provider. This will be considered a fraudulent billing practice and cause for termination of participation.*

6.21 - Durable Medical Equipment and Other Products Normally Found in a Pharmacy

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

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must be contracted and credentialed with FirstCare Health Plans and follow the claims submission process as described in Section 11 of this manual.

FirstCare will only be responsible for items dispensed that are a covered benefit under the member's plan. In order to determine what DME require preauthorization, please see the DME Preauthorization Requirements list at www.FirstCare.com/Providers. Preauthorization may be obtained by accessing the provider services web portal or by calling or faxing the request to the preauthorization department. Clinical information to support the request should be provided.

Any medical supply that can be purchased over-the-counter without a physician's order does not require authorization and is not a covered benefit for FirstCare STAR or CHIP members. However, for members with diabetes mellitus, some supplies that would otherwise not be covered are covered when the equipment is obtained from an in-network provider. Specific questions concerning these diabetic supplies should be directed to FirstCare.

Call 1-800-431-7798 for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

Rental vs. Purchase of DME
FirstCare will determine whether DME will be rented or purchased based upon the duration and usage needs of the FirstCare STAR member. Rental payments are made only for the period of time the equipment is medically necessary or when the total monthly rental payments equal the reasonable purchase cost for the equipment. Purchase is justified when the estimated duration of need multiplied by the rental payments would exceed the reasonable purchase cost of the equipment or it is otherwise more practical to purchase the equipment.

Maintenance and Repair of DME
Routine maintenance of rental equipment is the responsibility of the DME provider who supplied the equipment. Repair of DME and appliances will be considered based on the age of the item and the cost to repair the item. A request for repair of DME or appliance must include a statement or medical information from the attending physician substantiating that the medical appliance or equipment continues to serve a specific medical purpose and an estimated itemized cost list of the repairs. Rental equipment may be provided to replace purchased medical equipment or appliances for the period of time it will take to make necessary repairs to the purchased medical equipment or appliances.

Cancellation of Product Orders
A Network Provider that offers delivery services for covered products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products must reduce, cancel, or stop delivery if the member or the member's authorized representative submits an oral or written request. The Network Provider must maintain records documenting the request.

6.22 - Home Health Services

Home Health Services are covered benefits for STAR and CHIP members. An in-network provider must be utilized. If there is not an in-network provider available in the city where the member resides, the physician/provider is to contact the FirstCare medical department to coordinate these services.

Services are to be provided to those members who require skilled care in the home setting and only when ordered by the PCP or attending plan physician. Home Health Services are to be prior authorized in advance of the services being rendered and updated as needed in the member's plan of care.

6.23 - Outpatient Nutritional Services

Nutritional counseling is available for up to 4 outpatient visits with an individual counselor or up to 8 group therapy sessions in a rolling year.

Medical nutrition therapy and nutrition counseling may be considered beneficial for disease states for which dietary adjustment has a therapeutic role. Such disease states include, but are not limited to, the following conditions:

- Abnormal weight gain
- Cardiovascular disease
- Diabetes or alterations in blood glucose
- Eating disorders

- Gastrointestinal disorders
- Gastrostomy or other artificial opening of gastrointestinal tract
- Hypertension
- Inherited metabolic disorders
- Kidney disease
- Lack of normal weight gain
- Multiple food allergies
- Nutritional deficiencies

Nutrition intervention for the following conditions is considered experimental and investigational and is not a benefit:

- Attention-deficit hyperactivity disorder
- Chemical sensitivities
- Chronic fatigue syndrome
- Idiopathic environmental intolerance

6.24 - Physical Rehabilitation Services

Except for cardiac or pulmonary rehabilitation, therapy services performed outpatient or inpatient require authorization. Skilled therapy services include:

- Aqua therapy
- Balance/vestibular therapy
- Cognitive therapy
- Speech therapy
- Physical therapy
- Occupational therapy

The therapist may request additional therapy visits by submitting a new authorization request. The treatment plan must accompany the request.

Authorization for skilled therapy services are based on:

- Medical necessity;
- Treatment goals;
- Member's ability to meet or exceed treatment goals;
- Rehabilitation potential; and
- Degree of progress being made for ongoing therapy.

Although prior authorization is not required, outpatient cardiac and/or pulmonary rehabilitation services must be ordered by the member's PCP or a specialist. Services are to be performed at an in-network facility.

Preauthorization is NOT required for Early Childhood Intervention (ECI) Services. An in-network ECI provider must be utilized.

6.25 - Routine, Urgent and Emergent Care Services

Routine Care Services
Those covered health services a physician commonly performs within the scope of the physician's practice or license are considered routine care. Routine care services are to be performed in the same manner, in accordance with the same standards, and within the same time availability as offered by other physicians to private pay patients. Services must be provided in compliance with generally accepted medical and behavioral health standards for the community in which services are rendered. Routine care is to be scheduled within 2 weeks of member's request.

Urgent Care Services
Those medical conditions which are not an emergency but are severe or painful enough to cause a prudent layperson, possessing average knowledge of medicine and health, to believe that the condition requires medical treatment or evaluation within 24 hours to prevent serious deterioration of the member's condition or health is considered urgent care. Urgent care is to be schedule within 24 hours of request.

Emergency Care Services

Health care provided in a hospital emergency facility or trauma center for evaluating and stabilizing the onset of a severe medical condition that could reasonably be expected to cause permanent and significant physical harm, or loss of life or limb, is considered emergency care.

FirstCare uses the following set of criteria to determine when a member has an emergency condition: a medical condition of recent or sudden onset and severity that would lead a prudent layperson possessing an average knowledge of medicine, to believe the condition, sickness, or injury was of such a nature that failure to obtain immediate medical attention could result in:

- Placing the person's health in serious jeopardy;
- Serious impairment to bodily function;
- In the case of a pregnant woman, serious jeopardy to the health of the fetus;
- Serious dysfunction of any bodily organ or part; and/or
- Serious disfigurement.

FirstCare members may contact their PCP regarding a need for emergency care before receiving the care whenever possible and/or practical. The PCP shall determine the emergent nature of the situation and use professional discretion in directing the member to the most appropriate location to receive the service (i.e., the office, urgent care center, minor emergency room, or the hospital ER or trauma center). When the PCP directs the member to the nearest emergency facility, the member should be seen immediately.

FirstCare will cover the professional, facility, and ancillary services that are medically necessary to perform the medical screening examination and stabilization of a member with an emergency condition. Emergency services claims will be processed according to FirstCare's standard claims adjudication process in accordance with state and federal regulations.

Any need for post-emergency stabilization, such as admission to inpatient must be pre-authorized within the appropriate time frame by the FirstCare preauthorization department.

Outpatient follow-up care resulting from an emergency facility visit or facility stay must be rendered by an in-network provider.

Medicaid Emergency Dental Services

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

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

CHIP Emergency Dental Services

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

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

Texas Health Steps Dental Services
The applicable periodicity schedule for Texas Health Steps dental checkups follows the standards adopted by the American Academy of Pediatric Dentistry. The initial dental checkup exam by a Texas Health Steps dental provider should occur at 6 months of age, and every 6 months thereafter. Medical checkups include a referral for a dental checkup if the recipient has not been seen by a dentist in the past 6 months. Although an oral screening examination is part of the physical examination, it does not substitute for a dental checkup/exam by a dentist. Members through age 20 can also self-refer for dental care.

Medicaid Non-Emergency Dental Services
FirstCare is not responsible for paying for routine dental services provided to Medicaid members. These services are paid through Dental Managed Care Organizations.

FirstCare is responsible for paying for treatment and devices for craniofacial anomalies, and for Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for members aged 6 through 35 months. Texas Health Steps providers must be certified by the Department of State Health Services Oral Health program to bill for this service.

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

- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist members with establishing a Main Dental Home and document member's Dental Managed Care Organization choice in the members' file.

CHIP Non-Emergency Dental Services
FirstCare is not responsible for paying for routine dental services provided to CHIP and CHIP Perinate members. These services are paid through Dental Managed Care Organizations.

FirstCare is responsible for paying for treatment and devices for craniofacial anomalies.

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

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

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) The WIC program is designed to provide supplemental food and nutrition education for pregnant, postpartum, and breast-feeding women along with their infants and children up to the age of five. WIC provides infant formula, milk, cereal, juice and other foods to ensure proper nutrition. The program provides nutrition education, breast-feeding support, immunizations and referrals to other health care providers.

FirstCare STAR providers are to coordinate with the WIC Special Supplemental Nutrition program to provide medical information necessary for WIC eligibility determinations, such as height, weight and the results of the most recent hematocrit or hemoglobin on a prescription (Rx) note if performed in provider's office. For more information call the WIC program at 1-800- 942-3678.

Early Childhood Intervention (ECI)
Early Childhood Intervention is a federally mandated program for infants and children under the age of three with or at risk for developmental delays and/or disabilities.

Identification of ECI Eligible FirstCare STAR Members
Children are eligible for ECI comprehensive services if they are under age 3 and documented as having delays, a diagnosed physical or mental condition that has a high probability
of resulting in delays, or exhibit atypical development. A child with delays must show a significant delay, beyond acceptable variations in normal development, in one or more of the following areas:

- Cognitive;
- Gross or fine motor skills;
- Language or speech;
- Social or emotional; and/or
- Self-help skills.

A child who may perform within the appropriate age range, on testing instruments, but whose behavior or behavior patterns are atypical, is also eligible. Children are eligible if they have a medically diagnosed physical or mental condition that may contribute to a high probability of developmental delays.

ECI Service Coordination/Service Coordination
All health care professionals are required under federal and state regulations to refer children younger than 3 years of age to ECI within 2 business days of identification of a disability or suspected delay in development as defined by ECI criteria. A list of available ECI Programs is available at https://citysearch.hhsc.state.tx.us/.

For more information about ECI or to refer a child, call the DARS (Department of Assistive and Rehabilitative Services) Inquiries Line at **1-800-628-5115.**

PCP Responsibility and the Individual Family Service Plan (ISFP)
The PCP, upon identification of the need of ECI services for his/her patient, will make the appropriate referral to ECI within 2 days of determining a delay or disability.

The initial assessment by ECI does not require an authorization through FirstCare. ECI will evaluate and assess the child, and formulate an Individual Family Service Plan (IFSP) in conjunction with the PCP, a FirstCare case manager and the family. The PCP continues to remain the driver of the IFSP. Based on periodic re-evaluations by the PCP, updated progress reports by the therapists and case managers, the PCP can make recommendations and alterations in the IFSP as needed.

Individual Family Service Plan (IFSP)
The IFSP is intended to assist in promoting compliance with the treatments and therapies recommended. The importance of the PCP and the FirstCare Case Manager remaining informed and aware of the changing health status or setbacks is paramount to an effective IFSP and continued authorization of appropriate therapies and treatments.

Authorization Requirements
FirstCare members may self-refer to the local ECI Service Providers without health plan referral or referral from the Primary Care Physician. ECI services provided to Medicaid recipients do not require an authorization from FirstCare

ECI Referral Sources
Referrals to ECI may be initiated from several sources, including other state agencies or organizations on behalf of the FirstCare STAR member. The ECI providers area have been instructed to notify the PCP and the FirstCare Service Coordination department of the outside referral source. This contact by ECI will provide the PCP and FirstCare's Case Manager the
opportunity to assist in the formulation of the IFSP and authorization of any continued or new therapies or services, which have been recommended.

ECI Claims Submission
ECI providers must submit claims for all physical, occupational, speech, and language therapy to FirstCare.

Tuberculosis Reporting and Screening
FirstCare and FirstCare providers are to coordinate and cooperate with the local TB control program to ensure that FirstCare STAR members with confirmed or suspected cases of tuberculosis (TB) are reported to the local TB control program.

Providers in the FirstCare STAR network are required to report any confirmed or suspected cases of TB to the local TB control program. Providers must also report any member who is non-compliant, drug resistant, or who is or may be posing a public health threat to DSHS or the local TB control program.

All confirmed or suspected cases of TB are to be reported to the local TB control program within 1 working day for a contact investigation and directly observed therapy (DOT).

Sexually Transmitted Diseases and Human Immunodeficiency Virus
FirstCare provides sexually transmitted disease (STD) and human immunodeficiency virus (HIV) Covered Services that include STD and HIV prevention, screening, counseling, diagnosis, and treatment. FirstCare allows Members access to STD services and HIV diagnosis services without Prior Authorization or referral by a PCP. FirstCare provides education to Providers and Members on the prevention, detection, and effective treatment of STDs and HIV.

Provider Responsibilities

Providers who provide STD and HIV services must:

- Ensure that Members have prompt access to appropriate services for STDs and HIV;
- Comply with all state laws relating to communicable disease reporting requirements;
- Report all confirmed cases of STDs and HIV to the local or regional health authority according to 25 Tex. Admin. Code §§ 97.131 - 97.134, using the required forms and procedures.
- Coordinate with the HHSC regional health authority to ensure that Members with confirmed cases of syphilis, chancroid, gonorrhea, chlamydia, neonatal herpes, and HIV receive risk reduction and partner elicitation and notification counseling.
- Have established procedures to make Member records available to FirstCare, public health agencies with authority to conduct disease investigation, receive confidential Member information, and provide follow-up activities.
- Have procedures in place to protect the confidentiality of Members who receive STD and HIV services. These procedures must include, but are not limited to: the manner in which medical records are to be safeguarded, how employees are to protect medical information, and under what conditions information can be shared. FirstCare monitors Provider compliance with these confidentiality requirements; and
- Provide Members who receive STD and HIV services and counseling with informed consent.

Coordination with the Texas Department of Family and Protective Services (DFPS) FirstCare and its providers are to cooperate and coordinate with the Texas Department of Family and Protective Services (DFPS) and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS.

Providers are to fulfill the following requirements:

- Provide medical records;
- Schedule medical and behavioral health appointments within 14 days, unless requested earlier by DFPS; and
- Recognition of abuse and neglect and making an appropriate referral to DFPS.

All covered health services will continue to be provided to a member who is receiving services from or in the protective custody of DFPS until the member has been disenrolled from FirstCare.

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

The 72-hour emergency supply may be dispensed when a PA cannot be resolved within 24 hours for a medication on the Vendor Drug program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription. The emergency supply is subject to pharmacist clinical judgment. Some non-urgent medications are exempt from this emergency supply.

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

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information: The pharmacy should enter "8" in " Prior Authorization Type code" (Field 461-EU), '801' in Prior Authorization Number Submitted (Field 462-EV) and '3' in "Days'
Supply" in the claim segment of the billing transition (Field 405-D5). The quantity submitted in "Quantity Dispensed" (Field 442-E&) should not exceed the quantity necessary for a three-day supply. It is permissible that a pharmacy can dispense product packages in fixed dosage forms which are unbreakable(e.g. Inhalers, nebulized medications), as a 72-hour supply. Place "3" in
Days' Supply" but enter the full quantity dispensed. Important: If a pharmacy is not complying with the 72-hour emergency fill requirement, they can be reported to the HHSC Office of Inspector General and Navitus' Networks department at 877-908-6023 for review.

For more information about the 72-hour emergency prescription supply policy, call Navitus at 1-877-908-6023 or FirstCare at 1-806-784-4300.

Essential Public Health Services
It is the role of the PCP to coordinate all services for the member, which include coordination with essential public health services. FirstCare must also coordinate with Public health entities for essential public health care. It is critical that the following services are coordinated with the appropriate health entity:

- Reporting to public entities regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law;
- Notify the local public health entity, as defined by state law, of communicable disease outbreaks involving members; Coordinate with public health entities that have a child lead program, or with DSHS regional staff when the local public health entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure.

6.26 - Ambulance Services

Medically necessary ambulance services do not require authorization when used for emergency transportation to the nearest hospital emergency room or trauma center.

Services Requiring Preauthorization

- Member is transported from one facility to another for testing or for a procedure that cannot be performed at the inpatient facility;
- Member is discharged from inpatient status and ambulance transportation to a skilled nursing facility is necessary;
- Member is transported to his or her home or to a nursing home for custodial care; and/or
- Air ambulance services. Failure to obtain prior authorization for this service will render the service subject to retrospective medical review.

To avoid denial in payment, prior authorization should be obtained before the transport occurs for ambulance transports between facilities.

NOTE: *All ambulance services should be billed according to the FirstCare contract.*

6.27 - Coordination with Non-Medicaid Managed Care Covered Services (Non-Capitated Services)

The following Medicaid services have been excluded from the managed care covered services but Medicaid members are eligible to receive these services, as identified in the Texas Medicaid Provider Procedures Manual. In an effort to facilitate member's access to health care not covered by managed care, FirstCare will provide the appropriate referrals for members to obtain and access the following services:

- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) Service Coordination/service coordination
- Early Childhood Intervention Specialized Skills Training
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Health and Human Services Commission's Medical Transportation Program (MTP)
  - Summary of MTP services and phone numbers for MTP, including numbers for the Full-Risk Brokers (FRBs)
  - FRB-specific service areas
- Hospice services
- For STAR, Community First Choice (CFC) services
- For STAR, Texas Health Steps Personal Care Services for Members birth through age 20

Coordination with Non-CHIP Covered Services (Non-Capitated Services) for MCOs serving CHIP and CHIP Perinate Members

The following services have been excluded from the managed care covered services but CHIP and CHIP Perinate members are eligible to receive these services. In an effort to facilitate Member's access to health care not covered by managed care, FirstCare will provide the appropriate referrals for members to obtain and access the following services:

- Texas agency administered programs and Service Coordination services
- Essential public health services

ELECTRONIC VISIT VERIFICATION (EVV)

GENERAL INFORMATION ABOUT EVV

1. What is EVV?

EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV System documents the following:

- Type of service provided (Service Authorization Data);
- Name of the Member to whom the service is provided (Member Data);
- Date and times the visit began and ended;
- Service delivery location;
- Name of the Service Provider or CDS Employee who provided the service (Service Provider Data); and
- Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.

2. Is there a law that requires the use of EVV?

Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. § 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Section 531.024172, requires HHSC to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To comply with these statutes, HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. HHSC plans to require the use of

EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2023.

3. Which services must a Service Provider or CDS Employee electronically document and verify using EVV?
The EVV required services that must be electronically documented and verified through EVV are listed on the HHSC EVV website. Refer to the Programs, Services and Service Delivery Options Required to Use Electronic Visit Verification.
Check the EVV Service Bill Codes Table on the HHSC EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services.
https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification-evv

4. Who must use EVV?
The following must use EVV:

- Provider: An entity that contracts with an MCO to provide an EVV service.
- Service Provider: A person who provides an EVV required service and who is employed or contracted by a Provider or a CDS Employer.
- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
- Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employer as described in Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, § 41.103(25), Consumer Directed Services Option.
- CDS Employer: A Member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a service provider who delivers a service.

EVV SYSTEMS

5. Do Providers and FMSAs have a choice of EVV Systems?
Yes. A Provider or FMSA must select one of the following two EVV Systems:

- EVV vendor system. An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV proprietary system.
  https://www.tmhp.com/topics/evv/evv-vendors
- EVV proprietary system. An EVV proprietary system is an HHSC-approved EVV System that a Provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
  - Is purchased or developed by a Provider or an FMSA.
  - Is used to exchange EVV information with HHSC or an MCO; and
  - Complies with the requirements of Texas Government Code Section 531.024172 or its successors.
    https://www.tmhp.com/topics/evv/evv-proprietary-systems

6. Does a CDS Employer have a choice of EVV Systems?
No. A CDS Employer must use the EVV System selected by the CDS Employer's FMSA.

7. What is the process for a Provider or FMSA to select an EVV System?

- To select an EVV vendor from the state vendor pool, a Provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV vendor's website.
  https://www.tmhp.com/topics/evv/evv-vendors
- To use an EVV proprietary system, a Provider or FMSA, signature authority, and the agency's appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV PSO Onboarding process and HHSC EVV Proprietary System approval process.

  https://www.tmhp.com/topics/evv/evv-proprietary-systems

8. What requirements must a Provider or FMSA meet before using the selected EVV System?
Before using a selected EVV System:

- The Provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor.
  https://www.tmhp.com/topics/evv/evv-vendors
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:

    - An EVV Proprietary System Request Form
    - EVV PSO Detailed Questionnaire (DQ)
    - TMHP Interface Access Request
- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV proprietary system to comply with HHSC EVV requirements.
- If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
    - Complete all required EVV training as described in the answer to Question #18; and
    - Complete the EVV System onboarding activities:
        - Manually enter or electronically import identification data;
        - Enter or verify Member service authorizations;
        - Setup member schedules (if required); and
        - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

9. Does a Provider or FMSA pay to use the selected EVV System?

- If a Provider or FMSA selects an EVV vendor system, the Provider or FMSA uses the system free of charge.
- If a Provider or FMSA elects to use an EVV proprietary system, the Provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

10. Can a Provider or FMSA change EVV Systems?

Yes. A Provider or FMSA may:

- Transfer from an EVV vendor to another EVV vendor within the state vendor pool;
- Transfer from an EVV vendor to an EVV Proprietary System;
- Transfer from an EVV Proprietary System to an EVV vendor; or
- Transfer from one EVV Proprietary system to another EVV Proprietary system.

11. What is the process to change from one EVV System to another EVV System?

To change EVV Systems, a Provider or FMSA must request a transfer as follows:

- To request a transfer to an EVV vendor, a Provider or FMSA must submit an EVV Provider Onboarding Form to the new EVV vendor.
- To request a transfer to an EVV proprietary system, a Provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A Provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 Days before the desired effective date of the transfer.
- If a Provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the Provider or FMSA and the newly selected EVV vendor agree on an earlier date.
- If a Provider or FMSA is transferring to an EVV proprietary system, the Provider or FMSA, TMHP, and HHSC will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.
- An FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
- A Provider or FMSA must complete all required EVV System training before using the new EVV System.
- A Provider or FMSA who transfers to a new EVV vendor or proprietary system:
    - Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement; and
    - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.
- After a Provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

12. Are the EVV Systems accessible for people with disabilities?

The EVV vendors provide accessible systems, but if a CDS Employer, service provider or CDS Employee needs an accommodation to use the EVV System, the vendor will determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.

If the Provider or FMSA is using a proprietary system, the Service Provider, CDS Employer or CDS Employee must contact the Provider or FMSA to determine accessibility features of the system and if an accommodation can be

provided.

EVV SERVICE AUTHORIZATIONS

13. What responsibilities do Providers and FMSAs have regarding service authorizations issued by an MCO for an EVV required service?

A Provider and FMSA must do the following regarding service authorizations issued by an MCO for an EVV-required service:

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:
  - Name of the MCO;
  - Name of the Provider or FMSA;
  - Provider or FMSA Tax Identification Number;
  - National Provider Identifier (NPI) or Atypical Provider Identifier (API);
  - Member Medicaid ID;
  - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s);
  - Authorization start date; and
  - Authorization end date.
- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System; and
- Manually enter service authorization changes and updates into the EVV System as necessary.

EVV CLOCK IN AND CLOCK OUT METHODS

14. What are the approved methods a Service Provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?

A Service Provider or CDS Employee must use one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to end service delivery when providing services to a member in the home or in the community. A Service Provider or CDS Employee may use one method to clock in and a different method to clock out.

(1) Mobile method

- A Service Provider must use one of the following mobile devices to clock in and clock out:
  - the Service Provider's personal smart phone or tablet; or
  - a smart phone or tablet issued by the Provider.
- A Service Provider must not use a Member's smart phone or tablet to clock in and clock out.
- A CDS Employee must use one of the following mobile devices to clock in and clock out:
  - the CDS Employee's personal smart phone or tablet;
  - A smart phone or tablet issued by the FMSA; or
  - the CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.
- To use a mobile method, a Service Provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the Service Provider or CDS Employee has downloaded to the smart phone or tablet.
- The mobile method is the only method that a Service Provider or CDS Employee may use to clock in and clock out when providing services in the community.

(2) Home phone landline

- A Service Provider or CDS Employee may use the Member's home phone landline, if the Member agrees, to clock in and clock out of the EVV System.
- To use a home phone landline, a Service Provider or CDS Employee must call a toll-free number provided by the EVV vendor or the PSO to clock in and clock out.
- If a Member does not agree to a Service Provider's or CDS Employee's use of the home phone landline or if the Member's home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another approved clock in and clock out method.
- The Provider or FMSA must enter the Member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.

(3) Alternative device

- A Service Provider or CDS Employee may use an HHSC-approved alternative device to clock in and clock out when providing services in the Member's home.
- An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
- An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
- The alternative device codes are active for only seven days after the date of service and must be entered into the EVV system before the code expires.
- The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit.
- An alternative device must always remain in the Member's home even during an evacuation.

15. What actions must the Provider or FMSA take if a Service Provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?

- If a Service Provider does not clock in or clock out of the EVV System or an approved clock in or clock out method is not available, then the Provider must manually enter the visit in the EVV System.
- If a Service Provider makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the Provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to manually enter the clock-in and clock-out information and other service delivery information, if applicable.
- If a CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to correct the inaccurate service delivery information in the EVV System.
- After the Visit Maintenance time frame has expired, the EVV System locks the EVV visit transaction and the program provider, FMSA or CDS Employer may only complete Visit Maintenance if the MCO approves a Visit Maintenance Unlock Request.
- The EVV Policy Handbook requires the Provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

EVV VISIT MAINTENANCE

16. Is there a timeframe in which Providers, FMSAs, and CDS Employers must perform Visit Maintenance?

In general, a Provider, FMSA, or CDS Employer must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in HHSC EVV Policy Handbook.

Note: the standard Visit Maintenance timeframe as set in EVV Policy Handbook may be changed by HHSC to accommodate Providers impacted by circumstances outside of their control.

17. Are Providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance?

Yes. Program providers, FMSAs or CDS Employers must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing Visit Maintenance in the EVV System.

- Reason Code Number(s) describe the purpose for completing Visit Maintenance on an EVV visit transaction.
- Reason Code Description(s) describe the specific reason Visit Maintenance is necessary.
- Free text is additional information the program provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.
  https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification-evv

EVV TRAINING

18. What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training:

- EVV System training provided by the EVV vendor or EVV PSO;
- EVV Portal training provided by TMHP; and
- EVV Policy training provided by HHSC or the MCO.

- CDS Employers must complete training based on delegation of Visit Maintenance on Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities:
  - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked In the EVV System;
    - EVV System training provided by the EVV vendor or EVV PSO;
    - Clock in and clock out methods; and
    - EVV Policy training provided by HHSC, the MCO or FMSA.
  - Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
    - EVV System training provided by EVV vendor or EVV PSO; and
    - EVV Policy training provided by HHSC, the MCO or FMSA.
  - Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
    - Overview of EVV Systems training provided by EVV Vendor or EVV PSO; and
    - EVV policy training provided by HHSC, the MCO or FMSA.
- Providers and CDS Employers must train Service Providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends. http://firstcare.com/en/Providers/Electronic-Visit-Verification

COMPLIANCE REVIEWS

19. What are EVV Compliance Reviews?

- EVV Compliance Reviews are reviews conducted by the MCO to ensure Providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies.
- The MCO will conduct the following reviews and initiate contract or enforcement actions if Providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:
  - EVV Usage Review - meet the minimum EVV Usage Score;
  - EVV Required Free Text Review – document EVV required free text; and
  - EVV Landline Phone Verification Review - ensure valid phone type is used.

EVV CLAIMS

20. Are Providers and FMSAs required to use an EVV System to receive payment for EVV required services?
Yes. All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim by the MCO. The MCO may deny or recoup an EVV claim that does not match an accepted visit transaction.

21. Where does a Provider or FMSA submit an EVV claim?
Providers and FMSAs must submit all EVV claims to the HHSC Claims Administrator in accordance with the MCO's submission requirements.
http://firstcare.com/en/Providers/Important-Forms-Information

22. What happens if a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator?
If a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator, the MCO will reject or deny the claim and require the Provider or FMSA to submit the claim to the HHSC Claims Administrator.

23. What happens after the HHSC Claims Administrator receives an EVV claim from a Provider or FMSA? The HHSC Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHSC Claims Administrator for further claims processing. After completing the EVV claims matching process, the HHSC Claims Administrator forwards the claim to the MCO for final processing.

24. How does the automated EVV claims matching process work?
The claims matching process includes:

- Receiving an EVV claim line item.
- Matching data elements from each EVV claim line item to data elements from one or more accepted EVV transactions in the EVV Aggregator.
- Forwarding an EVV claim match result code to the MCO once the claims matching process is complete.

The following data elements from the claim line item and EVV transaction must match:

- Medicaid ID;
- Date of service;
- National Provider Identifier (NPI) or Atypical Provider Identifier (API);
- Healthcare Common Procedure Coding System (HCPCS) code;
- HCPCS modifiers; and
- Billed units to units on the visit transaction, if applicable.

Note: No unit match is performed on CDS EVV claims and unit match is not performed on visit transactions against the billed units on the claim line item for specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the units matching process.

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.
EVV claim match codes viewable in the EVV Portal are:

- EVV01 – EVV Successful Match
- EVV02 – Medicaid ID Mismatch
- EVV03 – Visit Date Mismatch
- EVV04 – Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 – Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 – Units Mismatch
- EVV07 – Match Not Required
- EVV08 – Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. The MCO will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHSC implements a bypass of the claims matching process for disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- The MCO will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- The MCO may still deny an EVV claim if other claim requirements fail the claims adjudication process.
- If allowed by HHSC, the MCO may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

25. How can a Provider and FMSA see the results of the EVV claims matching process?
Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and the MCO system. The MCO's Provider Portal also provides additional claims status information, such as whether the MCO has paid or denied the claim. In addition, the MCO provides an Explanation of Payment (EOP) to Providers and FMSAs to inform them of whether the MCO paid or denied the claim, and if denied, the reason for denial.
https://tmhp.exceedlms.com/student/collection/521629-evv-training

26. Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?
Yes. An MCO may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a Member's loss of program eligibility or the Provider's or FMSA's failure to obtain prior authorization for a service.

SECTION 7: Vision Care

FirstCare members may directly access vision services. For assistance in locating a vision provider in the FirstCare STAR/CHIP network, members should contact the FirstCare customer services department. Members have the right to select and have access to, without a primary care provider referral, a network ophthalmologist or therapeutic optometrist to provide eye health care, other than surgery.

7.1 - Vision Benefits for FirstCare STAR Members

STAR members through age 20 are eligible for the following:

- One eye exam for the purpose of obtaining eyeglasses or contact lenses every state fiscal year (September 1 through August 31). More than one vision test per state fiscal year may be reimbursed only when:
  - The parent, teach or school nurse requests medically necessary refraction testing
  - There is a significant change in vision, and documentation supports a diopter (d) change of 0.5d or greater in the sphere, cylinder, prism measurements, or axis changes.
- Eyewear: Non-prosthetic eyeglasses or contact lenses may be reimbursed once every 24 months. The eyeglasses or (hard) contact lenses must be:
  - Medically necessary.
  - Prescribed by a doctor of medicine, optometry, or osteopathy.
  - Prescribed to significantly improve vision or correct a medical condition.
  - In compliance with eyeglass program specifications for frames and lenses as stated in TAC Rule 354.1017, Specifications for Eyewear and Rule 363.503, Specifications for Eyewear.
- There is no limit for lost, stolen, or damaged glasses. The Vision Care Eyeglass Patient Certification must be completed and kept in the member's medical record.. Please refer to the Texas Medicaid Provider Procedures Manual, TMPPM, Sections 4.3.6.3, 4.3.6.4 and 4.3.6.4 for dispensing, repair and replacement.
- Unlimited medical necessary eye exams for a diagnosis of illness or injury.

STAR Adults (age 21 and older):

- One eye exam for the purpose of obtaining eyeglasses or contact lenses ever two state fiscal years (September 1 through August 31).
- Non-prosthetic eyeglasses or (hard) contact lenses may be reimbursed once every 24 months. The eyeglasses or contact lenses must be:
  - Medically necessary.
  - Prescribed by a doctor of medicine, optometry, or osteopathy.
  - Prescribed to significantly improve vision or correct a medical condition.
  - In compliance with eyeglass program specifications for frames and lenses as stated in TAC Rule 354.1017, Specifications for Eyewear and Rule 363.503, Specifications for Eyewear.

7.2 - Vision Benefits for FirstCare CHIP Members

CHIP members under age 19 are eligible for the following:

- One eye exam per 12 month period to determine the need for a prescription for corrective lenses, without an authorization
- Eyewear: one pair of non-prosthetic eyewear per 12 month period
  - Replacement of glasses for major changes in vision or from accidental loss or damage
- Unlimited medical necessary eye exams for a diagnosis of illness or injury

SECTION 8: Vaccinations

8.1 - Texas Health Steps Immunizations/Texas Vaccines for Children

Texas Health Steps providers are required to assess the immunization status of members at every Texas Health Steps checkup. Vaccines must be administered according to the current Advisory Committee on Immunization Practices (ACIP). "Recommended Childhood and Adolescent Immunization Schedule. The ACIP schedule can be found at http://www.cdc.gov/ vaccines/schedules/index.html.

Immunizations must be administered at the time of the checkup unless medically contraindicated or because of parental reasons of conscience, including religious beliefs. Immunizations which may be appropriate based on age and health history but which are medically contraindicated at the time of the screening may be rescheduled at an appropriate time.

Providers may not refer clients to local health departments or other providers for immunization administration.

Providers may obtain vaccines free of charge from the Texas Vaccines for Children (TVFC) Program, for client's birth through 18 years old, and must not charge the client for the vaccines.

Texas Department of State Health Services (DSHS) will purchase, store, and distribute vaccines using the vaccine delivery system operated by DSHS. DSHS will monitor vaccine reports and track vaccine distribution to providers to assure an adequate inventory of vaccines for providers.

Any providers who have not enrolled in the Texas Vaccine for Children program may contact DSHS at 1-800252-9152. DSHS will provide the location and telephone number of the local health department or regional office for providers to contact in order to become enrolled in the program and begin receiving the vaccine.

SECTION 9: Behavioral Health Services

FirstCare Health Plan defines "behavioral health" as both acute and chronic psychiatric and substance use disorders as referenced in the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

Access to behavioral health services may be initiated directly by the member or by the member's PCP by contacting the behavioral health service provider listed in the "Address and Telephone Guide" in the INTRODUCTION section of this manual. Although the member can access behavioral health services without a referral from his/her PCP, the PCP remains
responsible for coordinating all of the member's health care needs and is to be informed of any behavioral services provided to the member.

Confidentiality of all member information is to be maintained at every level of care. The servicing provider is responsible for obtaining the member's release of information signature. However, all providers must assure that appropriate protocols are in place to protect access to the clinical records of members seeking behavioral health services.

9.1 - List of Behavioral Health Covered Services

STAR Covered Services
The following is a non-exhaustive, high-level listing of acute care covered services included under the Medicaid STAR Program. For a complete listing of the limitations and exclusions that apply to each Medicaid benefit category, the reader should refer to the current Texas Medicaid Provider Procedures Manual (online at: http://www.TMHP.com). These services are subject to
modification based on federal and state mandates.

A PCP referral is not required to access behavioral health services. STAR covered behavioral health services include, but are not limited to, medically necessary:

- Psychiatry services
- Counseling services
- Substance use disorder treatment services, including:
  - Assessment
  - Detoxification services
  - Counseling treatment
  - Medication-assisted therapy
- Residential substance use disorder treatment services, including:
  - Detoxification services
  - Substance use disorder treatment (including room and board)
- Emergency services
- Hospital services, including inpatient and outpatient

When inpatient psychiatric services are ordered for a member age 21 and younger by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health

and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

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

The MCO may provide inpatient services for acute psychiatric conditions in a freestanding psychiatric hospital in lieu of an acute inpatient hospital setting.

The MCO may provide substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting.

CHIP Covered Services

- Inpatient mental health services: including serious emotional disturbance (SED), furnished in a freestanding psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to:
  - Neuropsychological and psychological testing.
  - When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. Referral for behavioral health services does not require PCP referral.
- Outpatient mental health services: including serious emotional disturbance (SED) for serious mental illness, provided on an outpatient basis, including, but not limited to:

The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.

- Neuropsychological and psychological testing.
- Medication management.
- Rehabilitative day treatments.
- Residential treatment services.
- Sub-acute outpatient services (partial hospitalization or rehabilitation day treatment).
- Skills training (psycho-educational skill development).
- When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
- A qualified mental health provider - Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.

CHIP behavioral health referrals do not require PCP referral. Other behavioral health services covered by CHIP include:

- Inpatient substance use disorder treatment services include, but are not limited to:
  - Inpatient and residential substance use disorder treatment services, including detoxification and crisis stabilization, and 25-hour residential rehabilitation programs
- Outpatient substance use disorder treatment services include, but are not limited to, the following:

- Prevention and intervention services that are provided by a physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders
- Intensive outpatient services defined as an organized, non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day.
- Partial hospitalization
- Outpatient treatment services is defined providing structured group, family and individual therapy, educational services, and life skills training

Primary Care Providers:

1. May treat for mental health and/or substance use disorders within the scope of their practice and bill using the DSM or appropriate ICD diagnoses codes;
2. Screen for behavioral health and substance use disorder;
3. Inform members how and where to obtain behavioral health services; and
4. Understand that members may self-refer to any behavioral health care provider without a referral from the member's PCP.

Attention Deficit Hyperactivity Disorder (ADHD)

MCO's Provider Manual pertaining to Attention Deficit Hyperactivity Disorder (ADHD) covered services for children including reimbursement for ADHD and availability of follow-up care for children who have been prescribed ADHD medications. Providers should be educated and trained to treat each Texas Health Steps visit as an opportunity for a comprehensive assessment of the member.

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

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

Coordination between behavioral health and physical health services

Coordination of Care

It is the intention of the CHIP and STAR program to integrate behavioral health and physical medicine services into a system that addresses the individual member's needs in a comprehensive and coordinated fashion.

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

Coordination between Physical and Behavioral Health

FirstCare is committed to coordinating medical and behavioral care for members who will be appropriately screened, evaluated, treated and/or referred for physical health, behavioral health or substance use, dual or multiple diagnoses, developmental delays, or disabilities. FirstCare will designate behavioral health liaison personnel to facilitate coordination of care and Service Coordination efforts.

Medical Records

To ensure that the appropriate clinical information is maintained within the member's treatment record, providers must follow the documentation requirements below, based upon NCQA standards. All documentation must be clear and legible. Further, the treatment record contains clear documentation using the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classifications.

Member Identification Information

The treatment record contains the following member information:

- Member name and health plan identification # on every page
- Member's address
- Employer or school
- Home and work telephone number
- Marital/legal status
- Appropriate consent forms
- Guardianship information, if applicable

Informed Member Consent for Treatment

The treatment record contains signed consents for the following:

- Implementation of the proposed treatment plan.
- Any prescribed medications.
- Consent forms related to interagency communications.
- Individual consent forms for release of protected health information to the member's PCP and other behavioral health providers, if applicable; each release of information to a new party (other than FirstCare Health Plan) requires its own signed consent form.
- For adolescents, ages 12-17, the treatment record contains consent to discuss substance use disorder issues with their parents.
- Signed document indicating review of patient's rights and responsibilities.

Medication Information

Treatment records contain medication logs clearly documenting the following:

- All medications prescribed
- Dosage of each medication

- Dates of initial prescriptions
- Information regarding allergies and adverse reactions are clearly noted
- Lack of known allergies and sensitivities to substances are clearly noted

Medical and Psychiatric History

Treatment record contains the member's medical and psychiatric history including:

- Previous dates of treatment
- Names of providers
- Therapeutic interventions
- Effectiveness of previous interventions
- Sources of clinical information
- Relevant family information
- Results of relevant laboratory tests
- Previous consultation and evaluation reports

Substance Use Information

Documentation for any member 12 years and older of past and present use of the following:

- Cigarettes
- Alcohol, and illicit, prescribed, and over-the counter drugs

Adolescent Depression Information

Documentation for any member 13-18 years was screened for depression

- If yes, was a suicide assessment conducted?
- Was the family involved with treatment?

ADHD Information

Documentation the members aged 6-12 were assessed for ADHD

- Was family involved with treatment?
- Is there evidence of the member receiving psychopharmacological treatment?

Diagnostic Information

- Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, elopement potential) are prominently documented and updated according to provider procedures.
- All relevant medical conditions are clearly documented, and updated as appropriate.
- Member's presenting problems and the psychological and social conditions that affect his/her medical and psychiatric status.

A complete mental status evaluation is included in the treatment record, which documents the member's:

- Affect
- Speech
- Mood
- Thought control, including memory
- Judgment
- Insight
- Attention/concentration
- Impulse control
- Initial diagnostic evaluation and DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information
- Diagnoses updated at least on a quarterly basis

Treatment Planning

The treatment record contains clear documentation of the following:

- Initial and updated treatment plans consistent with the member's diagnoses, goals and progress

- Objective and measurable goals with clearly defined timeframes for achieving goals or resolving the identified problems
- Treatment interventions used and their consistency with stated treatment goals and objectives
- Member, family and/or guardian's involvement in treatment planning, treatment plan meetings and discharge planning
- Copy of Outpatient Review Form(s) submitted, if applicable

Treatment Documentation
The treatment record contains clear documentation using the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classifications and the following:

- Ongoing progress notes that document the member's progress towards goals, as well as his/her strengths and limitations in achieving said goals and objectives
- Referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidality, suicidality or the inability to function on a day-to-day basis
- Referrals and/or member participation in preventive and self-help services (e.g., stress management)
- Relapse prevention (Alcoholics Anonymous, etc.) is included in the treatment record.
- Member's response to medications and somatic therapies

Coordination with the Local Mental Health Authority (LMHA) and state psychiatric facilities FirstCare will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning, treatment objectives, and projected length of stay for members committed by a court of law to the state psychiatric facility. FirstCare will comply with additional behavioral health services requirements relating to coordination with the LMHA and care for special populations. Covered services will be provided to members with Severe and Persistent Mental Illness (SPMI)/Severe Emotional Disturbance (SED) when medically necessary, whether or not they are receiving targeted Service Coordination or rehabilitation services through the LMHA.

Assessment instruments for behavioral health available for use by a PCP
Behavioral health and non-behavioral providers must use DSM-IV multi-axial classification when assessing members for behavioral health services. Providers are to document DSM-IV and instrument/outcome information in the member's medical record. Provided for PCP or specialist use is a "Behavioral Health Symptom Identification Grid" tool as an assessment instrument for behavioral health services. (See ATTACHMENTS section of this manual for a sample grid for non-behavioral providers use) PHQ-9

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

Utilization management reporting requirements (specify by individual mental health service type)

Outpatient Services Authorization Required	
Initial assessment	No
Individual therapy	No
Family therapy	No
Group therapy	No
Psychiatric evaluation	No
Medication management	No
Electro-convulsive therapy	No
Psychological testing	Yes
Rehabilitation skills training	Yes
Targeted Service Coordination	Yes

Higher levels of Care: Mental Health and Substance Abuse	
Intensive outpatient program	Yes
Partial hospital program	Yes
Residential treatment program	Yes
Inpatient Hospitalization	Yes

Emergency Services (crisis)
No prior/pre-authorization is required but the provider must notify FirstCare within 24 hours of the emergency to obtain an authorization.

Procedures for follow-up on missed appointments
Providers must document attempts to follow up calls within 24 hours to all members that have missed appointments.

Member discharged from inpatient psychiatric facilities need to have follow-up within 7 days from the date of discharge
FirstCare requires that all members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. FirstCare providers will follow up with members and attempt to reschedule missed appointments.

9.2 - Treatment Record Reviews

FirstCare reviews member charts and uses data generated to monitor and measure provider performance in relation to the Treatment Record Standards.

The following elements are evaluated:

- Use of screening tools for diagnostic assessment of substance use, adolescent depression and ADHD;
- Continuity and coordination with primary care providers and other providers;
- Explanation of member rights and responsibilities;
- Inclusion of all applicable required medical record elements as listed above; and
- Allergies and adverse reactions, medications, and physical exam.

FirstCare may conduct chart reviews onsite at a provider facility, or may ask a provider to copy and send specified sections of a member's medical record to FirstCare.

HIPAA regulations permit providers to disclose information without patient authorization for the following reasons: "oversight of the health care system, including quality assurance activities." FirstCare chart reviews fall within this area of allowable disclosure.

Court Ordered Commitments
A "court-ordered commitment" means a confinement of a member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C. FirstCare is required to provide inpatient psychiatric services to members under the age of 21, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, related to court-ordered commitments to psychiatric facilities. FirstCare will not deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a court-ordered commitment for members under age 21.

Quality Management Behavioral Health Medical Records, Behavioral Health Focus Studies, and Utilization Management Reporting Requirements
HHSC requires that there be, at a minimum, an 80 percent compliance with the requirements set by HHSC for medical record audits. FirstCare will implement a corrective action plan for those medical records that fall below the minimum requirements.

9.3 - Behavioral Health Scope of Services

FirstCare will coordinate the behavioral health services, which include, but are not limited to, the services listed in the Covered Services section. These services include acute, diversionary and outpatient services.

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

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

Behavioral Health Covered Services

Behavioral health services that are offered to CHIP and STAR members are:

- Reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
- In accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- Furnished in the most appropriate and least restrictive setting in which services can be

safely provided;

- The most appropriate level or supply of service that can safely be provided;
- Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered; and
- Not experimental or investigative, and not primarily for the convenience of the member or provider.

Other elements of members receiving behavioral health services are:

- Member may self-refer to any network behavioral health provider;
- Member has the right to obtain medication from any network pharmacy;
- A primary care provider may refer a member to a behavioral health provider;
- There will be coordination between behavioral health and physical health services;
- Member has the right to obtain a second opinion medical records and referral information must be documented using the DSM multi-axial classification;
- An authorization to release confidential information, such as medical records regarding treatment, should be signed by the patient or guardian prior to receiving care from a behavioral health provider;
- Who have been ordered to receive the services by a court of competent jurisdiction;
- Coordination will be conducted with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning, treatment objectives, and projected length of stay for members committed by a court of law to the state psychiatric facility;
- Assessment documents for behavioral health will be made available for the use of PCPs;
- FirstCare will work to ensure that quality behavioral health services are provided to all members. This coordination will include focus studies and utilization management reporting;
- Provider will make contact with the member within 24 hours of a missed appointment for the purposes of re-scheduling; and
- Members who are discharged from an inpatient psychiatric facility will have a follow-up appointment within seven days from the date of discharge by the provider.

9.4 - Accessible Intervention and Treatment

FirstCare promotes early intervention and health screening for identification of behavioral health problems and patient education. Providers are expected to screen, evaluate, treat and/or refer (as medically appropriate) any behavioral health problem.

Providers who need to refer members for further behavioral health care should contact FirstCare. FirstCare continuously evaluates providers who offer services to monitor ongoing behavioral health conditions, such as regular lab or ancillary medical tests and procedures.

9.5 - Routine, Urgent and Emergency Services

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

Urgent Behavioral Health Situation - A behavioral health condition that requires attention and assessment within 24 hours but that does not place the member in immediate danger to himself or others and the member is able to cooperate with treatment

Emergency Services - Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition, including post-stabilization care services.

9.6 - Accessibility Standards

Each provider shall provide covered services during normal business hours. Covered services shall be available and accessible to members, including telephone access, on a 24-hour, seven-day per week basis, to advise members requiring urgent or emergency services.

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

Acceptable:

1. Office phone is answered after hours by an answering service. All calls answered by an answering service must be returned within 30 minutes.
2. Office phone is answered after normal business hours by a recording in the language of each of the major population groups serviced, directing the patient to call another number to reach another provider designated to you. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.
3. Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact another designated medical practitioner.

Unacceptable:

1. Office phone is only answered during office hours.
2. Office phone is answered after hours by a recording, which tells the patients to leave a message.
3. Office phone is answered after hours by a recording that directs patients to go to an emergency room for any services needed.
4. Returning after-hours calls outside of 30 minutes.

Type of Appointment/Service Appointment must be offered:

General Appointment Standards

- Routine/Non-Urgent services within 14 calendar days, sooner if required by
- DFPS Urgent Care Within 24 hours
- Emergency Services Immediately, 24 hours per day, 7 days per week

Aftercare Appointment Standards

Inpatient and 24-hr diversionary service must schedule an aftercare follow-up prior to a member's discharge.

Type of Appointment/Service Appointment must be offered:

- Non-24 hour diversionary within 2 calendar days
- Psychopharmacology services/medication management within 14 calendar days
- All other outpatient services within 10 business days
- Crisis Intervention Services must be available 24 hours per day, 7 days per week
- Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours
- After hours, providers should have a live telephone answering service or an answering

machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room
- Outpatient providers should have services available Monday through Friday, from 8 a.m. to 5 p.m., CST, at a minimum. Evening and/or weekend hours should also be available at least 2 days per week.
- Interpreter Services Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.

Providers are required to meet these standards, and to notify FirstCare if they are temporarily or permanently unable to meet the standards. If a provider fails to begin services within these access standards, notice is sent out within one business day informing the member and provider that the waiting time access standard was not met.

9.7 - Emergency Transportation

Emergency transportation by ambulance is reimbursable with limitation to basic life support (BLS) ambulance services provided to the member in two situations:

- Emergency
- Non-emergency for the severely disabled

Emergency transportation does not require prior authorization.

Ambulance transports are covered for emergent transports and for transport from facility to facility for Medicaid and CHIP members. FirstCare staff will assist providers and members as needed to ensure appropriate transportation is available. Claims for ambulance transports should be submitted to the plan. FirstCare staff will assist providers and members as needed to ensure appropriate transportation is available.

9.8 - Non-Emergency Medical Transportation(NEMT)

What are NEMT services?

NEMT services provide transportation to covered health care services for Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips.

FirstCare partners with Access2Care to provide these services for our members.

What services are part of NEMT?

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

If you have a Member needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered

health care services are being provided but may remain in the waiting room during the Member's appointment.

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

If you have a Member you think would benefit from receiving NEMT services, please refer him or her to FirstCare at 833-779-3105 for more information.

FirstCare follows TMHP billing standards for STAR. If special billing requirements are necessary for NEMT Services, FirstCare Health Plans through our NEMT partner, Access2Care, will inform the Provider.

Mental Health Rehabilitative (MHR) Services and Targeted Service Coordination (TCM) (for MCO's serving MMC Members)

Definition of severe and persistent mental illness (SPMI)
A severe and persistent mental illness (SPMI) such as schizophrenia, major depression, bipolar disorder or another severely disabling mental disorder.

Definition of severe emotional disturbance (SED)
Children and adolescents ages 3 through 17 years with a diagnosis of a mental illness or who exhibit a serious emotional disturbance (SED).

Member access to and benefits of MHR Services and TCM

The following Mental Health Targeted Service Coordination services may be provided to individuals with a SPMI or a SED as defined in the DSM and who require the service as determined by either the ANSA or the CANS.

For members with SPMI and SED, Mental Health Rehabilitative Services and Targeted Service Coordination must be available to eligible STAR, STAR Health, and STAR+PLUS members.

9.9 - Mental Health Rehabilitative Services

The following Mental Health Rehabilitative Services may be provided to individuals with an SPMI or a SED as defined in the DSM and who require rehabilitative services as determined by either the ANSA or the CANS:

- Adult Day Program
- Medication Training and Support
- Crisis Intervention
- Skills Training and Development
- Psychosocial Rehabilitative Services

The above-listed Mental Health Rehabilitative Services, as well as any limitations to these services, are described in the most current Texas Medicaid Provider Procedures Manual (TMPPM), including the Behavioral Health, Rehabilitation, and Service Coordination Services Handbook. Mental Health Rehabilitative Services must be billed using appropriate procedure codes and modifiers as listed in the TMPPM with the following exception. The MCO is not responsible for providing Criminal Justice Agency-funded procedure codes with modifier HZ because these services are excluded from the capitation.

Mental Health Targeted Service Coordination Services

- Service Coordination for people who have SED (child, 3 through 17 years of age), hich includes routine and intensive Service Coordination services.
- Service Coordination for people who have SPMI (adult, 18 years of age or older).

The above-listed Mental Health Targeted Service Coordination services, as well as any limitations to these services, are described in the most current TMPPM, including the Behavioral Health, Rehabilitation, and Service Coordination Services Handbook. Mental Health Targeted Service Coordination services must be billed using appropriate procedure codes and modifiers as listed in the TMPPM with the following exception. The MCO is not responsible for providing
Criminal Justice Agency funded procedure codes with a Modifier HZ because these services are excluded from the capitation.

The MCO must maintain a qualified Network of entities, such as Local Mental Health Authorities (LMHAs) and multi-specialty groups that employ providers of Mental Health Rehabilitative Services and Targeted Service Coordination. Provider entities must attest to the MCO that the organization has the ability to provide, either directly or through sub-contract, members with the full array of resiliency and Recovery Utilization Management Guidelines (RRUMG) services.

The MCO must credential Provider entities, and any licensed Network Providers providing services through one of these entities, in accordance with the Contract. The MCO is not required to credential Providers of Mental Health Rehabilitative Services and Targeted Service Coordination who are not licensed provider types enrolled in Medicaid, such as a Peer Provider (PP), Family Partner (FP), Community Services Specialist (CSSP), and Qualified Mental Health Professional for Community Services (QMHP-CS) if the QMHP is not also a Licensed Practitioner of the Healing Arts (LPHA).

HHSC has established the following qualifications and supervisory protocols for providers of Mental Health Rehabilitative Services and Mental Health Targeted Service Coordination.

9.10 - Provider Requirements

Training and certification to administer Adult Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths (CANS) assessment tools

Also, the MCO must ensure that Providers of Mental Health Rehabilitative Services and Targeted Service Coordination use, and are trained and certified to administer, the ANSA and CANS assessment tools. Providers must use these tools to recommend a level of care to the MCO by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. The MCO must also ensure that Providers complete the Mental Health Rehabilitative and Mental Health Targeted Service Coordination Services Request Form in UMCM Chapter 15.2 and that they submit the completed form to the MCO.

Attestation from Provider entity to MCO that organization has the ability to provide, either directly or through sub-contract, the members with the full array of MHR and TCM services as outlined in the RRUMG.

Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG)

- Texas Resilience and Recovery Utilization Management Guidelines for Adult Mental Health Services can be found at Texas Resilience and Recovery Utilization Management Guidelines Adult Services (PDF).
- Texas Resilience and Recovery Utilization Management Guidelines for Child and Adolescent Services can be found at Texas Resilience and Recovery Utilization Management Guidelines Child and Adolescent Services (PDF).

- Adult Needs and Strengths Assessment (ANSA), manual, and glossary can be found at Attachment J ANSA Form October 2, 2013 (PDF), Attachment K ANSA Manual October 2, 2013 (PDF), and ANSA Glossary (Word).
- Child and Adolescent Needs and Strengths (CANS) (several versions), the corresponding manuals, and the interview facilitation guide can be found at Texas CANS Interview Facilitation Guide (PDF), Texas CANS 3-5 Manual (PDF), Texas CANS 3-5 (PDF) Texas CANS 6-17 Manual (PDF) Texas CANS 6-17 (PDF).

HHSC-established qualification and supervisory protocols

Qualified Mental Health Professionals for Community Services (QMHP-CS)

The minimum requirement for a QMHP-CS are as follows:

- Demonstrates competency in the work to be performed; and
- Has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
- An Advance Practice Registered Nurse (APRN) An LPHA, as defined in Attachment A of the MCO's relevant Contract, is automatically certified as a QMHP-CS. A Community Service Specialist (CSSP), a Certified Peer Provider (PP), and a Certified Family Partner (FP), as those terms are defined in Attachment A of the MCO's Contract, can be a QMHP-CS if acting under the supervision of an LPHA. If a QMHPCS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by an LPHA.

Mental Health Targeted Service Coordination Qualified Providers

A qualified provider of mental health targeted Service Coordination must:

- Demonstrate competency in the work performed; and
- Has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
- Be an APRN.

Individuals authorized to provide Service Coordination services prior to August 31, 2004, may provide Service Coordination services without meeting the minimum qualifications described above if they meet the following criteria:

- High school diploma or high school equivalency;
- Three continuous years of documented full-time experience in the provision of mental health Service Coordination services as of August 30, 2004; and
- Demonstrated competency in the provision and documentation of Service Coordination services.
- A case manager must be clinically supervised by another qualified case manager who meets the qualified provider mental health targeted Service Coordination criteria specified.

The MCO is prohibited from establishing additional supervisory protocols with respect to the above-listed provider types. Further, the MCO may not require the name of a performing provider on claims submitted to the MCO if that provider is not a type that enrolls in Medicaid (such as CSSPs, PPs, FPs, non-LPHA QMHPs, and Targeted Case Managers).

Behavioral Health Service Follow-Ups and Discharge

All members receiving inpatient psychiatric services will be scheduled for an outpatient follow-up and/or continuing treatment prior to discharge. Outpatient follow-up and/or treatment must occur within 7 days from the date of discharge. Behavioral health service providers are to contact members who have missed appointments within 24 hours to reschedule appointments.

Behavioral Health Coordination of Care for Substance Use Disorders

Providers are to coordinate care for members with a substance use disorder (SUD) to ensure members have access to the full continuum of covered services including without limitation assessment, detoxification, residential treatment, outpatient services, and medication therapy as medically necessary and appropriate.

Substance use disorder (SUD) treatment providers can refer members for treatment by calling the behavioral health phone number referenced on page 12 of this provider manual.

SECTION 10: Texas Health Steps

(Applicable to STAR Members)

NOTE: *The information below provides general guidelines regarding Texas Health Steps (THSteps). For comprehensive information on Texas Health Steps, please refer to the following resources:*

1. Texas Health Steps section of the Texas Medicaid Provider Procedures Manual Children's' Services Handbook, Volume 2, Section 5, Texas Health Steps Medical Checkups located at: http://www.TMHP.com/TMPPM/TMPPM Living Manual Current/Vol2 Children's Services Handbook.pdf
2. The Texas Health Steps Quick Reference Guide located at: http://www.TMHP.com/ TMHP File Library/Provider Manuals/THStepsQRG/THSteps QRG.pdf
3. Texas Health Steps provider information and current notices from the Texas Health Steps website at the Department of Human Services at: http://www.dshs.state.tx.us/thsteps/ providers.shtm
4. Online training modules with CEUs at: http://www.txhealthsteps.com/cms/

The Texas Health Steps program is, formerly known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. It is the Medicaid medical and dental preventive care program including medically necessary treatment or referrals for any diagnoses. Texas Health Steps medical checkups reflect the federal and state requirements for a preventive checkup.

Preventative care medical checkups are a benefit of the Texas Health Steps program if they are provided by enrolled Texas Health Steps providers and all the components are completed. All components are the required of the checkup, including immunizations and required lab work as indicated. An incomplete preventive medical checkup is not a benefit, unless there

is documentation in the medical record. Please refer to the Texas Health Steps periodicity schedule. It specifies screening procedures required at each stage of the member's life to ensure that health screenings occur at age-appropriate points in the member's life. Sports physicals are not a covered benefit however if the member is due for a Texas Health Steps medical checkup and a comprehensive medical checkup is completed, a Texas Health Steps medical checkup may be reimbursed and the provider may complete the documentation for a sports physical.

Please refer to: the Texas Health Steps Medical Checkups Periodicity Schedule at http://www. dshs.state.tx.us/thsteps/providers.shtm, or the Texas Medicaid Provider Procedures Manual (TMPPM) online at www.TMHP.com.

For more information about conducting a Texas Health Steps checkup, providers can refer to the Texas Health Steps online educational modules at www.txhealthsteps.com.

For Statutory Requirements of the program regarding newborn screenings, parental requirement during the checkup, reporting abuse or neglect, Early Childhood Intervention, newborn hearing screening, teen confidentiality issues please refer to the TMPPM, Volume 2,

Section 5.1.2 Statutory Requirements.

Texas Health Steps Provider Enrollment is available online through the Texas Medicaid Healthcare Partnership, TMHP at www.TMHP.com. A separate preventive care Texas Provider Identifier, TPI, is required to perform Texas Health Steps checkups.

The objectives of the Texas Health Steps program include the following:

- Early detection and treatment of medical and dental problems for Medicaid recipients from birth through 20 years of age;
- Bring infants into health supervision early in life;
- Link recipients with primary health care providers who can meet the need for care;
- Expand member awareness of services offered by the program;
- Encourage preventive services when due and according to the recommendations established by the American Academy of Pediatrics Periodicity Schedule;
- Provide comprehensive services available through private and public health care Providers; and
- Provide medical and dental care before health problems become chronic or irreversible.

FirstCare and HHSC or its subcontractor will validate, by chart review, a random sample of Texas Health Steps members against monthly Texas Health Steps medical checkup encounter data reported by FirstCare. The chart reviews will validate that all medical checkups are performed when due, as reported and that a complete medical checkup (based on age) was performed
in accordance with the required Texas Health Steps medical checkup protocol. They will also validate that the data is accurate and timely.

10.1 - Texas Health Steps Services

(Applicable to STAR members from birth through age 20)

Texas Health Steps medical checkups are an important preventive and diagnostic service that each FirstCare STAR member under age 21 should access in accordance with the Texas Health Steps medical periodicity schedule. It is the responsibility of the PCP to ensure that he/she discusses and performs these checkups when periodically due.

In addition, Texas Health Steps has developed online educational modules to provide additional information about the program, components of the medical checkup and other information. These modules provide free continuing education hours for a variety of providers. Providers do not have to be enrolled in Texas Health Steps . These courses may be accessed at www.txhealthsteps.com.

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

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

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

1. **Comprehensive health and developmental history** which includes nutrition screening, developmental and mental health screening and TB screening
    - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.

2. **Comprehensive unclothed physical examination** which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening
    - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.

3. **Immunizations,** as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
    - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule-United States," unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
    - The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
    - Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
    - Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit https://www.dshs.texas.gov/immunize/tvfc/.

4. **Laboratory tests,** as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia
    - Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
    - Anemia screening at 12 months.
    - Dyslipidemia Screening at 9 to 12 years of age and again 18-20 years of age
    - HIV screening at 16-18 years
    - Risk-based screenings include:
        - dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.

5. **Health education** (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.

6. **Dental referral** every 6 months until the parent or caregiver reports a dental home is established.
    - Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

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

Texas Health Steps medical checkups and immunizations are covered when delivered in accordance with the Texas Health Steps periodicity schedule. The periodicity schedule specifies the screening procedures recommended at each stage of the member's life and identifies the time period, based on the age, when screening services are covered.

Anticipatory Guidance for Texas Health Steps Providers

Anticipatory guidance is a federally mandated component of each Texas Health Steps medical and dental checkup. Education and counseling provided during a Texas Health Steps medical checkup is aimed at assisting the child, parent and/or guardian in understanding expected growth and development. It also serves as a way to provide information about the benefits

of healthy lifestyles and practices, as well as accident and disease prevention. Anticipatory guidance topics should be individualized and prioritized according to questions and concerns the child, parent and/or guardian may have as well as findings obtained during the completion of the health history and physical exam.

Anticipatory Guidance - Guide for Providers has been designed specifically for Texas Health Steps providers. It offers age-appropriate anticipatory guidance topics for children birth through 20 years of age and mirrors anticipatory guidance topics included on the Texas Health Steps Child Health Record Forms. Texas Health Steps encourages providers to adapt and enhance the age-appropriate topics to meet the needs of each child, parent and/or guardian.

To view individual age-specific anticipatory guidance, download or print, please go to the Dept. of State Health Services (DSHS) website at http://www.dshs.state.tx.us/thsteps/AnticipatoryGuidance.shtm.

Texas Health Steps Provider Forms for checkup documentation in the medical record In order to assure that all required components are covered and medical documentation is completed for each age specified in the Texas Health Steps periodicity schedule, the Department of State Health Services has downloadable forms available. These can be downloaded in Adobe or they can be ordered free of charge. These are the best resource to check against your electronic medical records, EMR, to assure the appropriate prompts for checkups. These forms are intended for use as a documentation tool for all required checkup components and should never be given out as a client questionnaire. The forms are recommended for your use by Texas Health Steps; they are not required. They are available at the DSHS website at: http://www.dshs.state.tx.us/thsteps/THStepsCatalog.shtm.

Eligibility for Texas Health Steps Services and Checkup Due Dates

New members under age 21 are encouraged to have a Texas Health Steps checkup within 90 days of enrollment in FirstCare. A member is considered new if they have not been on FirstCare for more than 90 days during the past two years.

Checkups for Existing Members

Existing FirstCare members are a due for a Texas Health Steps medical checkup in accordance with the Texas

Health Steps Medical Checkups Periodicity Schedule. Members ages three (3) and older will be due for a Texas Health Steps medical checkup on their birthday. Regardless of when a member (age 3 through 20) had their last checkup, they will become due on their birthday.

Exception to Periodicity
Exception-to-periodicity checkups are complete medical checkups completed outside the timeframes listed in the Texas Health Steps Periodicity Schedule due to extenuating circumstances. These checkups are might cause the total number of checkups to exceed the number allowed for the member's age range if the member were to have all regular scheduled checkups.

An exception-to-periodicity check is allowed when:

- Medically necessary, for example, for a member with developmental delay, suspected abuse, or other medical concerns or a member in a high-risk environment, such as living with a sibling with elevated blood lead. Required to meet state or federal checkup requirements for Head Start, day care, foster care, or pre-adoption.
- When needed before a dental procedure requiring general anesthesia.

As noted in the Periodic Checkup Age Range table, the number of checkups is set for each age range. This may avoid an exception-to-periodicity checkup and allow flexibility for the provider and family to schedule a checkup including before the child's birthday. If a member is due for a medical checkup, a checkup outside of the regular Texas Health Steps schedule must be billed as a regular checkup rather than an exception to periodicity.

The checkup is considered complete when all the required components are documented in the member's medical record or supporting documentation, which details the reason a component(s) was not completed. A plan to complete the component(s) if not due to reasons of conscious or parental concerns must be included in the documentation.

NOTE: *A sports physical is not a reason for an exception-to-periodicity checkup. When billing for an exception-to-periodicity visit, provider must also include the most appropriate exceptionto-periodicity modifiers. Claims for periodic Texas Health Steps medical checkups exceeding periodicity that do not include one for these modifiers will be denied as exceeding periodicity.*

Information concerning the appropriate ages for lead testing, development assessment, and dental referral can be found in the current Texas Medicaid Provider Procedure Manual and the Texas Health Steps Periodicity Schedule. This manual also contains detailed information about the components of the medical checkup.

Privacy and consent issues for teens and their parents; the Adolescent Health Guide
It is important for the provider to understand the privacy and consent issues involved in the efforts to educate, assess and inform teens and their parents. Parents have a legal right and

responsibility to consent to medical treatment for their minor teens. The problem arises when a teen faces sensitive health care problems. The mere need to inform parents to get consent prevents some teens from receiving care because they do not want their parents to know about sensitive problems or issues. FirstCare must ensure members (including minors) confidentiality for family planning services. If an in-network physician or specialist provides family planning services to adolescents, the physician/specialist must adhere to federal regulation, 42 C.F.R.
§ 59.15, which provides the following: "All information as to personal facts and circumstances obtained by the Title X project (Family Planning) staff about individuals must be held confidential and must not be disclosed without the individual's consent, except as may be necessary to provide services to the patient or as required by law with appropriate safeguards for confidentiality." Based on this federal regulation, neither FirstCare nor its provider network may require parental consent for minors to receive family planning services.

The Adolescent Health Guide provides guidelines on health and health-related legal issues for professionals who provide services, information, and support Please see this printable booklet at the DSHS Texas Health Steps website at http://www.dshs.state.tx.us/thsteps/providers.shtm.

Newborn Screenings
All newborn children of FirstCare STAR members must have an initial newborn checkup before being discharged from the hospital. Inpatient Texas Health Steps newborn screenings should be billed with procedure codes 99460, 99461, or 99463. Newborn checkups are also required at 3- 5 days old and again at 2 weeks of age. FirstCare STAR providers are to send all Texas Health Steps newborn blood screens to the Department of State Health Services (DSHS) Bureau of Laboratories.

Detailed information is to be included for all screened newborns and the FirstCare STAR member mother to allow HHSC or DSHS to link the screens performed at the hospital with screens performed at the two-week follow-up. If there is any doubt that a child under 12 months of age has not been properly tested, the provider should submit a blood sample on the appropriate DSHS form to the newborn screening laboratory at DSHS.

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

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

Texas Health Steps Medical Checkup Laboratory Services
All medical checkup laboratory studies performed as part of a Texas Health Steps medical checkup are to be performed by the DSHS Bureau of Laboratories. DSHS ensures that these services are available free of charge to all enrolled Texas Health Steps medical checkup providers for Medicaid recipients. Texas Health Steps providers are supplied with vacationers, needles, and postage-paid mailing containers. All order requests for forms and supplies should be submitted to the following address:

DSHS Bureau of Laboratories
1100 West 49th St
Austin TX 78756-3199

Supply requests can be faxed to the DSHS laboratory at 1-512-458-7672.
All Texas Health Steps laboratory requirements can be found online at:http://www.dshs.texas.gov/thsteps/providers.shtm.

FirstCare STAR providers are to send all Texas Health Steps medical checkup specimens to the DSHS Bureau of Laboratories and should include the member's Medicaid number on the Specimen Submission Form. If a number is not available, but pending, indicate PENDING in the Medicaid number space.

DSHS Laboratory Billing of Texas Health Steps Medical Providers
While there is no cost to the Texas Health Steps medical provider for laboratory supplies used during the course of a Texas Health Steps medical checkup, there is a cost to use the DSHS Laboratory for laboratory services outside of a Texas Health Steps checkup. The Texas Health Steps program normally reimburses the DSHS Laboratory for the cost of these supplies. However, if there is insufficient member information for Medicaid eligibility to be determined, Texas Health Steps cannot reimburse the DSHS Laboratory its cost. Therefore, Texas Health Steps allows for DSHS Laboratory to bill Texas Health Steps providers for laboratory tests when sufficient member information is not provided for Medicaid eligibility to be determined.

IMPORTANT: *These services and supplies are limited to Texas Health Steps medical checkup screening and laboratory services provided in the course of a medical checkup to Texas Health Steps recipients. Unauthorized use of services and supplies is in violation of federal regulations.*

Texas Health Steps Dental Checkups
The applicable periodicity schedule for Texas Health Steps dental checkups follows the standards adopted by the American Academy of Pediatric Dentistry. The initial dental checkup by a Texas Health Steps dental provider should occur at 6 months of age, and every 6 months thereafter. Medical checkups include a referral for a dental checkup if the recipient has not been seen by a dentist in the past 6 months. Although an oral screening is part of the Texas Health Steps checkup, it does not substitute for a dental checkup by a dentist. Members through age 20 can also self-refer for dental care.

Texas Health Steps members 6 months through 35 months of age can receive Oral Evaluation and Fluoride Varnish (OEFV). Texas Health Steps providers must be certified by the Department of State Health Services Oral Health program to bill for this service. An OEFV visit must be billed with CPT code 99429 with a U5 modifier, diagnosis code V20.2 and in conjunction with a Texas Health Steps medical checkup.

Texas Health Steps-Comprehensive Care Program (Texas Health Steps-CCP)
The Omnibus Budget Reconciliation Act of 1989 expanded Texas Health Steps program benefits to include payment for any federally allowable Medicaid service which is medically necessary to treat or ameliorate a defect, physical, or mental illness, or a condition identified in a Texas Health Steps medical or dental checkup. CCP services also include treatment of medical and dental

conditions, regardless of whether a formal Texas Health Steps medical or dental checkup has been performed. Individuals wishing to receive CCP services must be a Medicaid/Texas Health Steps recipient and under 21 years of age.

Immunizations/Imm Trac
FirstCare members under 21 years of age should be immunized during a Texas Health Steps medical checkup in accordance with the Texas Health Steps Periodicity Schedule. Providers are

required to submit immunizations that are given to FirstCare members the Texas Immunization Registry (ImmTrac). Verified consent from a parent or guardian is required. Immunizations are listed on the current Texas Health Steps Quick Reference Guide at http://www.TMHP.com/tmhp file library/provider manuals/thstepsqrg/thsteps qrg.pdf.

The latest immunization schedule for the Center for Disease Control is available at the website: http://www.cdc.gov/vaccines/schedules/hcp/index.html.

ImmTrac, the Texas Immunization Registry, is a no-cost service offered by the Texas Department of State Health Services (DSHS). It is a secure and confidential registry available to all Texans. ImmTrac safely consolidates and stores immunization information from multiple sources electronically in one centralized system. Texas law requires written consent for ImmTrac participation and limits access to the registry to only those individuals who have been authorized by law. ImmTrac contains over 120 million immunization records and continues to rapidly grow with increased participation.

The registry is a major component of the DSHS initiative to increase vaccine coverage across Texas. Please see the ImmTrac website at https://www.dshs.state.tx.us/immunize/immtrac/ default.shtm.

Texas Vaccines for Children
Texas Department of State Health Services (DSHS) will purchase, store, and distribute vaccines through the Texas Vaccines for Children program (TVFC). DSHS will monitor vaccine reports and track vaccine distribution to providers to assure an adequate inventory of vaccines for providers.

Any Texas Health Steps providers who have not enrolled in the Texas Vaccine for Children program (TVFC) may contact DSHS at 1-800-252-9152. DSHS will provide the location and telephone number of the local health department or regional office for providers to contact in order to become enrolled in the program and begin receiving the vaccine.

Providers enrolled in the TVFC program may not charge for the vaccine but may charge for the administration of the vaccine. More information is available at https://www.dshs.state.tx.us/ immunize/tvfc/.

Billing for Texas Health Steps Checkups
In order for a provider to administer a Texas Health Steps medical checkup to a FirstCare STAR member, the provider must have a Texas Health Steps Texas Provider Identifier (TPI). A qualified physician or pediatric/family nurse practitioner may perform Texas Health Steps medical checkups. An RN can perform components of the checkup under the supervision of a Texas Health Steps provider onsite. This is explained in detail in the Texas Medicaid Provider Procedures Manual. The Texas Health Steps checkup must be submitted with diagnosis code V202 and benefit code EP1. Rural Health Clinic (RHC) providers are required to bill with place of service 72. The following procedure codes, referral indicators, condition indicators, and modifiers that must be used when billing for Texas Health Steps checkups.

Diagnosis Codes

Procedure Codes
New member Preventive Visit - 99381, 99382, 99383, 99384 and 99385 Established member Preventive Visit - 99391, 99392, 99393, 99394 and 99395

Procedure codes 99385 and 99395 are for members' ages 18 through 20 when billing Texas Health Steps checkups.

Referral Indicator

Indicators should be used when there is or is not a referral made. Use the "N" referral indicator when no referral is given and the "Y" referral indicator when a Texas Health Steps referral was given to the member.

Condition Indicator

Condition indicators are required on the claim and describe the results of the checkup. The "NU" condition indicator means not used and should be billed when there is no referral given. The "S2" condition indicator means under treatment and should be used when a referral was made. The "ST" indicator means new services requested and should be used when a referral is made to another provider or the member needs another appointment with the provider.

Modifiers

Providers are required to bill one of the following modifiers when billing for Texas Health Steps checkups. The modifiers indicate who performed the Texas Health Steps checkup. In addition to the modifiers listed below, FQHC providers must use the EP modifier.

- AM - Physician, team member service
- SA - Nurse practitioner rendering service in collaboration with a physician
- TD - Registered nurse
- U7 - Physician assistant
- EP - Modifier required for Federally Qualified Health Centers (FQHC)

For other information related to Texas Health Steps Checkup procedures, updated news and procedures, and billing requirements please refer to the Texas Medicaid Provider Procedures Manual and to the Department of State Health Services Texas Health Steps program website at https://www.dshs.state.tx.us/thsteps/.

SECTION 11: Claims Submission and Administration

11.1 - Overview

FirstCare is committed to providing and maintaining a high level of excellence in service to our health care partners. From the time we receive a claim, to the time it is adjudicated; great measures have been taken and high quality standards have been established to ensure its accuracy and timely processing. Clean claims, as defined by law, are to be processed by FirstCare within 30 days for electronic claims and 45 for paper from the date of receipt for medical claims and within 18 days from the date of receipt for pharmacy claims.

FirstCare will pay providers interest at a rate of 18 percent annually calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing.

Clean claims that do not meet clean claim requirements will be denied, rejected, or considered deficient. Resubmissions of rejected claims are subject to timely filing requirements. Submission of claim redeterminations to adjudicated claims will be subject to the claim redetermination deadline of 120 days from original claim adjudication.

Claims should be submitted to FirstCare within the time limits noted in the Provider Agreement. 95 days from the date of the service is considered the maximum allowable time in the absence of extenuating circumstances. Providers are encouraged to submit claims electronically in 837 HIPAA compliant format. Paper submissions should be filed on the CMS-1500 or the UB-04.

- CMS-1500 - Physicians and Non-Institutional Providers Data Element Requirements for Non-Electronic Clean Claims; or
- UB-04 - Institutional Providers Data Element Requirements for Non-electronic Clean Claims.

FirstCare provides 30 days' notice to Providers before implementing changes to policies and procedures affecting the prior authorization process. Notices will be sent via fax blast to all affected Providers and will be posted to the Provider Portal. In the case of suspected Fraud, Waste, or Abuse by a single Provider, FirstCare may implement changes to policies and procedures affecting the prior authorization process without the required notice period.

Members and Providers will not be held liable for claims adjudication or transaction fees.

11.2 - Provider Identification Number Requirements

FirstCare STAR providers are to include their assigned ten (10) character National Provider Identifier (NPI) number for all STAR (Medicaid) claim submissions. The NPI should be submitted in the appropriate claims field as indicated below.

- UB04 (CMS-1450) Claim Form: Include the NPI number in box 56 (NPI) of the paper claim;
- HIPAA 837 Institutional Transactions: Include the NPI in Loop 2010AA, with a "EI" qualifier

- in the REF01 and Tax ID in the REF02
- CMS-1500 Claim Form: Include the NPI number of the billing provider in the bottom left corner Block 33a (Billing Provider Info and PH #) and if the billing provider and rendering provider are different include the rendering provider NPI in Block 24J (NPI); or
- HIPAA 837 Professional Transactions:
- If sending the Rendering Provider loop, include the NPI in 2310B, with a "EI" qualifier in the REF01 and Tax ID in the REF02
- If only the Billing Provider loop is sent, include the NPI in loop 2010AA, with a "EI" qualifier in the REF01 and Tax ID in the REF02

FirstCare CHIP Providers are to include their assigned ten (10) character National Provider Identifier (NPI) number for all CHIP claim submissions. The NPI should be submitted in the appropriate claims field as indicated below.

- UB04 (CMS-1450) Claim Form: Include the NPI number in box 56 (NPI) of the paper claim;
- HIPAA 837 Institutional Transactions: Include the NPI in Loop 2010AA in NM109
- CMS-1500 Claim Form: Include the billing provider NPI number in the bottom left corner Block 33a (Billing Provider Info and PH #) and if the billing provider and rendering provider are different include the rendering provider NPI in Block 24J (NPI); or
- HIPAA 837 Professional Transactions:
    - If sending the Rendering Provider loop, include the NPI in 2310B, with an "EI" qualifier in the REF01 and Tax ID in the REF02
    - If only the Billing Provider loop is sent, include the NPI in loop 2010AA, with an "EI" qualifier in the REF01 and Tax ID in the REF02

If you have been assigned more than on NPI number, please be sure to bill with the number specific to the appropriate billing address and/or TIN. This ensures reimbursement to the correct address.

The provider submitting the claim to FirstCare is responsible for ensuring the accuracy of the NPI number specified on each claim. Failure to place the NPI number on a claim or submitting a claim with the wrong NPI number will cause the claim to be denied or to be considered deficient and will be returned to the provider. Resubmission with a valid NPI number will be required for processing.

NOTE: *FirstCare does not require the submission of a TPI; however, providers are still required to obtain a TPI from TMHP.*

11.3 - Electronic Claims Submission

Advantages to Electronic Claim Filing
FirstCare recognizes the importance of having medical claim submissions processed accurately and promptly. Therefore, it is strongly encouraged that providers file claims electronically. Benefits of filing via electronic media include:

- Streamline the billing process;
- Reduction in costs for filing (i.e. postage costs, forms cost, printing costs, labor);
- Confirmation of receipt;
- Prompt identification of omitted/incorrect information; and
- Ability for the provider to quickly track number of rejected versus accepted claims.

Initiating Electronic Claim Filing
To begin submitting your claims electronically contact either of the following electronic claim clearinghouses:

- Availity (formerly THIN)
  FirstCare Payor ID is 949998
  Commercial Insurance Type Code “F”
  835 File Setup 1-877-334-8445

- Healthsmart (formerly CareVu)
  1-888-744-6638
  FirstCare Payor ID is 94999
  835 File Setup is auto-sent
  CPSI 1-800-711-CPSI FirstCare Payor ID is 94999

- Emdeon (formerly WebMD)
  (Emdeon is an intermediary to Availity)
  FirstCare Payor ID is TH003 (professional) and 12T03 (institutional)

The National Provider Identifier (NPI) is required on electronically (and paper) submitted claims.

Validating Electronic Claims and Notices of Receipt
The contracted clearinghouses edit electronic claims received for file format and required fields only. The clearinghouses do not perform validation of the provider's claim information. Upon completion of the editing, the clearinghouse will send the provider a confirmation notice for the batch indicating whether the batch was accepted.

This confirmation provides acknowledgement that the clearinghouse is in receipt of the claims. This confirmation does not verify the receipt of the claims by FirstCare. Clearinghouses also have the ability to accept or reject claim records on an individual basis.

Rejected claims and/or batches are the responsibility of the provider to correct and resubmit. The clearinghouse confirmation notice will **not** serve to support any claim appeals to FirstCare should one become necessary (i.e. for filing deadlines).

The clearinghouse submits the accepted claims to FirstCare and upon receipt of them from the clearinghouse FirstCare runs the claims through an edit program for format and a detailed validity check. Each claim will either be accepted or rejected in its entirety, not on a line-by-line basis, based upon information provided in the service lines. FirstCare will provide a confirmation report to the clearinghouse of both accepted and rejected claims.

It is the provider's responsibility to retrieve the FirstCare confirmation notice from the clearinghouse electronic mailbox or bulletin board system. The clearinghouse archives FirstCare confirmation reports for 60 days and are available for reloading during the 60-day time period. Providers unsure of how to send or retrieve items from their electronic mailbox or bulletin board system should contact their clearinghouse or software vendor for instructions.

NOTE: *The FirstCare confirmation report is the only acceptable acknowledgement of receipt by FirstCare of an electronically filed claim. A sample copy of the "FirstCare Report" is available in the ATTACHMENTS section of this manual.*

Providers are encouraged to reconcile FirstCare confirmation receipts and Explanation of Payment (EOP) prior to submitting a duplicate claim. Providers are also encouraged to verify the claim status on the web portal. Appeals to adjudicated claims are accepted in 837 format, via the web portal, or on paper.

Claims that require attachments (i.e., operative reports, invoices) are not accepted electronically. The claim should be submitted as a paper claim with attachment(s).

Transmission Frequency
Electronic claims can be transmitted daily; however, claims transmitted on non-business days, i.e. Saturday, Sunday, and nationally recognized holidays are not downloaded into FirstCare's claims processing system until the following business day.

Resolving Technical Questions
For issues or questions concerning your clearinghouse confirmation notices contact either your software vendor or the electronic claim clearinghouse. Please have your submitter ID ready when contacting the electronic claim clearinghouse.

For technical questions concerning your FirstCare confirmation report, contact FirstCare customer service department.

11.4 - Paper Claims Submission

Although we recommend electronic filing, you may occasionally need to submit your claims on paper. To help expedite the process, we have implemented technology that electronically images, sorts, and stores your paper claims.

General Requirements
FirstCare requires paper claims to be filed on a UB-04 form or a CMS-1500 form with accurate and valid information. Paper claims received on non-standard claim forms will be returned to the provider for resubmission on the appropriate claim form. In order to facilitate prompt processing and payment of claim, all required sections of the UB-04 and CMS-1500 should be completed.

- CMS-1500 - Physicians and non-institutional providers data element requirements for non-electronic clean claims; or
- UB-04 - Institutional providers data element requirements for non-electronic clean claims.

FirstCare will not accept super-bills or similar submissions as valid claims. Claims should be computer generated or typed. Hand written claims will be rejected without being entered into the claim system.

Claim Signature Requirements
When filing a paper claim, the provider representative's handwritten signature (or signature stamp) must be in the appropriate block of the CMS-1500 (box 31).

Providers delegating signature authority to office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment.

Claims prepared by computer billing services or office-based computers may have "Signature on File" in the signature block along with the printed name of the provider. For claims prepared by a billing service, the billing service should retain a letter on file from the provider authorizing the service. Initials are only acceptable for first and middle names. The last name should be spelled out.

For paper claims, mail to:
FirstCare Health Plans
P.O. BOX 211342
Eagan, MN 55121-1342

Confirmation of Receipt of Claims
When certified or returned receipt mail is received by FirstCare for claims submitted, the confirmation card will be signed by FirstCare, but only to indicate a package was received. The certified or returned receipt card does not provide evidence of receipt of a specific claim or batch of claims (i.e. on specific members and on specific dates of service). It will not be considered as proof that a claim on a given member was received, only that an unspecified UB04 or CMS-1500 was received by FirstCare.

- If a provider wishes to have proof of receipt by individual claim, the provider should submit the claim using the FirstCare Provider Portal or immediate confirmation of receipt.

FirstCare will image paper claims to improve the accuracy and efficiency of processing the claims. Providers are advised to file claims that meet the elements required to enable scanning. Failure to do so can result in delays in claims processing.

Below is a list of DO's and DON'Ts pertaining to the quality of paper claim submission.

Paper Claim Submission Guidelines

DO	DON'T
Do use original red claim forms.	Don't submit a copy of the original form.
Do use black ink for data entered on the claim form.	Don't use red ink.
Do print/type data on claims.	Don't use mixed fonts on the same form.
Do use an eight-digit date format (01282011).	Don't use dashes or slashes in date fields.
Do make sure data prints within the defined boxes on the claim form.	Don't submit more than six lines on the CMS-1500 claim form or twenty-three lines on the UB-04 form.
Do select a standard font with clear characters. Times Roman font works well.	Don't use italics or script fonts.
Do ensure print on claim/attachment is dark, clear, and legible.	Don't highlight information on the claim. Photocopies and faxed copies with small print are often blurry and unreadable.
Do circle information on attachments to identify critical criteria.	Don't put notes on the top or bottom of the claim form.
Do use all capital letters.	Don't use proportional fonts (Courier is a good example of a font that is not proportional).
Do use a laser printer for best results.	Don't fold claim forms.
Do use white correction tape for corrections.	Don't use correction fluid.
Do submit notes on 8 $^{1}/_{2}$ "x 11" paper.	Don't print slashes over the zeros.

11.5 - Claims Filing Deadlines

Initial Claim Filing
Claims should be submitted within 95 days following the date on which the covered health services were rendered, or for continuous covered health services, for which one charge will be made, the date on which the covered health services are completed by provider. Claims not received by FirstCare within 95 days will be denied and considered waived by the provider. These services are not to be billed to the member for payment. It is recommended that hospitals provide current insurance information to hospital-based physicians when available to allow those physicians to file claims to FirstCare in a timely manner.

Initial Claim Filing When There Is Other Insurance
If the member has other insurance and that insurance is the primary payor, the claim is required to meet the
following criteria.

- Claims should be filed with FirstCare within 95 days of the date on the primary payor's Explanation of Benefits (EOB) or Remittance Advice (RA); and

Exceptions to the Filing Deadline
Providers who fail to meet the filing deadline may request reconsideration of their claim through the claim redetermination process. FirstCare recognizes there are instances where extenuating circumstances may result in missing the filing deadline (e.g. theft or destruction of provider's records, complete system failure). In these instances, providers should submit a written claim redetermination to the FirstCare claims department/claim redetermination unit. FirstCare may waive the filing deadlines at its sole discretion.

11.6 - Deduction of Copayments

(Applicable to CHIP members only)

Providers are responsible for collecting all copayments at the time of service. It is recommended that providers check the member's CHIP member ID card on each visit as the status of copayment amounts are subject to change as members reach the maximum amounts of the cost sharing requirements.

Copayments shall not be charged or collected for the following:

- Well-baby and well-child care services, as defined by 42 C.F.R. §457.520 (regardless of the income level);
- Preventive services;
- Pregnancy-related services;
- Native Americans or Alaskan Natives;
- Members of the CHIP Perinatal subprogram (Perinates (unborn children) and Perinate Newborns).

IMPORTANT: *There are no copayments for covered health services provided to FirstCare STAR, CHIP Perinate, and CHIP Perinate newborn members; therefore copayments should not be collected at the time of service*

Federal law prohibits CHIP eligible families from incurring aggregate cost sharing liabilities above a certain maximum of their gross income during a calendar year. Families are to report to TAA (Trade Adjustment Assistance Program) when they are reaching this maximum and that information is electronically transmitted to FirstCare. FirstCare will then issue a new ID card to each family member.

CHIP Cost-Sharing Schedule	
	Effective January 1, 2014
Enrollment Fees (for 12-month enrollment period)	
	Change
At or below 151% of FPL*	$0
Above 151% up to and including 186% of FPL*	$35
Above 186% up to and including 201% of FPL*	$50
Co- Pays (per visit):	
At or below 151% of FPL*	**Change**
Office visit (non-preventative)	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Co-pay, Inpatient (per admission)	$35
Cost-Sharing Cap	5% of family's income**
Above 151% up to and including 186% of FPL*	**Change**
Office visit (non-preventative)	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$35
Facility Co-pay, Inpatient (per admission)	$75
Cost-Sharing Cap	5% of family's income**
Above 186% up to and including 201% of FPL*	**Change**
Office visit (non-preventative)	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$35
Facility Co-pay, Inpatient (per admission)	$125
Cost-Sharing Cap	5% of family's income**

**The federal poverty level (FPL) refers to income guidelines established by the federal government. **Per 12-month term of coverage.*

FirstCare is not responsible for payment of unauthorized non-emergency services provided to a CHIP member by an out-of-network provider. In such circumstances, the CHIP member will be responsible for all costs.

11.7 - Billing Members

A FirstCare STAR or CHIP member may be billed for services that are not covered by STAR or CHIP. Before rendering non-covered health services, providers are to inform the member of his/ her liability for the cost of services that are not a benefit of the Texas STAR or CHIP Programs. A provider who elects to furnish requested services that are not covered, including those services which have been determined as not medically necessary must obtain the member's signature on the Patient Acknowledgment Statement Form accepting responsibility for payment of services and his/her status as a private pay patient.

Without written, signed documentation that the FirstCare member has been properly notified of his/her private pay status, the provider cannot seek payment from an eligible FirstCare member.

A provider may bill a FirstCare member for a claim denied as being not medically necessary or a non-covered health service if both of the following conditions are met:

- Member requests the specific item or service; and
- The Provider obtains a signed Patient Acknowledgment Statement Form.

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

FirstCare members, or others on their behalf, are not to be billed for the amount above that which is paid by FirstCare for allowed services. The member is not to be billed for services denied or reduced as a result of errors made in claims filing, claims preparation, missed filing deadlines, or failure on the part of the provider to follow the appropriate appeals process.

11.8 - Coding

FirstCare requires use of standard revenue codes, CPT, HCPCS and ICD-10 coding (for dates of services 10/01/15 and after), unless otherwise directed by FirstCare as outlined in this Manual or in the Texas Medicaid Provider Procedures Manual or the Texas Medicaid Bulletin.

For ICD-10 coding, insure that you code according to the specificity required.

New and Deleted Codes

Providers should bill for services using current CPT or ICD-10, HCPCS, and revenue codes and modifiers that are appropriate for the service provided and approved by HIPAA. Annually, as CPT and HCPCS codes are added and deleted from the American Medical Association (AMA) and CMS listings of valid codes, FirstCare's policy for new and deleted codes submitted with claims for members participating in CHIP or STAR product will be the following:

FirstCare CHIP

- New codes are accepted by FirstCare at the beginning of the year in which they become effective in the CPT or HCPCS manual; and
- Services coded with deleted codes will be denied if they are submitted for any date(s) of service within the year the codes are deleted from the CPT or HCPCS manual.

FirstCare STAR

- New/updated codes are accepted by FirstCare at the beginning of the year on which they become effective in the CPT or HCPCS manual, or on or after the day of their effective date as announced in Medicaid banner messages or the monthly updates to the Texas Medicaid Provider Procedures Manual; and

- Services coded with deleted/invalid codes will be rejected/denied if they are submitted for any date(s) of service within the year the codes are deleted from the CPT or HCPCS manual, or on or after the day of their expiration date as announced in Medicaid banner messages or the monthly updates to the Texas Medicaid Provider Procedures Manual.

National Correct Coding Initiative (NCCI)
Providers must report services correctly. Using the general coding principles in Chapter I of the National Correct Coding Initiative (NCCI) manual is one step to coding correctly. Other steps include:

- Reporting the most comprehensive CPT code that describes the services performed - do not unbundle and do not fragment a procedure into component parts.
- Avoid down coding.
- Avoid upcoding.
- Report units of service correctly.

Unlisted Codes

Procedures
Unlisted procedures are used to identify services or procedures not described by other HCPCS/CPT codes. These are usually identified as XXX99 or XXXX9 codes. An unlisted code should be reported if a physician provides a service that is not accurately described by other codes. FirstCare requires supporting clinical documentation when an unlisted procedure code is billed. If this information is not provided, the claim line will deny. Since unlisted codes may be reported for a very diverse group of services, NCCI as well as iCES generally does not include edits for these codes. Therefore, these will be reviewed and determined if payable based on the clinical documentation provided.

Supplies/Drugs
FirstCare requires a description for unlisted supplies. A manufacturers invoice or more documentation maybe requested if the description submitted is abbreviated or cannot be determined as to what the supply may be. FirstCare requires the name of the drug as well as the dosage amount given to the patient for any unlisted drugs. If either of these is not present on the description the unlisted drug will be denied.

11.9 - Modifiers

Providers should use modifiers to indicate that a service provided to the patient has been altered by some special circumstance(s) while the code description itself has not changed.

FirstCare requests that providers bill with appropriate American Medical Association (AMA) and/or CMS two-digit numeric or alphanumeric character modifiers.

When processing claims FirstCare will evaluate the appropriateness of the modifiers used based on coding review logic of iCESTM (Ingenix Claims Editing System). iCESTM evaluates the modifier used applying various AMA and CMS guidelines. If iCESTM determines that a modifier was used inappropriately, the specific service or services may be denied by FirstCare. In addition, modifiers that are not necessary for payment may be denied (e.g. modifier 59 where no edit exists).

The use of a modifier alone does not ensure payment if other FirstCare criteria are not met. Some services that are identified by modifiers also require prior authorization and/or supporting documentation.

The following information outlines FirstCare guidelines and/or requirements when using any of the following modifiers.

- **-26 and TC modifiers:** Certain procedures have both technical and professional components (X-ray, pathology, etc.) as defined by CMS. FirstCare requires a provider performing only one of the two components to use the appropriate modifier.
- **-51 modifier:** This modifier should not be used to indicate procedures that are considered components of or are incidental to the primary procedure.
- **LT and RT modifiers:** Required when billing bilateral surgical procedures or when billing multiple sides of a unilateral procedure, including hearing aids.
  Please bill as specified below to ensure correct reimbursement:
  - Two service lines with a quantity of one (1) on each; and
  - Modifier RT on one line and modifier LT on the other line.
- **P1 - P6 modifiers:** Required when submitting anesthesia codes. See Anesthesia Services section for additional modifier requirements.
- **KR modifier:** Required when billing only a partial month for DME rentals. The unit field should indicate the number of rental days.
- **RR modifier:** Required when billing for a rental period for durable medical equipment.
- **NU modifier:** Required when billing for new durable medical equipment.
- **UE modifier:** Required for billing used durable medical equipment.

11.10 - Special Billing Situations

Global Fees
There may be some instances where a global fee for a surgery or other service (i.e., maternity care) has been established. The claim should be billed using the applicable code when services are rendered under these circumstances.

Laboratory Fees
Facility based laboratory fees will be paid only when appropriate CPT codes with modifiers are used. Please refer to the Texas Medicaid Provider Procedures Manual to view a list of Medicaid approved lab codes.

Technical vs. Professional Components
Certain procedures include both technical and professional components. It is necessary to define the components with the appropriate modifier when a provider performs only one of the components. The provider performing the technical aspect of the test should bill using the modifier "TC" following the code. The provider who reads the test should bill using the modifier "26" following the code. The provider performing both aspects should bill using the code and no modifier.

Professional fees for radiology readings (26 modifier) of films not taken in the physician's office will be paid only to radiologists. Non-radiologist physicians who perform radiology services in their office when allowed by regional policies and procedures, may charge global fees if they read their own films. Only one reading will be reimbursed per procedure.

Physician Extender Billing
If a physician extender is individually contracted with FirstCare or if his or her services are specifically contracted under the terms of the physician agreement with FirstCare, he or she will be assigned a unique Provider ID number by FirstCare and should bill using that number in addition to his or her TPI number for FirstCare STAR. Otherwise, the physician extender must bill under the supervising physician/provider's name and tax ID.

Services rendered by physician extenders using the tax ID number and name of the supervising physician/provider must list that physician or Medical Director in Box 31 of the claim form. The physician extender's name may appear elsewhere on the claim form.

Duplicate Billing/Same Day Services
If a patient is required to return to the office the same day for the same type of treatment, the services cannot be listed as a separate line item since the claims processing system will read this as a duplicate service. Such services must be billed on one line using the appropriate number of units, or using the appropriate coding/modifiers as per CPT coding guidelines. Examples of this are:

- For patients returning to the physician/provider's office for a same day follow-up visit, only one (1) office visit should appear for the same diagnosis and treatment; or
- Physician/providers visiting their patients more than one (1) time in the hospital may only bill one (1) code per day as per CPT guidelines.

Assistant Surgeon Billings
FirstCare has adopted guidelines for determining when an assistant surgeon is appropriate for the surgical procedure. If the procedure meets those clinical criteria guidelines for use of an assistant surgeon, then a specific authorization is not required for the assistant surgeon. Procedures not included in the list of procedures indicating an assistant is appropriate require specific authorization of the assistant surgeon.

A list of procedures not requiring authorization for the assistant surgeon (called "Assistant Surgeons List") may be viewed on the FirstCare website at www.FirstCare.com.
The only providers approved for reimbursement by FirstCare as assistant surgeons are:

- Assistant physician surgeons; and
- Advanced practitioners such as Physician Assistants (PAs), Nurse Practitioners (NPs), Registered Nurse First Assistants (RNFAs), and Licensed Surgical Assistants (LSAs).

Certified surgical assistants are not authorized for reimbursement as assistant surgeons by FirstCare. A separate claim form must be filed by assistant surgeons. A copy of the operative report may be requested by FirstCare when processing claims for assistant surgeon fees.

Modifiers: Assistant Surgeons (MD, DO or DDS) should file with modifier -80, -81, or -82. Nurse Practitioners (NP) or Physician Assistants (PA) or Certified Registered Nurse First Assistants (RNFA) acting as assistants should file with modifier -81 or -AS.

Provider ID numbers: If the mid-level practitioner's services are specifically contracted under the terms of the physician agreement with FirstCare or if the mid-level practitioner or physician assistant surgeon is independently contracted, they will be assigned a unique provider ID number by FirstCare and should bill using that number. Otherwise, bill under the primary surgeon's name and tax ID.

Multiple Surgery Billing
When billing for multiple surgical procedures performed on the same date of service, FirstCare classifies the procedure with the greatest allowable as primary. With the exception of bilateral procedures, no modifiers are required when billing for multiple surgeries, except where an NCCI edit may apply. Allowed amounts for additional procedures will be reduced based on CMS

guidelines or rates specified in the contract. All procedures billed with modifier 22 **must** be accompanied by an operative report to be considered for payment.

High Risk Maternity Care
High risk pregnancy care should be billed with appropriate high level evaluation and management code with modifier TH.

Perinatal Services

Antepartum Care
- FirstCare requires provider to use bill the appropriate E&M procedure code with modifier TH.
- Ancillary services (lab, X-ray, sonogram) provided during antepartum care should be billed using the appropriate code.

Delivery and Post Partum Care
- FirstCare requires provider to bill deliveries and post-partum care visits according to the Texas Medicaid Provider Procedures Manual.
- FirstCare requires provider to bill 59430 for postpartum care that is provided after discharge.

NOTE: *No additional payments will be made for the mother under the Chip Perinate program following delivery; therefore all post-partum care services will be included in the above global payment.*

FirstCare will monitor the post-partum visits provided either through chart review or other method of capturing the encounter such as completion of the CHIP Perinate Post-Partum Visit Encounter Form (see ATTACHMENTS sections for a sample of the "CHIP Perinate Post-Partum Visit Encounter Form").

Paper claims for FirstCare members are to be filed directly to FirstCare STAR at:
FirstCare Health Plans
P.O. BOX 211342
Eagan, MN 55121-1342

11.11 - Anesthesia Services

Anesthesia services are to be billed to FirstCare in accordance with the following guidelines:
- Use standard ASA and Medicare coding guidelines;
- Use the five-digit anesthesia codes (00100-01999), not surgical codes;
- Use appropriate modifiers specifying the level of service provided ("anesthesiologist" modifiers vs. "CRNA" modifiers);
- Follow ASA standards for all other appropriate modifiers (i.e. physical status modifier):
  - P1 - normal healthy patient;
  - P2 - patient with mild systemic disease;
  - P3 - patient with severe systemic disease;
  - P4 - patient with severe systemic disease that is a constant threat to life;
  - P5 - moribund patient who is not excepted to survive without the operation; or
  - P6 - declared brain-dead patient whose organs are being removed for donor purposes;
- Indicate time in minutes in the following format (0000 to 9999); and
- Unit field should always 1. FirstCare has assigned ASA unit values to specific procedure codes. Reimbursement formula is determined by the following formula: (base units + time units) x conversion factor.

Time Reporting

Anesthesia time begins when the anesthesiologist begins to prepare the patient to receive the anesthesia and ends when the anesthesiologist is no longer in personal attendance of the patient.

Qualifying Circumstances

Anesthesia services provided under difficult circumstances are billed with qualifying circumstance codes. These codes are not billed alone, but in addition to an anesthesia procedure. When billing for these codes always submit an operative report or anesthesia report for consideration of the additional payment.

- 99116 - Anesthesia complicated by utilization of total body hypothermia;
- 99135 - Anesthesia complicated by utilization of controlled hypotension; or
- 99140 - Anesthesia complicated by Emergency conditions.

NOTE: *The operative report is not required for 99100.*

CRNA Services

CRNAs billing must comply with anesthesia services billing requirements and one of the following medical direction modifiers:

- QX - CRNA medically directed by the anesthesiologist; or
- QZ - CRNA not supervised by the anesthesiologist; the surgeon is directing.

NOTE: *If a CRNA is independently contracted with FirstCare or if his or her services are specifically contracted under another agreement with FirstCare, he or she will be assigned a unique provider ID number by FirstCare and should bill using that number. Otherwise, the CRNA must bill under the supervising physician's name and tax ID number.*

Pain Management Services

Please use standard ASA and CPT coding guidelines when submitting a claim.

Providers should visit FirstCare.com/Providers or your provider portal for a list of services requiring preauthorization. Please contact Customer Service, 1-800-884-4901, if you have any questions.

11.12 - Allergy Services

Allergy testing and evaluation services, including injections and serum, are covered benefits. FirstCare recommends that benefits be verified with FirstCare's provider services web portal prior to administering services. These services are reported using CPT codes **95004 - 95199.**

Copayments applicable to allergy services depend upon the nature of service provided (i.e. allergy testing and evaluation, office visit, number of vials of serum, and/or injection). An office visit copayment may not apply if a patient visit is for immunotherapy injections. Copayments should be verified with FirstCare's provider services web portal prior to administration.
(Applicable to CHIP members only)

NOTE: *If an allergy injection is given in the physician's office and the primary diagnosis is not for an allergy or allergy-related symptom (i.e. sinusitis), the guidelines for processing allergy services may not apply. Allergy services, including allergy injections, should be specifically authorized.*

Allergy Testing: CPT codes 95004 - 95052 are used for allergy testing. Each procedure should be billed with the number of tests performed in the "units" field. 1 copayment should be taken for each series of tests.

Additional Allergy Testing: CPT 95056 - 95071 are additional codes for allergy testing. These procedures are not billed by the number of tests and have an MUE of 1. Any quantity billed greater than 1 will be denied.

Ingestion Challenge Tests: CPT 95076 is an additional allergy testing procedure.

Allergy Injections: CPT codes 95115-95117 are allergen immunotherapy codes that do not include the provision of allergenic extracts. These codes are used when the patient supplies the allergenic extracts and the service performed is only the injection and monitoring.

Allergy Serum, Single Dose Vials: CPT code 95144 describes the supervision and provision of single or multiple antigens using single dose vials. This code does not include the injection(s). The number of vials should be specified.

Allergy Serum, Insect Venom: CPT codes 95145 - 95149 describe the supervision and provision of allergen immunotherapy using single or multiple dose vials. These codes are used for insect venom and do not include the injection(s). The number of doses should be specified.

Allergy Serum, Multiple Dose Vials: CPT 95165 describes the supervision and provision of single or multiple antigens using multiple dose vials. CPT 95170 is for whole body extracts of biting insects or other arthropods. The number of doses should be specified in the "units" field on the claim form. FirstCare should be billed only for the actual number of doses used out of the multiple dose vials.

FirstCare requires providers to bill only one (1) vial per service line, since the number in the "units" field represents the number of doses rather than the number of vials. Each additional vial should be billed separately on a different service line.

Unlisted Procedures: CPT code 95199 should be used only for unlisted allergy/clinical immunological services or procedures. FirstCare requires this code to be billed with a complete description. If no description of the unlisted service or procedure is attached or indicated, the claim will be denied.

NOTE: *Providers are to bill using current CPT codes. The codes referenced above are subject to change as new or deleted codes occur*

11.13 - Checking the Status of a Claim

How to Inquire About a Claim
If a provider wishes to inquire on the status of a submitted claim, or if there is a question regarding a claim denial or amount paid, claim inquiries may be made in any of the following ways:

- Log on to my.FirstCare.com and access the provider self-service portal; or
- Call the customer service department.

Customer Service Department
The customer service unit is available to help with inquiries on claim status. Providers who elect to inquire by phone should be ready to provide the following information:

- Member's name and member identification number;
- Date of service;
- Amount of claim; and
- Provider's name and tax ID number.

Providers should allow 30 days from the date the claim was sent to FirstCare before inquiring as to the status of the claim. If an immediate answer is unavailable about the claim in question, the customer service department staff will research the issue and call the provider back with the results of their research.

Please contact the Provider Service Center at 1-800-431-7798 for all claims questions/assistance, where they will help guide you on next steps in issue resolution.

11.14 - Reimbursement Coding

FirstCare has developed Reimbursement Policies, which include coding information, to provide you with ready-access and general guidance on payment methodologies for medical, surgical and behavioral health services.

These policies are subject to all terms of the Provider Service Agreement as well as changes, updates and other Reimbursement Policy requirements. All of these policies are also subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD-10), FirstCare accepts codes valid for the date(s) of service. Additionally, Reimbursement Policies supplement certain standard FirstCare benefit plans and aid in administering benefits. Thus, federal and state law, contract language, etc., take precedence over the language in the policies i.e., Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and/or other published documents. Moreover, the terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from these Reimbursement Policies. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in Reimbursement Policies.

Most importantly, our Reimbursement Policies relate exclusively to the administration of health benefit plans and are not recommendations for treatment or treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member.

All Reimbursement Policies are subject to change prior to the annual review date.

Please view the policies at www.FirstCare.com/Provider-Reimbursement-Policies.

11.15 - FirstCare Provider Reimbursement

FirstCare reimburses all STAR and CHIP providers on a fee-for-service payment methodology. At this time, FirstCare does not capitate any providers participating in the FirstCare STAR/CHIP network.

FirstCare postings/check runs are performed on a weekly basis. Claims processed prior to the designated posting date will remain finalized until the weekly posting and mail date.

All Facilities will be responsible for promptly notifying FirstCare, in writing via Certified Mail, of any change in facility designation that impacts reimbursement rates to be paid such as its status as a rural or urban facility and/or encounter rate changes. Any claims payments due to the Facility will be paid at the new rate from the date FirstCare received the written notification (effective date prevails if notice is received by FirstCare prior to the rate change effective date).

To ensure your notification is received and processed promptly, please send all rate change notifications via Certified Mail to:

FirstCare Health Plans
Attn: Contracting-Rate Change Notices
1206 West Campus Drive
Temple, Texas 76502

NOTE: *FirstCare will not pay any claim submitted by a provider who is under investigation for or has been excluded or suspended from Medicare or Medicaid for fraud and abuse in the event FirstCare is on actual or constructive notice of the investigation, exclusion or suspension.*

Directed Payment Programs(DPP)
FirstCare will reimburse according to HHSC directive. For additional information, please refer to the TAC references below.

- CHIRP : TAC §353.1306 & §353.1307 including UHRIP TAC §353.1305
- TIPPS: TAC §353.1309 & §353.1311
- RAPPS: TAC §353.1315 & §353.1317
- BHS DPP: TAC §353.1320 & §353.1322

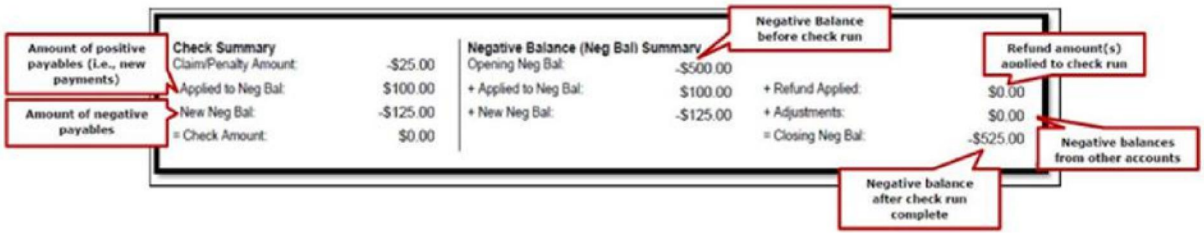
Explanation of Payment (EOP)
The Explanation of Payment (EOP) is the statement sent to the provider which lists the services provided, the amount billed, and the payment made. The EOP will accompany the reimbursement check and provide a summary of the finalized claims for a particular check run showing claim payment, denials, and adjustments.

A sample of the EOP and a table of EOP field descriptions immediately follow.

Understanding FirstCare's EOP
FirstCare Health Plans recently enhanced our EOP to include data to determine payment calculation and current balance information. The payment summary enhancements were designed to provide you with a greater understanding of the payment and calculation components. The EOP also defines your check and balance summaries separately.

Our goal with these EOP improvements to our payment summary is to simplify our EOP for you.

EOP Summary Example
The provider has an opening balance of -$500.00. There is one claim, which FirstCare originally paid at $125.00 and we are now paying at $0.00. The provider has three first-time claims paying for a total of $100.00. See below for how this would appear on the EOP.



EOP Definitions

Field/Component	Definition
Claim/Penalty Amount	Amount of claim and penalty/interest payments
Applied to Neg Bal	Amount of positive payables (new payments) applied to negative balance

New Neg Bal	Amount of negative payables (reversals of previous payments) which are not recouped on this payment
Check Amount	Net amount paid on this check
Opening Neg Bal	Amount of Negative Balance before this check run
Refund Applied	Refund amounts applied to negative balances on this check run
Adjustments	Negative balances transferred from other accounts
Closing Balance	Amount of Negative Balance after this check run

Table - Explanation of Payment Field Descriptions

The following is a field by field breakdown of an Explanation of Payment (EOP).

Field Number	Field Name	Description
1	FirstCare Name and Address	
2	FirstCare Logo	
3	Appeal Instructions and Addresses	
4	Provider to whom payment is generated	Payment is being generated to this Provider
5	Payment Amt	Amount the check is for
6	Check / EFT date	Check Date
7	Check No	Check Number
8	835 Trace#	Electronic Claim Trace Number
9	Provider ID	FirstCare Provider Number
10	IRS #	Provider's IRS Number
11	NPI#	Provider's NPI Number
12	Patient Name	
13	Patient Control Number	Provider Reference Number
14	Control Number	Claim Number
15	Age	Member's (Patient's) Age
16	Member ID #	Member's Member ID Number
17	DRG #	DRG Number (if applicable)
18	Acct	Account Number as Listed on the Claim
19	Auth #	Authorization Number (if applicable)
20	Sery	Service Line Number
21	Dates	Dates of Service
22	Diag #	Diagnosis Number
23	Proc #	Procedure Code
24	Days/Cnt	Number of Days or Unit Count
25	Charged	Charged Amount for Service Line

26	Adjusted Amount	Difference between Charged and Allowed Amounts
27	Allowed	Allowed Amount for Service Line
28	Explain Codes	Explanation Code (EX code) - an EX code serves as a message to the Provider to provide a reason for claim payment or denial at a service line level
29	Denied	Denied Amount of Service Line
30	Ded and Copayment	Deductible and Copayment Amount
31	Discount	Discount Amount
32	TPP	Third Party Payment
33	Payment	Payment Amount of Service Line
34	Benefit Limit	Type of Service Limits
35	Sub-total	Subtotals at per claim level
36	Total	Total for all claims on EOP
37	Summary of EOP	The Section of the EOP will provide a summary of payment to the hospital. The summary page will show any negative advances or prepayments against this Provider. (For example, a refund was set up in the AMISYS system to recoup out of the hospital's next check, or once money has been accrued.) The summary page will show the amount of this check, less any negative advance, for the total amount of this check.
38	Explanation and Code Description	Any EX Code listed on the EOP will be shown here, complete with a description of the EX code

11.16 - Coordination of Benefits

Coordination of Benefits (COB) is a function that audits for the non-duplication of benefit reimbursement. It is designed to ensure that total reimbursement does not exceed the billed amount or FirstCare's maximum allowable rate. Below are rules establishing the order of benefit determination between FirstCare and any other health care plan the member may have on whose behalf a claim is made.

Coverage under Medicaid and CHIP is secondary to all other insurance coverage, unless an exception applies under federal law. Coverage provided under Medicaid will pay benefits for Covered Services that remain unpaid after all other insurance coverage has been paid. For Network Providers and Out-of-Network providers with written reimbursement arrangements with the MCO, the MCO must pay the unpaid balance for Covered Services up to the agreed rates.

A member may receive collateral health benefits under a different type of insurance such as workers compensation or personal injury protection under an automobile policy. If a member is entitled to coverage for specific services payable under another insurance plan and the MCO

paid for such Covered Services, the MCO may obtain reimbursement from the responsible insurance entity not to exceed 100% of the value of Covered Services paid.

11.17 - Overpayments

When an overpayment is identified by FirstCare, a letter is sent to the provider that identifies the overpayment. This letter requests a refund of the overpaid amount within 45 days. If no refund from the provider is received within 45 days, the money is recouped from the next claims payment.

Failure to respond during this period triggers recoupments. It is the provider's responsibility to contact FirstCare if they disagree with the overpayment request.

When the provider identifies an overpayment made by FirstCare, the provider is advised to contact the customer service department for assistance in determining if an overpayment did indeed occur. If a true overpayment did occur, the provider should proceed with refunding the money back to FirstCare by following the process in the next paragraph.

Providers may refund the overpaid dollars directly to FirstCare by sending a check along with a "Refund Submission Form". This will expedite the processing time to post the refund check.

Mail the form to:

FirstCare Health Plans
P.O. BOX 211342
Eagan, MN 55121-1342

FirstCare requests overpayment refunds according to the time frame indicated in the participating provider contract. In cases when it is necessary, the same refund process and timelines outlined above will apply.

If an overpayment was made because FirstCare is not the primary payer, the payment made by FirstCare must be refunded in full. Upon receipt of the primary Payer's EOB, FirstCare will reprocess the claim issuing the corrected payment amount as the secondary payer.

11.18 - Claim Appeal Guidelines

A claim redetermination is defined as a formal electronic or written request from a provider for reconsideration of a claim already processed by FirstCare. All redeterminations of denied claims and requests for adjustments on paid claims are to be received by FirstCare within 120 days from the initial date of payment/EOP on which that claim appears. Appeals received after the 120 days filing limit will be denied and the original claim determination will be upheld.

Electronic Claim Redetermination

To ensure that claim redeterminations are processed accurately and in a timely manner, providers are encouraged to submit claim redeterminations electronically through the provider services web portal.

Written Claim Redetermination

If a provider wishes to submit a written redetermination of a claim decision with FirstCare, submit a Claim Redetermination Form.

Please be sure to provide missing information and/or attach any appropriate documentation (i.e. referral copy, operative report, etc. needed to support the appeal.

Submit the claim redetermination to the FirstCare claims department to:

FirstCare Health Plans
P.O. BOX 211342
Eagan, MN 55121-1342
Fax number: 512-597-3203

Acceptable Proof of Timely Filing
For electronic submitted claims, FirstCare's electronic filing confirmation report that indicates the claim was accepted by FirstCare will be accepted as documentation from the provider in support of redeterminations for claims denied as past filing deadline. A vendor's confirmation notice is not acceptable proof that FirstCare has received a provider's claims. ***NOTE:*** *If the claim was rejected, it is the provider's responsibility to re-file within the filing deadline. FirstCare will not waive the filing deadline for rejected claims not resubmitted within the filing deadline. Provider(s) that experience computer issues or lost data should contact the customer service department for assistance in filing your claims.*

Corrected Claim
If the original claim was denied for incorrect information, providers can submit a corrected claim. Electronic corrected claims should reflect a resubmission code of 7, and must reference the original claim number. Failure to do so may result in a denial for duplicate claim/service. Paper corrected claims should have corrected printed in either the header or the footer

of the claim (outside of the red margins of the claim) and must also reference the original claim number. Submission timeframes for corrected claims are within 120 days of the date of discharge if an inpatient or date of service if an outpatient. Paper corrected claims should be sent to the original claim submission address:

FirstCare Health Plans
P.O. BOX 211342
Eagan, MN 55121-1342

Provider Appeal Process to HHSC - related to claim recoupment due to Member disenrollment Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- **The Explanation of Benefits (EOB) showing the original payment.** Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- **The EOB showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment FOB.
- **Completed clean claim.** All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

11.19 - Subrogation

Subrogation is a procedure under which FirstCare can recover from third parties the full or some proportionate part of benefits payable for a member. For example, should a member who has received benefits under a state's statutory plan covering disability benefits enter into litigation or make a claim against a third party, FirstCare has a right to place a lien against any benefit the third-party action may provide.

FirstCare retains First Recovery Group, LLC (FRG) to recover benefits paid by FirstCare for services payable by a third-party. Examples of when FRG may be involved in recovery include the following situations:

- Motor vehicle accidents;
- Injuries recoverable by a homeowner's policy;
- Personal injuries; and
- All other injuries not related to workers compensation.

Members may seek provision of direct health services within the FirstCare provider network and according to their benefits as provided for in their plan document. Providers should give any necessary treatment and follow all policies and procedures established by FirstCare as they normally would.

Claims will be processed by FirstCare as they are submitted; any adjustments will be made once FRG has completed proper investigation of any third party liability. When FirstCare receives reimbursement from FRG for charges paid on a FirstCare member's behalf, claims paid in the system will be adjusted to reflect that a recovery was received by a third-party carrier.

11.20 - Motor Vehicle Accidents

Members are instructed to seek care within the FirstCare STAR/CHIP provider network and use their FirstCare benefits as usual. Providers should give any necessary treatment, bill FirstCare for such services, and follow all usual policies and procedures established by FirstCare.

In the event a member receives services due to the act or omission of another person or entity, then FirstCare is entitled to receive and will be fully subrogated to all rights of recovery (including, but not limited to, court costs and reasonable attorney fees).

> ***NOTE:*** *If a provider chooses to file his or her own lien, the claim(s) should not be filed with FirstCare as this voids the provider's lien. If the provider withdraws the lien, the provider must observe normal FirstCare filing deadlines.*

11.21 - Work Related Injuries

Workers' Compensation is a state-governed system designed to address work-related illnesses and/or injuries. Under the system, employers assume the cost of medical treatment and wage losses arising from the worker's job-related injury or disease, regardless of who is at fault. A work-related illness or injury is defined as an illness or injury identified as occurring while on the job, and/or is job related.

Work related injuries are not a FirstCare covered benefit; however, members are entitled to receive an evaluation by a FirstCare provider to determine if the injury or condition is work related. Providers must make every attempt to determine if the patient has a work-related illness or injury and to provide that information to FirstCare.

While the issue of whether or not the illness or injury is work-related is still being determined, FirstCare providers may continue to treat the member. FirstCare providers must proceed by following all referral and prior authorization requirements of FirstCare. Those services that do not meet the necessary requirements will not be the responsibility of FirstCare.

In the event services are provided or payments are made by FirstCare for services that are later determined to be work related, FirstCare shall have the right to recover usual, customary and reasonable charges for such services so provided. FirstCare will also deny any future claims related to the condition.

If the condition is contested by the workers' compensation carrier and the member needs care, FirstCare will provide for the member's care according to FirstCare plan provisions until a determination can be made by the worker's compensation carrier.

A letter from the workers' compensation carrier will be requested by FirstCare stating that the case is contested. In the event the case is denied, a letter of denial will be requested by FirstCare from the workers' compensation carrier.

11.22 - Fraud, Waste and Abuse & HIPAA

Reporting Provider or Recipient Fraud, Waste and Abuse

FirstCare is dedicated to maintaining excellence and integrity in all aspects of its operations and its professional and business conduct. FirstCare is committed to high ethical standards and compliance with all applicable governing laws, rules, and regulations, including the prohibition of misleading sales tactics. FirstCare also recognizes that the detection, investigation, and prevention of fraud, waste, and abuse are vital to maintaining an affordable health care system in this state and country.

Accordingly, FirstCare has developed and implemented a Compliance Program and a Fraud, Waste, and Abuse Plan to effectively articulate and demonstrate the organization's commitment to legal and ethical conduct and to become a function of daily operations. Compliance efforts are designed to establish an organizational culture that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law, federal and state health care program requirements (e.g., the Medicare and Medicaid programs), and FirstCare policies and procedures. These efforts also intend to improve operational quality, to ensure the provision of high-quality care, and to reduce fraud, waste, and abuse.

FirstCare has established the following mechanisms for reporting any potential compliance violation, including concerns of suspected fraud, waste and abuse, misleading sales tactics, or inappropriate disclosure of protected health information. Reports of potential violations made by employees, agents, contractors, providers, and enrollees are maintained in a confidential manner. These reporting mechanisms are available 24 hours a day, 7 days a week. Reports may also be made anonymously.

FirstCare Compliance HelpLine: 1-888-484-6977
Compliance HelpLine Website: https://oig.hhs.texas.gov
Compliance/SIU Email: HPCompliance@BSWHealth.org

You may also call the Federal OIG Fraud Hotline at 1-800-HHS-TIPS (1-800-447-8477), or the Texas OIG Fraud Hotline at 1-800-436-6184.

For more information about reporting fraud, please visit the FirstCare website and refer to https://www.firstcare.com/en/Compliance-Privacy-Legal-Notices/Identifying-FWA.

For more information about how FirstCare maintains the privacy of health information, please visit the FirstCare website and refer to https://www.firstcare.com/en/Important-Information/HIPAA-Information.

FRAUD INFORMATION

REPORTING WASTE, ABUSE, OR FRAUD BY A PROVIDER OR

CLIENT MEDICAID MANAGED CARE AND CHIP

Do you want to report Waste, Abuse, or Fraud?
Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use their Medicaid or CHIP ID
- Using someone else's Medicaid or CHIP ID
- Not telling the truth about the amount of money or resources he or she has to get benefits

To report fraud, waste and abuse, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/ and pick "Click Here to Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:
  FirstCare SIU
  1206 West Campus Drive
  Temple, TX 76502
  HPCompliance@BSWHealth.org

To report fraud, waste and abuse, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse or fraud

FirstCare may withhold payments in cases of fraud or willful misrepresentation.
In accordance with the Patient Protection and Affordable Care Act and the Code of Federal Regulations, FirstCare may withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under Medicaid. Payments may be withheld without first notifying the provider of its intention to withhold such payments. A provider may request, and must be granted, administrative review where state law so requires.

FirstCare will send notice of its withholding of program payments within 5 days of taking such action. The notice will set forth the general allegations as to the nature of the withholding action, but may not disclose any specific information concerning its ongoing investigation. All withholding of payment actions will be temporary and will not continue after FirstCare or other authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the provider; or legal proceedings related to the provider's alleged fraud or willful misrepresentation are completed.

SECTION 12: Complaints and Appeals Procedures

FirstCare is committed to providing quality health care service and achieving a high level of member and provider satisfaction within its networks. If a member or provider is dissatisfied with FirstCare's policies, procedures, coverage or benefit decisions or with any aspect of the member's treatment by physicians, hospitals or other providers, he or she have the legal right to file a complaint to FirstCare and/or the Health and Human Services Commission (HHSC).

Complainants are encouraged to communicate their dissatisfaction as soon as possible. To assist in this communication, FirstCare has developed the following complaint and appeal procedures specific to STAR and to CHIP providers/members.

"Complaint" means any dissatisfaction expressed by a member, anyone acting on behalf of a member, or any provider verbally or in writing to us with any aspect of our operation, including but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an adverse determination, the denial, reduction or termination of a service for reasons not related to medical necessity, the way a service is provided or disenrollment decisions. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the member or provider.

12.1 - Filing Complaints and Appeals to FirstCare STAR

(Applicable to STAR Providers/members only)

All member complaints are received both verbally and in writing with the majority of complaints received verbally. When the customer service representative (CSR) receives a complaint and it is resolved at the time of the call, the CSR documents it as a complaint and categorizes in the customer service database.

Providers can submit written complaints and provide documents within 60 days of the specific event on which the complaint is based. Once a complaint is received, FirstCare will investigate and resolve all complaints within 30 calendar days of the receipt of the written complaint. The response letter will contain the outcome of the investigation.

A member, or someone acting on behalf of the member, or the physician or other healthcare provider of the member may file a complaint at any time.

Can someone from FirstCare help me file an Appeal?

FirstCare Customer Service can assist a member with filing an appeal.

Complaints that are not resolved at the time of the call are forwarded to the Complaints and Appeals Department who documents the complaint in the complaints database. Additionally, written complaints received by mail and fax are sent directly to the Complaints & Appeals Department where the aforementioned steps are taken. Complaints must be resolved, and a written resolution sent to the member/provider within 30 calendar days of receipt.

All verbal complaints or requests for assistance in filing a complaint should be directed for FirstCare Customer Service at 1-800-431-7798. Complaints may be faxed to 1-806-784-4319. Written complaints

should be mailed to:

FirstCare Health Plans
Complaints and Appeals Department
1206 West Campus Drive,
Temple, TX 76502

Documentation

FirstCare sends a complaint acknowledgement letter within five (5) business days of receipt of a verbal or written complaint.

1. Oral Complaint: Oral complaints are received by Customer Service. The date of the call, identification of the individual filing the complaint, identification of the individual recording the complaint, and the nature or substance of the complaint and actions taken are documented in FirstCare's systems.

2. Written Complaint: Written complaints are received by mail, portal or fax. They are documented in FirstCare's systems within one business day. The documentation includes the date of the correspondence, identification of the individual filing the complaint, identification of the individual recording the complaint, and the nature of the complaint and the actions taken.

Retention of fax cover pages are saved in FirstCare's systems.

Retention of emails to and from FirstCare are saved in FirstCare's systems.

Telephone communication logs are saved in FirstCare's systems.

Appeals Procedure to Notice of Action (Adverse Determinations/Denials)

What can I do if the MCO denies or limits my Member's request for a Covered Service?

If FirstCare denies or limits a member's request for covered services, FirstCare has in place processes by which a member, someone acting on behalf of the member, or the physician or other health care provider of the member can file an appeal of an adverse determination, denial or limitation of a requested covered service, or for denial of payment for services in whole or part. FirstCare will ensure that all appeals processed in a timely manner and are consistent with all regulatory requirements.

How will I find out if services are denied?

If services are denied, FirstCare will issue a written notice of action (adverse determination/ denial) to the member or the person acting on behalf of the member and the member's provider of record. The notification of the action will include:

- Principal reason(s) for the action;
- Clinical basis for the action;
- Description or the source of the screening criteria that were utilized as guidelines in making the determination; and
- Description of the procedure for the complaint and appeal process

FirstCare will complete for the entire standard appeals process within 30 calendar days after the receipt of the oral or written request for appeal. A letter will be sent to you and the member outlining the decision of appeal and next level of appeals. For concurrent, emergent or urgent appeals, the provider will be informed orally with the outcome. The resolution letter will be mailed out to the member and provider after the decision outcome.

The member or the member's authorized representative can file a request for an appeal within 60 days from the date of receipt of FirstCare's notice of action. To ensure continuation of currently authorized services, the member or the member's representative must file the appeal on or before the later of 10 calendar days following FirstCare's mailing of the notice of the action or the intended effective date of the proposed action. FirstCare will continue the member's benefits currently being received, including the benefit that is the subject of the appeal, if all of the following criteria are met:

- The member or the member's representative files the appeal timely;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and the member requests an extension of the benefits.

NOTE: *The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.*

Appeals can be submitted orally or in writing. FirstCare Customer Service can help members file an appeal. Written appeals are to be mailed to:

FirstCare Health Plans
Complaints and Appeals Department
1206 West Campus Drive,
Temple, TX 76502

You can provide additional documentation that can support the appeal to the address above.

Upon being notified verbally or in writing of an appeal to an adverse determination, no later than the 5th business day after the date of the receipt of the appeal, FirstCare will send to the member a letter acknowledging:

- The date the appeal of the action was received;
- The format of the appeal (oral or written);
- A reasonable list of the documents to be submitted by the appellant for review by the provider;
- That the appeal will be reviewed by a physician or provider not previously involved in the original action;
- The date the appeal review will be completed; and
- If the appeal was received verbally, a one-page appeal form to be completed and returned to FirstCare.

Following the review by the physician or provider not previously involved in the original action, the complaints and appeals department will notify the member in writing of the appeal resolution within 30 days of FirstCare's receipt of the verbal or written appeal. This timeframe may be extended up to 14 calendar days if the member requests an extension; or FirstCare shows that there is a need for additional information and how the delay is in the member's interest. If the timeframe is extended, FirstCare will give the member written notice of the reason for delay if the member had not requested the delay.

If the appeal is denied, the appeal resolution letter will include:

- Clinical basis for the decision;
- Specialty of the physician or other health care provider consulted; and
- Notice of member's rights and information to request a State Fair Hearing.

If the appeal is denied, and within 10 working days, the health care provider sets forth in writing good cause for having a particular type of specialty provider review the case, the action will be reviewed by a health care provider in the same or similar specialty as typically manages the medical or dental condition, procedure, or treatment under discussion. The specialty review will be completed within 15 working days of the receipt of the request.

An emergency appeal will be available for denials of emergency care, care for life-threatening conditions, and continued stay for hospitalized patients. Elements of an emergency appeal include:

- The review will be performed by a health care provider who has not previously reviewed the case who is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under review;
- The time the appeal review is to be completed will be based on the medical or dental immediacy of

the condition, procedure, or treatment, but will in no event exceed 1 working day from the date all information necessary to complete the appeal is received; and

- Investigation and resolution of an emergency appeal for all other cases will be completed by FirstCare within 3 business days from receipt of a verbal or written request. This timeframe may be extended up to 14 calendar days if the member requests an extension; or the HMO shows that there is a need for additional information and how the delay is in the member's interest. If the timeframe is extended, FirstCare will give the member written notice of the reason for delay if the member had not requested the delay.

Member's option to request only an External Medical Review with and State Fair Hearing no later than 120 days after the MCO mails the internal appeal decision notice.

Member's option to request only a State Fair Hearing only, no later than 120 days after the FirstCare mails the internal appeal decision notice. at any time during or after the FirstCare's Appeals process

Who can help me file an Emergency Appeal?

Emergency appeals can be requested by phone or in writing. All verbal emergency appeals or requests for assistance in filing an appeal are to be directed to the customer service department at 1-800-431-7798. FirstCare Customer Service can help members file an emergency appeal. Written emergency appeals are to be mailed to:

FirstCare STAR
Complaints and Appeals Department
1206 West Campus Drive,
Temple, TX 76502

What happens if FirstCare denies the request for an emergency *Appeal?*

If the request for an emergency appeal has been denied by FirstCare, FirstCare will:

- Transfer the appeal within the timeframe for standard resolution, and
- Make a reasonable effort to give the member prompt oral notice of the denial, and follow-up within 2 calendar days with a written notice.

If FirstCare's decision is adverse to the member, FirstCare will proceed with the following procedures relating to the Notice of Disposition of Appeal:

- FirstCare will notify the member of their rights to access a State Fair Hearing after exhausting FirstCare's emergency appeal process; and
- FirstCare will provide documentation to the State and the member, indicating how the decision was made, prior to the State Fair Hearing.

STATE FAIR HEARING INFORMATION

Can a Member Ask for a State Fair Hearing?

If a Member, as a member of the health plan, disagrees with the health plan's decision, a Member has the right to ask for a State Fair Hearing. The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent him or her. A provider may be the Member's representative if the provider is named as the Member's authorized representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the Member does not ask for the State Fair Hearing within 120 days, the Member may lose his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member's representative should either send a letter to the health plan at:

FirstCare STAR
Complaints and Appeals Department
1206 West Campus Drive
or call 1-800-431-7798.

If the Member asks for a State Fair Hearing within 10 days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final hearing decision is made. If the Member does not request a State Fair Hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

If the member asks for a State Fair Hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most State Fair Hearings are held by telephone. At that time, the Member or the Member's representative can tell why the Member needs the service the health plan denied.

HHSC will give the member a final decision within 90 days from the date the member asked for the hearing.

EXTERNAL MEDICAL REVIEW INFORMATION

Can a Member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to FirstCare Health Plans by using the address or fax number at the top of the form.;
- Call the MCO at 1-800-431-7798;
- Email the MCO at Complaints@BSWHealth.org ,or;

If the Member asks for an External Medical Review within 10 days from the time the health plan mails the appeal decision, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, the State Fair Hearing decision is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can a Member ask for an emergency External Medical Review?
If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling FirstCare Health Plans. To qualify for an emergency External Medical Review and emergency State Fair Hearing the Member must first complete FirstCare's internal appeals process.

Filing Complaints to HHSC
Any person, including persons who have attempted to resolve complaints/appeals and appeals of an adverse determination through our procedures as outlined previously and who are dissatisfied with the resolution, may report their dissatisfaction to the Texas Health and Human Services Commission (HHSC). HHSC will investigate the complaint and provide a determination within HHSC established timelines.

Providers/members may file a complaint to HHSC at the following address:

Texas Health and Human Services Commission
Health Plan Operations - Resolution Services H-320
P.O. Box 85200
Austin, TX 78708

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

Provider Appeal Process to HHSC
Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)
Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- The Explanation of Benefits (EOB) showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- The EOB showing the recoupment and/or the plan's "demand" letter for recoupment. If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- Completed clean claim. All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

  Mail appeal requests to:
  Texas Health and Human Services Commission
  HHSC Claims Administrator Contract Management
  Mail Code-91X
  P.O. Box 204077
  Austin, Texas 78720-4077

12.2 - Filing Complaints and Appeals to FirstCare CHIP

(Applicable to CHIP and CHIP Perinatal Provider/members only)

Who do I call if I have a complaint?
We want to help. If you have a complaint, please call us toll free at 1-877-639-2477 to tell us about your problem.

Can someone from FirstCare Help me file a complaint?
A FirstCare Customer Service Representative can help you file a complaint. Most of the time we can help you right away or at the most within a few days. FirstCare cannot take any action against you as a result of your filing a complaint.

As with Medicaid complaints, All CHIP member and provider complaints are received both verbally and in writing. When the customer service representative (CSR) receives a complaint and it is resolved at the time of the call, the CSR documents it as a complaint and categorizes in the customer service database. A monthly report is then generated and sent to the Department to track and trend.

How long will it take to investigate and resolve my complaint?
Complaints that are not resolved at the time of the call are forwarded to the complaints and appeals department who documents the complaint in the complaints database. Complaints do not have to be followed up in writing. Additionally, written complaints received by mail, portal and fax are sent directly to the Complaints and Appeals Department where the aforementioned steps are taken. Complaints must be resolved and a resolution sent to the member/provider within 30 calendar days of receipt.

All verbal complaints or request for assistance in filing a complaint are to be directed to the customer service department at 1-877-639-2447/TTY or 1-806-784-4300; written complaints are to be mailed to:

FirstCare Health Plans
Complaints and Appeals Department
1206 West Campus Drive,
Temple, TX 76502

Following receipt of an oral or written complaint, FirstCare will investigate the complaint and provide a resolution letter. The total time for acknowledging, investigating and resolving the complaint will not exceed 30 calendar days after the date FirstCare receives a written complaint or complaint form. If investigation results in original denial being upheld, the response letter to the complainant will include the following:

- Statement of FirstCare's resolution to the complaint;
- Specific medical and contractual reasons for the decision;
- Specialty of the physician or other health care provider consulted; and
- Information on FirstCare's appeals process if complainant is not satisfied with FirstCare's decision.

Complaint Appeal Procedure
When does a Member have the right to request an Appeal?
A member has the right to request an appeal if services are reduced or denied. If the CHIP complaint is not resolved to the complainant's satisfaction, the complainant has the right either to appear in person before a Complaint Appeal Panel where the complainant normally render or receive health care, unless another site is agreed to by the complainant, or the complainant may elect to forward a written appeal to the Complaint Appeal Panel rather than appear in person. For assistance in filing a complaint appeal, contact FirstCare's customer service department at 1-877-639-2447.

FirstCare will send an acknowledgement letter to the complainant no later than the 5th business day after the date of receipt of the request for appeal.

FirstCare shall appoint members to the Complaint Appeal Panel to discuss and deliberate the appeal and render a decision. The Complaint Appeal Panel shall be composed of an equal number of our staff (not involved in any previous review of the issue being disputed), physicians or other providers, (who were not involved in any previous review of the issue being disputed and who are independent of any provider involved in any previous review) and members (who are not FirstCare employees). The provider representative will be of the same/similar specialty to which the appeal is relating unless the issue is specifically excluded as a non-covered benefit under the Texas Medicaid plan.

No later than the 5th business day before the scheduled meeting of the panel, unless the complainant agrees otherwise, FirstCare shall provide the complainant:

- Any documentation to be presented to the panel by our staff;
- Specialization of any providers consulted during the investigation; and
- Name and affiliation of each of our representatives on the panel.

The complainant is entitled to:

- Appear in person before the Complaint Appeal Panel;
- Present alternative expert testimony; and
- Request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

How will I find out if the Appeal is denied?
Written notification of FirstCare's final decision on the appeal will be provided no later than the 30th calendar day after the date we received the appeal. The notice of final decision will address the specific medical determination, clinical basis and/or contractual criteria used to reach the final decision. The notice will also include the toll-free telephone number and address of the Texas Department of Insurance (TDI).

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

Texas Department of Insurance
PO Box 12030
Austin, TX 78711-2030
Phone: 800.252.3439
Fax: 512.490.1007
Website: http://www.tdi.texas.gov

If you can get on the Internet, you can send your complaints in an email to:
http://www.tdi.texas. gov/consumer/complfrm.html.

The Complaint Appeal Panel decision is only a recommendation to FirstCare. FirstCare is not bound by the recommendation of the Complaint Appeal Panel. FirstCare is solely responsible for the final decision regarding the appeal, factoring in the recommendation of the Complaint Appeal Panel.

Appeals Procedure to Notices of Action (Adverse Determinations/Denials)

What can I do if FirstCare denies or limits my patient's request for a Covered Service?
FirstCare has in place processes by which a member, someone acting on behalf of the member, or the physician or other health care provider of the member can file a verbal or written request for appeal within 180 days of a

Notice of Action (Adverse Determination or limitation or denial of a covered service. FirstCare will ensure that all appeals are processed in a timely manner and are consistent with all regulatory requirements.

Upon receipt of a verbal or written request for an appeal to a Notice of Action, no later than the 5th business day after the date the appeal was received, FirstCare will send the member a letter acknowledging:

- The date the appeal of the action was received;
- The format of the appeal (oral or written);
- A reasonable list of the documents to be submitted by the appellant for review by the provider;
- That the appeal will be reviewed by a physician or provider not previously involved in the originally action;
- The date the appeal review will be completed; and
- If the appeal was received verbally, a one-page appeal form to be completed and returned to FirstCare.

Can someone from FirstCare help me file an Appeal?

All verbal appeals or requests for assistance in filing an appeal are to be directed to the customer service department at 1-877-639-2447. Written appeals are to be mailed to:

FirstCare Health Plans
Complaints and Appeals Department
1206 West Campus Drive,
Temple, TX 76502

Following the review by the physician or provider not previously involved in the original action, the medical department will notify the member in writing of the appeal resolution within 30 days of FirstCare's receipt of the verbal or written appeal.

If the appeal is denied, the appeal resolution letter will include:

- Clinical basis for the decision;
- Specialty of the physician or other health care provider consulted; and
- Notice of the member's right to seek review of the denial by an Independent review organization (IRO) and the procedures for obtaining that review.

Specialty Appeal: If the appeal is denied, and within 10 working days, the provider sets forth in writing good cause for having a particular type of specialty provider review the case, the action will be reviewed by a health care provider in the same or similar specialty as typically manages the medical or dental condition, procedure, or treatment under discussion. The specialty review will be completed within 15 working days of the receipt of the request.

An expedited appeal will be available for denials of emergency care, care for life-threatening conditions, and continued stay for hospitalized patients. Elements of an expedited appeal include:

- The review will be performed by a health care provider who has not previously reviewed the case who is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under review;
- The time the appeal review is to be completed will be based on the medical or dental immediacy of the condition, procedure, or treatment, but will in no event exceed 1 working day from the date all information necessary to complete the appeal is received; and
- Investigation and resolution of an expedited appeal for all other cases will be completed by FirstCare within 3 business days from receipt of a verbal or written request.

Who can help me file an Expedited Appeal?

FirstCare can help members request an expedited appeal. All verbal expedited appeals or requests for assistance in filing an expedited appeal are to be directed to the customer service department at 1-877-639-

2447. Written expedited appeals are to be mailed to:

FirstCare Health Plans
1206 West Campus Drive,
Temple, TX 76502

What happens if FirstCare denies the request for an Expedited Appeal?

If the request for an expedited appeal has been denied by FirstCare, FirstCare will:

- Transfer the appeal within the timeframe for standard resolution, and
- Make a reasonable effort to give the member prompt verbal notice of the denial, and follow-up within 2 calendar days with a written notice.

What is an Independent Review Organization (IRO)?

Any party whose appeal of an action is denied by FirstCare is entitled to seek review of that determination by an Independent Review Organization (IRO) assigned to the appeal as follows:

- The member or the member's designated representative will be provided with information on how to appeal the action to an IRO and will be provided this information at the time of the denial of the appeal;

- The member or the member's designated representative will be provided an IRO Request Form which must be completed and returned to FirstCare to begin the independent review process (see ATTACHMENTS section for a sample copy of an "IRO Request Form");
- In life-threatening situations, the member or the member's designated representative may contact FirstCare's customer service department to request the review and provide the required information by phone; and
- Retroactive reviews of adverse determinations are not subject to an IRO appeal process.

The appeal process does not prohibit the member from pursuing other appropriate remedies including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the member's health in serious jeopardy.

How to request a review by an IRO:

The member, or member's authorized representative or provider of record may initiate an appeal to an Independent Review Organization (IRO) within 4 (four) months of the final internal appeal decision. If the member does not submit an IRO request within four (4) months, the member will lose the right to appeal.

The IRO does not have an affiliation with your payor (insurance company or health plan), your health care providers, or the Utilization Review Agency (URA). The IRO decision is final and binding.

The member or member's authorized representative, or provider of record may request a copy of all the documentation and guidelines used to make your appeal determination at no cost to you.

The member or member's authorized representative can send a completed signed IRO form to FirstCare or directly to Maximus:

FirstCare Health Plans
Attention: Complaints and Appeals
1206 West Campus Drive,
Temple, TX 76502
Fax: 806-784-4319

The member or member's authorized representative can request an external review by submitting the request online at externalappeal.cms.gov, under the “Request a Review Online” heading, or in writing by faxing the request to 1-888-866-6190, or by sending it by mail to:

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

Website: https://externalappeal.cms.gov/

If the appeal needs to be expedited, select "expedited" if submitting the review request online, or by emailing FERP@maximus.com, or calling Federal External Review Process at 888-866-6205 ext. 3326. If there are any questions or concerns during the external review process, the claimant can call the toll-free number 1-888-866-6205 ext. 3326. You can also submit additional written comments to the external reviewer at the mailing address above.

FirstCare Health Plans will comply with the IRO's determination with respect to the medical necessity or appropriateness of health care items and services, and the experimental or investigational nature of health care items and services for an enrollee.

Additional help: If you need help understanding this notice or want to learn more, you can call customer service at 1-877-639-2447/ TTY 711.

Filing Complaints to TDI

Any person, including persons who have attempted to resolve complaints/appeals and appeals of an adverse determination through our procedures as outlined previously and who are dissatisfied with the resolution, may report their dissatisfaction to TDI. TDI will investigate the complaint and provide a determination within TDI established timelines.

Members/providers may file a complaint to TDI by calling 1-800-252-3439, or by mailing to:

Texas Department of Insurance
PO Box 12030
Austin, TX 78711-2030
Phone: 800.252.3439
Fax: 512.490.1007
Website: http://www.tdi.texas.gov

SECTION 13: Pharmacy

13.1 - Pharmacy Benefits Manager (PBM)

FirstCare's Pharmacy Benefit Manager (PBM) is Navitus Health Solutions. FirstCare members can access prescriptions through any pharmacy that is contracted with the Navitus Health Solutions. Navitus administers prescription benefits for FirstCare STAR, CHIP, and CHIP Perinate members. If the member is having problems accessing prescribed medications, please refer the member to the FirstCare customer service department.

Members have the right to obtain medication from any network pharmacy contracted with Navitus.

STAR Member Prescriptions: STAR children and adult members are eligible to receive an unlimited number of prescriptions per month.

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

13.2 - Pharmacy Provider Responsibilities

Pharmacy Provider Responsibilities
Eligibility Verification - Verifying Member Medicaid Eligibility

- Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. You must still verify eligibility. There are several ways to do this: www.YourTexasBenefits.com a secure website with a variety of useful features for Medicaid providers.
- TexMedConnect on the TMHP website at www.TMHP.com.
- Call the Your Texas Benefits provider helpline at 1-855-827-3747.
- Call Provider Services at the patient's medical or dental plan.
- Adhere to the Formulary and Preferred Drug List (PDL)
- Coordinate with the prescribing physician
- Ensure members receive all medications for which they are eligible
- Coordination of benefits when a member also receives Medicare Part D services or other insurance benefits.

Formularies (Covered, Provisional, and Preferred Drugs)
FirstCare uses the state mandated STAR and CHIP formularies. For a list of covered drugs please visit https://www.txvendordrug.com/formulary/formulary-search. For a list of provisional coverage drugs, please visit https://www.txvendordrug.com/formulary/provisional-formulary-search. For a list of preferred drugs please visit https://www.txvendordrug.com/formulary/preferred-drugs. To view the Preferred Drug List Criteria Guide, please vist https://paxpress-txpa.acentra.com/pdl_crit_guide.pdf. You may also contact FirstCare's PBM at 1-877908-6023.

13.3 - Prior Authorizations

To obtain a prior authorization please call FirstCare's PBM, Navitus, at 1-877-908-6023.Navitus processes pharmacy prior authorizations for FirstCare STAR and CHIP. The formulary, prior authorization criteria, and the length of the prior authorization approval are based on and approved by HHSC/TX-VDP. Information regarding the formularies and the specific prior authorization criteria can be found at the Vendor Drug Website, Epocrates, and Surescripts for ePrescribing.

Prior authorizations are available through:

1. Electronic Automation: This is performed at point of sale (POS). Upon submitting the prescription claims for payment, Navitus's electronic system will review the member's medical and pharmacy historical claims to determine whether criteria has been met.
    a. Where criteria have been met, claims will adjudicate and no further action is needed.
    b. Where criteria have not been met, claims will reject with a POS messaging notifying pharmacist that a prior authorization is required. Pharmacist (or personnel) is instructed to notify the prescriber of this information.
2. Written Requests: Prescribers can access prior authorization forms online via www.Navitus. com under the "Providers" section or have them faxed by Customer Care to the prescribers office. Prescribers will need their NPI and State to access the portal. Completed forms can be faxed 24/7 to Navitus at 1-855-668-8553 (toll free) or 1-920-735-5315.
3. Phone Requests: Prescribers can also call Navitus Customer Care at 1-877-908-6023 > prescriber option and speak with the Prior Authorization department between 6 a.m. to 7 p.m. Central Time (CT), Monday through Friday, or 8 a.m. to 4:30 p.m. Central Time (CT), weekends, holidays to submit a PA request over the phone.

Decisions regarding prior authorizations will be made within 24 hours from the time Navitus receives the PA request. The provider will be notified by fax of the outcome or verbally if an approval can be established during a phone request.

13.4 - Emergency Prescription Supply

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

The 72-hour emergency supply may be dispensed when a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription. The emergency supply is subject to pharmacist clinical judgement. Some non-urgent medications are exempt from this emergency supply.

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

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

Claim Submission Process
Place '8' in "Prior Authorization Type Code" (Field 461-EU), '801' in "Prior Authorization Number Submitted" (Field 462-EV) and '3' in "Days' Supply" in the claim segment of the billing transaction (Field 405-D5). The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply. It is permissible that a pharmacy dispense product packages in fixed dosage forms (e.g., inhalers, nebulized medications) that are unbreakable as a 72-hour supply. Place '3' in "Days' Supply" but enter the full quantity dispensed. Call Navitus at 1-877-908-6023 or FirstCare at 1-806-784-4300 for more information about the 72-hour emergency prescription supply policy.

Pharmacy claims should be sent to Navitus at the following address: Navitus
Health Solutions
Operations Division-Claims
P.O. Box 999
Appleton, WI. 54912-0999
Or fax to 920-735-5315

The filing deadline for claims is 95 days and the appeal deadline for claims is 120 days. Claims will be paid within 18 days of receipt of an electronic pharmacy claim and within 21 days of receipt of a paper pharmacy claim.

Pharmacies can receive payment by paper checks or ACH payment upon request.

For questions, please contact Navitus' Provider Help Desk at 1-877-908-6023. In addition, online pharmacy training can be found at www.Navitus.com > Pharmacies > Pharmacies Login.

13.5 - Compounded Prescriptions

A compound consists of two or more ingredients, that is weighed, measured, prepared or mixed according to the prescription order. The pharmacist is responsible for compounding approved ingredients of acceptable strength, quality and purity with appropriate packaging and labeling in accordance with good compounding practices.

Compound Drugs:

- All active ingredients must be covered on the patient's formulary. In general, drugs used in a compound follow the member's formulary as if each drug components were being dispensed individually.
- Any compounded prescription ingredient that is not approved by the FDA (e.g. Estriol) is considered a non-covered product and will not be eligible for reimbursement.
- If a compound includes a drug that requires Prior Authorization under the member's plan, the Prior Authorization must be approved before the compound is submitted.
- Compounds exceeding $200 may require Prior Authorization. Forms are available at www.Navitus.com.

Navitus uses a combination of the claims compound and DUR segment to fully adjudicate a compound prescription.

- Use the Compound Code of "02" (NCPDP field 406-D6) when submitting compound claims.
- The claim must include an NDC for each ingredient within the Compound Prescription. Must have a minimum of 2 NDCs and a maximum of 25 NDCs (NCDPD field 447-EC).
- The claim must include a qualifier of "03" (NDC) to be populated in NCPDP field 448-RE followed by NCPDP field 489-TE (NDC's).
- If an NDC for a non-covered drug is submitted, the claim will be denied.
- If the pharmacy will accept non-payment for the ingredient, submit an "8" in the Clarification Code Field (420-DK located on the D.0 Claim Segment Field). This will allow the claim to pay and the pharmacy will be reimbursed for all drugs except the rejected medication(s).
- Compound exceeding $200 may require Prior Authorization. Forms are available at www.Navitus.com
- Submit the minutes spent compounding the prescription for reimbursement. The minutes listed are to be populated within NCPDP D.0 Field 474-8E (level of effort- DUR segment).

Customer Service

Providers/Pharmacies (Navitus)	1-877-908-6023
Members (STAR)	1-800-431-7798
Members (CHIP)	1-877-639-CHIP (2447)

SECTION 14: Glossary of Terms

14.1 - Glossary of Terms

Adverse Determination - a determination made by plan that the health care furnished or proposed to be furnished are not medically necessary.

After-Hours - any time not included in the realm of normal business hours.

Agreement - a contract and application completed by the provider to become a participating provider.

Service Coordination - a method of managing the provision of health care to members with high-cost medical conditions; the goal is to coordinate the care to improve both continuity and quality of care and to lower costs.

Children's Health Insurance Program (CHIP) - means the health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§1397aa-13970 and administered by the Texas Health and Human Services Commission ("HHSC").

CHIP Perinatal Services - means the State of Texas program in which HHSC contracts with HMOs to provide, or arrange, and coordinate covered services for enrolled CHIP Perinate and CHIP Perinate newborn members.

CHIP Perinate - means a CHIP Perinatal member identified prior to birth.

CHIP Perinate Newborn - means a CHIP Perinate who has been born alive.

Concurrent Review - part of the FirstCare Utilization Management program in which provider services are monitored for appropriateness of setting and progress of discharge plans.

Copayment - the amount required to be paid by or on behalf of a member by the applicable plan document of such member to a participating provider or other FirstCare approved provider in connection with the payment of covered health services rendered by such provider. Copayments are only applicable to covered health services provided to CHIP members.

Covered Health Services - means those medical/health care and supplies specified and defined as covered benefits in the applicable plan document of a member.

Duplicate Claim - any claim submitted by provider for the same covered health service provided to a member on a particular date of service that was included in a previously submitted claim. This term does not include corrected claims.

Emergency Care - health care provided in a hospital emergency facility to evaluate, and stabilize medical conditions of a recent onset and severity that would lead a prudent layperson possessing an average knowledge of medicine to believe that the condition, sickness, or injury was of such a nature that failure to obtain immediate medical care could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions;
- In the case of a pregnant woman, serious jeopardy to the health of the fetus;
- Serious dysfunction of any bodily organ or part; and/or
- Serious disfigurement.

Member - means a person who: 1) is entitled to benefits under Title XIX of the Social Security Act and the Texas Medical Assistance program (Medicaid), is in a Medicaid eligibility category included in the STAR program, and is enrolled in the STAR program, or 2) is entitled to benefits under Title XXI of the Social Security Act and CHIP, and is enrolled in CHIP.

Evidence of Coverage (EOC) - means an agreement between FirstCare and an employer group, association, governmental entity, or an individual, the form of which has been approved by the Texas Department of Insurance (TDI), specifying the terms and conditions, under which covered health services are to be provided to members; hereinafter referred to as plan document. FirstCare must attach benefit information from the EOC/COC.

Expedited Appeal - the appeal of a Medical Director decision regarding emergency care, a life-threatening condition, or continued hospital stay that requires review by a physician not previously involved in reviewing the case, and who is of the same or similar specialty as typically manages the condition, procedure, or treatment under review. The review must be completed in a time frame based on the immediacy of the situation, but in no event will the decision exceed 1 working day.

Explanation of Payment (EOP) - refers to FirstCare's documentation, which accompanies and explains providers' reimbursement for covered health services.

Global Guideline - the number of visits and/or length of time allotted for the treatment of a specific medical condition established by the plan based on Medicare or Texas Law.

HHSC - means the Texas Health and Human Services Commission.

InterOual - a nationally recognized resource used to determine appropriateness of care setting, ELOS/LOS, ambulatory care standards and the need for assistant surgeons.

Medical Director - means a physician licensed in the State of Texas and designated by FirstCare who is responsible for monitoring the provision of covered health services to members.

Medically Necessary - means those services and supplies covered by the plan document, which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a member's medical condition, sickness, disease, injury, or bodily malfunction;
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; Not primarily for the convenience of the member, a participating physician, participating hospital, participating provider, or other health care provider; and
3. Economical supplies or levels or service as may be specified in the plan document that are appropriate for the safe and effective treatment of the member. When applied to hospitalization, this further means that the member requires acute care as a bed patient due to the nature of the services rendered or the member's condition, and the member cannot reasonable receive safe or adequate care as an outpatient.

Office-Based Procedure - a procedure performed in an office setting that has been determined to be safe for performance in an office setting. A procedure that does not require authorization when performed in the office, but does require authorization if performed in a setting other than the office.

Participating Hospital - means an acute care facility licensed as a hospital by the State of Texas and under contract with FirstCare to provide covered health services to members.

Participating Physician - means a duly licensed physician who has entered into an agreement with FirstCare, to provide or arrange for the provision of covered health services to members.

Participating Provider - means a physician, hospital, health care facility, or other health care provider who has agreed to provide covered health services to members.

Physician - means (1) an individual licensed to practice medicine in the State of Texas as either a medical doctor or a doctor of osteopathy; (2) a professional association organized under the Texas Professional Association Act or a nonprofit health corporation certified under Section 5.01, Texas Medical Practice Act; or (3) any entity wholly owned by physicians.

Prenatal - prior to birth; refers to both the care of the woman during pregnancy and the growth and development of the fetus.

Primary Care Physician (PCP) - a general/family practice, Internal medicine, or pediatric physician, selected by or assigned to the care of a FirstCare member with responsibility for providing, arranging, and coordinating all aspects of the member's health care.

Prior Authorization - shall mean FirstCare's issuance of a written or verbal notice, in accordance with its policies, procedures and medical guidelines, that covered health services ordered by a provider, including but not limited to inpatient admissions, outpatient surgical procedures, provision of post-stabilization care or ordering of certain ancillary services, prescription of certain medications, and referral to non-participating providers, based on the information provided to FirstCare, are determined to be medically necessary and appropriate.

Provider - means any practitioner, institution, organization or person that furnishes health care and that is licensed or otherwise authorized to practice in this state, other than a physician.

Quality Improvement - a comprehensive system designed to assess and continually improve the process of provider care and services to our members.

Referral - the request of a PCP for a member to seek services beyond the scope and/or expertise of the PCP.

Specialist - A non-primary care physician who has obtained specialty training.

STAR Program - is the name of the state of Texas Medicaid managed care program. "STAR" stands for the State of Texas Access Reform.

State - HHSC or an agency within the executive or legislative branch of Texas state government other than HHSC, as appropriate.

Texas Health Steps (THSteps) - is the name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. It includes the State's Comprehensive Care program extension to EPSDT, which adds benefits to the Federal EPSDT requirements contained in 42 United States Code §1396d(r), and defined and codified at 42 C.F.R. §440.40 and §§441.56-62. HHSC's rules are contained in 25 TAC, Chapter 33 (relating to Early and Periodic Screening, Diagnosis and Treatment).

Urgent Care - a health care need that requires medical attention within 24 hours and/or to prevent the possibility of the condition advancing to emergent status.

Utilization Review - the process of monitoring the delivery of health care for appropriateness of setting, provider, over and/or underutilization of services, and length of stay.

HEALTH PLAN

1206 West Campus Drive, Temple, TX 76502