

Chapter 2 ***Benefits and Covered Services***

A. Fee for Service: Texas Health Steps Services (THSteps)

THSteps Services (Medicaid Only)

The Medicaid service, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), is known in Texas as Texas Health Steps (THSteps). Molina encourages members to use THSteps preventive medical checkup service visits when they first become eligible for Medicaid and each time thereafter they are periodically due for their next medical checkup. On request by a Member, the Medical Transportation Program (MTP) can assist the Member with scheduling and transportation.

Providers must perform an EPSDT check up on all members within 90 days of initial enrollment and are encouraged to notify the Member when he or she is due for the next checkup according to the periodicity schedule. A periodicity schedule and narrative explaining the schedules may be found in appendix VI. Please refer to the current Texas Medicaid Provider Procedures Manual for information regarding THSteps.

Children of Migrant Farmworkers

Children of Migrant Farmworkers due for a THSteps medical check-up can receive their periodic check up on an accelerated basis prior to leaving the area. A check up performed under this circumstance is considered an exception to periodicity.

Performing a make-up exam for a late THSteps medical check up previously missed under the periodicity schedule is not considered an exception to periodicity not an accelerated service. It is considered a late check up.

Who Can Perform THSteps Examinations?

Only THSteps providers enrolled with TDH will be reimbursed for performing THSteps examinations. All THSteps enrolled PCP's are encouraged to perform THSteps examinations; however, any provider enrolled as a THSteps provider may perform THSteps medical examinations. If the PCP performing the examination is not the Member's PCP, the performing provider must provide a report to the PCP of record. If the performing PCP diagnoses a medical condition that requires additional treatment, the patient must be referred back to the PCP of record.

How Do I Become a THSteps Provider?

The Texas Medicaid & Healthcare partnership's (TMHP) Provider Enrollment Department introduces providers to the Texas Medicaid program through an efficient enrollment process as a commitment to quality improvement. If a provider wishes to become a THSteps provider, he/she can go to

www.tmhp.com and click on Provider Enrollment. This page will allow providers to complete the Medicaid Provider Enrollment Application Form as well as have access to other provider enrollment forms such as: THSteps Enrollment Application, TMHP Dental Provider Enrollment Application, and Children with Special Healthcare Needs (CSHCN) Provider Enrollment Application. If you have any questions, please contact TMHP at 1-800-925-9126, Option 2. Completed applications should be mailed to the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin, Texas 78720-0795

Documentation of Completed Checkups

To assure completion of comprehensive medical checkups and the quality of care provided, providers must document all components of the THSteps medical checkups as they are completed. Clinical charts are subject to quality review activities including random chart review and focused studies of well-child care.

In acknowledgment of the practical situations that occur in the office or clinic settings, the AAP has stressed the philosophy that the components of all medical checkups should be performed appropriate to the needs of the individual child. Therefore, completion of all recommended components of a THSteps medical checkup may require follow-up checkups.

The Centers for Medicare and Medicaid Services (CMS) has clarified, in its Medicaid guide to state entities, the following expectations for the content of comprehensive preventive health visits:

- Comprehensive health history, including developmental and nutritional assessment
- Comprehensive unclothed physical examination, including graphic recording of head circumference, height, and weight, through 24 months of age
- Appropriate Immunizations as recommended by the Advisory Committee on Immunization Practices
- Age-appropriate laboratory tests for anemia, lead poisoning, and newborn metabolic screening (In Texas, all laboratory screening tests, must be sent to the TDH Laboratory. If the provider needs to have immediate results of the anemia screening, this test may be done in the office or clinic at no additional reimbursement, and results must be clearly stated in the medical record.)
- Health education, including anticipatory guidance, is recommended; separate sessions for adolescents and their parents or guardians are also recommended
- Age-appropriate vision and hearing screening
- Direct referral to dental checkups beginning at 12 months of age

Information concerning the appropriate ages for lead testing, development assessment, and dental referral can be found on the “Medical Checkup Periodicity Schedule”.

THSteps medical checkups may be billed electronically or on a CMS-1500 claim form. Providers may request information about electronic billing or the claim form by contacting Provider Services 866-449-6849.

Reminder: A complete checkup is a screening provided in accordance with mandated procedures and the narrative standards outlined for each procedure in the *Texas Medicaid Provider Procedures Manual - Texas Health Steps*. Incomplete medical checkups are not reimbursed.

Reimbursement

Reimbursement is based on the Medicaid Fee schedule and includes payment for tuberculosis (TB) skin tests and collecting the blood specimens for all required laboratory services included on the checkup periodicity schedules. Immunizations, TB skin test and supplies, laboratory supplies, and laboratory testing are made available free of charge to screening providers through TDH. A \$5 reimbursement is made for each immunization administered during the medical checkup visit. Combined antigen vaccines (for example, DTaP and MMR) are reimbursed as one dose. The \$5 reimbursement is not made for performing the TB skin test.

In accordance with current federal policy, the Texas Medicaid Program and clients eligible for Medicaid cannot be charged when a client does not keep an appointment. Only services provided are considered for reimbursement.

Adult Accompaniment to Medical Checkup

THSteps policy requires, as a condition for provider reimbursement, that a child younger than age 15 must be accompanied by the child's parent, guardian, or other authorized adult during visits or checkups under the state Medicaid program.

Exception: School health clinics, Head Start programs, and child care facilities are exempt from this policy if the clinic, program, or facility encourages parental involvement and obtains written consent for the services. The consent from the child's parent or guardian must have been received within the one year period before the date the services are provided and must not be revoked.

Newborn Examination

Any provider attending the birth of a baby must require testing for PKU, galactosemia, hypothyroidism, sickle hemoglobin and congenital adrenal hyperplasia on all newborns as required by Texas Law. All infants must be tested a second time at one to two weeks of age.

These tests must be submitted to the TDH Bureau of Laboratories. For complete information, collection testing materials, supplies, instructions and newborn screening forms contact:

TDH – Bureau of Laboratories
1100 West 49th St.
Austin, Texas 78756-3199
512-458-7331

Inpatient newborn examinations billed with procedure codes 1-99221, 1-99431, 1-99239, 1-99432, and 1-99435 are counted as THSteps medical checkups and must include all components.

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

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

Include and document these components if procedure codes (1-99221, 1-99239, 1-99431, 1-99432, or 1-99435) are billed to Molina.

If the provider chooses to do a brief examination (not including all the above components), the provider may bill the HCPCS code 1-99431 or 1-99432 with modifier 52, which will not count as a THSteps checkup.

Providers billing these codes are not required to be THSteps providers, but they must be enrolled as Medicaid providers. Molina encourages THSteps enrollment for all providers who will be following the child for well-child care, immunizations, and offering a “medical home” for the child. Physicians and hospital staff are encouraged to inform parents eligible for Medicaid that the next THSteps checkup on the periodicity schedule should be scheduled at one to two weeks of age and that regular checkups should be scheduled during the first year.

Immunizations

The Texas Vaccines for Children (TVFC) Program provides vaccines to Medicaid children who are younger than age 19 years that are routinely recommended according to the *Recommended Childhood Immunization Schedule* (Advisory Committee on Immunization Practices [ACIP], American Academy of Pediatrics [AAP], and the American Academy of Family Physicians [AAFP]).

Children must be immunized during medical checkups according to the TDH routine immunization schedule. The screening provider is responsible for administration of immunizations and should **not** refer children to local health departments to receive the immunizations. Combined antigens are reimbursed as one immunization.

Reminder: A \$5 administration fee is paid for each immunization given during a THSteps checkup or as part of a follow-up claim, except for services performed in an FQHC or RHC setting.

For children not previously immunized, TDH requires immunizations be given unless medically contraindicated or excluded from immunizations for reasons of conscience, including a religious belief.

Immunizations are a required component of the THSteps medical checkup. Immunizations administered during a checkup must be indicated on the claim.

Benefits and Limitations

Medical checkup services are covered for members younger than age 21 years when delivered in accordance with the periodicity schedule. The periodicity schedule specifies the screening procedures recommended at each stage of the member's life and identifies the time period, based on the client's age, when medical checkup services are reimbursable.

In acknowledgment of the practical situations that occur in the office or clinic settings, the periodicity schedule published in this manual has stressed the philosophy that the components of the THSteps medical checkup should be completed according to the individual child's appropriate needs. If a component cannot be completed because of a medical contraindication of child's condition, then a follow-up visit is necessary.

Member eligibility for a medical checkup is determined by the Member's age on the first day of the month. If a Member has a birthday on any day except the first day during the month, the new eligibility period begins on the first of the following month. If a Member turns age 21 years during a month, the Member continues to be eligible for THSteps services through the end of that month.

If components of the THSteps checkup have been provided one month preceding the child's birthday month and the medical checkup occurs in the following month, providers should clearly refer to that previous documentation, including the date(s) of service in the current clinical notation, and add appropriate new documentation for the checkup currently being billed.

All components of the THSteps medical checkup are included in the reimbursement of the visit. The visit is a comprehensive medical checkup and must include all assessments, screenings, and laboratory tests as indicated on the periodicity schedule. Specifically, when there is an available CPT code for a component, it will not be reimbursed separately on the same day as a medical checkup.

ImmTrac is a central repository of a child's (younger than 18 years) immunization record. It is a free service offered to medical providers, parents, public health authorities, schools, and licensed child-care facilities. Texas law requires that medical providers report to *ImmTrac* any vaccines administered to children younger than age 18 years whose parents have consented in writing to participate in the registry.

B. STAR and STAR+Plus Benefits and Covered Services

Medicaid Covered Benefits Including STAR+Plus Benefits

Molina covers all medically necessary Medicaid-Covered services with no pre-existing condition limitations. This list is not all inclusive. Some services require Prior Authorization. Please refer to the Prior authorization list.

Services in your PCP's office, when medically necessary	No limit
Services in a specialist office, when referred by your PCP and medically necessary	No limit
Medically necessary inpatient and outpatient medical hospital services	No limit
Family planning service done by any qualified health care provider	No limit
Coverage for pregnancy and newborn baby services	No limit
Ambulance services in an emergency	No limit
Chiropractic services	No Limit
Emergency room and urgent care services	No limit
Outpatient behavioral health services (mental health)	30 visit per year
Outpatient behavioral health services(chemical dependency)	135 hours per year
Inpatient behavioral health (mental health and chemical dependency)	No Limit
Routine Medical Care	No Limit

Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to non-preferred drugs on the Preferred Drug List and any drug that is affected by a clinical or PA edit and would need prescriber prior approval.

Inpatient Services & Additional Benefits to STAR+Plus Members

STAR+PLUS members receive all the benefits of the traditional Texas Medicaid program; however, Molina is not responsible for paying providers for Inpatient Services. The provider must bill HHSC Claims Administrator for all Acute Care services. Molina's subcontracted Behavioral Health vendor, CompCare, is responsible for paying providers for the Behavioral Health Inpatient Services in the Harris Service Delivery Area effective June 1, 2007 and in the Bexar Service Delivery Area effective September 1, 2007. The provider must bill CompCare for Inpatient Behavioral Health Services. Additional benefits obtained through the STAR+PLUS program are:

- Annual Adult Well Checks
- Unlimited medically necessary prescription drugs for adults (available only to members who are not covered by Medicare)
- Value-Added Services
- Long-Term Care Covered Services

Medicaid Program Limitations and Exclusions

Molina Healthcare of Texas will not pay for services that are not covered by Medicaid. The following is a list of services that are not covered, **this list is not all-inclusive**:

- All services or supplies not medically necessary
- Services or supplies received without following the directions in this handbook
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid
- Organ transplants that are not covered by Medicaid
- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Infertility services, including reversal of voluntary sterilization procedures
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure
- Cosmetic surgery that is not medically necessary
- Shots (immunizations) for travel outside the United States
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services are covered)
- Services for treatment of obesity unless determined medically necessary
- Custodial or supportive care
- Sex change surgery and related services
- Sexual or marriage counseling
- Court ordered testing
- Education testing and diagnosis
- Acupuncture and biofeedback services
- Services to find the cause of death (autopsy)
- Comfort items in the hospital, like a television or telephone
- Paternity testing

Long Term Care providers participating in rate enhancements will receive rate enhancement payments included in rate according to level.

Spell of Illness Limitation

STAR Plus Members have a spell of illness limitation that could apply to members 21 years of age and older. Members under 21 years of age have no spell of illness if eligible for THSteps-CCP program. More than 30 days of inpatient hospital stay per spell of illness—each spell of illness must be separated by 60 consecutive days during which the client has not been an inpatient in a hospital. The spell of illness limitation does not apply for STAR members.

Long Term Care Covered Services (STAR+Plus Members Only)

Molina covers all medically necessary Medicaid-covered services. Some services may require prior authorization, please refer to list of Prior authorization.

- Primary Care Provider (PCP) services
- Yearly Well Adult Exams
- Well-child (Texas Health Steps) exams
- Shots (immunizations) (Texas Health Steps)
- Specialist services
- Preventative mammogram and cervical exams/pap tests
- *Family Planning services and supplies including clinic services
- Diagnostic services (x-ray, lab)
- *Obstetrical (maternity care-prenatal and postpartum including at risk pregnancy services) and gynecological services
- *Certified Nurse Midwife
- Speech and hearing services
- Physical and Occupational Therapy
- Emergency and Urgent Care services
- Outpatient hospital services
- In-patient hospital services
- Mental health and substance abuse services
- Prescription drugs
- Medical Supplies (in office)
- Durable Medical Equipment (DME)
- Ambulance transportation
- Vision (optical) services
- Eyeglasses
- Chiropractic (back) care
- Health education
- Services for children with medical handicaps
- Podiatry (foot) care
- Home health care
- Hospice care
- Renal Dialysis (kidney disease)
- *Services available at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)
- Transplantation of organs and tissues
- Day Activity and Health Services
- Attendant Care/Personal Assistance Services
- **Adult Foster Care
- **Assisted Living and Residential Care Services
- **Emergency Response Services
- **Home Delivered Meals

- **Minor Home Modifications
- **Respite Care Services
- **Transitional Assistance Services

*A referral from your PCP is not required

** STAR+PLUS waiver services – for a more inclusive listing of limitations and exclusions, please refer to the current Texas Department of Aging and Disability Services (DADS) Provider Manuals.

Routine, Urgent and Emergent Services

Definitions

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

Disability means a physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Urgent Condition means a health condition including an Urgent Behavioral Health Situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within twenty-four (24) hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within twenty-four (24) hours but which does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.

Emergency Behavioral Health Condition means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

- (1) requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or
- (2) which renders Members incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- (1) placing the patient's health in serious jeopardy;
- (2) serious impairment to bodily functions;
- (3) serious dysfunction of any bodily organ or part;
- (4) serious disfigurement; or
- (5) in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child

Emergency Services means 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 Poststabilization Care Services.

Emergency Transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes but is not limited to ambulance, air, or boat transports.

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Non-Emergency Transportation – Medical Transportation

When a client has a medical problem requiring treatment in another location and has no means of transportation, non-emergency service is covered. Non-emergency transports for a Medicaid client **must** be authorized prior to use.

Disability means a physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

A round-trip transport from the Member's home to a scheduled medical appointment is a covered service when the client meets the definition of severely disabled. All non-emergency ambulance transfers to a scheduled doctor's appointment require the doctor's name and address, the diagnosis, and treatment rendered at the time of visit.

Value Added Benefits

In addition to covered benefits, Molina offers value added services to its Members. These include:

Vision Services

STAR Vision Services

In addition to medically necessary covered, appropriate vision services, including corrective lenses, Molina will provide STAR and CHIP Members and adult Members polycarbonate lenses and a reasonable selection of wire frames at no additional cost to members (increase in benefit is limited to \$50 above the basic benefit per eligible member).

STAR+Plus Vision Services

In addition to medically necessary covered, appropriate vision services, including corrective lenses, Molina will furnish eye glasses (frames and lens) or contact lenses to non dual eligible Star Plus members in addition to the vision benefits under the STAR PLUS program. This added benefit is limited to \$200 every other year.

Dental Services (STAR+Plus)

Molina Healthcare of Texas also recognizes that routine dental services are provided to STAR and STAR+PLUS members under age 21 through Medicaid FFS (THSteps). As a value added service to **STAR+Plus** members, Molina Healthcare of Texas will provide a basic dental benefit not to exceed \$500 per year for exams, x-rays, cleaning every six months, fillings, and extractions for members age 21 and older. Any additional services are provided at a 25% discount.

Nurse Advice Line

Molina Healthcare of Texas has a toll free multi-lingual nurse advice telephone line available to Members and Providers on a 24-hour basis, 7 days per week. Staff on this advice line take calls from Members and perform triage services to help them determine the appropriate setting from which they should obtain necessary care. On-call physicians support staff for situations not covered by established criteria/protocols. After normal business hours, the staff also takes calls from providers and performs eligibility and authorization services. In all instances, the staff on the advice line coordinates medical care with the Member's primary care physician.

The nurse advice line is accessed through a toll free telephone number, as well as through information in the Member handbook and other written material. The Nurse Advice Line phone numbers are:

English:	(888AskUs50)	888-275-8750
Spanish:	(866Mi TeleSalud)	866-648-3537

Weight Reduction through Participation in a Weight Watchers® Program

Molina Healthcare of Texas will enroll interested and eligible Members aged 15 and older in a local Weight Watchers® program and provide vouchers for five consecutive weeks of program attendance. The initial mailing to the Member, with the vouchers, will include fact sheets about the program and suggestions for getting started with an exercise regimen; these materials are in addition to those that will be provided at the Weight Watchers® program meetings. Within two months of issuing the initial vouchers a MHT health educator will contact the Member to assess their success and commitment to the program. If the Member is fully participating in the program, the educator will issue vouchers for an

additional five weeks of program attendance. Eligible Members will be allowed a maximum of ten vouchers.

Information regarding the availability of this service will be provided to Members in handbooks and other written educational material. In addition, primary care physicians and other network providers will be informed of the availability of this service and encouraged to recommend program participation to Members who could benefit.

Smoking Cessation

MHT will utilize a nationally recognized telephonic smoking cessation program, called Free and Clear®, that also includes written informational and support material. Participating Members aged 18 and older will be mailed a smoking cessation “kit” including a workbook, smoking diary and other smoking cessation aids. A smoking cessation specialist will telephone the Member within two weeks of program registration to answer any questions and on three subsequent occasions in the months following the Member’s “quit date” to provide support and relapse prevention information. Program participants will have toll free telephone access to smoking cessation specialists for support and counseling.

Members will be able to call MHT health education staff directly, during regular business hours, to request participation in the Free and Clear® smoking cessation program. Physicians may also make referrals on behalf of their Member patients to MHT for program participation.

Behavioral Health Care

Definition of Behavioral Health

Behavioral health services are services provided for the treatment of mental disorders, emotional disorders, and chemical dependency disorders.

PCP Requirements for Behavioral Health

The member may self refer for behavioral health services to any in-network behavioral health provider. However, Primary Care Providers are responsible for coordinating Members’ physical and behavioral health care, including making referrals to Behavioral Health providers when necessary.

Consent for Disclosure of Information

Providers are required to obtain consent for the disclosure of information from the Member permitting the exchange of clinical information between the behavioral health provider and the Member’s physical health provider.

Member Access to Behavioral Health Services

Comprehensive Behavioral Care (CompCare) serves as Molina's behavioral health services provider. A behavioral health assessment tool for the PCP is located in Appendix III. Members may access services with any provider within CompCare's behavioral health care network by contacting CompCare at 800-818-5837 or by contacting Molina Member Services at 866-449-6849. CompCare Case Managers are available to answer questions regarding treatment options, medications, and behavioral health issues twenty four (24) hours per day, seven (7) days per week.

The treatment record documents dates of follow-up appointments or, as appropriate, discharge plan (OP appointment offered within 7 days following d/c from inpatient). Also need to see evidence of next outpatient appointment.

Coordination, Self Referral, and PCP Referral

A referral from the Member's PCP is not required. A PCP may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A PCP may also provide behavioral health services within the scope of their practice. For questions or inquiries regarding behavioral health services please contact CompCare at:

CompCare
3405 W. Dr. Martin Luther King Jr. Blvd
Suite 101
Tampa, FL 33607
800-818-5837

Behavioral health providers must enroll with CompCare to be reimbursed for services provided to our Members. Contact CompCare for specific in-network requirements.

Covered Behavioral Health Services

Behavioral Health Services, including:

- Inpatient and Outpatient behavioral health services
- Outpatient chemical dependency services
- Detoxification services
- Psychiatry services
- Counseling services for adults 21 years of age and over

Behavioral Health Utilization Management

CompCare utilization reports provide a means to track and trend levels of care. These daily, weekly, monthly, quarterly, and annual reports generated by Reporting are provided for clinical and operational discussion and improvement planning for Commercial, Medicare and Medicaid data. The VP of Clinical Operations, as the designated clinical staff, routinely meets with the Care Management staff to review the under/over utilization indicators to implement adjustments and action plans to improve on thresholds. The utilization, over, and under data reviewed during staffing and QI/UM committees are:

- IP days/k trend
- Re-admits 1-5 days (benchmark 1%/5%/5%)
- Re-admits 6-30 days (benchmark 3%/10%/10%)
- Re-admits 31-90 days (benchmark 5%/15%/15%)
- = 1 day admit trend
- > 8 day admit trend
- ALOS at benchmarks Commercial 3-5 days, Medicaid at 5-7 days and Medicare 7-10 days

Court-Ordered Commitments

Up to the annual limit, Molina will provide inpatient psychiatric services to Members under the age of 21 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, relating to court-ordered commitments to psychiatric facilities. Molina will not deny, reduce or controvert the medical necessity of any inpatient psychiatric services provided pursuant to a court-ordered commitment for Members under age 21. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Member who has been ordered to receive treatment under the provisions of Chapters 573 or 574 of the Texas Health and Safety Code can only appeal the commitment through the court system and cannot appeal the commitment through Molina's complaint and appeals process. Molina is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code.

Coordination with the Local Mental Health Authority

Molina will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning and treatment objectives, and projected length of stay for members committed by a court of law to the state psychiatric facility.

Medical Records and Referral Documentation

When reporting to HHSC, Behavioral health providers must use the DSM-IV multi-axil classification and report axes I, II, III, IV and V. For Medicaid members, HHSC requires the use of other assessment instruments/outcomes measures in addition to DSM-IV.

The treatment record documents dates of follow-up appointments or, as appropriate, discharge plan (OP appointment offered within 7 days following discharge from inpatient and the patient records shows the next outpatient appointment).

Missed Appointments

What if a member misses their scheduled appointment?

When a member is a no show for a scheduled appointment, the provider office contacts the member to reschedule the missed appointment. It also should be noted that a member cannot be billed for the missed appointment.

C. CHIP Benefits and Covered Services

CHIP Covered Services (this list is not all-inclusive)

Covered CHIP services must meet the CHIP definition of "Medically Necessary Covered Services," which includes health care services (1) that Molina must arrange to provide to CHIP Members, including all services required by the contract between Molina and HHSC and state and federal law, and all value-added services negotiated by Molina and HHSC; and (2) that are (a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life; (b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions; (c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies; (d) consistent with the diagnoses of the conditions; (e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; (f) are not experimental or investigative; and (g) are not primarily for the convenience of the Member or provider. As provided below and as determined by HHSC, Molina will also provide coverage for Medically Necessary Behavioral Health Services. **There are no pre-existing condition limits.** There are no spell of illness limitations for CHIP members. There is no lifetime maximum on benefits; however, annual, enrollment period or lifetime limitations do apply to certain services, as specified in the following chart.

Type of Benefit	Description of Benefit
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	<p>Medically necessary services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • 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 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) • Diagnostic tests (EEGs, EKGs, etc) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to TDH-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility 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 caesarian section • Hospital, physician and related medical services, such as anesthesia, associated with dental care.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	<p>Medically necessary services include, but are not limited to, the following services provided in a hospital clinic, a clinic or health center, or an ambulatory health care setting:</p> <ul style="list-style-type: none"> • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory Services • Radiation and chemotherapy • Blood or blood products not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.

<p>Physician/Physician Extender Professional Services</p>	<p>Medically necessary services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 • Invasive diagnostic procedures such as endoscopic examination • Hospital-based physician services (including physician-performed technical and interpretative components) • 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 caesarian section • Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation.
<p>Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies</p>	<ul style="list-style-type: none"> • \$20,000 annual limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap) • Covered 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), 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, but not limited to: <ul style="list-style-type: none"> • Orthotic braces and orthotics • Prosthetic devices such as artificial eyes, limbs and braces • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids • Other artificial aids • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME annual limit • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements

<p>Home and Community Health Services</p>	<p>Medically necessary services are provided in the home and community and include, but are not limited to:</p> <ul style="list-style-type: none"> • Home infusion • Respiratory therapy • 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. <p>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.</p>
<p>Inpatient Mental Health Services</p>	<ul style="list-style-type: none"> • Medically necessary services include, but are not limited to, mental health services furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities. • Inpatient mental health services are limited to 30 days annual inpatient limit per 12-month period. • Includes inpatient psychiatric services, up to annual limit, 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. • 20 days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or sub-acute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem cost • 10 of the inpatient days must be held in reserve for inpatient use only • Does not require PCP referral. • Neurological testing is covered under Inpatient and Outpatient Services.

<p>Outpatient Mental Health Services</p>	<ul style="list-style-type: none"> • Medically necessary services include, but are not limited to, mental health services provided on an outpatient basis. • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. • Includes outpatient psychiatric services, up to annual limit, 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, or placements as a Condition of Probation as authorized by the Texas Family Code. • The outpatient benefit can be converted to skills training (psychoeducational skills development) or rehabilitative day treatment. • Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards these limits. • Does not require PCP referral. • Up to 30 visits per 12-month period • Medication management visits do not count against the outpatient visit limit. • Neurological testing is covered under Inpatient and Outpatient Services.
<p>Inpatient Substance Abuse Treatment Services</p>	<ul style="list-style-type: none"> • Medically necessary 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. • 20 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost. • 10 days must be held in reserve for inpatient use only. • Does not require PCP referral. • 24-hour residential rehabilitation programs, or the equivalent, up to 30 days per 12-month period.
<p>Outpatient Substance Abuse Treatment Services</p>	<ul style="list-style-type: none"> • Medically necessary outpatient substance abuse treatment services include, but are not limited to, prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Includes aftercare for chemical dependency services that primarily focus on relapse prevention to the Member who completed treatment and/or their family members. • Does not require PCP referral. • Outpatient treatment services up to a maximum of 30 visits per 12-month period.
<p>Rehabilitation Services</p>	<p>Medically necessary 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:</p> <ul style="list-style-type: none"> • Physical, occupational and speech therapy • Developmental assessment

Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	<ul style="list-style-type: none"> • Health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery. <p>Medically necessary covered services include:</p> <ul style="list-style-type: none"> • 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 TDH designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air or water transportation
Transplants	<p>Medically necessary services include:</p> <ul style="list-style-type: none"> • 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.

CHIP Covered DME/Supplies

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X		For covered DME items.
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books	X		
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit and includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
			wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Ear Molds	X		Custom made, post inner or middle ear surgery.
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease.
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	<p>Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include:</p> <ul style="list-style-type: none"> • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product <p>Does not include formula:</p> <ul style="list-style-type: none"> • For Members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
			<p>daily caloric intake from this product)</p> <ul style="list-style-type: none"> For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. <p>What about this???</p> <p>Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are <i>not</i> medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.</p>
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the parenteral nutrition has been authorized by the Health Plan.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catheterization
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

CHIP Exclusions from Covered Services (this list is not all inclusive)

- Texas Agency Administered Programs and Case Management Services
- Essential Public 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
- 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
- Custodial care
- Mechanical organ replacement devices including, but not limited to artificial heart
- Private duty nursing services when performed on an inpatient basis
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Eye exams for assessment of visual acuity
- Prostate and mammography screening
- Elective surgery to correct vision
- Cosmetic surgery/services 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 caesarian 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
- 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
- Routine refraction services and glasses/contacts
- Corrective orthopedic shoes
- Convenience items
- 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.)
- 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
- Reimbursement for physical therapy, occupational therapy, and speech therapy school-based 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
- Chiropractic services
- Tobacco cessation services
- Skilled Nursing Facilities
- Hospice Care

Routine, Urgent and Emergent Services

Definitions

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

Disability means a physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Urgent Condition means a health condition including an Urgent Behavioral Health Situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within twenty-four (24) hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within twenty-four (24) hours but which does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.

Emergency Behavioral Health Condition means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

- (1) requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or
- (2) which renders Members incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- (1) placing the patient's health in serious jeopardy;
- (2) serious impairment to bodily functions;
- (3) serious dysfunction of any bodily organ or part;
- (4) serious disfigurement; or
- (5) in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child

Emergency Services means 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 Poststabilization Care Services.

Emergency Transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes but is not limited to ambulance, air, or boat transports.

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Non-Emergency Transportation – Medical Transportation

When a client has a medical problem requiring treatment in another location and has no means of transportation, non-emergency service is covered. Non-emergency transports for a Medicaid client **must** be authorized prior to use.

Severely disabled means that the Member's physical condition limits mobility and requires the client to be bed-confined at all times or unable to sit unassisted at all times, or requires continuous life-support systems (including oxygen or IV infusion) or monitoring of unusual physical or chemical restraint.

A round-trip transport from the Member's home to a scheduled medical appointment is a covered service when the client meets the definition of severely disabled. All non-emergency ambulance transfers to a scheduled doctor's appointment require the doctor's name and address, the diagnosis, and treatment rendered at the time of visit.

Value Added Benefits

In addition to covered benefits, Molina offers value added services to its Members. These include:

Vision Services

In addition to medically necessary covered, appropriate vision services, including corrective lenses, Molina will provide STAR and CHIP Members and adult Members polycarbonate lenses and a reasonable selection of wire frames at no additional cost to members (increase in benefit is limited to \$50 above the basic benefit per eligible member).

Nurse Advice Line

Molina Healthcare of Texas has a toll free multi-lingual nurse advice telephone line available to Members and Providers on a 24-hour basis, 7 days per week. Staff on this advice line take calls from Members and perform triage services to help them determine the appropriate setting from which they should obtain necessary care. On-call physicians support staff for situations not covered by established criteria/protocols. After normal business hours, the staff also takes calls from providers and performs eligibility and authorization services. In all instances, the staff on the advice line coordinates medical care with the Member's primary care physician.

The nurse advice line is accessed through a toll free telephone number, as well as through information in the Member handbook and other written material. The Nurse Advice Line phone numbers are:

English:	(888AskUs50)	888-275-8750
Spanish:	(866Mi TeleSalud)	866-648-3537

Weight Reduction through Participation in a Weight Watchers® Program

Molina Healthcare of Texas will enroll interested and eligible Members aged 15 and older in a local Weight Watchers® program and provide vouchers for five consecutive weeks of program attendance. The initial mailing to the Member, with the vouchers, will include fact sheets about the program and suggestions for getting started with an exercise regimen; these materials are in addition to those that will be provided at the Weight Watchers® program meetings. Within two months of issuing the initial vouchers a MHT health educator will contact the Member to assess their success and commitment to the program. If the Member is fully participating in the program, the educator will issue vouchers for an additional five weeks of program attendance. Eligible Members will be allowed a maximum of ten vouchers.

Information regarding the availability of this service will be provided to Members in handbooks and other written educational material. In addition, primary care physicians and other network providers will be informed of the availability of this service and encouraged to recommend program participation to Members who could benefit.

Smoking Cessation

MHT will utilize a nationally recognized telephonic smoking cessation program, called Free and Clear®, that also includes written informational and support material. Participating Members aged 18 and older will be mailed a smoking cessation "kit" including a workbook, smoking diary and other smoking cessation aids. A smoking cessation specialist will telephone the Member within two weeks of program registration to answer any questions and on three subsequent occasions in the months following the Member's "quit date" to provide support and relapse prevention information. Program participants will have toll free telephone access to smoking cessation specialists for support and counseling.

Members will be able to call MHT health education staff directly, during regular business hours, to request participation in the Free and Clear® smoking cessation program. Physicians may also make referrals on behalf of their Member patients to MHT for program participation.

Behavioral Health Care

Definition of Behavioral Health

Behavioral health services are services provided for the treatment of mental disorders, emotional disorders, and chemical dependency disorders.

PCP Requirements for Behavioral Health

The member may self refer for behavioral health services to any in-network behavioral health provider. However, Primary Care Providers are responsible for coordinating Members' physical and behavioral health care, including making referrals to Behavioral Health providers when necessary.

Consent for Disclosure of Information

Providers are required to obtain consent for the disclosure of information from the Member permitting the exchange of clinical information between the behavioral health provider and the Member's physical health provider.

Member Access to Behavioral Health Services

Comprehensive Behavioral Care (CompCare) serves as Molina's behavioral health services provider. A behavioral health assessment tool for the PCP is located in Appendix III. Members may access services with any provider within CompCare's behavioral health care network by contacting CompCare at 800-818-5837 or by contacting Molina Member Services at 866-449-6849. CompCare Case Managers are available to answer questions regarding treatment options, medications, and behavioral health issues twenty four (24) hours per day, seven (7) days per week.

The treatment record documents dates of follow-up appointments or, as appropriate, discharge plan (OP appointment offered within 7 days following d/c from inpatient). Also need to see evidence of next outpatient appointment.

Coordination, Self Referral, and PCP Referral

A referral from the Member's PCP is not required. A PCP may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A PCP may also provide behavioral health services within the scope of their practice. For questions or inquiries regarding behavioral health services please contact CompCare at:

CompCare
3405 W. Dr. Martin Luther King Jr. Blvd
Suite 101
Tampa, FL 33607
800-818-5837

Behavioral health providers must enroll with CompCare to be reimbursed for services provided to our Members. Contact CompCare for specific in-network requirements.

Covered Behavioral Health Services

Behavioral Health Services, including:

- Inpatient and Outpatient behavioral health services
- Outpatient chemical dependency services
- Detoxification services
- Psychiatry services
- Counseling services for adults 21 years of age and over

Behavioral Health Utilization Management

CompCare utilization reports provide a means to track and trend levels of care. These daily, weekly, monthly, quarterly, and annual reports generated by Reporting are provided for clinical and operational discussion and improvement planning for Commercial, Medicare and Medicaid data. The VP of Clinical Operations, as the designated clinical staff, routinely meets with the Care Management staff to review the under/over utilization indicators to implement adjustments and action plans to improve on thresholds. The utilization, over, and under data reviewed during staffing and QI/UM committees are:

- IP days/k trend
- Re-admits 1-5 days (benchmark 1%/5%/5%)
- Re-admits 6-30 days (benchmark 3%/10%/10%)
- Re-admits 31-90 days (benchmark 5%/15%/15%)
- = 1 day admit trend
- > 8 day admit trend
- ALOS at benchmarks Commercial 3-5 days, Medicaid at 5-7 days and Medicare 7-10 days

Court-Ordered Commitments

Up to the annual limit, Molina will provide inpatient psychiatric services to Members under the age of 21 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, relating to court-ordered commitments to psychiatric facilities. Molina will not deny, reduce or controvert the medical necessity of any inpatient psychiatric services provided pursuant to a court-ordered commitment for Members under age 21. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A Member who has been ordered to receive treatment under the provisions of Chapters 573 or 574 of the Texas Health and Safety Code can only appeal the commitment through the court system and cannot appeal the commitment through Molina's complaint and appeals process. Molina is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code.

Coordination with the Local Mental Health Authority

Molina will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning and treatment objectives, and projected length of stay for members committed by a court of law to the state psychiatric facility.

Medical Records and Referral Documentation

When reporting to HHSC, Behavioral health providers must use the DSM-IV multi-axil classification and report axes I, II, III, IV and V. For Medicaid members, HHSC requires the use of other assessment instruments/outcomes measures in addition to DSM-IV.

The treatment record documents dates of follow-up appointments or, as appropriate, discharge plan (OP appointment offered within 7 days following d/c from inpatient and the patient records shows the next outpatient appointment.

Missed Appointments

What if a member misses their scheduled appointment?

When a member is a no show for a scheduled appointment, the provider office contacts the member to reschedule the missed appointment. It also should be noted that a member cannot be billed for the missed appointment.