Molina Healthcare
Provider Manual
March 1, 2012

Service Areas:

STAR and STAR+PLUS

Bexar, Dallas, El Paso, Harris, Hidalgo and Jefferson Service Areas
Provider Services
1-866-449-6849

CHIP

Dallas, Harris, and Jefferson Service Areas
Provider Services
1-866-449-6849

CHIP Rural Service Area (RSA)
Provider Services
1-877-319-6825

www.molinahealthcare.com

TEXAS Health and Human Services Commission

TEXAS STAR PROGRAM Your Health Plan ■ Your Choice

STAR+PLUS PROGRAM Your Health Plan ■ Your Choice

CHIP We've got your kids covered.

MHT2012PROVMN

Molina Healthcare Provider Manual and Orientation Acknowledgement

Please sign and return to Molina Healthcare Provider Services acknowledging receipt of the Molina Healthcare Edition of the Provider Manual and Orientation

____ Molina Healthcare History and Overview
____ Molina Product Lines
____ Molina Healthcare Service Delivery Areas
____ Molina Benefits by Product Line
____ Eligibility, Claims, Appeals & Reimbursement
____ Children of Migrant Farm Workers (FREW)
____ THSteps
____ Medical Management (Quality Improvement, Disease Management,
____ Case Management & Utilization Management)
____ Long Term Support Services (if applicable)
____ Prior Authorization
____ Out-of-Network Referrals
____ Provider Complaint Process
____ E-Portal
____ Behavioral Health (if applicable)

Group Practice Name: _____

Provider Name: _____

Address: _____

City/ZIP: _____

County:_____

Phone: _____

Date: _____

Name (If not Provider):_____

Signature:_____

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Introduction

Background

Molina Healthcare (Molina) is a newly formed for-profit corporation in the State of Texas, and a subsidiary of Molina Healthcare, Inc. Molina Healthcare, Inc. (MHI) is a publicly traded, multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. The parent company's operations are based in Long Beach, California. MHI was incorporated in the state of Delaware.

MHI was founded in 1980 by C. David Molina, M.D. as a provider organization serving the Medicaid population through a network of primary care clinics in California. In 1994, Molina Healthcare of California received its license as a health maintenance organization, and began operating as a health plan. Over the past several years, MHI has expanded our operations into multiple states. MHI now touches the lives of approximately 5 million Medicaid members in 15 different states.

Continuing the Vision

MHI has taken great care to become an exemplary organization caring for the underserved by overcoming the financial, cultural and linguistic barriers to healthcare, ensuring that medical care reaches all levels of our society. We are committed to continuing our legacy of providing accessible, quality healthcare to those children and families in our communities.

Vision Statement

Molina Healthcare is an innovative healthcare leader providing quality care and accessible services in an efficient and caring manner.

Core Values

We strive to be an exemplary organization;
We provide quality service;
We are healthcare innovators and respond quickly to change;
We respect each other and value ethical business practices;
We are careful in the management of our financial resources;
We care about the people we serve.

Molina Healthcare

Provider Quick Reference Guide | IMPORTANT NUMBERS

APPEALS ADDRESS
15115 Park Row Blvd. Suite # 110
Houston, Texas 77084
Bexar, Harris, Dallas, Jefferson,
El Paso & Hidalgo Service Areas 866-449-6849
CHIP Rural Service Area 877-319-6826

BEHAVIORAL HEALTH SERVICES
..... 800-818-5837
BH Fax for Prior Authorization 866-617-4967
For Behavioral Health Services in Dallas Service Area
(STAR & STAR+PLUS), please call NorthSTAR at 888-800-6799

CONTRACTING
texasexpansioncontracting@molinahealthcare.com
- How to join the network
- Contract Clarifications
- Fee schedule inquires

CUSTOMER SERVICE (MEMBERS AND PROVIDERS)
- Claims Status
- Member Eligibility
- Benefit Verification
- Complaint & Appeals Status

Bexar, Harris, Dallas, Jefferson, El Paso &
Hidalgo Service Areas (Voice) 866-449-6849
..... (Fax) 281-599-8916
CHIP Rural Service Area ..... (Voice) 877-319-6826
..... (Fax) 281-599-8916

DENTAL SERVICES
Delta Dental Insurance Company 866-561-5891
Denta Quest 800-508-6775
MCNA Dental 800-494-6262

ELECTRONIC CLAIMS SUBMISSION VENDORS
- Payor Identification for all - 20554
- Availity, Zirmed, Practice Insight, SSI & EMDEON

MEDICAL MANAGEMENT
- Prior Notification
- Prior Authorization
- Referrals
- Disease Management

STAR+PLUS Service
Coordination Department ..... (Voice) 866-409-0039
..... (Fax) 866-420-3639

MOLINA COMPLAINTS ADDRESS
N.E. Loop 410, #200,
San Antonio, TX 78216
Bexar, Harris, Dallas, Jefferson,
El Paso & Hidalgo Service Areas 866-449-6849
CHIP Rural Service Area 877-319-6826

NURSE ADVICE LINE
- Clinical Support for Members

..... 888-275-8750 (English) or
..... 866-648-3537 (Spanish)

PAPER & CORRECTED CLAIMS ADDRESS
P.O. Box 22719
Long Beach, CA 90801

PHARMACY
Prior Authorization
Assistance/Inquiries
..... (Voice) 866-449-6849
..... (Fax) 888-487-9251

PROVIDER SERVICES
Bexar, Harris, Dallas, Jefferson,
El Paso & Hidalgo Service Areas 866-449-6849
CHIP Rural Service Area 877-319-6826

STAR+PLUS SERVICE COORDINATION
..... 866-409-0039
..... (Fax) 866-420-3639

VISION SERVICES:
(www.opticarevisionplans.com;
provrel@opticare.net)
..... 800-537-6697 (CHIP)
..... 866-492-9711 (STAR)
..... 877-832-4118 (STAR+PLUS)

MEDICAID CONTACTS

CHIP ELIGIBILITY 800-645-7164
CHIP MEMBER ENROLLMENT 800-647-6558
EARLY CHILDHOOD INTERVENTION 800-628-5115
EPORTAL TECHNICAL SUPPORT 866-449-6848
FAMILY PLANNING PROGRAM 512-458-7796
MEDICAL TRANSPORTATION PROGRAM (MTP)
STAR & STAR+PLUS 877-633-8747
MEDICAID HOTLINE 800-252-8263
MEDICAID PROGRAM MEMBER
Verification (NAIS) 800-925-9126
NPI # REQUEST
https://nppes.cms.hhs.gov 800-925-9126
STARLINK-MEDICAID MANAGED CARE HELPLINE
General Member Assistance 866-566-8989
STAR & STAR+PLUS PROGRAM ENROLLMENT
PCP Information
Plan Changes
Health Plan Information 800-964-2777
TEXAS HEALTH STEPS
STAR & STAR+PLUS 877-847-8377
TEXAS DEPARTMENT OF INSURANCE
HMO Division 512-322-4266
HMO Complaint 512-305-6745
Consumer Division 512-463-6500
Consumer Hotline 800-525-3439

TEXAS VACCINES FOR CHILDREN PROGRAM 800-252-9152

Please visit www.MolinaHealthcare.com

Objectives of Program(s)

The objectives of the STAR and STAR+PLUS programs are to:

- Promote a system of health care delivery that provides coordinated and improved access to comprehensive health care and enhanced provider and client satisfaction.
- Improve health outcomes by ensuring the quality of health care provided to members and by promoting wellness and prevention.
- Achieve cost effectiveness without compromising access and quality.
- Implement and administer the program in a way that meets state and federal requirements.
- Evaluate the effectiveness and efficiency of the Medicaid managed care program.
- Hire, train, retain, and develop a diverse, competent and productive staff.
- Maintain a flexible, team-oriented environment that supports the knowledge and experience of individuals, and promotes employee morale and creativity.
- Build partnerships with our customers by: regular communication; responding in a timely and accurate manner; and consistently seeking input for program improvements and strategic planning.
- Increase quality and continuity of care for Medicaid members;
- Improve the access to care for members;
- Achieve cost-effectiveness and efficiency for the State;
- Decrease inappropriate usage of the health care delivery system;
- Promote provider and member satisfaction;
- Integrate acute and Long-term care services for the STAR+PLUS members.
- Coordinate Medicare services for STAR+PLUS members who have SSI-Medicare and Medicaid

The objectives of the CHIP program are to:

- Raise awareness of the children's health insurance options available in the State:
- Texas families obtain and utilize affordable coverage of their uninsured children (0-19);
- Increase the number of insured children within the state;
- Decrease the cost of healthcare by utilizing comprehensive and preventative care.

Role of Primary Care Provider & Medical Home (STAR, STAR+PLUS, & CHIP)

Primary Care Providers participating in the Texas Medicaid and CHIP Programs practice the "medical home concept" for members with Medicaid and CHIP. The term "medical home" refers to the relationship between a primary physician and a patient. Care delivered through a medical home is intended to reduce fragmentation, increase access to care, reduce costs and stimulate the development of more appropriate use of services and be a sensible basis to deliver quality health care in a reasonable manner. The medical home will serve as the member's initial and primary point of contact for accessing health care services.

The providers in the medical home are knowledgeable about the individual's and family's specialty care and health-related social and educational needs and are connected with necessary resources in the community that will assist the family in meeting those needs. When referring for consultation, to specialists, network facilities and contractors, health and health-related services, the medical home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism, and accepts them back into the medical home for continuing primary medical care and preventive health services.

Role of Specialty Care Provider (STAR, STAR+PLUS, & CHIP)

The specialty care provider coordinates care with the member's PCP, who is the member's medical home provider, through the submission of consultation letters and recommendations for inclusion in the member's medical record. This includes the coordination, documentation and communication of all physical medicine and behavioral health care on behalf of members.

Specialist as a PCP (STAR, STAR+PLUS, & CHIP)

Specialty Providers who agree to provide the full range of required primary care services may be designated by Molina as a PCP for Members with a chronic, disabling or life-threatening illness or condition. Upon request by a Molina Member or provider, Molina shall consider whether to approve a specialist to serve as a Member's PCP. The criteria for a specialist to serve as a PCP includes:

- whether the Member has a chronic, disabling, or life-threatening illness
- whether the requesting specialist has certified the medical need for the Member to utilize the non-PCP specialist as a PCP;
- whether the specialist is willing to accept responsibility for the coordination of all of the Member's health care needs;
- whether the specialist meets Molina requirements for PCP participation, including credentialing; and
- Whether the contractual obligations of the specialist are consistent with the contractual obligations of Molina PCPs.

For further information about Molina's policy on the process for a specialist to serve as a Member's PCP please contact Member Services.

Direct Access to OB/GYN (STAR, STAR+PLUS, & CHIP)

Molina Healthcare Inc. does not limit the member's selection of an OB/GYN to your PCPs network.

ATTENTION FEMALE MEMBERS*:*

You have the right to select an OB/GYN without a referral from your PCP. The access to health care services of an OB/GYN includes:

- one well-woman check-up per year
- care related to pregnancy
- care for any female medical condition, and
- referral to specialist doctor within the network

Members Right to Designate an OB/GYN (STAR, STAR+PLUS, & CHIP)

Females may request an OB/GYN be their PCP especially during their pregnancy. If the OB/GYN agrees to be the PCP the physician must refer the Member if care outside of their scope of expertise is required. A certified nurse midwife may act as a PCP only during and immediately after a women's pregnancy. Otherwise, specialists may serve as PCPs only as set forth. All PCPs must have admitting privileges to a hospital within the Molina network.
If a member is pregnant when she/her daughter start coverage with Molina, and are seeing a doctor that is not a Molina doctor, she/her daughter can still see that doctor if she/her daughter are in the second or third trimester of the pregnancy, or have a health problem that would make changing to a new doctor unsafe. Otherwise, she/her daughter will need to pick a doctor from the Molina Provider Directory for care.

Role of Long Term Services & Supports Providers for STAR+PLUS Members

The provider is responsible for contacting the care coordinator to extend services beyond the initial authorization period. The provider must complete a re-authorization form and send it to Molina Healthcare for re-authorization. The provider must verify member eligibility on a monthly basis.

All LTSS Providers must obtain a prior authorization before providing services to an eligible member or prior to admitting an eligible member to their facility. All Skilled Nursing Facilities must submit a Resident Transaction Notice (included in your provider manual) to the State Claims Administrator within 72 hours of an admission or discharge of a STAR+PLUS member.

Role of CHIP Perinatal Provider

It is the role of CHIP PCPs and Perinatal Care Providers to coordinate services for Members, including coordination with essential public health services such as:

- Reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization;
- Referring communicable disease outbreaks to the local Public Health Entity;
- Referring to the local Public Health Entity for Tuberculosis investigation,
- evaluation, and preventive treatment of persons whom the member has come into contact;
- Referring to the local Public Health Entity for STD/HIV contact investigation, evaluation, and preventive treatment of persons whom the member has come into contact;
- Coordinating care for suspected or confirmed cases of lead exposure,
- Coordinate care for the health and well being of the unborn baby and pregnant mother
- Coordinate care for CHIP members to ensure they receive the most appropriate care in the most appropriate setting

Role of Pharmacy (STAR, STAR+PLUS, & CHIP)

Pharmacy Role and Responsibility

- Adhere to the Formulary d 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

There is no Preferred Drug List (PDL) for CHIP

Hospital Responsibilities (STAR, STAR+PLUS, & CHIP)

Molina has contracted with area hospitals to provide services to Molina Healthcare members.

Hospitals must:

- Notify the PCP immediately, or no later than close of business the next business day after a Member's appearance in an Emergency room
- Obtain Prior authorization for inpatient and outpatient services
- Obtain authorization for services listed in the Section "What Requires Pre-Authorization."
- Notify Molina of all emergency admissions upon the close of the next business day.

Network Limitations (i.e. PCPs, Specialists, OB/GYN) (STAR, STAR+PLUS, & CHIP)

Molina prefers that a Pediatrician, General Practice, Family Practice, Family Advanced Practice Nurse or Physicians Assistant under the supervision of a physician act as the PCP for children. In addition, if an internist accepts the responsibility of being the PCP for a person under 20, the internist must have hospital admitting privileges to the pediatric unit.

Adults may choose from among the following specialties for their PCPs: General Practice, Family Practice, Internal Medicine, Family Advanced Practice Nurses and Physician Assistants practicing under the supervision of a physician, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHC), and similar community clinics.

A family practitioner will only be allowed to serve as an OB/GYN if he/she is board certified, is actively practicing with hospital privileges at a network hospital and has been credentialed as both a family practitioner and an OB/GYN.

Service Coordination STAR+PLUS Members

Service Coordination is a special program offered by Molina Healthcare to help members manage their health, long-term and behavioral health care needs.

Molina will furnish a Service Coordinator to all STAR+PLUS Members who request one. The Molina will also furnish a Service Coordinator to a STAR+PLUS Member when the Molina determines one is required through an assessment of the Member's health and support needs.

Molina will ensure that each STAR+PLUS Member has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, serves as a central point of integration and coordination of Covered Services, including primary, Acute Care, Long-term Services and Supports, and Behavioral Health Services.

The Service Coordinator will work as a team with the PCP to coordinate all STAR+PLUS Covered Services and any applicable Non-capitated Services.

Service Coordinators will:

- Review assessments and develop plan of care utilizing input from member, family and providers
- Coordinate with the member's PCP, specialists and providers to ensure the member's health and safety needs are met in the least restrictive setting
- Refer members to support services such as disease management and community resources
- Authorize services

All Care coordinator staff members can assist with basic inquires. If additional follow up is needed, the assigned Service Coordinator will contact the provider or member within 24 hours. To contact Molina's care coordinator team call 1-866-409-0039.

Chapter 1:
Members with Special Needs **(STAR, STAR+PLUS, & CHIP)**

Overview

Molina uses a program specifically designed to meet the needs of adults and children identified as having special health care needs.

Molina will use Health Risk Coordinators (HRC) familiar with health assessment screening tools and application to work with those new Members who require special needs if identified as meeting Molina's assessment criteria for MSHCN, HRC professionals will coordinate their activities with the Quality Improvement/Utilization Management Department. Members identified with a special health care need will be referred to their PCP. Molina will assign a Case Manager to work with the PCP to establish a plan of care, to assist the PCP with necessary referrals (if needed by the PCP), and to aid the Member in accessing the services, including any out-of-network referrals, transportation or translation/interpretation services needed.

Medical Transportation Program (MTP) (STAR, STAR+PLUS)

The Medical Transportation Program (MTP) is a free service provided through Medicaid when Members or their children have no other way of getting to appointments with Medicaid-enrolled doctors, dentists, or other health care service providers (including pharmacies). MTP offers free rides by bus, van, taxi, or airplane to appointments and back home. You can also receive gas money or bus tokens from MTP. Children younger than twenty-one (21) years of age may qualify for money in advance for their transportation. They may also qualify for meals and lodging when they, and/or the adult responsible for them, must stay overnight at a medical facility such as a hospital. Members can call 1-877-MED-TRIP (1-877-633-8747) between 8:00 a.m. and 5:00 p.m. Central Standard Time, Monday-Friday. For Members with hearing or speech impairments, they can call TDD Relay Texas at 1-800-735-2989.

Other transportation **(STAR, STAR+PLUS, & CHIP)**

On some occasions Molina must provide medically necessary transportation that is not covered by the MTP program. Members and providers may call member services at 1-866-449-6849 for assistance.

Interpreter/Translation Services (STAR, STAR+PLUS, & CHIP)

All eligible Members who are Limited English Proficient (LEP) will be entitled to receive interpreter services. An LEP individual has a limited ability or inability to read, speak, or write English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations). Molina Members will be entitled to:

- Be provided with effective communications with medical providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Individuals with cognitive difficulties will have ready access to care managers trained to work with cognitively impaired individuals.
- Be notified by the medical provider that interpreter services are available at no cost to the client.
- Decide, with the medical provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
- Interpreters must adhere to HHSC policies and procedures regarding confidentiality of client records.
- Interpreters may, with client written consent, share information from the client's records only with appropriate medical professionals and agencies working on the client's behalf.
- Interpreters must ensure that this shared information is similarly safeguarded.

In addition, Members are advised in their welcome packet regarding interpretive and translation services and how to access the AT&T Language Line or the TTY line for Members who are hard of hearing or speech impaired. Molina's language assistance offers members the opportunity to discuss utilization management issues as well.

Molina/Provider Coordination (STAR, STAR+PLUS, & CHIP)

Members and their families, or authorized representatives including the PCP, are key to the success of a plan of care. Plans of care will be less likely to be followed and result in less than satisfactory outcome without the involvement of the member and when appropriate, the family. Member involvement and family support is important to the completion of necessary treatment.

Molina's care coordination program is designed to identify potential clinical problems, especially those of a chronic or complex nature, engage the Member and PCP in determining a care plan, providing ongoing case management support and care coordination, tracking and reporting efforts, adjusting staff levels as needed and monitoring the program for outcomes.

Once a plan of care is developed, case managers authorize all needed services, including those to specialists (in or out of network). If the specialist will be delivering care on an on-going basis, a

standing referral will be established. At the Member's discretion and with the specialist's okay, the specialist may be designated as the Member's PCP.

Reading/Grade Level Consideration (STAR, STAR+PLUS, & CHIP)

Member materials are written at a 6th grade reading level or lower. The only exception to this is for medical or legal terminology.

Cultural Sensitivity (STAR, STAR+PLUS, & CHIP)

Molina responds to the cultural, racial, and linguistic needs (including interpretive service as necessary) of the Medicaid population. Molina is backed by an organization that has focused on serving low-income families and individuals for the past 24 years, providing a wealth of experience in meeting the diverse needs of the Medicaid population. This experience provides Molina access to the experience, resources, and programs designed to meet the unique healthcare needs of a culturally diverse membership. In demonstration of Molina's commitment to meeting the needs of a culturally diverse membership, cultural advisory committees have been established and are supported by one full-time cultural anthropologist who routinely advises Molina staff and committees about the differing needs.

Molina has significant expertise in developing targeted health care programs for culturally diverse Members. Molina maintains cultural advisory committees and employs one full-time cultural anthropologist to advise Molina staff about the differing needs.

It is Molina's intention to mail provider material that is culturally and linguistically appropriate for use by themselves and their patients. In addition, interpretation services will be available and in-service trainings and discussions will be encouraged on these topics.

All provider promotional, educational, training, or outreach material will include an inventory control number per the requirements of HHSC.

Chapter 2
Benefits and Covered Services

Texas Health Steps Services (THSteps) (STAR and STAR+PLUS)

Texas Health Steps is the Medicaid health-care program for children, teens and young adults, birth through age 20.

Texas Health Steps gives your child:

- Free regular medical checkups starting at birth.
- Free dental checkups starting at 6 months of age.
- A case manager who can find out what services your child needs, and where to get these services.

Texas Health Steps checkups:

- Find health problems before they get worse and harder to treat.
- Prevent health problems that make it hard for children to learn and grow like others their age.
- Help your child have a healthy smile.

When to set up a checkup:

- You will get a letter from Texas Health Steps telling you when it's time for a checkup. Call your child's doctor to set up the checkup.
- Set up the checkup at a time that works best for your family.
- To avoid health problems for your children, teens, and young adults, make sure they get their Texas Health Steps medical and dental checkups.
- Look at the boxes below and find the one for your child's age. They will tell you when to take your child to each Texas Health Steps checkup.

Birth to 9 Months

- Babies need checkups when they are 3 to 5 days old, 2 weeks old, then at 2, 4, 6, and 9 months old.
- Doctors make sure babies are healthy and growing as they should.
- During a checkup, the doctor will look at your baby from head to toe, checking for health problems you may not know about.
- During a checkup, the doctor may do tests to check for other problems.
- Babies can also get free vaccines at a checkup to protect them from disease.
- Dental checkups start at the age of 6 months and then every 3 to 6 months.
- The dentist or doctor might put fluoride on your child's teeth during a dental or medical checkup.

1 to 4 Years

- Children need medical checkups at 12, 15, and 18 months old, and at 2, 2 1/2, 3, and 4 years old.
- During a checkup, the doctor may do tests to check for other problems.
- Toddlers can also get free vaccines at a checkup to protect them from disease.
- During the checkup, the doctor will ask you questions about what your child is learning to do and how they are getting along with others.
- Children need dental checkups every 3 to6 months unless the dentist needs to see them more often.

5 to 10 Years

- Children need medical checkups at 5, 6, 7, 8, 9, and 10 years old.
- Children will get vaccines to help protect them from disease.
- During a checkup, the doctor may do tests to check for other problems.
- Finding and treating health problems can help your child do better in school.
- Children need dental checkups every 6 months.
- Dentists can put special coatings on children's teeth (called "sealants") that help protect their teeth.

11 to 20 Years

- Teens and young adults need to have a checkup each year.
- During checkups, doctors talk to teens about eating habits, exercise, ways to prevent injury, and how to have a healthy lifestyle.
- During a medical checkup, the doctor will ask if your teen has any worries that may cause problems with their mental or physical health. This medical checkup is not the same as a sports physical exam.
- Your teen will need to see the dentist every 6 months.

If the doctor or dentist finds a health problem during a checkup, your child can get the care he or she needs, such as:

- Eye tests and eyeglasses.
- Hearing tests and hearing aids.
- Other health and dental care.and/or treatment for other medical conditions.

Call Texas Health Steps toll-free at 1-877-847-8377 (1-877-THSTEPS) if you:

- Need help finding a doctor or dentist.
- Need help setting up a checkup.
- Have questions about checkups or Texas Health Steps or Need help finding and getting other services.

If you need a free ride or gas money to get to your child's checkup, call toll-free 1-877-633-8747 (1-877-MED-TRIP).

Case Management for Children and Pregnant Women

Need help finding and getting services? You might be able to get a case manager to help you.

Who can get a case manager?

Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

- Have health problems.
- Are at a high risk for getting health problems.

What do case managers do?

A case manager will visit with you and then:

- Find out what services you need; find services near where you live; teach you how to find and get other services.
- Make sure you are getting the services you need.

What kind of help can you get?

Case managers can help you:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

How can you get a case manager?

Call the **Texas Health Steps at 1-877-847-8377** (toll-free), Monday to Friday, 8 a.m. to 8 p.m.

To learn more, go to: **www.dshs.state.tx.us/caseman**

Timely Medical Checkups

• Checkups received before the periodic due date are not timely medical checkups.
• For reporting periods prior to September 1, 2010: A checkup is considered to have been provided timely if the checkup occurs within 60 days beyond the periodic due date based on an Existing Member's birthday.
• For reporting periods on and after September 1, 2010:
    o Member is less than 36 months of age: A checkup is considered to have been provided timely if the checkup occurs within 60 days beyond the periodic due date based on an Existing Member's birthday.
    o Member is 36 months of age or older: A checkup is considered to have been provided timely if the checkup occurs within 364 calendar days after the child's birthday in a non-leap year or 365 calendar days after the child's birthday in a leap year.

If a provider has documentation that a member has already received a checkup there will be no need to conduct another checkup until the next checkup is due whenever appropriate.

Children of Migrant Farm workers

Children of Migrant Farm workers 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 checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late check up.

Who Can Perform THSteps Examinations?

Only Medicaid-enrolled THSteps providers 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?

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, 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
(Please refer to Periodicity Schedule in the Forms Section of this manual)

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. Providers must treat each THSteps visit as an opportunity for a comprehensive assessment of the member.

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 DSHS 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 6 months of age, and every six months afterward until the parent confirms a dental home has been established.

Information concerning the appropriate ages for lead testing, development assessment, and dental referral can be found on the **Periodicity Schedule in the Forms Section of this manual**.

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 1-866-449-6849.

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 DSHS. 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 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.

Oral Evaluation and Fluoride Varnish Benefit (OEFV)

OEFV is a THSteps covered benefit. This benefit may be rendered and billed by certified Texas Health Steps providers when performed on the same day as the Texas Health Steps medical checkup. This benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, Dental anticipatory guidance, and referral to a dental home.

The visit is billed in conjunction with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier. Provider must document all components of the OEFV on the appropriate documentation. The provider should assist members with referral to a dentist to establish a dental home whenever appropriate and maintain record of such referral in the member's record.

Newborn Examination

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.

Any provider attending the birth of a baby must require testing for PKU, galactosemia, hypothyroidism, sickle hemoglobin and congenital adrenal hyperplasia on all newborns before discharge 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 DSHS Laboratories. For complete information, collection testing materials, supplies, instructions and newborn screening forms contact:

DSHS Laboratories
1100 West 49th St.
Austin, Texas 78756-3199
1-512-458-7331

You may also go to their link at www.dshs.state.tx.us/lab

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:

- The expected required components of a medical checkup must be age-appropriate and include the following:
- Comprehensive health and developmental history including:
- Nutrition screening
- Developmental screening
- Mental health
- Tuberculosis screening
- Comprehensive unclothed physical examination, including graphic recording of measurements including:
- Height/length and weight
- Body mass index (BMI) calculated beginning at 2 years of age
- Fronto-occipital circumference through the first 24 months of age
- Blood pressure beginning at 3 years of age
- Sensory screening
- Vision screening
- Hearing screening
- Immunizations
- Status
- Administration, as necessary
- Laboratory testing
- Anemia screening
- Blood lead screening
- Age-appropriate laboratory testing
- Risk-based laboratory testing
- Dental referral
- Health Education including anticipatory guidance

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

Providers that administer THSteps immunizations must comply with the Immunization Standard Requirements set forth in Chapter 161, Health and Safety Code; the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule; the AAP Periodicity Schedule for CHIP Members; and the Texas Health Steps Periodicity Schedule for Medicaid Members.

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]).

Medicaid members under age 21 must be immunized during the THSteps check up according to the ACIP 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: An 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, DSHS 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 proceeding 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.

Medicaid Covered Benefits for STAR and STAR+PLUS

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 on forms section of this manual (page 200).

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)	**No limit (first 30 without PA)**
Outpatient behavioral health services (chemical dependency ages under 21)	**135 hours group therapy per year; 26 hours individual therapy**
Inpatient behavioral health **Mental health: STAR ages under 21; STAR+PLUS children & adults** **Chemical dependency: detox**	**No limit**
Routine Medical Care	**No limit**

Early Childhood Intervention (ECI)

The Texas Interagency Council on Early Childhood Intervention (ECI) was established in 1981 to develop a statewide system of comprehensive services for infants and toddlers with developmental disabilities. ECI serves children, birth to age 3, with disabilities or delays and supports families to help their children reach their potential through education and developmental services.

ECI provides evaluations and assessments, at no cost to families, to determine eligibility and need for services. Families and professionals work as a team to plan appropriate services based on the unique needs of the child and family.

Providers are required, under Federal and State law, to:

- Screen/ identify Members under age of three suspected of having a developmental delay or disability, or who are at risk of delay and
- Refer them to the Texas Early Childhood Intervention program for assessment and evaluation within ***two*** (2) business days from the day the provider identifies the member(s).
- Using materials from Department of Assistive and Rehabilitative Services (DARS) available on: http://www.dars.State.tx.us/ecis/index.shtml
- With parent's consent, participate in the development and implementation of the Individual Family Service Plan (IFSP) including the provision of services and diagnostic procedures necessary to develop and carry out the plan.
- Complying with the release of records within 45 days so that screening may be completed.

Early identification will facilitate the development of an effective treatment plan that may prevent or reduce a disability that may last a lifetime.

Who should be referred to ECI?
Families with children between the ages of 0 – 35 months, with a disability or suspected delays in development should be referred to the ECI DARS Inquiries Line 1-800-628-5115.

Comprehensive Care Program (CCP)

Comprehensive Care Program (CCP) is Texas' name for the expanded portion of Texas Health Steps. CCP covers services for children birth through 20 years old that are not usually allowed or are more limited under Medicaid for the adult population. CCP is a result of a Congressional mandate that took effect in 1990.

Federal changes made in the Omnibus Reconciliation Act of 1989 (OBRA 89) expanded Medicaid services and Texas Health Steps in particular. Under OBRA 89, children 20 years old and younger are eligible for any medically necessary and appropriate health care service that is covered by Medicaid, regardless of the limitations of the state's Medicaid Program. Texas Health Steps-CCP services include benefits which were not available to children before OBRA 89, such as:

- Treatment in freestanding psychiatric hospitals
- Developmental speech therapy
- Developmental occupational therapy
- Augmentative Communication Devices/Systems
- Private Duty Nursing

These services do not require prior authorization from Molina.

Emergency Prescription Supply (STAR, STAR+PLUS, & CHIP)

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.

Additional Benefits to STAR+PLUS Members

STAR+PLUS members receive all the benefits of the traditional Texas Medicaid program; Effective December 1, 2009, Molina is responsible for paying providers for the Behavioral Health Inpatient Services in the Harris and Bexar Service Delivery Area. The provider must bill Molina Healthcare for Inpatient Behavioral Health Services. Additional benefits obtained through the STAR+PLUS program are:

Unlimited medically necessary prescription drugs for STAR+PLUS Medicaid-only members
Value-Added Services
Long-Term Care Covered Services

Medicaid Program Limitations and Exclusions (STAR & STAR+PLUS)

Molina Healthcare 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
- Educational 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 and STAR+PLUS Only

In the traditional Medicaid program, the Spell of Illness Limitation is defined as 30 days of inpatient Hospital care, which may accrue intermittently or consecutively. After 30 days of an inpatient care admission, reimbursement for additional inpatient care is not considered until the patient has been out of an acute facility for 60 consecutive days. The spell of illness limitation does not apply for STAR and STAR+PLUS members.

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

Long Term Support Services

- Personal Assistant Services (PAS): provides in-home assistance to individuals as authorized on his/her individual service plan with the performance of activities of daily living, household chores, and nursing tasks that have been delegated by a registered nurse (RN).
- Day Activity and Health Services (DAHS): include nursing and personal care services, physical rehabilitative services, nutrition services, transportation services, and other supportive services. These services are given by facilities licensed by the Department of Aging and Disability Services (DADS). • 1915(c) Waiver Services for those members qualified for 1915(c) services:
    - Adaptive aids and medical supplies: include devices, controls, or medically necessary supplies that enable individuals with functional impairments to perform activities of daily living or control the environment in which they live.
    - Adult Foster Care (AFC): provides a 24-hour living arrangement in a Department of Aging and Disability Services (DADS) contracted foster home for persons who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, minimal help with personal care, help with activities of daily living and provision of or arrangement for transportation. The unit of service is one day.
    - Assisted living and Residential Care (AL/RC) services: a 24-hour living arrangement in licensed personal care facilities in which personal care, home management, escort, social and recreational activities, twenty-four hour supervision, supervision of, assistance with, and direct administration of medications, and the provision or arrangement of transportation is provided. Under the 1915 (c) waiver, personal care facilities may contract to provide services in three distinct types of living arrangements: assisted living apartments, residential care apartments, or residential care non-apartment settings.

- Emergency Response Services (ERS): are provided through an electronic monitoring system for use by functionally impaired individuals who live along or are isolated in the community. In an emergency, the individual can press a call button to signal for help. The electronic monitoring system, which has a 24-hour seven-day-a-week monitoring capability, helps insure that the appropriate person or service agency responds to an alarm call from the individual.
- Home delivered meals: Meal services provide hot, nutritious meals served in an individual's home. The benefit limitation is one meal per day, and the need for a home delivered meal must be part of the individual service plan (ISP). Home delivered meals will be provided to individuals who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet individual requirements. Menu plans will be reviewed and approved by a registered dietician licensed by the Texas State Board of Examiners of Dietitians or has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management. Any agency providing home delivered meals must comply with all state and local health laws and ordinances concerning preparation, handling and serving of food.
- In-home skilled nursing care: includes, but is not limited to, the assessment and evaluation of health problems and the direct delivery of nursing tasks, providing treatments and health care procedures ordered by a physician and/or required by standards of professional practice or state law, delegation of nursing tasks to unlicensed persons according to state rules promulgated by the Texas Board of Nurse Examiners, developing the health care plan, and teaching individuals about proper health maintenance.
- Minor home modifications: services that assess the need for, arrange for, and provide modifications and/or improvements to an individual's residence to enable them to reside in the community and to ensure safety, security, and accessibility.
- Respite care services: temporary relief to persons caring for functionally impaired adults in community settings other than AFC homes or AL/RC facilities. Respite services are provided on an in-home and out-of- home basis and are limited to 30 days per ISP year. Room and board is included in the waiver payment for out-of-home settings.

- Therapy (occupational, physical, speech): includes the evaluation, examination and treatment of physical, functional, speech and hearing disorders or limitations. The full range of activities provided by an occupational or physical therapist, speech or language pathologist, or a licensed occupational or physical therapy assistant under the direction of a licensed occupational or physical therapist, within the scope of his/her state licensure are covered LTSS services.
- Transitional Assistance Services (TAS): assists individuals who are nursing facility residents to discharge to the community and set up household. A maximum of $2500 is available on a one-time basis to help defray the costs associated with setting up a household. TAS include, but are not limited to, payment of security deposits to lease an apartment, purchase of essential furnishings (table, eating utensils), payment of moving expenses, etc.

*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 located at www.dads.state.tx.us.

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 and CHIP Perinate 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.

CHIP Covered Services

Type of Benefit	Description of Benefit
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Medically necessary 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 • 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.

Type of Benefit	Description of Benefit
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	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: • 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.

Type of Benefit	Description of Benefit
Physician/Physician Extender Professional Services	Medically necessary 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 • 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.

Type of Benefit	Description of Benefit
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	• $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: • 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
Home and Community Health Services	Medically necessary services are provided in the home and community and include, but are not limited to: • 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. 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.

Type of Benefit	Description of Benefit
Inpatient Mental Health Services	• 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 45 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. • 25 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 • 20 of the inpatient days must be held in reserve for inpatient use only • Does not require PCP referral. • Neuropsychological and psychological testing is covered.

Type of Benefit	Description of Benefit
Outpatient Mental Health Services	• 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. • Up to 60 outpatient visits per 12-month period (first 30 visits do not require PA) • Medication management visits do not count against the outpatient visit limit. • The 60 outpatient visits can be converted to skills training (psycho educational skills development) or rehabilitative day treatment based on financial equivalence. • Up to 60 days per 12 month period for rehabilitative day treatment. • The 60 rehabilitative day treatment days can be converted to outpatient visits based on financial equivalence. • Inpatient days converted to outpatient services are in addition to the outpatient limits and do not count towards these limits. • Neuropsychological and psychological testing is covered. • Does not require PCP referral.
Inpatient Substance Abuse Treatment Services	• Medically necessary services include, but are not limited to, inpatient and residential substance abuse treatment services including detoxification and crisis stabilization (up to 14 days per 12 month period), and 24-hour residential rehabilitation programs(up to 60 days per 12 month period). • 30 days of residential rehab may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost. • 30 days must be held in reserve for residential rehab use only. • Does not require PCP referral.

Type of Benefit	Description of Benefit
Outpatient Substance Abuse Treatment Services	• 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. • Outpatient treatment is defined as consisting of at least 1 – 2 hours per week of structured group and individual therapy, educational services and life skills training • Outpatient treatment services are covered up to 6 months per 12 month period • Intensive outpatient services are defined as organized non-residential services providing structured group and individual therapy, educational services and life skills training that consists of at least 10 hours per week for 4 to 12 weeks but less than 24 hours per day. • Intensive outpatient services are covered up to 12 weeks per 12 month period. • Does not require PCP referral.
Rehabilitation Services	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: • Physical, occupational and speech therapy • Developmental assessment
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	• Health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Medically necessary covered services include: • 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

Type of Benefit	Description of Benefit
Transplants	Medically necessary services include: • 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.

In addition to covered benefits, Molina offers value added services to its Members. Please refer to the Member Handbook on www.molinahealthcare.com for more information on value added benefits.

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.
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	

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
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 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.
Enternal Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
			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	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: • Identification of a metabolic disorder, dysphasia 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 Does not include formula: • 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 daily caloric intake from this product)

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
			• 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. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
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.

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
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.
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.
Perinatal Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Perinatal 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.

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
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.

In addition to covered benefits, Molina offers value added services to its Members. Please refer to the Member Handbook on

http://www.molinahealthcare.com/MEDICAID/MEMBERS/TX/HANDBOOK for more information on value added benefits.

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

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

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
Inpatient General Acute and Inpatient Rehab 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	Facility charges are not a covered benefit for the initial Perinate Newborn admission. • However, facility charges are a covered benefit after the initial Perinate Newborn admission. "Initial Perinate Newborn Admission" means the hospitalization associated with the birth: • 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-

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	• 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 caesarian section. • Hospital, physician and related medical services, such as anesthesia associated with dental care • Surgical implants • Other artificial aids including surgical implants • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12 month period limit	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 caesarian section. • Hospital, physician and related medical services, such as anesthesia, associated with dental care • Surgical implant • Other artificial aids

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
		including surgical implants • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit
Skilled Nursing Facilities (Includes Rehab 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	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 Rehab 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, dressings • Preventive health services • Physical, occupational	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, dressings • Preventive health services • Physical, occupational

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	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 • 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 • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12 month period limit	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 • 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 • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12 month period limit
Physician/PE/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,	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,

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	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 • Invasive diagnostic procedures such as endoscopic examinations • Hospital-based Physician services (including Physician-performed technical and interpretive 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	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 • Invasive diagnostic procedures such as endoscopic examinations • Hospital-based Physician services (including Physician-performed technical and interpretive 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

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	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	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
Prenatal Care and Pre-pregnancy Family Service and Supplies	• Not a Covered Benefit	• Not a Covered Benefit
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 • Prosthetic devices such as artificial eyes, limbs, and braces • Prosthetic eyeglasses and contact lenses for the management of	$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 • Prosthetic devices such as artificial eyes, limbs, and braces • Prosthetic eyeglasses and contact lenses for the management of

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	severe ophthalmologic disease • Other artificial aids including surgical implants • Hearing aids • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.	severe ophthalmologic disease • Other artificial aids including surgical implants • Hearing aids • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. • 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	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

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	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	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 • Inpatient mental health services are limited to: • 45 days, 12-month inpatient limit • Includes inpatient psychiatric services, up to 12-month period 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. 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. • 25 days of the	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 • Inpatient mental health services are limited to: • 45 days, 12-month inpatient limit • Includes inpatient psychiatric services, up to 12-month period 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. 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. • 25 days of the

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	inpatient benefit can be converted to residential treatment, therapeutic foster care or 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. • 20 of the inpatient days must be held in reserve for inpatient use only. • Does not require PCP referral.	inpatient benefit can be converted to residential treatment, therapeutic foster care or 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. • 20 of the inpatient days must be held in reserve for inpatient use only. • Does not require PCP referral.
Outpatient Mental Health Services	Mental health services, including serious mental illness, provided on an outpatient basis, including, but not limited to: • Medication management visits do not count against the outpatient visit limit. • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility • Up to 60 days, 12-month period limit for rehabilitative day treatment • 60 outpatient visits, 12-month period limit • 60 rehabilitative day treatment days can be	Mental health services, including serious mental illness, provided on an outpatient basis, including, but not limited to: • Medication management visits do not count against the outpatient visit limit. • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility • Up to 60 days, 12-month period limit for rehabilitative day treatment • 60 outpatient visits, 12-month period limit • 60 rehabilitative day treatment days can be

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost • 60 outpatient visits can be converted to skills training (psycho educational skills development) or rehabilitative day treatment on the basis of financial equivalence against the outpatient visit cost • Includes outpatient psychiatric services, up to 12-month period 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. Court order serves as binding determination of medical necessity. Any modification or termination of services must b presented to the court with jurisdiction over the matter for determination • Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards those limits • A Qualified Mental Health Professional (QMHP), as defined	converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost • 60 outpatient visits can be converted to skills training (psycho educational skills development) or rehabilitative day treatment on the basis of financial equivalence against the outpatient visit cost • Includes outpatient psychiatric services, up to 12-month period 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. Court order serves as binding determination of medical necessity. Any modification or termination of services must b presented to the court with jurisdiction over the matter for determination • Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards those limits • A Qualified Mental Health Professional (QMHP), as defined

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	by and credentialed through Texas Department of State Health Services (DSHS) standards (TAC Title 25, Part II, Chapter 412), is a Local Mental Health Authorities provider. A QMHP must be working under the authority of a DSHS entity and be supervised by a licensed mental health professional or physician. QMHPs are acceptable providers as long as the services would be within the scope of the services that are typically provided by QMHPs. 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	by and credentialed through Texas Department of State Health Services (DSHS) standards (TAC Title 25, Part II, Chapter 412), is a Local Mental Health Authorities provider. A QMHP must be working under the authority of a DSHS entity and be supervised by a licensed mental health professional or physician. QMHPs are acceptable providers as long as the services would be within the scope of the services that are typically provided by QMHPs. 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 • 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 • Does not require PCP referral • Medically necessary

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	detoxification/stabilization services, limited to 14 days per 12-month period • 24-hour residential rehabilitation programs, or the equivalent, up to 60 days per 12-month period • 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost • 30 days must be held in reserve for inpatient use only	detoxification/stabilization services, limited to 14 days per 12-month period • 24-hour residential rehabilitation programs, or the equivalent, up to 60 days per 12-month period • 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost • 30 days must be held in reserve for inpatient use only
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 is defined as an organized non-residential 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 24 hours per day • Outpatient treatment service is defined as consisting of at least	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 is defined as an organized non-residential 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 24 hours per day • Outpatient treatment service is defined as consisting of at least

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	one to two hours per week providing structured group and individual therapy, educational services, and life skills training • Outpatient treatment services up to a maximum of: • Intensive outpatient program (up to 12 weeks per 12-month period) • Outpatient services (up to six-months per 12-month period) • Does not require PCP referral	one to two hours per week providing structured group and individual therapy, educational services, and life skills training • Outpatient treatment services up to a maximum of: • Intensive outpatient program (up to 12 weeks per 12-month period) • Outpatient services (up to six-months per 12-month period) • Does not require PCP referral
Rehab 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	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 for	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 for

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	unrelated conditions is unaffected • Up to a maximum of 120 days with a 6 month life expectancy • Patients electing hospice services waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime • Services apply to the hospice diagnosis	unrelated conditions is unaffected • Up to a maximum of 120 days with a 6 month life expectancy • Patients electing hospice services waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime • Services apply to the hospice diagnosis
ER, 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 I and Level II trauma centers of hospitals meeting equivalent levels of care for emergency 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 I and Level II trauma centers of hospitals meeting equivalent levels of care for emergency services

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	• Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	• Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts
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.	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 pair of non-prosthetic eyewear per 12-month period	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 pair of non-prosthetic eyewear per 12-month period
Chiro. Services	Services do not require physician prescription and are limited to spinal subluxation	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	• Covered up to $100 for a 12-month period limit for a plan approved program • Health Plan defines plan approved program

Type of Benefit	CHIP Perinate Newborn 186% to 200%	CHIP Perinate Newborn below 185%
	• May be subject to formulary requirements	• May be subject to formulary requirements
Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination and community referral.	These services include outreach informing, case management, care coordination and community referral.

CHIP Perinate Newborn 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.
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	

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
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 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.
Enternal 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.

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	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: • Identification of a metabolic disorder, dysphasia 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 Does not include formula: • 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 daily caloric intake from this product) • 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. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
			of whether these regular food products are taken orally or parenterally.
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.
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,

SUPPLIES	COVERED	EXCLUDED	COMMENTS//MEMBER CONTRACT PROVISIONS
			and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Perinatal Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Perinatal 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 Perinate Newborn Exclusions from Covered Services (this list is not all inclusive)

- For CHIP Perinate Newborns in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit for the initial Perinate Newborn admission. "Initial Perinate Newborn admission" means the hospitalization associated with the birth.
- 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

Definitions

CHIP Children's Health Insurance Program

CHIP Perinatal Eligibility Period The continuous eligibility period is a 12-month period that begins when the unborn child is enrolled in the CHIP Perinatal Program and continues after the child is born. (Month of enrollment + 11 months).

CHIP Perinate Program Means the State of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn Members. Although the CHIP Perinatal Program is part of the CHIP Program, for Contract administration purposes it is identified independently in this Contract. An HMO must specifically contract with HHSC as a CHIP Perinatal HMO in order to participate in this part of the CHIP Program.

CHIP Perinate A CHIP Perinatal Program member identified prior to birth

CHIP Perinate Member The Mother of the UNBORN CHIP Perinate Newborn who is eligible to receive Medically Necessary Covered Services related to antepartum care, labor and delivery services and two post partum visits.

CHIP Perinate Newborn Means a CHIP Perinate who has been born alive.

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

Type of Benefit	CHIP Perinate 186% to 200%	CHIP Perinate below 185%
Inpatient General Acute and Inpatient Rehab Hospital Services	Benefits are limited to professional service charges and facility charges associated with labor and delivery. 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.	The facility charges are <u>not</u> a covered benefit however professional service charges associated with delivery are a covered benefit.
Skilled Nursing Facilities (Includes Rehab Hospitals)	Not a Covered Service	Not a Covered Service.
Outpatient Hospital, Comprehensive Outpatient Rehab 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. (1) Laboratory and radiological services are limited to services	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. (1) Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the

Type of Benefit	CHIP Perinate 186% to 200%	CHIP Perinate below 185%
	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, or gestational age confirmation. (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,	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, or gestational age confirmation. (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

Type of Benefit	CHIP Perinate 186% to 200%	CHIP Perinate below 185%
	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.	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.
Physician/PE/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, inpatient 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 • 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	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, inpatient 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 • 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

Type of Benefit	CHIP Perinate 186% to 200%	CHIP Perinate below 185%
	anesthesia by Physician (other than surgeon) or - Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. • 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, Cordocentesis, and FIUT.	- Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. • 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, Cordocentesis, and FIUT.
Prenatal Care and Pre-pregnancy Family Service and Supplies	Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: • One visit every four weeks for the first 28 weeks of pregnancy; • One visit every two to three weeks from 28 to 36 weeks of pregnancy; and • One visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to:	Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: • One visit every four weeks for the first 28 weeks of pregnancy; • One visit every two to three weeks from 28 to 36 weeks of pregnancy; and • 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

Type of Benefit	CHIP Perinate 186% to 200%	CHIP Perinate below 185%
	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.	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.
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	Not a Covered Benefit	Not a Covered Benefit
Home and Community Health Services	Not a Covered Benefit	Not a Covered Benefit
Inpatient Mental Health Services	Not a Covered Benefit	Not a Covered Benefit.
Outpatient Mental Health Services	Not a Covered Benefit	Not a Covered Benefit
Inpatient Substance Abuse Treatment Services	Not a Covered Benefit	Not a Covered Benefit
Outpatient Substance Abuse Treatment Services	Not a Covered Benefit	Not a Covered Benefit
Rehab Services	Not a Covered Benefit	Not a Covered Benefit
Hospice Care Services	Not a Covered Benefit	Not a Covered Benefit.
ER, including Emergency Hospitals, Physicians, and Ambulance Services	HMO 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	HMO 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

Type of Benefit	CHIP Perinate 186% to 200%	CHIP Perinate below 185%
	until birth. • Emergency services based on prudent lay person 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	birth. • Emergency services based on prudent lay person 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
Transplants	Not a Covered Benefit	Not a Covered Benefit
Vision Benefit	Not a Covered Benefit	Not a Covered Benefit
Chiropractic Services	Not a Covered Benefit	Not a Covered Benefit
Tobacco Cessation Program	Not a Covered Benefit	Not a Covered Benefit.
Case Management and Care Coordination Services	Covered Benefit	Covered Benefit

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

- For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit for 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, and
- postpartum care related to the covered unborn child until birth.
- Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
- 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 services.
- 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 the labor or threatened labor 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 post partum 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.
- 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
- 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
- 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
- Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
- Charges incurred as a donor of an organ

Chapter 3
Claims and Billing

(Billing, Claims, and Encounter Data Administration)

As a contracted provider, it is important to understand how the claims process works to avoid delays in the processing of your claims.

A. Claims and Encounter Data Guidelines

Paper Claims and Encounter Data Guidelines

Non-electronic claims must be submitted to Molina on a CMS 1500 or UB-04 claim form that is legible and accurate within ninety-five (95) days of the date of service. Molina is also able to accept the UB92. Non-electronic claims that meet the requirements of a clean claim as defined in Title 28 of the Texas Administrative Code Chapter 21 Subchapter T will be paid or denied within thirty (30) days of receipt. Claims that do not meet the clean claim requirements will still be paid or denied in a timely manner where possible, but Molina will not be liable for any late payment penalties on claims that do not meet the requirements of a clean claim.

Non-electronic claims should be mailed to:

Molina Healthcare
Attn: Claims
PO Box: 22719
Long Beach, CA 90801

Electronic Claims Submission Guidelines

Electronic claims must be submitted to Molina using the Professional 837 format within 95 days of the date of service. Electronic claims that meet the clean claim requirements as defined in Title 28 Texas Administrative Code Chapter 21 Subchapter T will be paid or denied within thirty (30) days of receipt. Molina shall pay Network Providers interest at a rate of 1.5% per month (18% per annum) on all clean claims that are not paid within 30 days. Claims that do not meet the requirements of a clean claim will still be paid or denied in a timely manner where possible, but Molina will not be liable for any late-payment penalties on claims that do not meet the requirements of a clean claim.

Molina shall pay or deny Network Pharmacies submitting electronic claims that meet the clean claim requirements as defined in Title 28 Texas Administrative Code Chapter 21 Subchapter T within eighteen (18) days of receipt.

Electronic claims can be sent to Molina via: www.molinahealthcare.com
Additionally, Molina's accepts electronic claims through most major claims clearinghouses. Providers submitting claims electronically should use Payor ID 20554.

It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When your claims are filed electronically:

A. You should receive an acknowledgement from your current clearinghouse
B. You should receive an acknowledgement from WebMD within five to seven business days of your transmission
C. You should contact your local clearinghouse representative if you experience any problems with your transmission

Note: Molina will notify Network Providers in writing of any changes in the list of claims processing or adjudication entities at least thirty (30) days prior to the effective date of change. If Molina is unable to provide at least thirty (30) days notice, the Molina will give Network Providers a 30-day extension on their claims filing deadline to ensure claims are routed to correct processing centers.

Coordination of Benefits and Third Party Claims

The following information pertains to COB/TPA billed claims:

Molina is secondary to all private insurance. Private insurance carriers and Medicare or medical groups/IPAs must be billed prior to billing Molina. The Provider must include a copy of the other insurance's explanation of benefits (EOB) with the claim. Molina will pay the difference between payment made by the primary insurance carrier and Molina's maximum contracted allowable rate. If the primary insurance paid more than Molina's maximum contracted allowable rate the claim will pay zero.

Molina will pay claims for covered services when probable TPL/COB has not been established or third party benefits are not available to pay a claim. Molina will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL/COB collections on behalf of Members for audit and review.

Physicians and Non-Institutional Providers

Requirements for a Clean Claim

A clean claim relating to physicians or non-institutional providers is comprised of the following (Included are the appropriate CMS references to specific fields):

1. Subscriber's/patient's plan ID number (CMS 1500, field 1a)
2. Patient's name (CMS 1500, field 2)
3. Patient's date of birth and gender (CMS 1500, field 3)
4. Subscriber's name (CMS 1500, field 4) is required, if shown on the patient's ID card
5. Patient' address (street or P.O. Box, city, state, zip) (CMS 1500, field 5) is required
6. Patient's relationship to subscriber (CMS 1500, field 6)
7. Subscriber's address (street or P.O. Box, city, state, zip) (CMS 1500, field 7) required but physician or provider may enter "same" if the subscriber's address is the same as the patient's address required by requirement "E"
8. Subscriber's policy number (CMS 1500, field 11)
9. HMO or insurance company name (CMS 1500, field 11c)
10. Disclosure of any other health benefit plans (11d)
11. Patients or authorized person's signature or notation that the signature is on file with the physician or provider (CMS 1500, field 12)
12. Subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (CMS 1500 field 13)
13. Date of injury (CMS 1500, field 14) is required, if due to an accident
14. Name of referring physician or other source (CMS 1500, field 17) is required for primary care physicians, specially physicians and hospitals; however, if there is no referral, the physician or provider shall enter "Self-referral" or "None".
15. I.D. Number of referring physician (CMS 1500 field 17a) is required for primary care physicians, specialty physicians and hospitals; however, if there is no referral, the physician or provider shall enter "Self-referral" or "None".
16. Narrative description of procedure (CMS 1500, field 19) is required when a physician or provider uses an unlisted or not classified procedure code or an NDC code for drugs.
17. For diagnosis codes or nature of illness or injury (CMS 1500, field 21), up to four diagnosis codes may be entered, but at least one is required (Primary diagnosis must be entered first);
18. Verification number (CMS 1500, field 23), is required if services have been verified. If no verification has been provided, a prior authorization number (CMS 1500, field 23), is required when prior authorization is required and granted;
19. Date(s) of service (CMS 1500, field 24A)
20. Place of service codes (CMS 1500, field 24B)
21. Procedure/modifier code (CMS 1500, field 24 D)
22. Diagnosis code by specific service (CMS 1500, field 24E) is required with the first code linked to the applicable diagnosis code for that service in field 21
23. Charge for each listed service (CMS 1500, field 24F)

24. Number of days or units (CMS 1500, field 24G)
25. Rendering physician's or provider's Medicaid TPI number (Note for CHIP only provider-federal tax ID number) (CMS 1500, field 24, 12-90 version). For CMS 1500 08-05 version, rendering physician's or provider's NPI number in field 24J.
26. Whether assignment was accepted (CMS 1500, field 27), is required if assignment under Medicare has been accepted.
27. Total charge (CMS 1500, field 28)
28. Amount paid, (CMS 1500, field 29), is required if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber.
29. Signature of physician or provider or notation that the signature is on file with the HMO or preferred provider carrier (CMS 1500, field 31)
30. Name and address of facility where services rendered (if other than home or office) (CMS 1500, field 32,)
31. Physician's or provider's billing name, address and telephone number is required, and the provider number (CMS 1500, field 33, 12-90 version) is required if the HMO or preferred provider carrier required provider numbers and gave notice of that requirement to physicians and providers prior to June 17, 2003. For CMS 1500 08-05 version, physician's or provider's **billing** NPI number should be in field 33a.

Per the NUCC (National Uniform Claim Committee) the rendering provider NPI should be submitted in box 24J and the billing provider NPI in box 33A on the paper claim. Below is information regarding the appropriate fields for the rendering and billing provider NPIs. Please work with your billing representative to ensure that NPIs are correctly populated on electronic and paper claims. This will allow Molina to submit accurate claims data to the state agency per state requirements.

Required NPI Fields

CMS-1500	Field Location	Required
Referring Provider	Box 17b	Requested*
Rendering Provider	Box 24j	**Required**
Facility	Box 32a	Requested*
Billing Provider	Box 33a	**Required**
LTSS Provider Only	Box 33b	**Required**

Institutional Providers

Claims must be submitted on UB-04 form.

Requirements for a Clean Claim

Required data elements for institutional providers are listed as follows:

1. Provider's name, address and telephone number (UB-04, field 1)
2. Pay to Provider's name, address and telephone number (UB-04, field 2) Optional, use if pay to address is different from address in field 1.
3. Patient control number (UB-04, field 3)
4. Type of bill code (UB-04, field 4) is required and shall include a "7" in the third position if the claim is a corrected claim.
5. Provider's federal tax ID number (UB-04, field 5)
6. Statement period (beginning and ending date of claim period) (UB-04, field 6)
7. Covered days (UB-04, field 7), is required if Medicare is a primary or secondary payor
8. Patient's name (UB-04, field 8)
9. Patient's address (UB-04, field 9)
10. Patient's date of birth (UB-04, field 10)
11. Patient's gender (UB-04, field 11)
12. Date of admission (UB-04, field 12) is required for admissions, observation stays, and emergency room care
13. Admission hour (UB-04, field 13) is required for admissions, observation stays, and emergency room care
14. Type of admission (e.g., emergency, urgent, elective, newborn) (UB-04, field 14)
15. Source of admission code (UB-04, field 15)
16. Discharge hour (UB-04, field 16), required for admissions, outpatient surgeries or observation stays
17. Patient-status-at-discharge code (UB-04, field 17) is required for admissions, observation stays, and emergency room care
18. Condition codes (UB-04, fields 18-28), required if appropriate
19. Occurrence codes and all dates (UB-04, fields 31-34) required if appropriate
20. Occurrence span codes, from and through dates (UB-04, fields 35-36) required if appropriate
21. Value code and amounts (UB-04, field 39-41) required for inpatient admissions, If no value codes are applicable to the inpatient admission, the provider may enter value code 01
22. Revenue code (UB-04, field 42)
23. Revenue description (UB-04, field 43)
24. HCPCS/Rates (UB-04, field 44) required if Medicare is a primary or secondary payor
25. Service date (UB-04, field 45) required if the claim is for outpatient services
26. Units of service (UB-04, field 46)
27. Total charge (UB-04, field 47) not applicable for electronic billing
28. Non-Covered charge (UB-04, field 48) required if information is available and applicable

29. Payor identification (UB-04, field 50)
30. Health Plan identifier number (UB-04, field 51) required
31. Release of information indicator (UB-04, field 52) required.
32. Prior payments-payor and patient (UB-04, field 54) required if payments have been made to the physician or provider by the patient or another payor or subscriber, on behalf of the patient or subscriber.
33. Billing provider name and identifiers, including NPI (UB-04, field 56) required on all claims.
34. Other Provider ID (UB-04, field 57) Required, Texas providers should include their TPI in this field.
35. Insured's name (UB-04, field 58) is required if shown on the patient's ID card
36. Patient's relationship to insured (UB-04, field 59)
37. Insured's unique ID number (UB-04, field 60), required, shown on patient's ID card.
38. Insurance Group Name (UB-04, field 61) required if shown on patient's ID card.
39. Insurance group number (UB-04, field 62), required if shown on patient's ID card
40. Treatment authorization codes (UB-04, field 63) required if services have been authorized.
41. Diagnosis and procedure code qualifier (UB-04, field 66)
42. Principle diagnosis code (UB-04, field 67) Required on all claims
43. Diagnoses codes other than principal diagnosis code (UB-04, field 67A-Q), are required if there are diagnoses codes other than principal diagnosis.
44. Admitting diagnosis code (UB-04, field 69)
45. Patient's reason for visit (UB-04, field 70), required for unscheduled outpatient visits
46. Principal procedure code (UB-04, field 74) required if the patient has undergone an inpatient or outpatient surgical procedure
47. Other procedure codes (UB-04, fields 74A-E), are required as an extension of "46" if additional surgical procedures were performed
48. Attending physician name and identifiers, including NPI (UB-04, field 76) Required on all claims
49. Operating Physician name and identifier, including NPI (UB-04, field 77) Required only when surgical procedure on claim
50. Other providers name and identifiers, including NPI (UB-04, fields 78-79) Requested if information is available

UB-04

Molina began accepting the new UB-04 on March 1, 2007. We are accepting institutional claims filed by facilities such as hospitals, skilled nursing facilities, hospices, and others, using either the UB92 or UB04. The new UB04 claim form may be obtained from the National Uniform Billing Committee web site at www.nubc.org.

Information regarding the revised form may also be found on the CMS website: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf.

Molina Required/Requested NPI Fields

UB04	Field Location	
Billing Provider	Box 56	**Required**
Attending Provider	Box 76	Requested*
Operating Provider	Box 77	Requested*
Other Provider	Boxes 78 & 79	Requested*

Emergency Services Claims

If the claim is for emergency service(s), no authorization is required. If Molina has reasonable grounds for suspecting fraud, misrepresentation or unfair billing practices, then additional information from the provider may be requested.

Claims Codes

Providers must use good faith effort to bill Molina Healthcare for services with the most current coding (ICD-9, CPT, HCPCS etc.) available. These current claims, coding and processing guidelines will be available upon request to contracted, Molina network providers. The following information must be included on every claim:

A. Member name, date of birth and ID number or PIC number
B. Date(s) of service
C. ICD-9 diagnosis and procedure codes
D. Revenue, CPT or HCPCS code for service or item provided
E. Billed charges for service provided
F. Place and type of service code
G. Days or units, as applicable
H. Provider tax identification and NPI number
I. Provider name and address

Billing Members

Providers are not allowed to bill Molina Members for any amounts billed but not paid by Molina. It is important to note that there are no co-pays for Medicaid managed care members.

Member Acknowledgement Statement

The provider may bill the client only if:

• A specific service or item is provided at the client's request.

•The provider has obtained and kept a written Client Acknowledgment Statement signed by the client that states:

•"I understand that, in the opinion of (*provider's name*), the services or items that I have requested to be provided to me on (*dates of service*) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

•"Comprendo que, segun la opinion del (*nombre del proveedor*), es posible que Medicaid no cubra los servicios o las provisiones que solicite (*fecha del servicio*) por no considerarlos razonables ni medicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad medica de los servicios o de las provisiones que el cliente solicite o reciba. Tambien comprendo que tengo la responsibilidad de pagar los servicios o provisiones que solicite y que reciba si despues se determina que esos servicios y provisiones no son razonables ni medicamente necesarios para mi salud."

Private Pay Agreement

A provider may bill the following to a Member without obtaining a signed Member Acknowledgment Statement:

- Any service that is not a benefit under Molina's Program (for example, personal care items).
- The provider accepts the Member as a private pay patient. Providers must advise Members that they are accepted as private pay patients at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the Member signs written notification so there is no question how the Member was accepted. Without written, signed documentation that the Medicaid Member has been properly notified of the private pay status, the provider does not seek payment from an eligible Medicaid Member.
- All services incurred on noncovered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered days. Spell of illness limitations do not apply to medically necessary stays for THSteps clients birth through 20 years of age.
- The reduction in payment that is because of the medically needy spend down MNP is limited to children 18 years of age or younger and pregnant women. The client's potential liability would be equal to the amount of total charges applied to the spend down. Charges to clients for services provided on ineligible days must not exceed the charges applied to spend down.
- The provider accepts the Member as a private pay patient. Providers must advise Members that they are accepted as private pay patients at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the Member signs written notification so there is no question how the Member was accepted. Without written, signed documentation that the Medicaid Member has been properly notified of the private pay status, the provider does not seek payment from an eligible Medicaid Member.

- The Member is accepted as a private pay patient pending Medicaid eligibility determination and does not become eligible for Medicaid retroactively. The provider is allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactively, the Member notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the Member becomes eligible, the provider must refund any money paid by the Member and file Medicaid claims for all services rendered.

A provider attempting to bill or recover money from a Member in violation of the above conditions may be subject to exclusion from Molina. In accordance with current federal policy, Members cannot be charged for the Member's failure to keep an appointment. Only billings for services provided are considered for payment. Members may not be billed for the completion of a claim form, even if it is a provider's office policy.

Private Pay Form Agreement

A private pay form agreement allows for a reduction in payment by a provider to a Member due to a medically needy spend down (effective September 1, 2003, the MNP is limited to children younger than age 19 years and pregnant women). If a provider accepts a Member as a private pay patient, the Provider must advise Members that they are accepted as private pay patients at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the Member signs written notification so there is no question how the Member was accepted. Without written, signed documentation that the Medicaid Member has been properly notified of the private pay status, the provider does not seek payment from an eligible Medicaid Member.

There are instances in which the Member is accepted as a private pay patient and a provider may bill a member. This is acceptable, if the provider accepts the patient and informs the member at the time of service that they will be responsible for paying for all services. In this situation, it is recommended that the provider use a Private Pay Form. The provider is allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactively, the Member notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the Member becomes eligible, the provider must refund any money paid by the Member and file Medicaid claims for all services rendered.

SAMPLE

Member Acknowledgment Statement

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

"Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicaid no cubra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que Molina Healthcare o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el miembro solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

_____

Member Signature **Date**

Special Billing

Newborns

The following name conventions are to be used for newborns:

- If the mother's name is "Jane Jones," use "Boy Jane Jones" for a male child and "Girl Jane Jones" for a female child.
- Enter "Boy Jane" or "Girl Jane" in first name field and "Jones" in last name field. Always use "boy" or "girl" first and then the mother's full name. An exact match must be submitted for the claim to process.
- ***Do not*** use "NBM" for newborn male or "NBF" for newborn female.

Claims Review and Audit

Provider acknowledges Molina's right to review Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current Uniform Billing manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices.

Provider acknowledges Molina's right to conduct such review and audit on a line-by-line basis or on such other basis as Molina deems appropriate, and Molina's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Molina's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider shall cooperate with Molina's audits of claims and payments by providing access to requested claim information, all supporting medical records, Provider's charging policies, and other related data. Molina shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding and payment.

Partially Payable Claims

If Molina believes a claim is only partially payable, the non-disputed sections shall be paid and notification to the physician or provider in writing as to why a disputed section shall not be paid is sent.

If additional information is needed in order to process a claim Molina shall request in writing no later than fifteen (15) days after receipt of claim that the physician or provider attach the information necessary. After receipt of the requested information, Molina shall reply within fifteen (15) days as to whether the claim is then payable.

If Molina audits a submitted claim Molina must pay 100 percent of a claim, within thirty (30) days, subject to the audit. Molina must complete the audit within 180 days after a clean claim is received, and any refund due to Molina shall be made no later than thirty (30) days after the competed audit.

Changes to Claims Guidelines

Molina will provide all Network Providers at least ninety (90) days notice prior to implementing a change in claim guidelines, unless the change is required by statute or regulation in a shorter timeframe.

Claims Questions, Re-Consideration and Appeals

Additional details regarding the process and timelines to appeal claim payments can be found in the "Complaints and Appeals" Chapter of this manual.

If a provider has a question or is not satisfied with the information or payment they have received related to a claim, they should contact Customer Services at 1-866-449-6849.

How to file a claims determination appeal:

An appeal must be filed in writing. If you do not agree with the claims determination, then:

- Submit a written letter of appeal detailing the reason for appeal along with supporting documentation within 120 days of your original claims determination.
- Mail or Fax your appeal to:

MOLINA
Fax: 1-877-319-6852
Write to: Molina Healthcare Attn: Appeals 15115 Park Row Blvd, Ste 110 Houston, TX 77084

CHIP Cost Sharing Schedule

CHIP Cost Sharing Schedule:

Above 150% up to and including 185% of the FPL*	
Office Visit	**$12**
Non-Emergency ER	**$50**
Generic Drug	**$8**
Brand Drug	**$25**
Cost-sharing Cap	**2.5% of family's income****
Facility Co-pay, Inpatient (per admission)	**$50**
Above 185% up to and including 200% of the FPL*	
Office Visit	**$16**
Non-Emergency ER	**$50**
Generic Drug	**$8**
Brand Drug	**$25**
Cost-sharing Cap	**2.5% of family's income****
Facility Co-pay, Inpatient (per admission)	**$100**

No co-payments for CHIP Perinate Members and/or CHIP Perinate Newborn Members.

Chapter 4
Member Eligibility

Medicaid (STAR and STAR+PLUS) Eligibility

Medicaid Eligibility Determination

The HHSC is responsible for determining eligibility in the Texas Medicaid program. The following groups are eligible for the STAR program:

- TANF Adults – Individuals age 21 and over who are eligible for Temporary Aid for Needy Families (TANF). This category may include some pregnant women.
- TANF Children – Individuals under the age of 21 who are eligible for the TANF program. This category may include some pregnant women and some children less than one year of age.
- Pregnant Women – pregnant women who are receiving Medical Assistance Only (MAO).Their family income is below 185% of the Federal Poverty Level (FPL).
- Newborn MAO – children under the age one born to Medicaid eligible mothers.
- Expansion Children (MAO) – Children under age one whose family's income is below 185% FPL.
- Expansion Children (MAO) – Children age 1-5 whose family's income is at or below 133% of FPL.
- Federal Mandate Children (MAO) – Children under age 19 born before October 10, 1983 whose family's income is below the TANF limit.
- CHIP under age 19 born before October 1, 1983 with family income below 100% FPL.

Verifying Medicaid Eligibility

Medicaid (STAR and STAR+PLUS) Eligibility

Providers are responsible for requesting and verifying current Medicaid eligibility information about the member by asking for the Your Texas Benefits Card and their Molina Healthcare Identification Card (ID card). The Member's Your Texas Benefits Card takes precedence over their Molina Healthcare ID Card.

Medicaid identification include:

- State Medicaid Your Texas Benefits Card
- Form 1027-A, Temporary Medicaid Identification Form

Providers can verify eligibility by:

- Using the Texas Benefit Medicaid Card; or on the secure website—YourTexasBenefitsCard.com
- Through the TMHP Contact Center at 1-800-925-9126
- On TexMedConnect on the TMHP website
- Molina Member ID Card
- Call Molina Member services at 1-866-449-6849
- MESAV
- Monthly PCP Elgibility listing
- Electronic eligibility verification e.g., NCPDP E1 Transaction (for Pharmacies only)
- Provider Self Service Portal (ePortal)

Providers can log into the Molina Healthcare Provider Self Service Portal (ePortal) at https://eportal.molinahealthcare.com/eportal/providers/login.aspx. (Use of ePortal requires provider registration.)

Temporary ID Card – Form 1027-A

If a member loses the Your Texas Benefits Medicaid card and needs quick proof of eligibility, HHSC staff can still generate a Temporary Medicaid Eligibility Verification Form (Form 1027-A). Members must apply for the temporary form in person at an HHSC benefits office. To find the nearest office they can call 2-1-1 (pick a language and then pick option 2).

Overview

The Texas Health and Human Services Commission is introducing a new system that uses digital technology to streamline the process of verifying a person's Medicaid eligibility and accessing their Medicaid health history. The two main elements of the system are:

- The Your Texas Benefits Medicaid card, which replaces the Medicaid ID letter (Form 3087) members used to get in the mail every month.
- YourTexasBenefitsCard.com—a secure website where Medicaid providers can get up-to-date information on a patient's eligibility and history of services and treatments paid by Medicaid.

About the Your Texas Benefits Medicaid Card

The design of the new card conforms to the standards of the Workgroup for Electronic Data Interchange (WEDI). It is designed to show the same type of information shown on private health insurance cards.

The ***front of the card*** has:	***The back of the card*** has:
• Member name and Medicaid ID number. (i.e. patient control number – PCN). • Managed care program name, if applicable (STAR, STAR Health, STAR+PLUS). • Date the card was issued. • Billing information for pharmacies. • Health plan names and plan phone numbers. • Pharmacy and physician information for members in the Medicaid Limited program	• A statewide toll-free number that members can call if they need help or have questions about using the card. • A website (www.YourTexasBenefits.com) where members can get more information about the Medicaid card and access their personal Medicaid health history. The website will be fully functional in a later phase of the project

While there are multiple options for providers to access Texas Medicaid member and health information with the new Medicaid ID card, no card reader is required to access the Your Texas Benefits Card provider website.

Option 1: Manual input
The Medicaid ID number (patient control number—PCN) is printed on the front of the card. You can type this number into the provider website—YourTexasBenefitsCard.com—to access your patients' Medicaid eligibility and health information.

Option 2: Basic magnetic stripe card reader
A magstripe card reader can be used to read the Medicaid ID number from the magstripe and automatically enter it into YourTexasBenefitsCard.com.
If you already have a magstripe card reader it will probably work with the card. If not, the Medicaid contractor, HP, is selling a basic USBbased card reader device that can be easily installed and used by providers. Providers also can buy similar card readers online and from other retailers.

Option 3: Integrated point-of-sale (POS) devices
Emdeon, an HP subcontractor, offers a third-party solution for an integrated POS device that can process multiple payers and commercial financial transactions. This commercial solution does not use the Your Texas Benefits card provider portal, but will have electronic access to some limited Medicaid eligibility and health information. Pricing from Emdeon varies based on selected services.

If you already own a compatible POS device, you may be able to update the software to read the Medicaid ID number from the card, submit an eligibility verification transaction through their third-party processor, and/or retrieve high-level Medicaid health information. Call the
Your Texas Benefits Card help desk at 1-855-827-3747 for more information.

Option 4: Electronic transactions
Provider systems can use an electronic data interface (EDI) to request Medicaid eligibility and health data and then represent or store that information within their own systems. The specifications for the EDI transactions will be published for provider system vendors to use to make updates to their systems. Call the Your Texas Benefits Card help desk at 1-855-827-3747 for more information.

Cost to providers for automation options: Access to the provider portal is available at no cost. Any costs for optional hardware or software are the responsibility of the providers. Specific costs will vary based upon the device purchased, the associated services, and the specific seller. Call the Your Texas Benefits Card help desk at 1-855-827-3747 for more information about optional automation devices that are available from HP and Emdeon.

Does having a card mean the patient is eligible for Medicaid?
- No. Just because a patient has a Your Texas Benefits Medicaid card, it does not necessarily mean he or she has current Medicaid coverage. You must still verify eligibility.
- Patients are told to keep their Your Texas Benefits Medicaid card even if their Medicaid coverage expires.
- The card can be reused if the patient later regains Medicaid coverage.

What if the member doesn't bring the card to my office?
- You can verify eligibility without a card:
- On the secure website—YourTexasBenefitsCard.com
- Through the TMHP Contact Center at 1-800-925-9126
- On TexMedConnect on the TMHP website

Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can get a new card mailed to them by calling 1-855-827-3748. Until then, you can verify their eligibility in one of the ways described above.

How am I supposed to use the Your Texas Benefits card?

Use the new Your Texas Benefits Medicaid card to verify a patient's Medicaid eligibility just like you did with the paper Medicaid ID (Form 3087) or verify eligibility through the YourTexasBenefitsCard.com website.
The card's magnetic stripe has the member's Medicaid ID number (PCN) and it can be read by most swipe- style card readers. The Your Texas Benefits Medicaid card is designed to work with standard magnetic card readers that are available at many electronics retailers or online. These readers interface with your computer through a standard USB connection.

The technology company Emdeon is offering Medicaid providers an enhanced point-of-sale device that processes Medicaid eligibility verifications as well as credit card transactions. As with more standard card reading options, Medicaid providers that choose this device are responsible for the cost. For more information, visit **www.emdeon.com/pos/**. Click on "Contact Us."

What if I don't have a swipe-style card reader?

- You don't have to buy a card reader to verify patient eligibility. Medicaid providers can continue to verify eligibility by using a patient's Medicaid ID number (PCN), which will be printed on the card. Then you can:
- Use the secure website— YourTexasBenefitsCard.com
- Call the TMHP Contact Center at 1-800-925-9126
- Visit TexMedConnect on the TMHP website

What if I have questions about the card, card reader or the provider website?

- Call 1-855-827-3747.

What will I be able to do with the new provider website?

- The new website lays the foundation for the emerging electronic health network. For now, the YourTexasBenefitsCard.com gives providers another way to verify their patients' Medicaid eligibility.
- In the future, providers will be able to use the website to instantly access their Medicaid patients' Medicaid related:
    - Claims and encounter data
    - Prescription drug history
    - Lab results
    - Immunization information

- The website will give providers a way to capture information showing the time and date their Medicaid patient receives treatment as well as the type of treatment the patient receives.
- You can use as much or as little of the provider website's features as you want to. The existing systems for doing business such as checking a patient's Medicaid eligibility and prescribing medication for Medicaid patients will not change.

When will I be able to use the provider website?

- Providers can verify a patient's eligibility using the website now.
- In the coming months, providers will be able to check patient Medicaid health history information.
- Look for updates about the provider website on the HHSC and TMHP websites.

Is e-prescribing available on the provider website?

- Not yet—but it will be at a later date. E-prescribing will allow doctors to instantly see if a drug they want to prescribe is covered by Medicaid and what negative interactions the drug is likely to have with other drugs before submitting an electronic prescription to the pharmacy. This will reduce the number of calls from pharmacists proposing alternative drugs and save time for the provider, the pharmacist, and the patient.

CHIP Eligibility

Who is Eligible?

If they do not qualify for Medicaid, Children under age 19 whose family's income is below 200% of the federal poverty level are eligible to enroll in the CHIP program. Members are enrolled with the CHIP program for a continuous 12 months, yet they must re-enroll every 12 months. Eligibility is determined by HHSC for the CHIP program.

Verifying CHIP Member Eligibility

It is important for Providers to check the Member's eligibility each time he/she presents to the office for consultation. Molina providers may verify a Member's eligibility by checking the following:

- Through the TMHP Contact Center at 1-800-925-9126
- On TexMedConnect on the TMHP website
- Molina Member ID Card
- Molina's eportal
- Call Molina Member services at 1-866-449-6849
- MESAV
- Monthly PCP Elgibility listing
- Electronic eligibility verification e.g., NCPDP E1 Transaction (for Pharmacies only)
- Calling CHIP Helpline at 1-877-543-7669

Molina sends an identification card to each family Member covered under the plan. The Molina Identification Card has the name and phone number of the Member's assigned Primary Care Provider (PCP). A sample of the Molina Identification Card is also included for your reference at the end of this section.

CHIP Perinate Eligibility, Who is Eligible?

A CHIP Perinate (unborn child) who lives in a family with an income at or below 185% of the FPL will be deemed eligible for Medicaid and moved to Medicaid for twelve months of continuous coverage (beginning on the date of birth). A CHIP Perinate will continue to receive coverage through the CHIP program as a "CHIP Perinate Newborn" if: born to a family with an income above 185% to 200% FPL. A CHIP Perinate Newborn is eligible for twelve months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus eleven months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan. Eligibility is determined by HHSC.

Continuity of Care (STAR, STAR+PLUS & CHIP)

Molina Members who are involved in an "active course of treatment" have the option to complete that treatment with the practitioner who initiated the care. The lack of a contract with the Provider of a new Member or terminated contracts between Molina and a Provider will not interfere with this option. This option includes the following Members who are:

- have pre-existing conditions
- In the 24th week of pregnancy (STAR only)
- Receiving care for an acute medical condition
- Receiving care for an acute episode of a chronic condition
- Receiving care for a life threatening illness, and
- Receiving care for a disability

For each Member identified in the categories above, Molina will work with the treating Provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the Member's needs.

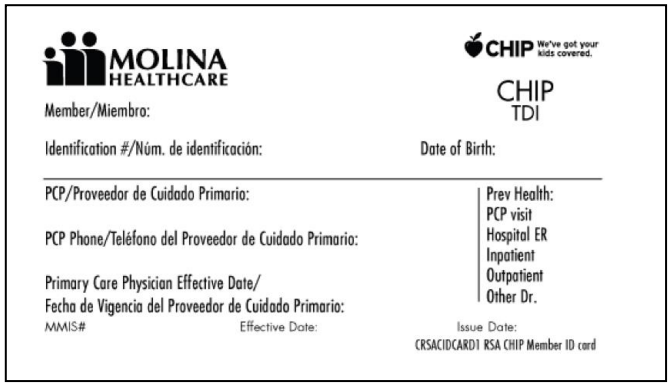
What if a member moves?

If a member moves out of the service area, Molina will continue to cover medically necessary care through the end of the month.

Molina ID Cards

Attached are examples for member ID cards for the CHIP, CHIP Perinate Newborn, CHIP Perinate, STAR, STAR+PLUS and STAR+PLUS Dual Eligible members:

CHIP


MOLINA HEALTHCARE

CHIP We've got your kids covered.

CHIP
TDI

Member/Miembro:

Identification #/Núm. de identificación: Date of Birth:

PCP/Proveedor de Cuidado Primario:

PCP Phone/Teléfono del Proveedor de Cuidado Primario:

Primary Care Physician Effective Date/
Fecha de Vigencia del Proveedor de Cuidado Primario:

MMIS# Effective Date:

Prev Health:
PCP visit
Hospital ER
Inpatient
Outpatient
Other Dr.

Issue Date:
CRSACIDCARD1 RSA CHIP Member ID card

KEY TO Molina ID CARDS


MEMBERS: Call Molina Healthcare Member Services at (866) 449-6849, Monday through Friday, between 8:00 a.m. and 5:00 p.m. For hearing impaired, call the TTY/Texas Relay English at (800) 735-2989, or 711; Spanish at (800) 662-4954, or 711. **Emergency Services:** In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

Behavioral Health Services Hotline: (877) 319-6826
MIEMBRO: Llame a Servicios para Miembros de Molina Healthcare al (866) 449-6849, de lunes a viernes entre 8:00 a.m. y 5:00 p.m. Si tiene impedimentos auditivo, llame a la línea TTY/Texas Relay en inglés al 1 (800) 735-2989 ó al 711; ó en español al 1 (800) 662-4954 ó al 711.
Servicios de emergencia: En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible.

Linea Directa de Servicios de Salud Mental y Abuso de Sustancias: 1 (877) 319-6826
PRACTITIONERS/PROVIDERS/HOSPITALS: For prior authorization, post stabilization, eligibility, claim or benefit information call (877) 319-6826. **Hospital Admissions:** Authorization must be obtained by the hospital prior to all non-emergency admissions.
For Prescription Drug Information: Call CHIP at 1-866-274-9154.
Claims Submission: PO Box 22719, Long Beach, CA 90801 **For EDI Submissions:** Payor ID 20554
www.molinahealthcare.com

KEY TO Molina ID CARDS

- Molina Healthcare Logo
- Molina Healthcare Member Services phone numbers
- Patient Information
- Behavioral Health Hotline number
- Program the Member is enrolled in
- PCP Information. This area consists of the PCP's name, phone number and effective date the member was assigned to that PCP.
- Information on who to call in an emergency and information on the 24-hour Nurse Advice Line (for Members to get advice on health care from registered nurses).
- Name and address to which you must submit your claims.
- Some Co-pays/co-insurance and deductibles may apply.

CHIP PERINATE


MOLINA HEALTHCARE

CHIP We've got your kids covered.

CHIP Perinatal
TDI

Member/Miembro:

Identification #/Núm. de identificación: Date of Birth:

Plan Type (Mother <185%)
Delivery Facility Charges: Send claims to TmHP
Delivery Professional Charges: Send claims to Molina

Effective Date:
5611TX0709

Issue Date:
CRSAPMDCARD1 RSA Perinate Mom ID card

KEY TO Molina ID CARDS


MEMBERS: Call Molina Healthcare Member Services at (866) 449-6849, Monday through Friday, between 8:00 a.m. and 5:00 p.m. For hearing impaired, call the TTY/Texas Relay English at (800) 735-2989, or 711; Spanish at (800) 662-4954, or 711. **Emergency Services:** In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

Behavioral Health Services Hotline: (877) 319-6826
MIEMBRO: llame a Servicios para Miembros de Molina Healthcare al (866) 449-6849, de lunes a viernes entre 8:00 a.m. y 5:00 p.m. Si tiene impedimentos auditivo, llame a la línea TTY/Texas Relay en inglés al 1 (800) 735-2989 ó al 711; ó en español al 1 (800) 662-4954 ó al 711.
Servicios de emergencia: En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible.

Linea Directa de Servicios de Salud Mental y Abuso de Sustancias: 1 (877) 319-6826
PRACTITIONERS/PROVIDERS/HOSPITALS: For prior authorization, post stabilization, eligibility, claim or benefit information call (877) 319-6826. **Hospital Admissions:** Authorization must be obtained by the hospital prior to all non-emergency admissions.
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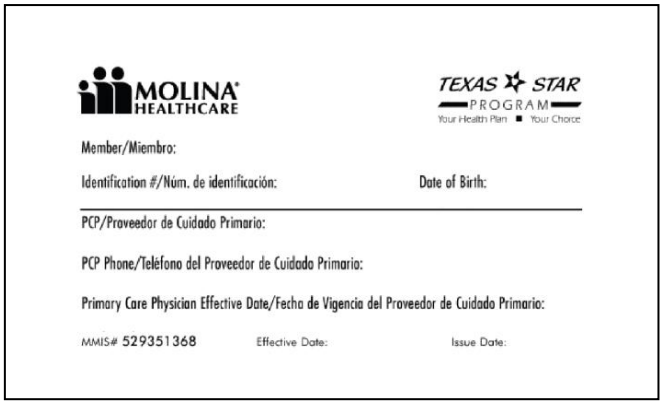
Claims Submission: PO Box 22719, Long Beach, CA 90801 **For EDI Submissions:** Payor ID 20554
www.molinahealthcare.com

- Molina Healthcare Logo
- Program the Member is enrolled in
- Patient Information
- Plan Type is based on the member's FPL (>< 185%)
- Delivery Facility Charges is based on member's FPL
- Delivery Professional Charges is based on member's FPL
- Date Member is effective with Plan
- Molina Healthcare Member Services phone numbers
- Information on who to call in an emergency and information on the 24-hour Nurse Advice Line (for Members to get advice on health care from registered nurses).
- Practioners/Providers/Hospitals information for prior authorizations
- Name and address to which you must submit your claims

STAR Member ID


MOLINA HEALTHCARE

TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

Member/Miembro:

Identification #/Núm. de identificación: Date of Birth:

PCP/Proveedor de Cuidado Primario:

PCP Phone/Teléfono del Proveedor de Cuidado Primario:

Primary Care Physician Effective Date/Fecha de Vigencia del Proveedor de Cuidado Primario:

MMIS# 529351368 Effective Date: Issue Date:

KEY TO Molina ID CARDS


MEMBERS: Call Molina Healthcare Member Services at (866) 449-6849, Monday through Friday, between 8:00 a.m. and 5:00 p.m. For hearing impaired, call the TTY/Texas Relay English at (800) 735-2989, or 711; Spanish at (800) 662-4954, or 711.
Emergency Services: In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

Referral Services: You must have a referral from your PCP for all services or care except as noted in your Member Handbook.
Behavioral Health Services Hotline: (800) 818-5837, Hearing Impaired Service (800) 955-8770 24 hour/7 days a week Toll-Free
MIEMBRO: llame a Servicios para Miembros de Molina Healthcare al 1 (866) 449-6849, de lunes a viernes entre 8:00 a.m. y 5:00 p.m. Si tiene déficit auditivo, llame a la línea TTY/Texas Relay en inglés al 1 (800) 735-2989 ó al 711; ó en español al 1 (800) 662-4954 ó al 711.
Servicios de emergencia: En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible.

Envíos a servicios: tiene que tener un envío a servicios de su PCP para todos los servicios o atención médica excepto como se indica en el Manual para Miembros.
Línea Directa de Servicios de Salud Mental y Abuso de Sustancias: 1 (800) 818-5837; servicios para las personas con déficit auditivo, 1 (800) 955-8770, gratis las 24 horas del día, los 7 días de la semana.
PRACTITIONERS/PROVIDERS/HOSPITALS: For prior authorization, post stabilization, eligibility, claim or benefit information call (866) 449-6849.
Hospital Admissions: Authorization must be obtained by the hospital prior to all non-emergency admissions.
Claims Submission: PO Box 22719,Long Beach,CA 90801

www.molinahealthcare.com

- Molina Healthcare Logo
- Molina Healthcare Member Services phone numbers
- Patient Information
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- Information on who to call in an emergency and information on the 24-hour Nurse Advice Line (for Members to get advice on health care from registered nurses).
- Name and address to which you must submit your claims.

STAR+PLUS

STAR+PLUS Medicaid Only


MOLINA HEALTHCARE

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

Member/Miembro:

Identification #/Núm. de identificación: Date of Birth / Fecha de nacimiento

PCP/Proveedor de Cuidado Primario:

PCP Phone/Teléfono del Proveedor de Cuidado Primario:

Primary Care Physician Effective Date/Fecha de Vigencia del Proveedor de Cuidado Primario:

MMIS# 530885826 Effective Date: Issue Date:

KEY TO Molina ID CARDS


MEMBERS: Call Molina Healthcare 24/7 Member Services at (866) 449-6849. For hearing impaired, call the TTY/Texas Relay English at (800) 735-2989, or 711; Spanish at (800) 662-4954, or 711.
Emergency Services: In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

Service Coordination: 1-866-409-0039
Referral Services: You must have a referral from your PCP for all services or care except as noted in your Member Handbook.
Behavioral Health Services Hotline: (800) 818-5837, Hearing Impaired Service (800) 955-8770 24 hour/7 days a week Toll-Free
MIEMBRO: llame a Servicios para Miembros de Molina Healthcare al 1 (866) 449-6849, de lunes a viernes entre 8:00 a.m. y 5:00 p.m. Si tiene déficit auditivo, llame a la línea TTY/Texas Relay en inglés al 1 (800) 735-2989 ó al 711; ó en español al 1 (800) 662-4954 ó al 711.
Servicios de emergencia: En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible.

Envíos a servicios: tiene que tener un envío a servicios de su PCP para todos los servicios o atención médica excepto como se indica en el Manual para Miembros.
Línea Directa de Servicios de Salud Mental y Abuso de Sustancias: 1 (800) 818-5837; servicios para las personas con déficit auditivo. 1 (800) 955-8770 gratis las 24 horas del día, los 7 días de la semana.
PRACTITIONERS/PROVIDERS/HOSPITALS: For prior authorization, post-stabilization, eligibility , claim or benefit information call (866) 449-6849. **Hospital Admissions:** Authorization must be obtained by the hospital prior to all non-emergency admissions.
Inpatient claims: TWHP PO Box 200555 Austin, TX 78720-0555
All other medical claims: Molina P.O. Box 22719, Long Beach, CA 90801
www.molinahealthcare.com

- Molina Healthcare Logo
- Molina Healthcare Member Services phone numbers
- Patient Information
- Behavioral Health Hotline number
- Program the Member is enrolled in
- PCP Information. This area consists of the PCP's name, phone number and effective date the member was assigned to that PCP.
- Information on who to call in an emergency and information on the 24-hour Nurse Advice Line (for Members to get advice on health care from registered nurses).
- Name and address to which you must submit your claims.

STAR+PLUS Dual Eligible
(Member also covered by Medicare)

If the member gets Medicare, Medicare is responsible for most primary, acute and behavioral health services; therefore, the PCP's name, address and telephone number are not listed on the Member's ID card. The Member receives long-term services and supports through Molina Healthcare.


MOLINA HEALTHCARE

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

Member/Miembro:

Identification #/Núm. de identificación: Date of Birth/Fecha de nacimiento

Long Term Care Benefits Only - Medicare is responsible for primary, acute and behavioral health services; therefore, the PCP's name, address and telephone number are not listed. The member receives only long-term care services through Molina Healthcare.

Solo beneficios de atencion a largo plazo: Medicare cubre servicios basicos y agudos de salud mental y abuso de sustancias. Por lo tanto, no se indica el nombre, la direccion ni el telefono del proveedor de cuidado primario. El miembro recibe solo servicios de atencion a largo plazo mediante Molina Healthcare.

MMIS# 525223667 Effective Date: Issue Date:

KEY TO Molina ID CARDS


MEMBERS: Call Molina Healthcare 24/7 Member Services at (866) 449-6849. For hearing impaired, call the TTY/Texas Relay English at (800) 735-2989, or 711; Spanish at (800) 662-4954, or 711.
Emergency Services: In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

Service Coordination: 1-866-809-0039
Referral Services: You must have a referral from your PCP for all services or care except as noted in your Member Handbook.
Behavioral Health Services Hotline: (800) 818-5837, Hearing Impaired Service (800) 955-8770 24 hour/7 days a week Toll-Free
MIEMBRO: llame a Servicios para Miembros de Molina Healthcare al 1 (866) 449-6849, de lunes a viernes entre 8:00 a.m. y 5:00 p.m. Si tiene déficit auditivo, llame a la línea TTY/Texas Relay en inglés al 1 (800) 735-2989 ó al 711; ó en español al 1 (800) 662-4954 ó al 711.
Servicios de emergencia: En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible.

Envíos a servicios: tiene que tener un envío a servicios de su PCP para todos los servicios o atención médica excepto como se indica en el Manual para Miembros.
Línea Directa de Servicios de Salud Mental y Abuso de Sustancias: 1 (800) 818-5837; servicios para las personas con déficit auditivo, 1 (800) 955-8770, gratis las 24 horas del día, los 7 días de la semana.
PRACTITIONERS/PROVIDERS/HOSPITALS: For prior authorization, post stabilization, eligibility , claim or benefit information call (866) 449-6849. **Hospital Admissions:** Authorization must be obtained by the hospital prior to all non-emergency admissions.
Inpatient claims: TMHP PO Box 200555 Austin, TX 78720-0555
All other medical claims: Molina P.O. Box 22719, Long Beach, CA 90801
www.molinahealthcare.com

- Molina Healthcare Logo
- Molina Healthcare Member Services phone numbers
- Patient Information
- Behavioral Health Hotline number
- Program the Member is enrolled in
- PCP Information. This area consists of the PCP's name, phone number and effective date the member was assigned to that PCP.
- Information on who to call in an emergency and information on the 24-hour Nurse Advice Line (for Members to get advice on health care from registered nurses).
- Name and address to which you must submit your claims.

Eligibility Listing

Molina distributes eligibility reports monthly to provide information on Members' enrollment with a PCP. The reports are generated and mailed by the first week of each month to all participating providers who practice as PCPs. If a Member arrives at a PCP's office to receive care but does not appear on the current month's eligibility list, the Provider should contact Member Services at 1-866-449-6849 to verify eligibility. A sample of the monthly eligibility list is included for your reference.

Eligibility List - SAMPLE
Molina Healthcare

Fee For Service
Provider Name
Address
City, State Zip

Member	SSN/PIC	Gender	Date of Birth	Enroll Eff.	PCP Eff.	Copay	Member Address
Program: CHIP (Children's Health Insurance Program)							
DUCK, DONALD	101010101	M	05/28/1998	04/01/2004	05/01/2004		123 MAIN ST, ANYTOWN, TX 98000
	PATIENT IDENTIFICATION CODE			ENGLISH			PHONE NUMBER
Program: STAR							
MOUSE, MICKEY	202020202	M	12/03/1981	02/01/2004	02/01/2004		456 MAINT ST, ANYTOWN, TX 98000
	PATIENT IDENTIFICATION CODE			ENGLISH			PHONE NUMBER
			Total Number of Members:				**2**

Chapter 5
Enrollment, Disenrollment and Member Transfers

STAR Members

Enrolling/Changing Health plan:

Members can change health plans by calling the enrollment broker, Maximus at 1-800-964-2777. However, a member **cannot** change from one health plan to another health plan during an inpatient hospital stay.

If a member calls to change health plans on or before the 15th of the month, the change will take place on the first day of the next month. If they call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If a request for plan change is made on or before April 15, the change will take place on May 1.
- If a request for plan change is made after April 15, the change will take place on June 1.

STAR Member Enrollment

A member is free to choose a STAR health plan and PCP. The member will not begin to receive benefits under a Medicaid Managed Care program until the first day of the following month (provided enrollment takes place before the cut-off date for the following month). The cut-off date is generally the 15th of the month.

Example; if enrollment takes place *PRIOR* to cut-off	
Member certified for Texas Medicaid	January 1
Medicaid Benefits Begin	January 1
Member selects health plan and PCP	January 1
Managed care benefits begin	February 1

Example; if enrollment takes place *AFTER* to cut-off	
Member certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Member selects health plan and PCP	January 20
Managed care benefits begin	March 1

Enrollment of Pregnant Women:

Women who are on Medicaid type program 40 may be retroactively enrolled in STAR. Women who are certified for Medicaid type program 40 on or before the 10th of the month will be enrolled in STAR beginning the first of the month of certification. Women who are certified after the 10th of the month will be on fee-for-service Medicaid the month of certification and will be enrolled in STAR beginning the first of the month following the month of certification.

There are two exceptions to this rule:

- Women who are certified at any time in their estimated month of delivery will be enrolled in STAR the first of the following month (prospective enrollment).
- Women who are certified at any time in their actual month of delivery (if known by HHSC before certification) will be enrolled in STAR the first of the following month (prospective enrollment).

Enrollment of Newborns:

Newborns are covered under their mother's Health Plan up to 90 days from the date of birth. Mothers are encouraged to contact Maximus at 1-800-964-2777 to enroll the newborn in the STAR program. Mothers can choose to select another health plan for their newborn at the time of enrollment. Mothers are also encouraged to select a PCP for the newborn prior to birth. The PCP assignment can be done by calling Molina Healthcare Member Services at 1-866-449-6849.

It is important that providers call the number listed on the Medicaid ID card for plan and provider information (Maximus at 1-800-964-2777) or the STAR health plan number listed on the Medicaid ID card.

Health Plan Changes

Member initiated change/Span of Eligibility:

Members can change health plans by calling Maximus at 1-800-964-2777. However, a member cannot change from one health plan to another health plan during an inpatient hospital stay.

If a member calls to change their health plan on or before the 15th of the month, the change will take place on the first day of the following month. If they call after the 15th of the month, the change will take place the first day of the second month after the request has been made. For Example:

- If a request for plan change is made on or before April 15, the change will take place on May 1.
- If a request for plan change is made after April 15, the change will take place on June 1.

Members can change their health plan as often as monthly. If a member chooses to change their health plan, retaliatory action cannot be taken against the member by the Health Plan or provider.

Health Plan Initiated Change (Disenrollment):

Molina has a limited right to request a Member be disenrolled from HMO without the Member's consent. HHSC must approve any HMO request for disenrollment of a Member for cause. HHSC would consider disenrollment under the following circumstances:

- Member misuses or loans Member's Molina membership card to another person to obtain services.
- Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs Molina's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Molina to treat the underlying medical condition).
- Molina must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation is sent to HHSC, the final decision will be made by HHSC.

Molina must notify the Member of Molina's decision to disenroll the Member if all reasonable measures have failed to remedy the problem. If the Member disagrees with the decision to disenroll the Member from Molina, Molina must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process.

Molina cannot request a 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.

Disenrollment

If a Member makes a request for disenrollment, Molina must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

Automatic Disenrollment/Re-enrollment:

When a member no longer meets the criteria for Managed Care enrollment, the state will automatically disenroll the member. The disenrollment will be effective the first of the following month in which HMO eligibility changes.

Examples for loss of Medicaid managed Care eligibility are:

- The Member has left the service area Molina is contracted to provide HMO coverage in.
- The Member qualifys for DADS hospice services
- The Member begins Medicare coverage

If a member loses Medicaid eligibility and then regains eligibility within six months, the member is automatically reassigned to their previous health plan and PCP. The member will have the right to request a plan change or PCP change by following the process outlined in the previous pages.

Member's disenrollment request from managed care will require medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment from managed care. HHSC will make final decision.

Note: Providers are prohibited from taking retaliatory action against a member for any reason.

STAR+PLUS Member Enrollment & Disenrollment

The information covered in this section will address eligibility, enrollment, and disenrollment from the program.

Span of Eligibility

Members can change health plans by calling the Texas MEDICAID MANAGED CARE Program Helpline at
1-800-964-2777. However, a member cannot change from one health plan to another health plan during an inpatient hospital stay.
If a member calls to change health plans on or before the 15th of the month, the change will take place on the first day of the next month. If they call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If a request for plan change is made on or before April 15, the change will take place on May 1.
- If a request for plan change is made after April 15, the change will take place on June 1.

STAR+PLUS Member Eligibility Categories

STAR+PLUS Member Enrollment
A member is free to choose a STAR+PLUS health plan and PCP. The member will not begin to receive benefits under a Medicaid Managed Care program until the first day of the following month (provided enrollment takes place before the cut-off date for the following month). The cut-off date is generally the 15th of the month.

Example; if enrollment takes place *PRIOR* to cut-off	
Member certified for Texas Medicaid	January 1
Medicaid Benefits Begin	January 1
Member selects health plan and PCP	January 1
Managed care benefits begin	February 1

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Member certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Member selects health plan and PCP	January 20
Managed care benefits begin	March 1

Enrollment of Newborns:
Newborns are covered under their mother's Health Plan up to 90 days from the date of birth. Mothers are encouraged
to contact Maximus at 1-800-964-2777 to enroll the newborn in the program. Mothers can choose to select another health plan for their newborn at the time of enrollment. Mothers are also encouraged to select a PCP for the newborn prior to birth. The PCP assignment can be done by calling Molina Healthcare Member Services at
1-866-449-6849.

It is important that providers call the number listed on the Medicaid Identification Form (Form H3087) for plan and provider information STAR+PLUS Help Line at 1-800-964-2777 or the STAR+PLUS health plan number listed on the Medicaid Identification Form [Form H3087]).

Health Plan Changes

Member initiated change/Span of Eligibility:
Members can change health plans by calling the STAR + PLUS Help Line at 1-800-964-2777. However, a member cannot change from one health plan to another health plan during an inpatient hospital stay.

If a member calls to change their health plan on or before the 15th of the month, the change will take place on the
first day of the following month. If they call after the 15th of the month, the change will take place the first day of the second month after the request has been made. For Example:

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- Member misuses or loans Member's Molina membership card to another person to obtain services.
- Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs Molina's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Molina to treat the underlying medical condition).
- Molina must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation is sent to HHSC, the final decision will be made by HHSC.

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Molina cannot request a 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.

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- The Member has left the service area Molina is contracted to provide HMO coverage in.
- The Member qualifys for DADS hospice services
- The Member begins Medicare coverage

If a member loses Medicaid eligibility and then regains eligibility within six months, the member is automatically reassigned to their previous health plan and PCP. The member will have the right to request a plan change or PCP change by following the process outlined in the previous pages.

Member's disenrollment request from managed care will require medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment from managed care.

Note: Providers are prohibited from taking retaliatory action against a member for any reason.

Health Plan Initiated (Disenrollment):
Molina has a limited right to request a Member be disenrolled from Molina without the Member's consent. HHSC must approve any Molina request for disenrollment of a Member for cause.

HHSC may permit disenrollment of a Member under the following circumstances:

- Member misuses or loans Member's Molina membership card to another person
- to obtain services.
- Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs Molina's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Molina to treat the underlying medical condition).
- Molina must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation is sent to HHSC, the final decision will be made by HHSC.

CHIP Enrollment and Disenrollment

Children's Health Insurance Program (CHIP) is a health insurance program for children under the age of 19. CHIP is available to children whose families have low to moderate income, but have earned too much money to qualify for Medicaid and do not qualify for private insurance.

CHIP Enrollment

Applying for CHIP:

Families can apply for the CHIP program in one of three ways:

- Complete and mail in a printed application.
- Call 1-800-647-6558 and complete the application over the phone.
- Download, complete and mail in an application from http://www.hhsc.state.tx.us/chip

Mail Applications to:
P.O. Box 149276
Austin, TX 78714-9983

Children enrolling in CHIP for the first time, or returning to CHIP after disenrollment, will be subject to a waiting period before coverage actually begins. The waiting period for a child is determined by the date on which he/she is found eligible for CHIP, and extends for the duration of three (3) months. If the child is found eligible for CHIP on or before the fifteenth (15th) day of a month, then the waiting period begins on the first day of that same month. If the child is found eligible on or after the 16th day of a month, then the waiting period begins on the first day of the next month.

Please refer to the table below for examples of how the waiting period affects the beginning of coverage. A child will remain covered for a term of twelve (12) continuous months. Families must re-enroll their children every twelve (12) months.

Sample Enrollment Timeline

Action	A	B
Eligibility determination date	January 1-15	January 16-31
1st day of waiting period	January 1	February 1
Family completes enrollment in CHIP program	Before March CHIP enrollment cut-off (Usually around March 20th)	Before April CHIP enrollment cut-off (Usually around April 20th)
First possible date coverage can begin	April 1	May 1

Note*:* Auto-enrollment of newborns is not permitted. Newborns eligible for Medicaid will not be able to enroll in CHIP.

Enrollment/Disenrollment for Pregnant Members and Infants:

The Administrative Services Contractor will refer pregnant CHIP members, with the exception of Legal Permanent Residents and other legally qualified aliens barred from Medicaid due to federal eligibility restrictions, to Medicaid for eligibility determinations. Those CHIP members who are determined to be Medicaid Eligible will be disenrolled from Molina's CHIP plan. Medicaid coverage will be coordinated to begin after CHIP eligibility ends to avoid gaps in health care coverage.

In the event Molina remains unaware of a member's pregnancy until delivery, the delivery will be covered by CHIP. The Administrative Services contractor will then set the member's eligibility expiration date at the later of (1) the end of the second month following the month of the baby's birth or (2) the Member's original eligibility expiration date. Most newborns born to CHIP Members or CHIP heads of household will be Medicaid eligible. Eligibility of newborns must be determined for CHIP before enrollment can occur. For newborns determined to be CHIP-eligible, the baby will be covered from the beginning of the month of birth for the period of six (6) months.

Note: Providers are required to notify the Health Plan immediately when a pregnant CHIP or Medicaid member is identified.

Re-enrollment:

Children's Insurance Program will send the Member a notice two (2) months before it is time to renew that child's coverage. To continue enrollment in CHIP the member must reapply for coverage. Members can call the Children's Health Insurance program at 1-800-647-6558 for more information on re-enrollment.

Health Plan Changes

Member Initiated:

A Member can ask to change their health plan during the first (initial) three (3) months they are enrolled in Molina Healthcare, or during the one open enrollment month every year in their county. To request a plan change the member can call the Children's Health Insurance program at 1-800-647-6558.

After the first (initial) three (3) months of enrollment in the health plan or when it is not open enrollment in a Member's county, a Member may, with good reason, disenroll. The following are examples of reasons members can disenroll:

- The Primary Care Provider (PCP) that has been automatically selected no longer is in the Molina Network of Providers and there are no other doctors in the health plan that will accept that Member's family or that is close to their home.
- The Primary Care Provider (PCP) that the Member picked is no longer in their health plan and he/she was the only doctor in the health plan that spoke the Member's language.
- The Primary Care Provider (PCP) that a family member needs to see because of a special medical need is not a provider for Molina Healthcare.
- The Member no longer lives near any of the Primary Care Providers (PCP) in Molina Healthcare's Provider Network.
- Other - If the Member believes that staying enrolled with Molina Healthcare is harmful and not in their best interest.

Reminder: Members are only allowed to make plan changes once a year. Members may request to change health plans for exceptional reasons or good cause at any time. HHSC will make the final decision.

Health Plan Initiated (Disenrollment):

Molina has a limited right to request a Member be disenrolled from Molina without the Member's consent. HHSC must approve any Molina request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

- Member misuses or loans Member's Molina membership card to another person to obtain services.
- Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs Molina's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Molina to treat the underlying medical condition).
- Molina must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation is sent to HHSC, the final decision will be made by HHSC.

Molina must notify the Member of Molina's decision to disenroll the Member if all reasonable measures have failed to remedy the problem. If the Member disagrees with the decision to disenroll the Member from Molina, Molina must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process. Molina cannot request a 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.

Molina will not disenroll a child based on a change in the child's health status or because of the amount of Medically Necessary Services that are used to treat the child's condition.

Note: Providers are prohibited from taking retaliatory action against a Member for choosing to disenroll or for any other reason whatsoever.

Disenrollment

Disenrollment may also occur if the Member's child loses CHIP eligibility. A child may lose CHIP eligibility for the following reasons:

- "Aging-out" when CHILD turns nineteen;
- Failure to re-enroll by the end of the 6-month coverage period;
- Failure to pay enrollment fee when due or within the grace period;
- Change in health insurance status, i.e., a CHILD enrolls in an employer-sponsored health plan;
- Death of a CHILD;
- CHILD permanently moves out of the state;
- CHILD is enrolled in Medicaid.
- Failure to drop current insurance if child was determined to be CHIP-eligible because cost sharing under the current health plan totaled 10% or more of the family's gross income.
- Child's parent or Authorized Representative reports a non-qualifying alien status for a non-citizen child, thereby disqualifying the child from CHIP
- Child's parent or Authorized Representative requests (in writing) the voluntary disenrollment of a child.

CHIP Perinate Enrollment and Disenrollment

Enrollment
Once a health plan is selected (or assigned) for the unborn child, the member must remain in that health plan until the end of the CHIP Perinatal Program continuous eligibility period. The continuous eligibility period is 12-month period that begin. When the unborn child is enrolled in the CHIP Perinatal Program and continues after the child is born.

If a health plan is not selected within 15 calendar days of the member receiving their enrollment packet an automatic assignment will be made. The Perinate mom then has 30 days to select another health plan.

If the family includes members enrolled in the CHIP Program and the CHIP Perinatal Program, the CHIP Program members will remain in the CHIP Program, but will be placed with the health plan providing CHIP Perinatal Program coverage. All members enrolled in the CHIP program must remain with this health plan until the end of the CHIP Perinatal Program continuous eligibility period. At the first CHIP Program renewal after the CHIP Perinatal Program eligibility ends, the family may choose a new plan.

Newborn Process

All CHIP Program and CHIP Perinatal Program Members in a household must be enrolled in the same health plan. Upon certification of CHIP Perinatal Program eligibility, children in the household enrolled in the CHIP Program must be prospectively enrolled in the health plan providing the CHIP Perinatal Program coverage and disenrolled from their current health plan the first possible month. Co-payments, cost-sharing, and enrollment fees still apply to children enrolled in the CHIP Program.

In order to synchronize all CHIP Program and CHIP Perinatal Program Members in a household, all Members will remain with the health plan providing CHIP Perinatal Program coverage until the CHIP Perinate Newborn completes its 12-month eligibility. 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 Program Members' information. Once the child's CHIP Perinatal Program coverage expires, the child will be added to his or her siblings' existing CHIP program case. The coverage period for the newly enrolled child will be the remaining period of coverage of the siblings already enrolled in the CHIP Program.

Disenrollment

Health Plan Changes

Member Initiated:

A CHIP Perinate (unborn child) who lives in a family with an income at or below 185% of the FPL will be deemed eligible for Medicaid and will receive 12 months of continuous Medicaid coverage (beginning on the date of birth).

- A CHIP Perinate will continue to receive coverage through CHIP Program as a "CHIP Perinate Newborn" if born on or after September 1, 2010, to a family with an income above 185% to 200% FPL. 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.

- If the mother of the CHIP Perinate lives in an area with more than one CHIP MCO, and does not select an MCO within 15 calendar days of receiving the enrollment packet, 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 form their current health plans and prospectively enrolled in the CHIP Perinatal member's health plan. 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.

CHIP Perinatal Members may request to change health plans under the following circumstances: for any reason within 90 days of enrollment in CHIP Perinatal ; and for cause at any time.

Reminder: Members are only allowed to make plan changes once a year. Members may request to change health plans for exceptional reasons or good cause. HHSC will make the final decision.

Health Plan Initiated (Disenrollment):

Molina has a limited right to request a Member be disenrolled from Molina without the Member's consent. HHSC must approve any Molina request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

- Member misuses or loans Member's Molina membership card to another person to obtain services.
- Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs Molina's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Molina to treat the underlying medical condition).
- Molina must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation is sent to HHSC, the final decision will be made by HHSC.

Molina must notify the Member of Molina's decision to disenroll the Member if all reasonable measures have failed to remedy the problem. If the Member disagrees with the decision to disenroll the Member from Molina, Molina must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process. Molina cannot request a 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.

Molina will not disenroll a child based on a change in the child's health status or because of the amount of Medically Necessary Services that are used to treat the child's condition.

Note: The switch of the CHIP Program Members from their health plan to the health plan providing the CHIP Perinatal Program coverage does not count as their one health plan change per year.

Note: Providers are prohibited from taking retaliatory action against a Member for choosing to disenroll or for any other reason whatsoever.

Disenrollment:

Disenrollment may also occur if the Member's child loses CHIP eligibility. A child may lose CHIP eligibility for the following reasons:

- "Aging-out" when CHILD turns nineteen;
- Failure to re-enroll by the end of the 6-month coverage period;
- Failure to pay enrollment fee when due or within the grace period;
- Change in health insurance status, i.e., a CHILD enrolls in an employer-sponsored health plan;
- Death of a CHILD;
- CHILD permanently moves out of the state;
- CHILD is enrolled in Medicaid.
- Failure to drop current insurance if child was determined to be CHIP-eligible because cost sharing under the current health plan totaled 10% or more of the family's gross income.
- Child's parent or Authorized Representative reports a non-qualifying alien status for a non-citizen child, thereby disqualifying the child from CHIP
- Child's parent or Authorized Representative requests (in writing) the voluntary disenrollment of a child.

Chapter 6
Prior Authorizations and Utilization Management

Utilization Management (UM) (STAR, STAR+PLUS, & CHIP)

Utilization Management is an on-going process of assessing, planning, organizing, directing, coordinating, monitoring and evaluating utilization of health care services for Molina members. The UM process utilizes a multidisciplinary, comprehensive approach to support the continuum of care by evaluating the necessity and efficiency of health care through systematic monitoring of the medical necessity and quality, and by maximizing the cost effectiveness of the care and service provided to members.

The UM Program encompasses all services and practitioners who have an impact on the provision of health care. This includes the evaluation of medical necessity and the efficient use of medical services, procedures, facilities, specialty care, inpatient, outpatient, home care, skilled nursing services, ancillary services and pharmaceutical services. In addition decisions are made within the scope of the benefit plan. A team of physicians and nurses, who hold unrestricted licenses in the state of Texas, perform utilization activities within their scope of practice and utilize InterQual, Medicaid and Medicare criteria to determine medical necessity. Other resources include clinical practice guidelines recommended and adopted by national professional physician organizations, the Hayes Directory and available scientific medical evidence.

One of the goals of Molina Healthcare Utilization Management (UM) department is to render appropriate UM decisions that are consistent with objective clinical evidence. To achieve that goal, Molina Healthcare maintains the following guidelines:

- Decision making is based only on appropriateness of care and service and existence of coverage.
- Molina Healthcare does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- UM decision makers do not receive incentives to encourage decisions that result in underutilization.
- Molina Healthcare ensures that all criteria used for UM decision-making are available to practitioners upon request. To obtain a copy of the UM criteria used in the decision-making process, call our UM department at 1-866-449-6849.

The Utilization Management Department maintains a process for gathering pertinent clinical information, applying criteria/guidelines during the utilization review decision making process based on individual needs, age, co-morbidities, complications, progress of treatment, psychosocial situation, home environment, when applicable, and assessment of the local delivery system. Each medical decision must be case specific regardless of available practice guidelines.

The authorization process is comprehensive and, includes the following review processes:

- Direct Referral
- Prospective Review
- Concurrent Authorization
- Retrospective review

The Utilization Management Department adheres to the HHSC and TDI approved standards for processing referrals, providing authorizations or denial decisions and the notification time frames. These standards are applied to urgent or routine requests for prospective, concurrent and retrospective service. Practitioners / providers and members may obtain urgent services twenty-four (24) hours a day, seven (7) days a week. Molina Healthcare maintains a toll-free (800) number that is staffed by Telephone Advice Nurses to assist in obtaining services. UM Staff is available eight hours a day during normal business hours for calls regarding UM issues. Staff can receive inbound communication regarding UM issues after normal business hours. Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon. Staff member identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. The toll free number to reach UM staff for any/all inquiries or questions regarding the UM process is 1-866-449-6849 and you will be prompted to the UM department.

Potential or actual cases of over or underutilization of healthcare services for members will be identified by the Medical Director and the UM staff during all components of UM:

- Prior Authorization (Referrals/Denials to specialty care providers)
- Concurrent Review (Bed-days in comparison to the community standard, length of stay)
- Emergency Room Visits (Frequency of ER use based on community standards)
- Pharmacy Utilization (Outpatient prescription patterns, Brand fill rate)
- Member Satisfaction Survey (Referral process, Obtaining needed care)
- Re-admissions to an acute care facility based on same or similar diagnosis within 30 days following discharge.

Molina Healthcare/Molina Medicare of Texas
Prior Authorization/Pre-Service Review Guide

Effective: 07/15/2012

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare/Molina Medicare Members.
Referrals to Network Specialists do not require Prior Authorization

Authorization required for services listed below.
Pre-Service Review is required for elective services.
Only covered services will be paid

- **All Non-Par providers/services:** services, including office visits, provided by non-participating providers, facilities and labs, except professional services for ER visit, approved Ambulatory Surgical Center or inpatient stay. ER visits do not require PA
- **Alcohol and Chemical Dependency Services**
- **All Inpatient Admissions:** Acute hospital, SNF, Rehab, LTACS, Hospice(notification only)
- **Behavioral Health Services:** - Inpatient, Partial hospitalization, Day Treatment, Intensive Outpatient Programs (IOP), ECT, and > 12 Office Visits/year for adults and 20 Office visits/year for children
- **Cardiac Rehabilitation, Pulmonary Rehabilitation, and CORF (Comprehensive Outpatient Rehab Facility services for Medicare only)**
- **Chiropractic Services**
- **Cosmetic, Plastic and Reconstructive Procedures in any setting:** which are not usually covered benefits include but are not limited to tattoo removal, collagen injections, rhinoplasty, otoplasty, scar revision, keloid treatments, and surgical repair of gynecomastia, pectus deformity, mammoplasty, abdominoplasty, venous injections, vein ligation, venous ablation or dermabrasion, botox injections, etc
- **Dental General Anesthesia:** > 7 years old or per state benefit (Not a Medicare covered benefit)
- **Dialysis:** notification only
- **Durable Medical Equipment/Orthotics/Prosthetics:**
  - >$500 allowed amount per line item or >$2000 total
  - C-PAP and Bi-PAP
  - All customized orthotics, prosthetics, wheelchairs and braces
  - Hearing Aids – including anchored hearing aids
  - Medicare Hearing Supplemental benefit: Contact Avesis at 800-327-4462
- **Enteral Formulas & Nutritional Supplements**
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing NOT related to pregnancy**
- **Home Healthcare: after 3 skilled nursing visits**
- **Home Infusion**
- **Outpatient Hospice & Palliative Care:** notification only.
- **Imaging:** CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms, intimal media thickness testing, three dimensional imaging
- **LTC Services (per state benefit)- e.g., Personal Attendant Services (PAS), Personal Care Services, Day Adult Health Services (DAHS). Not a Medicare covered benefit**
- **Neuropsychological Testing and Therapy**
- **Occupational Therapy, Physical Therapy and Speech Therapy after initial eval plus 6 visits. (Home or outpatient setting)** [An auth is not required for therapy listed on the ECI IFSP provided by an ECI provider (for children from birth through 35 months of age)]
- **Office-Based Surgical Procedures do not require auth except for Podiatry Surgical Procedures** (excluding routine foot care)
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** except for see attached**
- **Pain Management Procedures:** including sympathectomies, neurotomies, injections, infusions, blocks, pumps or implants, and acupuncture (Not a Medicare covered benefit)
- **Pregnancy and Delivery:** notification only
- **Sleep Studies**
- **All Specialty Pharmacy including, but not limited to:** Hemophilia drugs, Avastin, Enbrel, Lupron, Remicade, Avonex, Interferon, Xolair, Humira, Raptiva, Amevive, Synagis, Synvisc, growth hormone, monoclonal antibody, genomic preparations, etc. (except for specific state regulatory requirements)
- **Solid Organ and Bone Marrow Transplant Services:** including the evaluation (except Cornea transplants)
- **Transportation:** non-emergent ground and air ambulance
- **Unlisted CPT procedures (all),**
  - **miscellaneous codes >$500 billed charges per line item**
- **Wound Therapy including Wound Vacs and Hyperbaric Wound Therapy**

***STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with claim. (Medicaid benefit only)**

** Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:

The following procedures do NOT require PA if performed in a participating ASC or Outpatient Hospital setting:

Appendectomy	44950, 44970
AV Fistula	36831, 36832, 36833
Bladder Tumor	52234, 52235, 52240
Blood Patch	62273
Breast Biopsy	19120
Bronchoscopy	31622, 31623, 31624, 31625, 31626, 31627, 31628, 31629, 31630, 31631, 31632, 31633, 31635, 31636, 31637, 31638, 31640, 31641, 31643, 31645, 31646, 31656
Cardiac Cath	93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93462, 93463, 93464, 93530, 93531, 93532, 93533
Cardiovascular Intra-Arterial/Intra-Aortic Catheter	36100, 36120, 36140, 36147, 36148, 36160, 36200, 36215, 36216, 36217, 36218, 36245, 36246, 36247, 36248. Also please note that the following associated Aortography/Angiography procedures do not require authorization as well: 75600, 75605, 75625, 75630, 75650, 75658, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 75705, 75710, 75716, 75722, 75724, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75774, 75791
Cataract	66820, 66821, 66830, 66982, 66983, 66984
Cecostomy tube	49442
Cerclage during Pregnancy	59320
Colonoscopy	44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392
Cystourethroscopy	52270, 52275, 52276, 52265, 52260, 52000,52001, 52005
D&C	58120, 59812, 59820, 59821
Endometrial/Endocervical Sampling (biopsy)	58100
Gastrostomy Tube	49440, 49450, 43760, 43761, 49460
Gastrostomy Tube to Jejunostomy Tube	49446, 49452
GI Endoscopy	43234, 43235, 43236, 43237, 43238, 43239, 43240, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, 43256, 43257, 43258, 43259, 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272
Hardware Removal	20680, 20670
Inguinal Hernia	49505, 49507, 49520, 49521, 49525, 49650, 49651
Jejunostomy Tube	49441, 49451
Lacrimal Duct	68811, 68815, 68816
Lap Cholecystectomy	47563, 47564, 47562
Laryngoscopy	31505, 31510, 31511, 31512, 31513, 31515, 31520, 31525, 31526, 31527, 31528, 31529, 31530, 31531, 31535, 31536, 31540, 31541, 31545, 31546, 31560, 31561, 31570, 31571, 31575, 31576, 31577, 31578, 31579
Malignant Lesion	11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11640, 11641, 11642, 11643, 11644, 11646, 17260, 17261, 17262, 17263, 17264, 17266, 17270, 17271, 17272, 17273, 17274, 17276, 17280, 17281, 17282, 17283, 17284, 17286
Orchiopexy	54640
PICC line placement/ replacement	36568, 36569, 36582, 36584, 36589, 36590, 36598
PORT-A-CATH	36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36576, 36578
Sigmoidoscopy	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345
Sterilization*	55250, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58600, 58605, 58611, 58615, 58671, 58940
Tonsillectomy/Adenoidectomy	42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836
TURP	52601, 52630
Tympanoplasty/ Myringotomy	69420, 69421, 69424, 69433, 69436, 69631, 69632, 69633, 69635, 69636, 69637, 69641, 69642, 69643, 69644, 69645, 69646

Important Information For Molina Healthcare/Molina Medicare

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT Lab or X-ray report/results)
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone or fax. Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition.

Providers can request a copy of the criteria used to review requests for medical services.

Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at 1-866-449-6849 (Bexar, Dallas, El Paso, Harris, Hidalgo & Jefferson Service Areas) or 1-877-319-6826 (CHIP Rural Service Area).

Important Molina Healthcare/Molina Medicare Information	
Prior Authorizations: 8:00 a.m. – 5:00 p.m. Phone: 1-866-449-6849 (Bexar, Dallas, El Paso, Harris, Hidalgo, & Jefferson Service Areas) 1-877-319-6826 (CHIP Rural Service Area) Fax: 1-866-420-3639 **Behavioral Health Authorizations:** Phone: 1-800-818-5837 Fax: 1-866-617-4967 For Behavioral Health Services in Dallas Service Area (STAR+PLUS), please call NorthSTAR at 1-888-800-6799 **Member/Provider Customer Service Benefits/Eligibility:** Phone: 1-866-449-6849 (Bexar, Harris & Dallas Service Areas) 1-877-319-6826 (CHIP Rural Service Area) Fax: 1-281-599-8916	**24 Hour Nurse Advice Line** English: 1-888-275-8750 [TTY: 1-866/735-2929] Spanish: 1-866-648-3537 [TTY: 1-866/833-4703] **Vision Care:** (www.opticarevisionplans.com provrel@opticare.net) Phone: 1-800-368-4790 (CHIP) 1-866-492-9711 (STAR) 1-877-832-4118 (STAR+PLUS) **Dental:** Liberty Dental Phone: 1-888-359-1084 (Bexar, Dallas, El Paso, Harris, Hidalgo & Jefferson Service Areas)

Providers may utilize Molina Healthcare's ePortal at: www.molinahealthcare.com

Available features include:

- Authorization submission and status
- Claims submission and status (EDI only)
- Download Frequently used forms
- Member Eligibility
- Provider Directory
- Nurse Advice Line Report

Molina Healthcare/Molina Medicare Prior Authorization Request Form

Phone Number: 1-866-449-6849 (Bexar, Dallas, El Paso, Harris, Hidalgo, & Jefferson Service Areas)
or 1-877-319-6826 (CHIP Rural Service Area)
Fax Number: 1-866-420-3639

Member Information

Plan: ☐ **Molina Medicaid** ☐ **Molina Medicare** ☐ **Other:**_____

Member's Name:_____ DOB: _____/_____/_____

Member's ID#:_____ Member Phone #: ( ) _____

Service Is: ☐ Elective/Routine ☐ Expedited/Urgent*

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

Referral/Service Type Requested		
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Rehab (PT, OT, & ST) ☐ Diagnostic Procedure ☐ Chiropractic ☐ Wound Care ☐ Infusion Therapy	☐ **Home Health** ☐ **DME** ☐ **In Office**

ICD-9 Code & Description:_____

CPT/HCPC Code & Description:_____

Number of visits requested:_____ Date(s) of Service:_____

Please send clinical notes and any supporting documentation

Provider Information

Requesting Provider Name: _____

Facility Providing Service: _____

Contact @ Requesting Provider's: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

For Molina Use Only:

How to Request an Authorization

Current (up to 6 months), adequate patient history related to the requested services should be submitted when seeking prior authorization. Examples of information needed include:

- Physical examination that addresses the problem
- Lab or X-ray results to support the request
- PCP or Specialist progress notes or consultations
- Any other information or data specific to the request

To obtain a prior auth, please fill out form attached (in ATTACHMENT IX) completely and fax to number located on top of Service request form (Fax # 1-866-420-3639). If you have an urgent request, please mark on fax "URGENT". Urgent requests are usually processed within 24-72 hours. If it needs to be processed Stat, please call 1-866-449-6849.

Authorization Turn-Around Times

Type of Request	HHSC Requirement (Star & Star Plus)	28 TAC 19.1710 (CHIP)
Non-Urgent Pre-Service Decisions	Within 3 business days of receipt of request	Within 2 business days after receipt of request -or- If received after business hours, within 3 calendar days of the beginning of the next business day
Urgent Pre-Service	Within 72 hours (3 calendar days or receipt)	Within 72 hours (3 calendar days of receipt)
Urgent Concurrent Review	Within 24 hours (1 calendar day of receipt)	Within 24 hours (1 calendar day of receipt)

Definitions:

Pre-Service – A request that must be approved in part or whole in advance of the member obtaining medical care or services. Pre-authorizations and Pre-certifications are pre-service decisions.

Post-Service – Any request for coverage of care of service that a member has already received.

Concurrent – Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care.

Urgent – Any request for medical care of treatment which could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or in the opinion of the practitioner would subject the member to severe pain that cannot be managed adequately without the care or treatment that is subject of the request.

Non-Urgent – This request will not involve any unnecessary interruption in the member's treatment for decision-making that may jeopardize the member's life, health, or ability to recover.

Hospital Admissions

All admissions must notify Molina Healthcare of current admission within next business day.

Once the complete information is received, Molina Healthcare will process any "non-urgent" requests within two (2) business days. "Urgent" requests will be processed within one (1) business day. Providers who request prior authorization approval for patient services and/or procedures can request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at 1-866-449-6849.

Notification of Denied Services

Molina will notify the Member, the Member's Authorized Representative, or the Member's Provider of Record of the Determination. A licensed nurse will verbally notify a provider of the offer for a Peer to Peer and provide information on how to reach the Molina Healthcare Medical Director within 24 hrs prior to issuing a denial. If, after the treating and/or attending physician discusses the case with the CMO/Medical Director, and the decision for a denial is made, an adverse determination letter is generated and mailed to the member, physician and facility within 24 hours of the determination.

Continuity of Care

Molina Members who are involved in an "active course of treatment" have the option to stay with the practitioner who initiated the care. The lack of a contract with the Provider of a new Member or terminated contracts between Molina and a Provider will not interfere with this option. This option includes the following Members who are:

- exhibit pre-existing conditions
- In the 24th week of pregnancy (STAR only)
- Receiving care for an acute medical condition
- Receiving care for an acute episode of a chronic condition
- Receiving care for a life threatening illness, and
- Receiving care for a disability

For each Member identified in the categories above, Molina will work with the treating Provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the Member's needs.

What if a member moves?

If a member moves out of the service area, Molina will continue to cover medically necessary care through the end of the month.

Chapter 7
Coordination of Care, Medical Case Management, and Disease Management

Coordination of Covered Services Not Directly Provided by the Molina Network (STAR, STAR+PLUS, & CHIP)

Molina will assist providers in making necessary arrangements to provide home and community support services to integrate covered services not directly provided by the Molina network, including:

Case Management Services

Coordination with Non-Medicaid Managed Care Covered Services
Molina will make our best effort to implement a systematic process to enlist the involvement of community organizations that may not be providing STAR+PLUS or STAR-covered services but are otherwise important to the health and well being of Members. Molina will also make our best effort to establish relationships with these community organizations in order to make referrals for CSHCN and other members who need community services. These organizations may include, but are not limited to:

- Primary and preventative dental THSteps dental services
- Texas agency administered programs and case management services
- Essential public health services
- School Health and Related Services (SHARS)
- Texas Department of Mental Health and Mental Retardation (TDMHMR)
- Mental health rehabilitation
- Case management for children and pregnant women
- Texas Health Steps medical case management
- Department of Assistive and Rehabilitation Services (DARS)
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Medical transportation services available through the Texas Health and Human Services Commission
- DADS hospice services

Additional coordination of services will be provider for: Dental services, Texas agency administered programs and case management services as well as Vendor Drugs (out-of-office drugs).

Coordination with Non-CHIP Covered Services

Molina will also make its best effort to coordinate Non-Chip covered services with various community organizations in order to make referrals for members who need community services. We will assist our CHIP Program and/or CHIP Perinatal Program Members with accessing programs such as Texas agency administered programs and case management services; and essential public health services.

Medical Case Management (MCM)

The MCM Program is designed to be a systematic approach to monitoring known or potentially complex and high cost medical cases. The program is based on a member advocacy philosophy designed and administered to assure the member value-added coordination of healthcare and services; to increase continuity and efficiency; and produce optimal outcomes. The focus and responsibility of the program integrates all phases of care for members with complex needs and/or members who require services that are "carved out" from coverage based on contractual arrangements, to ensure continuity and prevent disruption of needed medical care.

MCM is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitates communication between the member's Primary Care Physician, the member, family members, other practitioners, facility personnel, ancillary providers and community resources as applicable.

Practitioners may also contact Molina's Provider Services or Medical Case Management during business hours Monday-Friday toll free 1-866-449-6849 for questions regarding the referral process to medical case management.

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women (CPW) provides services to children with a health condition/health risk, birth through 20 years of age and to high-risk pregnant women of all ages, in order to encourage the use of cost-effective health and health-related care. Together, the case manager and family shall assess the medical, social, educational and other medically necessary service needs of the eligible recipient. The disclosure of medical records between Providers, Molina Healthcare and CPW does not require a medical release form from the member.

To request case management services, please call the Texas Health Steps Outreach and Informing Hotline at 1-877-847-8377. Providers may also visit the Texas Department of State Health Services website for additional information.
(http://www.dshs.state.tx.us/caseman/default.shtm)

Disease Management (DM)

The Disease Management Program is a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for chronic medical conditions. Disease management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall health.

Molina Healthcare systematically identifies members who qualify for its DM programs, but also accepts provider referrals and member self-referrals. Systematic identification means use of a rules-based, consistent, population-based process to identify all eligible members according to the eligibility criteria defined for the program. Eligibility for DM programs may be based on the intensity of the disease or special characteristics of the population.

Currently, Molina Healthcare offers Disease Management Programs for **Asthma, Diabetes, Congestive Heart Failure, COPD, CAD and At-Risk Pregnancy**. For more information on these programs or to refer your Molina patients, please call 1-866-449-6849.

Chapter 8
Member Rights and Responsibilities

STAR and STAR+PLUS Member Rights and Responsibilities

What are my rights and responsibilities?

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 complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and 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 a fair hearing from the state Medicaid program and get 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 - limits 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-assist 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 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.

Let us know if you can think of ways to make changes to this policy.

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 –relating to your health with your primary care provider and other providers and learn about service and treatment options. That includes the responsibility to:
    a. Tell your primary care provider, other providers and Molina about your health in order for them to continue to provide care that they need for you
    b. Always follow primary care providers and other providers' plans and instructions for care that you have agreed upon.
    c. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    d. Help your providers get your medical records.

4. You must be involved-Actively participate in decisions relating to service and treatment options and agreed upon goals, make personal choices, and take action to keep yourself-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.

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.

CHIP & CHIP PERINATE MEMBER RIGHTS AND RESPONSIBILITIES

MEMBERS HAVE THE RIGHT TO:

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 and/or medically necessary. You have the right to know about the people in the health plan who decides 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. You have the right to be treated fairly and with respect and with recognition of your dignity and privacy by your health plan, doctors, hospitals and other providers.

10. 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.

11. You have the right to speak for your child in making decisions with your doctor about all treatment choices in their care.

12. You have the right to talk to your child's doctor about all clinical and medical treatment options for your child's condition, regardless of the cost or benefit coverage.

13. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.

14. You have the right to voice a complaint in order to solve problems with your health plan, the plan's doctors, hospitals and others who provide services for your child. If your health plan says it will not pay for a covered service or benefit that your doctor thinks is medically necessary, you have the right to have another doctor outside of the health plan tell you whether or not they think it is necessary. This is called an appeal.

15. You have right to get information and make suggested changes about the rights and responsibilities.

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.

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.

MEMBER RESPONSIBILITIES

1. 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 the CHIP Perinatal.

2. You have the right and responsibility to take part in all the choices about your child's health care. Follow the plans and instructions for care you have agreed upon with your child's doctors.

3. You have the responsibility to supply information that your doctor, other providers and the plan need in order to provide care for your child.

4. Work together with your health plan's doctors and other providers to understand health care problems and pick treatment goals for your child that you have all agreed upon.

5. You have the right to speak for your child in making decisions with your doctor about all treatment choices.

6. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.

7. 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.

8. 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.

9. 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.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services 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.

Chapter 9
Provider Roles and Responsibilities
(STAR, STAR+PLUS & CHIP)

Provider Responsibilities

PCP Duties and Responsibilities

The PCP must provide a medical home to Members. The PCP must provide primary care to patients, maintain the continuity of patient care, and initiate and manage referrals for specialized care. Included within that responsibility are the following obligations:

- Verifying eligibility,
- Supervising, coordinating and providing initial and basic care to Members;
- Initiating and authorizing their referral for specialist care, inpatient care, and other Medically Necessary services;
- Following Members admitted to Inpatient Facilities;
- Maintaining continuity of Member care.

Primary care services are all medical services required by a Member for the prevention, detection, treatment and cure of illness, trauma, or disease, which are covered and/or required services under the Texas Medicaid and CHIP program as required or required by State and/or federal guidelines.

The PCP must ensure that Members under the age of 21 receive all services required by HHSC including but not limited to the American Academy of Pediatrics (AAP) recommended schedule for CHIP Members and the THSteps periodicity schedule published in the THSteps Manual located at on the forms section of this manual- for Medicaid Members. Adults must be provided with preventive services in accordance with the U.S. Preventative Task Force requirements. All services must be provided in compliance with all generally accepted medical standards for the community in which services are rendered.

Note: *Network Providers who are Primary Care Physicians must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. A Primary Care Physician may provide behavioral health related services within the scope of his/her practice.*

Specialty Care Provider Responsibilities

Some specialty services require a referral from the PCP. The Specialist may order diagnostic tests without PCP involvement; however, the Specialist may not refer to another specialist except in a true emergency situation. Specialists must abide by the referral and authorization guidelines as described in "What Requires Authorization."

The Specialist provider must:

- Verify eligibility,
- Obtain referral or authorization from the PCP before providing certain services,
- Refer the member to another specialist provider,
- Provide the PCP with consultation reports and other appropriate records in a timely manner,
- Participate in Peer Review Process and be available for or provide on call coverage through another source 24 hours a day.

Long Term Services & Support Provider Responsibilities

Long term services and support providers are responsible to:

- Verify member eligibility prior to performing services
- Adhere to the Molina Healthcare authorization policies
- Determine if members have medical benefits through other insurance coverage
- Ensure that there is ongoing continuity of care between the member's Molina Healthcare coordinator and the PCP
- Notify the plan whenever there is change in the member's physical or mental condition and a change in their eligibility

Long Term Services & Support Role

Molina's Service Coordinators are responsible for authorizing approved services for Long Term Care providers. The Provider must submit an authorization request with all appropriate CPT and ICD codes along with the company and member information including dates requested to the Molina Service Coordination department. If an authorization requires utilization management's intervention, it may take up to 5 days for the authorization to be returned. All authorizations that are sent to the provider will have specific dates and services that have been approved and are always based upon member enrollment at the time services are rendered. Verbal authorizations will not be given. For details on how to verify Member eligibility please refer to (page 89).

Early childhood intervention case management/service coordination and the Case management for children and pregnant women Providers

Early Childhood intervention (ECI) **Comprehensive Care Program (CCP)**

Effective March 1, 2012 both the early childhood intervention (ECI) and the Comprehensive Care Program (CCP) programs will be part of Medicaid managed benefits. ECI and CCP Providers must submit claims to Molina for reimbursement. Providers are responsible to:

- Verify member eligibility prior to performing services
- Adhere to the Molina Healthcare authorization policies

Pharmacy Provider Responsibilities

- 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 and other benefits

Note: STAR+PLUS Members dually eligible for Medicare will receive most prescription drug services through Medicare rather than Medicaid. The STAR+PLUS Program does cover a limited number of medications not covered by Medicare.

Molina's Quality Assurance Program and Provider Responsibilities

Molina Healthcare has a comprehensive quality assurance program and will audit and review contracted providers upon its discretion. Providers have the responsibility to report any member fraud, waste, or abuse. Members also have the responsibility to report any provider fraud or abuse via the protocol listed in your provider manual.

The provider Performance program is also listed in this provider manual and will assist providers in highly recognized disease management areas such as Hypertension, Diabetes, Asthma, Hyperlipidemia, and preventing unnecessary waste and over utilization.

Member's right to select and have access to, without a Primary Care Provider referral, a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery

You have the right to select an Ophthalmologist or Optometrist to provide eye Health Care services, other than surgery, without a referral from your PCP.

Member's right to obtain medication from any Network Pharmacy. Members can call 1-866-488-4708.

Molina Healthcare Inc. does not limit your ability to obtain medication from any Network pharmacy.

Provider Termination and Dismissal

Providers may terminate their agreement with Molina Healthcare upon sixty (60) days prior written notice in the event that provider rejects any written material modification to policies, procedures or products provided the notice is received no later than 30 days from the date the provider received the notification.

Request to Discharge a Member

It may become necessary for a PCP to discharge a member from his/her panel. Prior to discharging a member, the primary care physician must counsel the patient regarding the patient/physician relationship. Such counseling must be documented appropriately in the medical chart, an incident report or treatment plan. If the behavior does not improve, the PCP may request in writing to the Plan, the member be dismissed from his/her panel. The Member Services department will send written notification to the member advising them to select a new PCP. The PCP is required to continue treating the member for 30 days following the notification to the member.

Access and Availability

Emergency and After Hours Access
A Contracted Primary Care Provider must ensure that he/she will be available or accessible, or arrange to have another qualified medical professional available or accessible twenty-four (24) hours a day, seven (7) days a week.

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

The following are acceptable and unacceptable telephone arrangements for contracted PCPs after their normal business hours:

Acceptable after-hours coverage

A. The office telephone is answered after-hours by an answering service, which meets language requirements of the Major Population Groups and which can contact the PCP or another designated medical practitioner.
B. All calls answered by an answering service must be returned within 30 minutes;

C. The office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the patient to call another number to reach the PCP or another provider designated by the PCP.
D. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
E. The 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 30 minutes.

Unacceptable after-hours coverage

- The office telephone is only answered during office hours;
- The office telephone is answered after-hours by a recording that tells patients to leave a
- message;
- The office telephone is answered after-hours by a recording that directs patients to go to
- an Emergency Room for any services needed; and
- Returning after-hours calls outside of 30 minutes.

Appointment Availability/Waiting Times for Appointments

The following schedule should be followed by all Molina network providers regarding appointment availability:

- Routine exams should be provided within 14 days of request.
- Preventive health services for children within 60 days
- Preventive health services for adults within 90 days
- Urgent care should be received within 24 hours of the request.
- Emergency care should be received immediately.
- Referrals to a specialist should be seen within 30 days of a request.
- Prenatal Care in 3rd Trimester to an OB/GYN should be seen within 5 days of a
- New Member 90 daysrequest.
- Prenatal 14 days Unless high risk
- THSteps according to Periodicity Schedule (see schedule in forms section of this manual)

Referrals and Coordination of Care

Referral to Specialists

The PCP must assess the medical needs of Members and make medically necessary referrals to specialty care providers who are currently enrolled as participating provider with Molina Healthcare. If PCP believes that a Member needs to be referred to an Out-of Network provider, including medical partners not contracted with Molina, documentation demonstrating the need must be submitted to Molina Healthcare for review and prior authorization before referral can occur.

Members with disabilities, special health care needs, or chronic or complex conditions are allowed direct access to a specialist.

Coordination with Texas Department of Family & Protective Services

Molina works with TDFPS to ensure children in custody, or under the supervision, of TDFPS receive needed services. The needs of this population are special in that children will transition in and out of care more frequently than the general population.

Providers must:

- Coordinate with DFPS and Foster parents for the care of a child who is receiving services from, or has been placed in the conservatorship of DFPS and respond to requests from DFPS, including provide medical records to TDFPS
- Schedule medical and Behavioral Health Services appointments within 14 days unless requested earlier by TDFPS
- Refer suspected abuse and neglect to TDFPS.

Molina must continue to provide all Covered Services to a Member receiving services from, or in the protective custody of TDFPS until the Member has been disenrolled from Molina due to loss of eligibility or placed into foster care.

Coordination and Referral to Other Health and Community Resources

The PCP must coordinate the care of Members with other Medicaid programs, public health agencies and community resources which provide medical, nutritional, educational, and outreach services to Members, including Women, Infants and Children Program (WIC), school health clinics, and local health and mental health departments.

Admissions for Inpatient Hospital Care

The Provider must maintain admitting privileges with a Molina participating hospital, or make arrangements with another Texas licensed physician who is an eligible Medicaid provider and who maintains admitting privileges with a participating Molina hospital

Confidentiality and HIPAA

Confidentiality

All Member information, records and data collected, or prepared by the Provider, or provided to the Provider by HHSC or another state agency is protected from disclosure by state and federal laws. The Provider must ensure that all information relating to Members is protected from disclosure except when the information is required to verify eligibility, provide services or assist in the investigation and prosecution of civil and criminal proceedings under state or federal law. The Provider must inform Members of their right to have their medical records and Medicaid information kept confidential.

The Provider must educate employees and Members concerning the human immunodeficiency virus (HIV) and its related conditions including acquired immunodeficiency syndrome (AIDS), and must develop and implement a policy for protecting the confidentiality of AIDS and HIV-related medical information and an anti-discrimination policy for employees and Members with communicable diseases. See also Health and Safety Code, Chapter 85, Subchapter E, relating to Duties of State Agencies and State Contractors.

HIPAA (Health Insurance Portability and Accountability Act) Requirements

Molina Healthcare's Commitment to Patient Privacy

Protecting the privacy of members' personal health information is a core responsibility that Molina Healthcare takes very seriously. Molina Healthcare is committed to complying with all federal and state laws regarding the privacy and security of members' protected health information (PHI).

Provider/Practitioner Responsibilities

Molina Healthcare expects that its contracted Providers/Practitioners will respect the privacy of Molina Healthcare members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

Applicable Laws

Providers/Practitioners must understand all state and federal healthcare privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that Providers/Practitioners must comply with. In general, most Texas healthcare Providers/Practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
    a. HIPAA
    b. Medicare and Medicaid laws

2. TX Medical Privacy Laws and Regulations

Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers/Practitioners should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider/Practitioner may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI.

Uses and disclosures for TPO apply not only to the Provider/Practitioner's own TPO activities, but also for the TPO of another covered entity. (See, Sections 164.506(c)(2) & (3) of the HIPAA Privacy Rule.) Disclosure of PHI by one covered entity to another covered entity, or healthcare provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services." (See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule.)

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

    - Quality improvement
    - Disease management
    - Case management and care coordination
    - Training Programs
    - Accreditation, licensing, and credentialing

Importantly, this allows Providers/Practitioners to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS and quality improvement.

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Healthcare Providers/Practitioners must allow patients to exercise any of the below-listed rights that apply to the Provider/Practitioner's practice:

- **Notice of Privacy Practices**
  Providers/Practitioners that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider/Practitioner should obtain a written acknowledgment that the patient received the notice of privacy practices.

- **Requests for Restrictions on Uses and Disclosures of PHI**
  Patients may request that a healthcare Provider/Practitioner restrict its uses and disclosures of PHI. The Provider/Practitioner is not required to agree to any such request for restrictions.

- **Requests for Confidential Communications**
  Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners must accommodate reasonable requests by the patient.

- **Requests for Patient Access to PHI**
  Patients have a right to access their own PHI within a Provider/Practitioner's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider/Practitioner includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.

- **Request to Amend PHI**
  Patients have a right to request that the Provider/Practitioner amend information in their designated record set.

- **Request Accounting of PHI Disclosures**
  Patients may request an accounting of disclosures of PHI made by the Provider/Practitioner during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

HIPAA Security

Providers/Practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers/Practitioners should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information – without the person's knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina Healthcare.

HIPAA Transactions and Code Sets

Molina Healthcare strongly supports the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare Providers/Practitioners are encouraged to submit claims and other transactions to Molina Healthcare using electronic formats. Certain electronic transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advice

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at www.molinahealthcare.com for additional information.

National Provider Identifier

Provider/Practitioners must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider/Practitioners must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider/Practitioner. The Provider/Practitioner must report its NPI and any subparts to Molina Healthcare and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within (30) days and should also be reported to Molina Healthcare within (30) days of the change. Provider/Practitioners must use its NPI to identify itself on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Healthcare. **NPI must be attested with TMHP for more information call Provider Services at 1-866-449-6849.**

Additional Requirements for Delegated Providers/Practitioners

Providers/Practitioners that are delegated for claims and utilization management activities are the "business associates" of Molina Healthcare. Under HIPAA, Molina Healthcare must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers/Practitioners must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Non-Discrimination

The Provider agrees to provide services to Molina Members on the same basis, at the same level, and the same quality as all other patients.

PCP Patient Capacity

There are no limitations on the number of patient's a PCP can have assigned to his/her practice; however, all PCP's reserve the right to state the number of patients they are willing to accept into their practice.

If a provider desires to make a change to his/her capacity, provider must contact the Provider Services Department. If the change request is received between the 1st and the 15th of the month, the change will be effective on the 1st day of the following month. If the change request is received after the 15th of the month, the change will be effective on the 1st day of the 2nd month following the request.

Medical Records

Providers must maintain confidential and complete medical records. Records must reflect all aspects of patient care, including ancillary services. Such records will enable providers to render the highest quality health care and enable Molina to review the quality and appropriateness of services.

Medical Record Keeping Practices

The following record keeping practices must be followed:

- Each patient has a separate medical record and pages are securely attached in the medical record.
- Medical records are organized with dividers.
- A chronic problem list is included in the record for all adults and children.
- Records are available at each encounter or are traceable.
- A complete health history is part of the record.
- Health maintenance forms include dates of preventive services.
- Medication sheets are complete and sample medications are documented.
- A system is in place to document missed appointments and phone messages.
- Advance Directives are discussed and documented for those over 18 years of age.
- Medical record retention is sufficient (at least 6 years).

Medical Record Documentation

A confidential medical record must be maintained for each Member that includes all pertinent information regarding medical services rendered. Providers must maintain established standards for accurate medical record keeping. Six categories have been designated as critical areas. These areas are:

- Problem lists
- Allergy designation
- Past medical history
- Working diagnosis consistent with findings
- Plans of action/treatment consistent with diagnosis
- Care medically appropriate

Providers must demonstrate 85% overall compliance in medical record documentation and 85% in each of the six critical categories. Molina uses the guidelines below when evaluating medical record documentation.

- A completed problem list is in a prominent space. Any absence of chronic/significant problems must be noted.
- Allergies are listed on the front cover of the record or prominently in the inside front page. If the patient has no known allergies, this is appropriately noted.
- A complete medical history is easily identified for patients seen three or more times. For children under seven (7) years of age, this includes source of history, family medical history, family social history, prenatal care and summary of birth events, developmental history, allergies, medication history, lead exposure, tobacco exposure, safety practices, serious accidents, operations and illnesses.
- A working diagnosis is recorded with the clinical findings. SOAP charting is recommended but not mandatory when progress notes are written.

- The plan of action and treatment is documented for the diagnosis.
- There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Patient name and identifying number is on each page of the record.
- The registration form or computer printout contains address, home, and work phone numbers, employer, gender and marital status. An emergency contact should also be designated.
- All staff and Provider notes are signed with initials or first initial, last name and title.
- All entries are dated.
- The record is legible to someone in the office other than the Provider. - Dictation is preferred.
- There is an appropriate notation concerning tobacco exposure for children of all ages and the use of alcohol, tobacco, and substance abuse for patients 12 years old and older. - query history of the abuse by the time the patient has been seen three or more times.
- Pertinent history for presenting problem is included.
- Record of pertinent physical exam for the presenting problem is included.
- Lab and other studies are ordered as appropriate.
- There are notations regarding follow-up care, calls, or visits. - the specific time of return is noted in weeks, months, or as needed. Include the preventive care visit when appropriate.
- Previous unresolved problems are addressed in subsequent visits.
- Evidence of appropriate use of consultants. - this is reviewed for under and over utilization.
- Notes from consultants are in the record.
- All reports show initials of practitioner who ordered them.
- All consult and abnormal lab/imaging results show explicit follow-up plans.
- There is documentation of appropriate health promotion and disease prevention education. Anticipatory guidance is documented at each well child check.
- An immunization record and appropriate history of immunizations have been made for both children and adults.
- Preventive services are appropriately used/offered in accordance with accepted practice guidelines.

Medical Record Confidentiality

Molina Members have the right to full consideration of their privacy concerning their medical care. They are also entitled to confidential treatment of all Member communications and records. Case discussion, consultation, examination, and treatments are confidential and should be conducted with discretion. Written authorization from the Member or his/her authorized legal representative must be obtained before medical records are released to anyone not directly connected with his/her care, except as permitted or required by law.

Confidential Information is defined as any form of data, including but not limited to, data that can directly or indirectly identify individual Members by character, conduct, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. Conversations, whether in a formal or informal setting, e-mail, faxes and letters are also potential sources of Confidential Information.

All participating Providers must implement and maintain an office procedure that will guard against disclosure of any Confidential Information to unauthorized persons. This procedure should include:

- Written authorization obtained from the Member or his/her legal representative before medical records are made available to anyone not directly connected with his/her care, except as permitted or required by law.
- All signed authorizations for release of medical information received must be carefully reviewed for any limitations to the release of medical information.
- Only the portion of the medical record specified in the authorization should be made available to the requestor and should be separated from the remainder of the Member's medical records.
- Notification to Molina of change in client condition, physical or eligibility

Second Opinions

Members or Member's PCP can request a second opinion on behalf of the Member. If you or a Member request a second opinion, Molina will give you a decision within 48 hours. If it is an imminent and serious threat, Molina will respond within one (1) day and the second opinion will be given within seventy-two (72) hours. If a qualified Participating Provider is not available to give the Member a second opinion, Molina will make arrangements for a Non-Participating Provider to give them a second opinion. If Molina denies the second opinion because it is not medically necessary, we will send the Member a letter. Members or Providers may appeal the decision. The letter from Molina will tell you how to appeal.

Advance Directives

An advance directive is a formal document, written in advance of an incapacitating illness or injury, in which one can assign decision-making for future medical needs and treatments. Any provider delivering care to a Molina Member must ensure Members receive information on Advance Directives and are informed of their right to execute Advance Directions. Providers must document such information on the permanent medical record. Advance Directive forms may be found in the attachment section of this manual.

Routine, Urgent and Emergent Services

Definitions

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

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.

Urgent Services means services for a health condition, including an Urgent Behavioral Health Situation, which 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 evaluation or treatment within 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 24 hours but which does not place the Member in immediate danger to themselves 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 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 Post- stabilization Care Services.

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 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 should be dispensed any time 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.

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.

The 72-hour emergency supply is not applicable if the three prescription limit for certain adults has been met.

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.

Medicaid Emergency Dental Services:

Molina Healthcare is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for devices for craniofacial anomalies, 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;
- treatment of oral abscess of tooth or gum origin; and
- treatment of craniofacial anomalies.

CHIP Emergency Dental Services:

Molina Healthcare 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;
- treatment of oral abscess of tooth or gum origin; and
- treatment and devices for craniofacial anomalies.

Member Billing Practices

Member Acknowledgement Statement

A provider may bill the following to a Member without obtaining a signed Member Acknowledgment Statement:

- Any service that is not a benefit under Molina's Program (for example, personal care items).
- The provider accepts the Member as a private pay patient. Providers must advise Members that they are accepted as private pay patients at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the Member signs written notification so there is no question how the Member was accepted. Without written, signed documentation that the Medicaid Member has been properly notified of the private pay status, the provider does not seek payment from an eligible Medicaid Member.
- The Member is accepted as a private pay patient pending Medicaid eligibility determination and does not become eligible for Medicaid retroactively. The provider is allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactively, the Member notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the Member becomes eligible, the provider must refund any money paid by the Member and file Medicaid claims for all services rendered.

A provider attempting to bill or recover money from a Member in violation of the above conditions may be subject to exclusion from Molina.

In accordance with current federal policy, Members cannot be charged for the Member's failure to keep an appointment. Only billings for services provided are considered for payment. Members may not be billed for the completion of a claim form, even if it is a provider's office policy.

Private Pay Form Agreement

A private pay form agreement allows for a reduction in payment by a provider to a Member due to a medically needy spend down (effective September 1, 2003, the MNP is limited to children younger than age 19 years and pregnant women). If a provider accepts a Member as a private pay patient, the Provider **must** advise Members that they are accepted as private pay patients at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the Member signs written notification so there is no question how the Member was accepted. Without written, signed documentation that the Medicaid Member has been properly notified of the private pay status, the provider does not seek payment from an eligible Medicaid Member.

There are instances in which the Member is accepted as a private pay patient and a provider may bill a member. This is acceptable, if the provider accepts the patient and informs the member at the time of service that they will be responsible for paying for all services. In this situation, it is recommended that the provider use a Private Pay Form. The provider is allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactively, the Member notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the Member becomes eligible, the provider must refund any money paid by the Member and file Medicaid claims for all services rendered.

SAMPLE

Private Pay Agreement Form
Member Acknowledgment Statement

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

"Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicad no cubra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que Molina Healthcare de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el miembro solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

_____

Member Signature **Date**

Chapter 10
Complaints and Appeals

Medicaid Member Complaints and Appeals

Complaint Process

What should I do if I have a complaint? Who do I call?

We want to help. If you have a complaint, please call us toll-free at 1-866-449-6849 to tell us about your problem. A Molina Member Service Advocate can help you file a complaint. Most of the time, we can help you right away, or at the most, within a few days.

Once you have gone through the Molina complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

If you can get on the Internet, you can send your complaint in an email to HPM_Complaints@hhsc.state.tx.us.

Can someone from Molina help me file a complaint?

Yes we want to help you with the complaint process. When you have a complaint, you can call our Member Advocate. They will help you file the complaint. They will be your contact through the complaint process. You can also call Member Services.

Any of our Member Services team members can help you with your complaint.

Member Advocates

- **Bexar Service Area**
  1-210-366-6500
  Extension 203011
- **Harris Service Area**
  1-281-676-2268
  Extension 202282
- **Dallas Service Area**
  1-972-536-7201
  Extension 207240
- **Hidalgo and El Paso Service Area**
  1-866-449-6849
- **Jefferson Service Area**
  1-866-449-6849 Extension 202282

Member Services Toll Free: 1-866-449-6849

You can send the complaint in writing to:

Molina Healthcare of Texas
Complaint and Appeal Unit
84 N.E. Loop 410, Suite 200
San Antonio, TX 78216

How long will it take to process my complaint?

Your complaint will be processed within (30) calendar days or less, from the date Molina gets your complaint.

Requirements and timeframes for filing a Complaint:

- When we get your complaint, we will send you a letter within five days telling you we have your complaint.
- We will look into your complaint and decide the outcome. We will send you a letter telling you the final outcome. We will not take more than (30) calendar days to complete this process.
- We will keep track of all of your complaint information in a complaint log. If you need more information on your complaint, call our Member Advocate.

Information on how to file a complaint with HHSC, once I have gone through the Molina complaint process.

Once you have gone through the Molina complaint process, you can complain to the Texas Health and Human Services Commission (HHSC) by calling toll free at 1-866-566-8989.

If you would like to make your request in writing, please send it to the following address:

Texas Health and Human Services Commission
Health Plan Operations - H320
P.O. Box 85200
Austin, TX 78708-5200
Attn: Resolution Services

Appeal Process

What can I do if my doctor asks for a service or medicine for me that is covered but Molina denies it or limits it?

You can request an appeal for denial of payment for services in whole or in part.

You can file an appeal with Molina anytime a service is denied or limited. You will need to file the appeal within (30) calendar days from the day you get a letter telling you a service was denied or limited. If you are getting services and the service is now being denied or limited, you will need to file your appeal within (10) calendar **day**s from the day you get a letter telling you the service is being denied so you continue to receive the services you are now getting until your appeal is processed. We will need your appeal in writing; we can help you write your appeal. Every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless an Expedited Appeal is requested.

How will I find out if services are denied?

We will send you a letter telling you a service has been denied.

What happens after I file an appeal?

Once we have your appeal in writing we will send you a letter within (5) business days telling you we have your appeal and it is being worked on. The letter will also tell you that you can ask for a State Fair Hearing anytime during the appeal process. Molina will than review the information about your appeal. We may need to ask for more information from you or your doctor to help us make a decision. You can review the information about your appeal at any time. You can also appear in person, by telephone or tell us about your appeal in writing. Once the final decision is made, we will send you and your doctor a letter with the final decision. This process will not take more than then (30) calendar days. You have the option to request an extension up to 14 calendar days. Sometimes Molina may need more information. If this happens we may extend the appeals process by 14 days. If we extend the appeals process, we will let you know. We will send you a letter. This letter will let you know the reason for the delay.

Who Do I Call?

Just call a Member Advocate, and tell them you would like to file an appeal, they will help you file the appeal and give you updates during the appeal process. You can also call Member Services for help with the appeal process from a team member.

Member Advocates

- **Bexar Service Area**
  1-210-366-6500
  Extension 203011
- **Harris Service Area**
  1-281-676-2268
  Extension 202282
- **Dallas Service Area**
  1-972-536-7201
- **Hidalgo and El Paso Service Area**
  1-866-449-6849
- **Jefferson Service Area**
  1-866-449-6849 Extension 202282

Member Services Toll Free = 1-866-449-6849
You can also write your appeal and send it to:

Molina Healthcare of Texas
Attention: Complaint and Appeal Unit
84 N. E. Loop 410, Suite 200
San Antonio, TX 78216

Can someone from Molina help me file an appeal?
Yes, a Member Advocate or someone in Member Services can help you file your appeal. Just ask for help when you call to file your appeal. **You can also request a State Fair Hearing any time during or after Molina's appeal process.**
Member Advocates

- **Bexar Service Area**
  1-210-366-6500
  Extension 203011
- **Harris Service Area**
  1-281-676-2268
  Extension 202282
- **Dallas Service Area**
  1-972-536-7201
  Extension 207240
- **Hidalgo and El Paso Service Area**
  1-866-449-6849
- **Jefferson Service Area**
  1-866-449-6849 Extension 202282

Expedited MCO Appeal

What is an expedited appeal?
An Expedited Appeal is when the health plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for an expedited appeal?

You can call a Member Advocate or Member Services and ask to file an expedited appeal. We will help you. **Expedited Appeal may be requested either orally or in writing.**
Member Advocates

- **Bexar Service Area**
  1-210-366-6500
  Extension 203011
- **Harris Service Area**
  1-281-676-2268
  Extension 202282
- **Dallas Service Area**
  1-972-536-7201
  Extension 207240
- **Hidalgo and El Paso Service Area**
  1-866-449-6849
- **Jefferson Service Area**
  1-866-449-6849 Extension 202282

Does my request have to be in writing?
No, an Expedited Appeal may be requested either orally or in writing. You can send a written expedited appeal to:

Molina Healthcare of Texas Attention: Complaint and Appeal Dept.
84 N. E. Loop 410, Suite 200
San Antonio, TX 78216

You can call Member Services Toll Free = 1-866-449-6849.

You can call a Member Advocate:

- **Bexar Service Area**
  1-210-366-6500
  Extension 203011
- **Harris Service Area**
  1-281-676-2268
  Extension 202282
- **Dallas Service Area**
  1-972-536-7201
  Extension 207240
- **Hidalgo and El Paso Service Area**
  1-866-449-6849
- **Jefferson Service Area**
  1-866-449-6849 Extension 202282

What are the time frames for an expedited appeal?
Molina will make a decision on an expedited appeal within (3) business days. Your appeal can also be extended up to (14) calendar days, to gather more information, if it is in your best interest to do so. You will be notified if an extension is needed by phone and you will get a letter within two business days.
If there is a risk to your life, a decision will be made within 24 hours from the time Molina gets your expedited appeal.

What happens if Molina denies the request for an expedited appeal?
Molina may make a decision that your appeal should not be expedited. If this decision is made, we will follow the standard appeal process. As soon as this is decided, we will try to call you to let you know the standard appeal process will be followed. We will also send you a letter within (2) calendar days with this information.

Who can help me file an Expedited Appeal?
You can call a Molina Member Advocate and ask for help, or you can call Member Services. When you call, just tell them you would like to file an expedited appeal, they will know to work on it very quickly.

Member Advocates

- **Bexar Service Area**
  1-210-366-6500
  Extension 203011
- **Harris Service Area**
  1-281-676-2268
  Extension 202282
- **Dallas Service Area**
  1-972-536-7201
  Extension 207240
- **Hidalgo and El Paso Service Area**
  1-866-449-6849
- **Jefferson Service Area**
  1-866-449-6849 Extension 202282

State Fair Hearing

Can I ask for a State Fair Hearing?
If you, as a member of the health plan, disagree with the health plan's decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the fair hearing within 90 days of the date on the health plan's letter with the decision. If you do not ask for the fair hearing within 90 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should either send a letter to the health plan at:
Molina Healthcare of Texas

Attention Complaint & Appeal Dept.
84 N. E. Loop 410, Suite 200
San Antonio, TX 78216

Or by telephone Toll Free at: 1-866-449-6849

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision is made if you ask for a fair hearing by the later of: (1)10 days from the date you get the health plan's decision letter, or (2) the day the health plan's letter says your service will be reduced or end. If you do not request a fair hearing by this date, the service the health plan denied will be stopped.

If you ask for a fair hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.
If the decision is that you did not need the service, you may need to pay for it.

Complaint Process (CHIP & CHIP Perinate)

COMPLAINTS

What should I do if I have a complaint?
We want to help. If you have a complaint, please call us toll-free at 1-866-449-6849 (Dallas, Harris and Jefferson SA) or 1-877-319-6826 (CHIP RSA) to tell us about your problem. A Molina Member Services Advocate can help you file a complaint. Most of the time, we can help you right away or at the most within a few days.

If I am not satisfied with the outcome, who else can I contact?
If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance 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
Consumer Protection
P.O Box 149091
Austin, Texas 78714-9091

Who do I call?
You can also call Member Services. Any of our Member Services team members can help you with your complaint.

Member Services Toll Free:
Bexar, Dallas, El Paso, Harris, Hidalgo and Jefferson SA Toll Free Number: 1-866-449-6849
CHIP Rural Service Area (RSA)-Toll Free Number: 1-877-319-6826

You can also write your complaint and send it to:

Molina Healthcare Complaint and Appeal Unit
84 N.E. Loop 410, Suite 200
San Antonio, TX 78216

Texas Department of Insurance Consumer Protection (111-1A)
P.O. Box 149091
Austin, TX 78714-9091

E-mail: ConsumerProtection@tdi.state.tx.us
Main Number: 1-512-463-6500
1-800-252-3439
Fax Number: 1-512-475-1771
Information can also be accessed on the State website at:
www.tdi.state.tx.us/consumer/cpportal.html

Can someone from Molina help me file a complaint?
Yes, we want to help you with the complaint process. When you have a complaint, you can call Member Services and ask for help with your complaint.
Member Services Toll Free:
Dallas, Harris and Jefferson SA Toll Free Number: 1-866-449-6849
CHIP Rural Service Area (RSA)-Toll Free Number: 1-877-319-6826

How long will it take to handle my complaint?
Your complaint will be handled within (30) calendar days from the date Molina receives your complaint. It could take less than30 days. You will get a letter. The letter will tell you how your complaint was resolved. This letter will explain the complete complaint and appeal process. It will also tell you about your appeal rights. If the complaint is for an emergency for inpatient hospital or on-going care, Molina will resolve your complaint within one (1) business day.

What do I need to do to file a complaint? How long do I have to file a complaint?
You can file a complaint at anytime. You will receive a letter within five calendar days. The letter will tell you your complaint was received. Your complaint will be resolved within (30) calendar days from the day Molina gets your complaint.

If I am not satisfied with the results, who else can I contact?
You can call the Texas Department of Insurance.

Do I have the right to meet with a complaint appeal panel?
Yes, if you are not happy with the results of your complaint, call Member Services. They will help you set up a meeting with the Complaint Appeal Panel. Molina's appeal panel includes a doctor, a Member and an employee of Molina. The providers will be familiar with your kind of complaint. Members of the panel have not been involved in your case before. We will let you know we received your appeal. A letter will let you know the complete complaint and appeal process. This letter will tell you about your appeal rights.

You can call Member Services: (Dallas, Harris and Jefferson SA) -Toll Free Number: 1-866-449-6849 or CHIP Rural Service Area (RSA)-Toll Free Number: 1-877-319-6826

Process to Appeal a CHIP Adverse Determination (CHIP & CHIP Perinate)

What can I do if Molina denies or limits my doctor's request for a covered service?

You can file an appeal any time with Molina.

How will I be notified if services are denied?
Molina will send you a letter. It will tell you if a service is denied or limited.

How long does the appeals process take?

You will get a letter. You should get it in five (5) business days. The letter will tell you Molina got your appeal. Your appeal will be handled within thirty (30) calendar days. Calendar day starts from the day Molina gets it. Some appeals are for an emergency for inpatient hospital or on-going care. For emergency appeals Molina will resolve your appeal within one (1) business day. Molina will send you a letter to let you know you that your complaint has been handled. Molina will send a copy of this letter to your provider.

When do I have the right to request an appeal?
You can file an appeal anytime after you have had a benefit denied. You can file one if a service was limited.

Does my request have to be in writing?
No, you can request an appeal by telephone. You can call Member Services.
Member Services Toll Free:
Dallas, Harris and Jefferson SA - Toll Free Number: 1-866-449-6849
CHIP Rural Service Area (RSA)-Toll Free Number: 1-877-319-6826

You can write the appeal on paper and send it to us. You can send your written appeal to:

Molina Healthcare
Attention: Complaint and Appeal Unit
84 N. E. Loop 410, Suite 200
San Antonio, TX 78216

Can someone from Molina help me file an appeal?

Yes, someone in Member Services can help you file your appeal

Expedited Appeal (CHIP & CHIP Perinate)

What is an expedited appeal?
An Expedited Appeal is when the health plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health.

How do I ask an expedited appeal?
You can call Member Services and ask to file an expedited appeal. We will help you.
Member Services Toll Free:
Dallas, Harris and Jefferson SA Toll Free Number: 1-866-449-6849
CHIP Rural Service Area (RSA)-Toll Free Number: 1-877-319-6826

Does my request have to be in writing?
No, you can call Member Services and ask for help with your appeal. We will accept them orally or in writing.
Member Services Toll Free:
Dallas, Harris and Jefferson SA -Toll Free Number: 1-866-449-6849 or CHIP Rural Service Area (RSA)-Toll Free Number: 1-877-319-6826
You can send your written appeal to:

Molina Healthcare Attention: Complaint and Appeal Dept.
84 N. E. Loop 410, Suite 200
San Antonio, TX 78216

How long will it take to handle an expedited appeal?
Molina will make a decision within one (1) business day. For emergency appeals, we will send a letter telling you your complaint have been handled. We will send your provider a letter telling him/her that your complaint has been resolved.

What happens if Molina denies the request for an expedited appeal?
Molina may make a decision that your appeal should not be expedited. If so, we will follow the regular appeal process. Once the process is complete, we will call you to let you know the regular appeal process. We will tell what you can do next. We will send you a letter within one (1) calendar day. The letter will tell you of the denial. Molina will send a copy of this letter to your provider. This letter will have the complete complaint and appeal process. It will tell you about your appeal rights.

Who can help me in filing an appeal?
Molina wants to help you with the expedited appeal process. You can call Member Services. When you call, just tell them you would like to file an expedited appeal, they will know to work on it very quickly.
Member Services Toll Free:
Dallas, Harris and Jefferson SA Toll Free Number: 1-866-449-6849
CHIP Rural Service Area (RSA)-Toll Free Number: 1-877-319-6826

Independent Review Organization (IRO) Process (CHIP & CHIP Perinate)

What is an Independent Review Organization (IRO)?
It will review the medical necessity of health care services. It is not part of Molina. It has no connection with our providers. Their decision is final.

External Review by Independent Review Organization (CHIP & CHIP Perinate)

What is an Independent Review Organization (IRO)?
It will review the medical necessity of health care services. It is not part of Molina. It has no connection with our providers. Their decision is final.

How do I request an IRO review?
You can call Member Services for help with the IRO process.
Member Services Toll Free:
Dallas, Harris and Jefferson SA -Toll Free Number: 1-866-449-6849
CHIP Rural Service Area (RSA)-Toll Free Number: 1-877-319-6826

How long will the IRO review take?
Molina will call TDI. We will call TDI the day you call asking for an IRO review. TDI will assign your case within one (1) business day. TDI will let everyone know who your case was given to. Molina will send all the information TDI needs. Molina will send the information within three (3) business days of the day you asked for the review. The IRO will make a decision on your case within fifteen (15) business days. It will be no later than twenty (20) business days. You asked for the review because of something life threatening. In this case TDI will make a decision within five (5) business days. It will not be later than eight (8) business days of getting the assignment.
IRO Information Line:
1-888-TDI-2IRO (834-2476)
1-866-554-4926 in Austin

Provider Complaints and Appeals

Provider Complaints

A provider has the right to file a complaint with Molina Healthcare at anytime. The provider also has the right to file a complaint directly with HHSC.

How to file a Medicaid Complaint:

Medicaid (STAR and STAR+PLUS) complaints
- A complaint can be oral or written:

MOLINA	HHSC
Call: 1-866-449-6849 or 713-418-1999	**Call:** 1-800-252-8263
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Provider Complaints San Antonio, TX 78216	**Write to:** HHSC Po Box 85200 Austin, TX 78708

How to file a CHIP Complaint:

CHIP complaints
- A complaint can be oral or written:

MOLINA	TDI
Call: 1-866-449-6849	**Call:** 1-800-252-3439
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Provider Complaints San Antonio, TX 78216	**Write to:** TDI Consumer Protection (111-1A) Po Box 149091 Austin, Texas 78714-9091

Complaint Timeframes:

- A provider can file a complaint anytime.
- When a complaint is received verbally, Molina will send an acknowledgement letter along with a one page complaint form within 5 business days.
- When Molina Healthcare receives a written complaint from a provider we will send an acknowledgement letter to the provider within 5 business days.
- Complaints will be investigated, addressed, and the provider will be notified of the outcome, in writing, within 30 calendar days from the date the complaint is received by Molina Healthcare.

Appeal Process

Appeal means the formal process by which a Provider requests a review of the HMO's Action.

Action means:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial in whole or in part of payment for services;
- The failure to provide services in a timely manner;
- The failure of an HMO to act within the timeframes set forth in the contract;
- For a resident of a rural area with only one HMO, the denial of a Medicaid Members' request to obtain services outside of the Network.

How to file an appeal:

- An appeal can be filed in writing or verbally.

MOLINA
Call: 1-866-449-6849
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Provider Complaints San Antonio, TX 78216

Appeal Timeframes:

- Provider or Practitioner appeal of a Utilization Management (UM) decision shall be adjudicated in a thorough, appropriate, and timely manner.
- The provider or practitioner is allowed **120 days** from the date of the initial denial notification to submit a first level appeal.
- A first level appeal for decisions made by Molina shall be reviewed by a Medical Director not involved in the initial denial decision.
- The provider or practitioner is allowed **thirty (30) days** from the first level appeal decision notification to submit a second level appeal.
- A second level appeal of a first level appeal decision may be made by a Molina Healthcare Medical Director or an independent reviewer for reconsideration.

Expedited Appeals (Medicaid)

Expedited Appeal (Medicaid) – Means an appeal to the HMO in which the decision is required quickly based on the Member's health status, and the amount of time necessary to participate in a standard appeal could jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

How to File an Expedited Appeal:

- A Member or Member's representative have the right to file an expedited appeal with Molina. Molina's expedited appeal process must be complete prior to requesting a fair hearing:
- Expedited appeals can be filed orally or in writing.

MOLINA	HHSC
Call: 1-866-449-6849	**Call:** 1-800-252-8263
Write to: Molina Health Care of Texas 84 NE Loop 410, Suite 200 Attn: Provider Complaints San Antonio, TX 78216	**Write to:** HHSC Appeals Division, Fair Hearing Y-613 P.O. Box 149030 Austin, TX 78714

Expedited Appeal Process (CHIP)

1. A member, member's representative, authorized representative, or provider may submit an oral or written request for an expedited appeal to Molina. The expedited appeals request is forwarded to the Appeals Coordinator the same business day.
2. The Appeals Coordinator reviews the request and forwards the request for specialty review to ensure the provider reviewing the case has not previously reviewed the case and is of the same or similar specialty as typically manages the condition, procedure to treatment under review.
3. The time for resolution of an expedited appeal is based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received
4. If the appeal is denied, the resolution includes the following:
    a. The clinical basis for the denial;
    b. The specialty of the physician or other health care provider making the denial; and
    c. The appealing party's right to seek review of the denial by an independent review organization under Subchapter I, and the procedures for obtaining that review.
5. If, upon review of the case, the request for an expedited appeal is denied, the following is implemented:
    a. The appeal is transferred to the timeframe for standard resolution, and
    b. A reasonable effort is made to give the Member prompt oral notice of the denial, and follow up within 2 (two) calendar days with a written notice.

Expedited Appeal Timeframes:

- Molina must acknowledge receipt of the Member's request for an expedited appeal within one business day.
- After Molina receives the request for an Expedited Appeal, it must notify the Member of the outcome of the Expedited Appeal within 3 business days.
- Except Molina must complete investigation and resolution of an Expedited Appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one (1) business day after receiving the Member's request for Expedited Appeal is received.
- Except for an Expedited Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the Expedited Appeal may be extended up to 14 calendar days if the Member requests an extension or Molina shows (to the satisfaction of HHSC, upon HHSC's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, Molina must give the Member written notice of the reason for delay if the Member had not requested the delay.

External Review by Independent Review Organization (CHIP)

What is an Independent Review Organization (IRO)?

The Member may be able to have an Independent Review Organization (IRO) review a decision by Molina to not pay for a treatment it considers medically unnecessary or inappropriate. In most cases, the Member or Member's representative must first appeal to Molina before requesting an IRO review. The Member can skip the appeal process if the Member's doctor believes the condition is life threatening.

How To Request an IRO Review:

When Molina or Molina's Utilization Review Agent deny the appeal, the Member, Member's designated representative, or your child's provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

IRO Review Timeframes:

The entire independent review process should be completed by the IRO, including the IRO's determination, no longer than the earlier of the 15th day after the IRO receives all the information or the 20th day after the IRO receives the request for independent review.

In circumstances involving a Life-threatening condition, the child is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In Life-threatening situations, Member, Member's designated representative or your child's Physician or Provider of record may contact Molina or Molina's Utilization Review Agent by telephone to request the review by the IRO and Molina or Molina's utilization review agent will provide the required information. In cases involving a Life-threatening condition, the IRO should complete the entire independent review process and make a determination in no more than 8 calendar days from the date the IRO receives a completed form and all the necessary information.

When the IRO completes its review and issues its decision, Molina will abide by the IRO's decision. Molina will pay for the IRO review. If you have any questions about the independent review process, you can contact the Texas Department of Insurance at: 1-888-TDI-2IRO.

The appeal procedures described above do not prohibit the Member from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if he/she believes that the requirement of completing the appeal and review process places the child's health in serious jeopardy.

Additional Resolution Options

Dissatisfied with STAR, STAR+ PLUS Complaint or Appeal Outcome?

Upon receipt of the **STAR** complaint outcome, if the provider is still dissatisfied, the provider may contact HHSC or TDI for further resolution. For more information:

Call HHSC at: 1-512-338-6569; Fax: 1-512-794-6815; or
E-mail: provider.resolutions@hhsc.state.tx.us
Texas Health and Human Services Commission
Medical Appeals and Provider Resolution Division, Y-929
1100 West 49th Street
Austin, TX 78756-3172

Dissatisfied with CHIP Complaint or Appeal Outcome?

Upon receipt of the **CHIP** complaint outcome, if the provider is still dissatisfied, the provider may contact HHSC or TDI for further resolution. For more information:

Call TDI at: 1-800-232-3439; Fax 1-512-475-1771; or
E-mail: ConsumerProtection@tdi.state.tx.us
Texas Department of Insurance
P.O. Box 149091
Austin, TX 78714-9091

The Complaint and Appeal Coordinator will provide, upon request, a summary of the steps followed internally regarding the grievance to both the provider and HHSC.

Chapter 11
Quality Improvement

Quality Improvement

The Quality Improvement Program (QIP) is established to provide the structure and key processes that enable the health plan to carry out its commitment to ongoing improvement of care and services, and improvement of the health of its members. The QIP assists Molina Healthcare to achieve these goals. It is an evolving program that is responsive to the changing needs of the health plan's customers and the standards established by the medical community, regulatory and accrediting bodies.

The QIP encompasses the quality of acute, chronic and preventive health care and service provided in both the inpatient and outpatient setting to our population as determined by age, disease categories, risk status and products. Molina Healthcare maintains the following values, assumptions, and operating principles for the Quality Improvement Program:

- The QIP provides a structure for promoting and achieving excellence in all areas through continuous improvement.
- Improvements are based on industry "best practice" or on standards set by regulators or accrediting organizations.
- The QIP is applicable to all disciplines comprising the health plan, at all levels of the organization.
- Teams and teamwork are essential to the improvement of care and services.
- Data collection and analysis is critical to problem-solving and process improvement.
- Each employee is highly valued as a contributor to quality processes and outcomes.
- Compliance with NCQA Standards and achievement of accreditation demonstrates Molina Healthcare's commitment to quality improvement.
- Information about the QIP is available for members and providers upon request.

Focus Studies, Utilization Management and Practice Guidelines

The QIP establishes and maintains focused review and clinical study processes to monitor, review, measure, track/trend and provide for the development and implementation of corrective action plans for specifically identified practitioners, processes, illnesses, diagnostic treatments, meaningful clinical issues.

The Utilization Management Department submits quarterly reports to the Medical Advisory Committee, subcommittee of the Quality Improvement Committee. The MAC review utilization trends in the areas of emergency room, NICU, inpatient, outpatient and top diagnosis and identifies opportunities for improvement. Clinical Practice Guidelines are reviewed and updated annually using evidenced based criteria. The updated guidelines are approved by the MAC annually and distributed to providers.

Chapter 12
Behavioral Health (STAR, STAR+PLUS & CHIP)

Molina Healthcare (Molina Healthcare) recognizes that the access to high quality behavioral healthcare is critical to the overall health and well being of their members.

What is Behavioral Health?

Behavioral health services are provided for the treatment of mental disorders, emotional disorders, and chemical dependency disorders. Molina offers a behavioral health program that integrates management of behavioral health care with medical care needs for children and adults.

Molina behavioral health services are offered through a large and comprehensive network of Behavioral Health (BH) providers located within each service area. In order to better assist these valued BH providers Molina Healthcare now manages behavioral health services with a newly designed Behavioral Health Care Management Team. This team is comprised of licensed behavioral health professionals who will assist the behavioral health provider network, as well as medical care providers and other community support programs to communicate, coordinate and meet the integrated care needs of our members.

Dallas service area

If the member lives in the Dallas Service Area, the member will receive treatment for mental health, alcohol and drug use through North STAR. North STAR provides these types of behavioral health services to members who live in the following counties: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall. If the member has behavioral health issues, call the North STAR program toll-free at 1-888-800-6799 to receive services in their area. Members do not need a referral from a Primary Care Physician but members may want to talk to their Primary Care Physician about the issue.

Behavioral Health Care Management Team

The Molina Healthcare Behavioral Health Care Management Team provides co-location of licensed behavioral health professionals with the medical care management, care co-ordination and general utilization management teams. This cross-disciplinary team consists of dedicated professionals (e.g., psychiatrists, nurse practitioners, clinical social workers, licensed professional counselors) who are on hand to work in collaboration with the medical care managers to assist with appropriate coordination between behavioral health and physical health services.

Behavioral Health for STAR, STAR+PLUS and CHIP/CHIP Perinate Newborn Members

Behavioral Health Services Hotline

Molina Healthcare maintains a 24 hour/7 days a week toll-free Behavioral Health Hotline. During normal business hours calls are be answered by the Molina Healthcare Behavioral Health Care Management Team. Behavioral Health Hotline staff are available to address referral needs, and can place the member in direct contact with immediate crisis responders if necessary. These services are provided after hours by the Molina Healthcare, Inc. Nurse Advice Line (NAL). **English:** 1-888-AskUs50 or 1-888-275-8750
S**panish:** 1-866-Mi TeleSalud or 1-866-648-3537

Nurse Advice Line (NAL)

Molina Healthcare 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 determine the appropriate setting from which they should obtain necessary care. 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: 1-888-AskUs50 1-888-275-8750
Spanish: 1-866-Mi TeleSalud 1-866-648-3537

Coordination, Self Referral, PCP Referral

The member may self refer for behavioral health services to any in-network Behavioral Health provider. However, Primary Care Providers participating in the Texas Medicaid STAR, STAR+PLUS and CHIP Programs are responsible for coordinating Members' physical and behavioral health care, including making referrals to BH providers when necessary. PCPs may provide any clinically appropriate behavioral health services within the scope of their practice.

The Molina Healthcare Behavioral Healthcare Management Team will assist in the cross communication of patient information, referral needs, treatment progress, etc. between Behavioral Health providers and the PCP. You can call them at 1-800-818-5837.

Member Access to Behavioral Health Services

Members may access services with any participating provider within the Molina Healthcare behavioral health care network by contacting the Molina BH team at 1-800-818-5837 or by contacting Molina Member Services at 1-866-449-6849. 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.

Covered Behavioral Health Services

A wide range of behavioral health and chemical dependency services are available although specific benefits and benefit limits vary according to coverage group and member age (e.g., CHIP, CHIP Perinate, STAR or STAR+PLUS). Generally, the following services may be available:

- Inpatient and Outpatient behavioral health services
- Outpatient chemical dependency services
- Detoxification services
- Psychiatry services

For detail list of behavioral health services please refer to Medicaid Covered Benefits for STAR and STAR+PLUS members listed on page (22) CHIP Benefits, Covered Services listed on pages (27).

Court Ordered Commitments

Up to the annual limit, Molina will provide inpatient psychiatric services to Members 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. 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-axial 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. Providers must document DSM-IV diagnoses and any assessment or outcome information in the Member's medical record.

The Member's medical record must document dates of follow-up or next appointments as well as any discharge plans. Post-discharge appointments are to occur within 7 days of discharge.

Missed Appointments

When a member fails to keep an appointment, the provider office is to contact the member to reschedule. It also should be noted that a member cannot be billed for the missed appointment.

Routine, Urgent and Emergent Services

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

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 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 render Members incapable of controlling, knowing or understanding the consequences of their actions.

Authorizations Information

How to Request an Authorization:
To obtain a prior auth, please fill out the appropriate **Molina Healthcare BH forms** completely and fax to number located on top of the request form **Fax: 1-866-617-4967.** Forms may be found in the attachment section of this manual.

- Request for Extended Outpatient Psychotherapy/Counseling Form
- Psychiatric Inpatient Initial Admission Request Form
- Psychiatric Inpatient Extended Stay Request Form
- Extended Psych/Neurological Testing Request Form

Please refer to previous sections regarding **benefit limitations** and **prior authorization requirements** for CHIP, CHIP Perinate, STAR and STAR+PLUS.

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.

Behavioral Health Value Added Services

STAR+PLUS: Intensive outpatient treatment / day treatment, off-site services and partial hospitalization / extended day treatment (prior authorization required for all).

Focus Studies

Molina Healthcare conducts annual focus studies on the coordination of care and continuity of services for both behavioral and medical providers. Members are encouraged to actively participate in the selection of their BH practitioner and may speak with a Molina Healthcare clinical representative at any time to coordinate their behavioral care. Molina also runs annual focus studies to insure member satisfaction with the services delivered through the Behavioral Health Hotline.

Utilization Management Reporting Requirements

Molina addresses utilization management requirements through the use of an annual chart audit review to insure provision of services by behavioral health providers is in accordance with both state and federal regulations. The chart audits may include but are not limited to treatment plan reviews, assessment of services delivered by licensed clinical staff, a listed complete DSM-IV diagnosis and adherence to PHI standards.

Quick Reference Phone List for BH Services

Contact	Telephone/Fax/Prompt
Behavioral Health Services • Provider Contract Status • Member Eligibility • Benefit Verification	1-800-818-5837 (Phone) 1-866-617-4967 (Fax)
Provider Services Department • Contract Terms • Provider Changes • Information on Education In-Services	1-866-449-6849
Claims Call Provider Services for Questions. Call 1-866-449-6849	
Paper Claims Molina Healthcare Attn: Claims PO Box 22719 Long Beach, CA 90801	**Electronic Claims** **Payor ID: 20554** Payor ID is for use with all claims clearinghouses
First Level Paper Appeals Molina Healthcare Attn: Appeals 15115 Park Row, Suite 110 Houston, Texas 77084-4288	**Second Level Paper Appeals** Molina Healthcare Attn: Second Level Appeals 84 NE Loop 410 #200 San Antonio, TX 78216

Behavioral Health Forms (located in Appendices)

Form	Purpose
Extended Outpatient Psychotherapy Form	Form for authorization of services beyond the initial 30 visits within a benefit year.
Psychiatric Inpatient Initial Request Form	Form for initial authorization for an inpatient stay.
Psychiatric Inpatient Extended Stay Request Form	Form to be completed at a minimum of every 3 business days or as otherwise determined in telephonic concurrent review.
Psychological/Neuropsychological Testing Request Form	Form for any testing beyond 8 hours or if the testing is requested after use of the first 30 initial visits allowed without prior authorization in a benefit year.
Behavioral Health Service Request/Notification Form	Form for requesting outpatient behavioral health services. This form replaces previous UM Service Request Form. This form can also be used to give notification on services that don't require authorization.
Behavioral Health Provider Quick Reference Guide	A behavioral health benefits listing by line of business (STAR, STAR+PLUS, CHIP, CHIP Perinate) that includes a description of covered services, prior authorizations requirements, and limitations.

Chapter 13
Fraud

Fraud Information

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 ID.
- Using someone else's Medicaid ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, 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 Molina at:

Molina Healthcare of Texas Attn: Director of Compliance
84 N. E. Loop 410, Suite 200, San Antonio, TX 78216
1-866-887-1748

To report waste, abuse or fraud, get 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

Chapter 14
Pharmacy Benefits

Prescription Drugs (STAR, STAR+PLUS, & CHIP)

How do I find a network drug store?

You can find a drugstore in your provider directory. You have to go to a Molina pharmacy and we can help you find one. Just call Member Services. This call is free. Bexar, Dallas, El Paso, Harris, Hidalgo and Jefferson SA or 1-877-319-6826 (CHIP RSA). You can also go to the internet. Our website is www.molinahealthcare.com. You can click on the find a pharmacy link. This will show you the list of pharmacies.

What if I go to a drug store not in the network?

You have to go to a Molina pharmacy and we can help you find one. Just call Member Services. This call is free. 1-866-449-6849 Bexar, Dallas, El Paso, Harris, Hidalgo and Jefferson SA or 1-877-319-6826 (CHIP RSA). Call us if you are out of state and need emergency prescriptions. We can help find you a Molina pharmacy. If there are no Molina pharmacies you will have to pay for your prescription. You will have to send us the receipt so Molina can pay you back.

What do I bring with me to the drug store?

You have to take your Molina ID card and Your Texas Benefits Medicaid Card.

What if I need my medications delivered to me?

If you cannot leave home Molina can provide you with mail order pharmacy. This is done by CVS Caremark Mail Services. Please call Molina Member Services at The call is Free: 1-866-449-6849 Bexar, Dallas, El Paso, Harris, Hidalgo and Jefferson SA or 1-877-319-6826 (CHIP RSA) and we will tell you how to get mail delivery.

Who do I call if I have problems getting my medications?

We can help you. Call Member Services. The call is Free: 1-866-449-6849 (Bexar, Dallas, El Paso, Harris, Hidalgo and Jefferson SA) or 1-877-319-6826 (CHIP RSA).

What if I can’t get my prescription approved?

If your doctor cannot be reached, the pharmacy must give you a three-day emergency supply of the drug on the prescription.

What if I lose my medication(s)?

If you prescription is lost or stolen, we can help. Your pharmacy can call Molina. They can get authorization from us. They can ask us to give early refill prescriptions.

What if I need/my child needs an over the counter medication for CHIP?

The pharmacy cannot give you an over the counter medication as part of your/your child's CHIP benefit. If you need/your child needs an over the counter medication, you will have to pay for it.

What if I need/my child needs more than 34 days of a prescribed medication?

The pharmacy can only give you an amount of a medication that you need/your child needs for the next 34 days. For any other questions, please call Member Services. The call is Free: 1-866-449-6849 (Bexar, Dallas, El Paso, Harris, Hidalgo and Jefferson SA) or 1-877-319-6826 (CHIP RSA).

What if I need/my child needs birth control pills?

The pharmacy cannot give you/your child birth control pills to prevent pregnancy. You/your child can only get birth control pills if they are needed to treat a medical condition.

What are my unborn child's prescription drug benefits?

Language pending HHSC clarification

CHIP Perinate

How do I get my medications CHIP Perinate Members?

Molina covers most of the medicine your unborn child's doctor says you need. Your doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription for you. There are no co-payments required for CHIP Perinate Members.

Forms

To Access all updated provider forms please go to our provider website at:

www.molinahealthcare.com

ADVANCE DIRECTIVE TO PHYSICIANS
For Persons 18 Years of Age and Over

Directive made this _____ day of _____, 20_____

I _____ being of sound mind, willfully and voluntarily make it known my desire that my life shall not be artificially prolonged under the circumstances set forth in this directive.

1. If at any time I should have an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and if the application of life sustaining procedures would serve only to artificially postpone the moment of my death, and if my attending physician determines that my death is imminent or will result within a relatively short time without the application of life-sustaining procedures, I direct that those procedures be withheld or withdrawn and that I be permitted to die naturally.
2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.
3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, the directive shall have no force or effect during the course of my pregnancy.
4. This directive shall be in effect until it is revoked.
5. I understand the full import of this directive and am emotionally and mentally competent to make this directive.
6. I understand that I may revoke this directive at any time.
7. I understand that Texas law allows me to designate another person to make a treatment decision for me should I become comatose, incompetent, or otherwise mentally or physically incapable or communication. I hereby designate:

Name (print):
_____

Address:
_____

Phone (home):
_____

Phone (work\cell):
_____

to make such treatment decisions for me if I should become incapable of communication with my physician. If the person I have named above is unable to act on my behalf, I authorize the following alternate person to do so:

Name (print):

_____

Address:

_____

Phone (home):

_____

Phone (work\cell):

_____

I have discussed my wishes with these persons and trust their judgment.

8. I understand that if I become incapable of communication, my physician will comply with this directive unless I have designated another person to make treatment decisions for me, or unless my physician believes this directive no longer reflects my wishes.

Signed:

_____

Social Security Number: _____ Date: _____

Full Address: _____

Two witnesses must sign in the spaces below:

"I am not related to the individual by blood or marriage. I would not be entitled to any portion of the individual's estate on the individual's death. I am not the attending physician of the individual or an employee of the attending physician. I am not an employee of the health facility in which the individual is a patient. I have no claim against any portion of the individual's estate on the individual's death. Furthermore, if I am an employee of a health facility in which the individual is a patient, I am not involved in providing direct patient care to the individual and I am not directly involved in the financial affairs of the health facility."

Witness Signature: _____Printed Name:_____

Witness Signature: _____Printed Name:_____

PRIVATE PAY AGREEMENT FORM

Acknowledgment Statement

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

"Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicad no cubra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que Molina Healthcare de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el miémbro solicite o reciba. También comprendo que tengo la responsibilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

_____

Member Signature **Date**

PATIENT HEALTHCARE QUESTIONAIRE
Behavioral Health Assessment Tool
Nine System Checklist

Patient Name:_____ Date:_____

Over the last 2 weeks, how often have you been bothered by all of the following Problems?

	Not at all 0	**Several days 1**	**More than half the days 2**	**Nearly every day 3**
1. Little interest or pleasure in doing things	□	□	□	□
2. Feeling down, depressed, or hopeless	□	□	□	□
3. Trouble falling/staying asleep, sleeping too much	□	□	□	□
4. Feeling tired or having little energy	□	□	□	□
5. Poor appetite or overeating	□	□	□	□
6. Feeling bad about yourself – or that you are a failure or have let your family down	□	□	□	□
7. Trouble concentrating on things, such as reading the newspaper or watching TV	□	□	□	□
8. Moving or speaking so slowly that other people could have noticed. Or the opposite –being so fidgety or restless that you could have been moving around more than usual	□	□	□	□
9. Thoughts that you would have been better off dead or of hurting yourself in some way	□	□	□	□

If you have checked <u>any</u> problem on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

	Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
	□	□	□	□

TOTAL

SCORE:_____

If you have scored 5 or greater on the first questions above, you may have symptoms consistent with a depressive condition. For more information about depression and treatment options that are available, you are encouraged to make an appointment with your family physician or primary healthcare provider. Depression is a ***common*** and ***treatable*** disease. You deserve to feel better.

CLINICAL PRACTICE GUIDELINES
Clinical Practice Guidelines

ASTHMA

- Based on the National Heart Lung and Blood Institute of National Institutes of Health Practical Guide for the Diagnosis and Management of Asthma 2007.
- Access the NHLBI Guideline via Internet at www.nhlbi.nih.gov/guidelines/asthma/index.htm
- Changes to previous year's guidelines? Yes

CHANGES TO ASTHMA GUIDELINES

- Based on the National Heart Lung and Blood Institute of National Institutes of Health Practical Guide for the Diagnosis and Management of Asthma 2007.
- Access the NHLBI Guideline via Internet at

  www.nhlbi.nih.gov/guidelines/asthma/index.htm
- Changes to previous year's guidelines? Yes

DIABETES

- Based on the American Diabetic Association Standards of Medical Care for Patients with Diabetes Mellitus.
- Diabetes Care, Volume 33, Supplement 1, Page S11-S61, January 2010.
- Access the ADA Guideline via Internet at:
- Go to: Clinical Practice Guidelines.

Access via Internet directly to Clinical Practice Recommendations at:
http://care.diabetesjournals.org/content/33/Supplement_1

HYPERLIPIDEMIA

- Based on the National Heart, Lung and Blood Institute, Third Report on the Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III).
- Updated based on ATP III Update 2004: Implications of Recent Clinical Trials for the ATP III Guidelines
- Modifications to cholesterol clinical practice guideline are available at National Heart and Lung and Blood Institute Website, "Implications of Recent Clinical Trials for the National Cholesterol Education Program Adult Treatment Panel III Guidelines"
- http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3upd04.htm

HYPERTENSION

- Based on the National Heart, Lung and Blood Institute of National Institutes of Health. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC-7).

- Access the NHLBI Guideline via Internet at

- www.nhlbi.nih.gov/guidelines/hypertension/index.htm

HEART FAILURE

- Based on the American College of Cardiology and the American Heart Association Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult.

- Access the ACC/AHA Guideline via Internet at content.onlinejacc.org/cgi/reprint/46/6/e1

DEPRESSION

- Based on the Institute for Clinical Systems Improvement Guideline, Major Depression in Adults in Primary Care, May, 2009.

- Access the ICSI Guideline via Internet at www.icsi.org . Select Health Care Guidelines By Title.

ADHD

- Based on the American Academy of Pediatrics Clinical Practice Guideline: Diagnosis and Evaluation of the Child with Attention- Deficit/Hyperactivity Disorder (Pediatrics Vol. 105 No. 5, May 2000).

- Attention Deficit/Hyperactivity Disorder Practice Guidelines

COPD

- Based on the Global Initiative for Chronic Obstructive Lung Disease (GOLD) COPD Diagnosis, Management, and Prevention.

Access the GOLD Pocket Guide to COPD Diagnosis, Management, and Prevention

Texas Health Steps Periodicity Schedule

Comprehensive Health Screening* - Birth through 10 Years

*Comprehensive Health Screening is defined as: both objective screening with use of standardized procedures or screening tools and subjective screening of those components when a standardized procedure or screening tool is not required, for example, visits when audiometric hearing screening is not required. Screening must be age-appropriate and based on recognized national standards such as the National Center for Education in Maternal and Child Health (NCEMCH) Bright Futures. The absence of a symbol indicates that subjective screening is appropriate unless the provider determines an objective screen or test is necessary. Refer to the Texas Medicaid Provider Procedure Manual (TMPPM) for further detail.

Age	Measurements										Developmental screening															tb screening		
	Length	Height	Weight	BMI	Fronto-Occipital Circumference	Blood Pressure	Vision Screening (objective)	Parent Hearing Checklist	Hearing Screening (objective)	Nutritional Screening	ASQ or PEDS or other standardized tool	Autism Screening: MCHAT or other standardized tool	Mental Health Screening	Newborn Hereditary/ Metabolic Testing	Hemoglobin Type	Lead Questionnaire	Blood Lead Screening	Anemia	Hyperlipidemia (as indicated)	Diabetes Type II (as indicated)	TB risk screening tool	TB Skin Test	Dental Referral
Newborn																							
3-5 days	●		●		●			●															
2 weeks																							
Months 2	●		●		●			●															
4																							
6	●		●		●			●								●		●					●
9																							
12	●		●		●			●									●	●			▲	▲	●
15																							
18	●		●		●			●			●	●				●							●
24																							
30	●		●	●				●								●							●
Years 3																							
4		●	●	●		●	●		●		●					●					▲	▲	●
5																							
6		●	●	●		●	●		●							●		●			▲		●
7																							
8		●	●	●		●	●		●												▲		●
9																							
10		●	●	●		●	●		●												▲		●

Legend of Symbols

●	Indicates a component is mandatory to complete during the checkup. If a component is not completed at the required age, then the provider must complete at the next checkup, if age-appropriate, or whenever medically necessary.
▲	TB screening: In counties designated as having a high incidence of TB, administer an intradermal skin test at ages 1 and 4 years of age and the DSHS approved questionnaire annually beginning at 2 years of age. In all other counties, administer the DSHS approved questionnaire annually beginning at 1 year of age.

TEXAS Department of State Health Services

Texas Health Steps

Check regularly for updates to this schedule: dshs.state.tx.us/thsteps/providers_components.shtm

For free online provider education: txhealthsteps.com

E03-1363
June 2011

REQUEST FOR NON-PCP SPECIALIST TO SERVE AS PCP

Molina Healthcare

The Molina Healthcare (Molina) member listed below has been diagnosed with a chronic, disabling, or life threatening illnesses and is requesting to utilize a non-primary care physician specialist as a primary care physician (PCP). This application hereby requests consideration for patient transfer based on the following information:

Date of Request: _____

Member Name: _____
Member Identification Number: _____

Member Diagnosis: _____
Member Prognosis: _____
Medical Need: _____
Copy of Member's Medical Records attached to this request: ☐ Yes ☐ No

Requirements: (Check Boxes)

- ☐ Specialist certifies the medical need listed above for the Member to utilize Specialist as member's PCP.
- ☐ Specialist meets HMO's requirements for participation including credentialing requirements.
- ☐ Specialist is contracted with Molina.
- ☐ Specialist agrees to perform all PCP duties as outlined in the Molina provider agreement, attachments and policies.
- ☐ Specialist is willing to accept the coordination of all the Member's health care needs.
- ☐ The services to be provided are within the scope of Specialist's license.
- ☐ Specialist will accept the same reimbursement as in-network PCPs.
- ☐ Specialist has received a current directory of participating specialist physicians and providers.

_____ _____
Specialist Signature Date

_____ _____
Member Signature Date

Please return Form to Molina Medical Director.

Notification of the decision will be provided to both the specialist and requesting member in writing by certified mail within 30 days from the date request is received by the Molina Medical Director. An explanation of findings will be provided with this form and include decision criteria from Milliman & Robertson, InterQual and review of clinical record findings.

☐ *Approved* ☐ *Denied*

_____ _____
Molina Medical Director *Date*

Molina Healthcare of Texas, Inc.

Psychological / Neuropsychological Testing Request (Outpatient)

Please submit this form for any testing requests for more than 8 hours of service or if the request comes after 30 other outpatient service encounters within a benefit year.

Member: _____ DOB: _____ Age: _____

Molina #: _____ Parent name (if child member): _____

DSM-IV Diagnosis: _____

Referral Source (identify by name and function): _____

Referral Question: _____

Relevant History: _____

_____

_____

Past Assessment & Service Summary (testing, school evaluation / IEP / Early Intervention, ADHD dx/tx, behavior ratings, etc.): _____

_____

_____

Tests Requested (may substitute with attached list):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Hours Requested (enter in applicable box/boxes below)):

Hours	CPT/Service	Hours	CPT/Service
	96101 Psychological Testing by Psychologist		96118 Neuropsychological Testing by Neuropsychologist

Provider Name & Degree: _____ License #: _____

Supervisor Name (if provider is unlicensed): _____ License #: _____

TIN or SSN: _____ Agency or Facility: _____

Address: _____

Phone: _____ Fax: _____

Fax to: 1-866-617-4967 Questions: Call the Behavioral Health Hotline @ 1-800-818-5837

MOLINA HEALTHCARE

Synagis Authorization Form

Phone: 1-866-449-6849 Bexar, Harris, Dallas, Jefferson, El Paso & Hidalgo Service Areas
1-877-319-6826 CHIP Rural Service Area
Fax: 1-866-420-3639

Date:	Patient DOB:
Patient. Name	Patient Street Address
Patient Medicaid ID#	City State Zip
Patient's Gestational Age at Birth	Weeks Days Birth Wt:
Provider Name	Provider Address
Provider Phone	City State Zip
Provider Fax Number	Provider DEA #
Parent/Guardian	Parent/Guardian Phone

Molina Healthcare authorizes Synagis™ (palivizumab) based on American Academy of Pediatrics criteria. For the 2011-2012 RSV season, Caremark will be the exclusive clearinghouse for all Synagis referrals for your Molina patients. Caremark will be performing enrollment functions once treatment authorization is given by Molina. Synagis will in turn be shipped by Caremark Specialty Pharmacy. If you have questions about the Synagis distribution, please call Molina (numbers listed above). The timing of season will be October 1st, 2011 through March 31st, 2012. Please note that depending on where the child fits within AAP criteria, the total number of doses allowed during the season may vary (see below). The season is defined by The National Respiratory and Enteric Virus Surveillance System (NREVSS): RSV season is over when virology is < 10% for 2 consecutive weeks.

For dose requests outside of above season: provider must submit:

- Letter of medical necessity (LMN)
- Current local virology information showing virology > 10% for most recent two consecutive weeks

Please note how the patient meets AAP criteria below and include copies of clinic notes with supportive documentation:

	Currently receiving medical therapy (supplemental 02, bronchodilator, diuretic, or chronic corticosteroid) for CLD within 6 months before the start of RSV season, **AND** child is < 24 months of age.[1] *Due to limited data regarding effectiveness, requests for a 2nd season will be considered on a case by case basis.*
	Presence of hemodynamically significant cyanotic or acyanotic congenital heart disease *as defined by the AAP*, **AND** child is <24 months of age .[1]
	Presence of congenital abnormality of the airway or a neuromuscular condition that compromises handling of respiratory secretions, **AND** birth is < 34 6/7 weeks gestation.[1] Approved during the first year of life only.
	History of premature birth ≤ 28 6/7 weeks gestation **AND** child is < 12 months old at start of RSV season.[1]
	History of premature birth from ≥ 29 0/7 to < 31 6/7 weeks gestation **AND** child is < 6 months old at start of RSV season[1]
	History of premature birth from ≥ 32 0/7 to < 34 6/7 weeks gestation **AND** child is < 3 months old at start of RSV season or born during the RSV season[2], **AND** child has one or both of the following additional risk factors: * Infant has a sibling younger than 5 years of age * Infant attends childcare, defined as a home or facility where care is provided for any number of infants or young toddlers in the child care facility[3]

[1] A maximum of 5 doses total will be allowed. For additional doses, please see virology requirement above.
[2] A maximum of 3 doses total will be allowed, up through 90 days of age.
[3] AAP recommends that participation in group child care should be restricted during the RSV season for high-risk infants whenever feasible.

Revised 10-14-11

Texas Consortium for Perinatal HIV Prevention

HIV, Syphilis and HBV Testing and Pregna
State Requirements for Texas Clinic

Texas Department of State Health Services HIV/STD P

HIV, Syphilis and HBV Testing and Pregnancy in Texas

August 2009

Effective January 1, 2010, Texas law (Chapter 81.090 of the Texas Health and S code) requires any health care provider allowed to care for a pregnant woman to t for human immunodeficiency virus (HIV), syphilis and hepatitis B virus (HBV), she objects. These tests must take place during the pregnant woman's first prenat second HIV test must be conducted during the third trimester, and upon her adr for delivery, if no record of the third trimester HIV test is available. The law also for the expedited HIV testing of infants at delivery, if a mother's results are not a These tests apply to each pregnancy.

Stage of Pregnancy	Perinatal HIV/STD Tests Required by Texas Law
First Trimester	• HIV, HBV and syphilis test required
Third Trimester	• HIV test required
Delivery	• Expedited HIV test[1] required if no record of third trimester result • HBV and Syphilis tests required
Newborn Tests	• Expedited HIV test[1] required if no record of third trimester result

[1]Expedited test. Test must be expedited and result obtained < 6 hours. For newborn test, blood must be drawn <2 hours after birth.

Stage of Pregnancy	Recommended Perinatal Tests and Precautions[1]
First Trimester	• Chlamydia and gonorrhea screening, especially for populations at ri • Retest 3-4 weeks after treatment for gonorrhea or chlamydia
Third Trimester	• Syphilis test recommended between 28-32 weeks for high risk popu and where syphilis prevalence is high • Chlamydia test for high-risk populations[2]
Delivery	• Any woman delivering a stillborn infant should be tested for syphilis • Testing for HBV for women not previously tested or at high risk for H
Newborn Vaccinations and Precautions	• First of three HBV vaccinations is given • Required prophylaxis to prevent ophthalmia neonatorum (conjunctiv sometimes caused by gonorrhea or chlamydia bacteria)

[1] Recommendations from the Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecolo
[2]High risk for chlamydia includes women under age 25 and those with a new or more than one sex partner.
[3] High risk for syphilis may include women who previously test positive for syphilis, multiple sex partners, and low access to healthca
[4] High risk for HBV includes more than one sex partner in the previous six months, evaluation or treatment for an STD, recent or cur drug use, HBsAg-positive sex partner, and those with clinical hepatitis should be retested at the time of admission to the hospital for

Why test pregnant women?

Testing and treatment for HIV, HBV and syphilis prevents infected infants. Wi knowledge of HIV status, a mother with HIV has an approximately 25 percent c of transmitting HIV to her unborn child. If HIV positive pregnant women and t children know their status and receive appropriate care and treatment during preg labor, delivery and postpartum, the perinatal transmission rate can be decreased t percent or less. Therapy includes antiretroviral medicine as well as cesarean delive for women with high HIV viral loads (>1,000 copies/ml). Even when antiretrovi medicine is not started until labor and delivery, mother-to-child HIV transmissio are reduced to 10%. Testing and treatment also decreases rates of syphilis and red hepatitis B (HBV) infection. Perinatal syphilis screening allowed Texas clinicians identify 95 cases of congenital syphilis in 2007, enabling them to provide treatme follow up. Regarding HBV, 90 percent of infants born to women with infectious B will not be infected if they receive appropriate hepatitis B vaccine and treatmen 12 hours of delivery.

Consent and Information Distribution

Before testing a patient for HIV, HBV and syphilis, the clinician must inform the woman that the test will be performed and provide written information. Separate consent forms are not required and verbal notification is acceptable. Most women give consent to be tested. According to birth records, of the 405,347 Texas women delivering in 2008, 99% were tested for HIV either prenatally or at labor and delivery. If a woman objects, a referral to an anonymous testing site should be made. In addition to giving a referral to an anonymous testing site, the clinician can discuss testing with the patient. Women refuse testing for different reasons. A clinician can listen to the patient and give information about risk factors, advantages of testing, ease of testing, and inform the woman of resources in the event the result is positive. A clinician cannot test a woman without consent. Medical records should reflect that the test was explained to the patient and she consented.

All women, regardless of consent, must receive printed materials about HIV, HBV and syphilis. Materials must include information about disease transmission and prevention, frequency, infection consequences for the child and available treatment. When possible, material should be provided in a language and literacy level patients understand. Appropriate materials are available in English and Spanish through the Texas Department of State Health Services (DSHS). Medical records should also note the patient received printed materials.

Positive Test Results

If a woman receives a preliminary positive HIV result to an expedited test at labor and delivery, CDC and ACOG recommend starting prophylaxis treatment to the woman and her infant. When a pregnant woman has HIV, syphilis or hepatitis B, the clinician must provide disease-specific treatment information she can understand. The clinician may also refer her to another clinic for appropriate treatment.

Clinicians must provide the opportunity for individual, face-to-face counseling to each HIV-positive pregnant woman immediately upon revealing her HIV test results.

Post-test HIV counseling *must* include the:

- Meaning of the test result;
- Possible need for additional testing;
- Measures to prevent transmission of HIV;
- Benefits of partner notification;
- Availability of confidential partner notification services through local public health departments (www.dshs.state.tx.us/hivstd/info/edmat/provider.pdf); and
- Availability of health care services, including mental health social and support services, in the area where the patient lives (refer patients to 211).

Post-test HIV counseling *should*:

- Increase understanding of HIV infection;
- Explain potential need for confirmatory testing
- Explain ways to change behavior to prevent HIV transmission
- Encourage the patient to seek appropriate medical care
- Encourage the patient to notify her sex or needle-sharing partners or access

Perinatal Hotline

Call 888-448-8765 for free 24-hour clinical consultation and advice on treating HIV-infected pregnant women and their infants as well as indications and interpretations of rapid and standard HIV testing in pregnancy.

Records Retention

Clinicians must retain a report of each client case for nine months and deliver the report to any successor in the case.

Confidential Test

A confidential test means the test result is in the medical record.

Anonymous Test

An anonymous test means that the patient's name is not used.

Visit hivtest.org to find an HIV or STD testing site.

Call 211 or (800) CDC-INFO to find an HIV/AIDS service provider in Texas or locate other patient resources.

Texas HIV Medication Program

Refer patients unable to pay for HIV medications to (800) 255-1090.

TEXAS Department of State Health Services

HEDIS Measure Help Sheet

Category	Service Needed	Description of Services
Access to Primary Care	Children, Adolescent's and Adults Access to Primary Care Physicians	Members age 12 months and older need a visit with their PCP every year
Immunizations	Childhood Immunizations	4 DTaP; 3 IPV; 1 MMR; 3 HIB; 3 HepB; 1 VZV; 4 PCV; 2 HepA; 2 or 3 RV (depending on which vaccine is administered) and 2 flu vaccinations BEFORE the child's 2nd birthday.
	Adolescent Immunizations	1 Tdap/Td between the age of 10-12 years and 1 MCV between the age of 11-12 years. Both must be completed BEFORE childs 13th birthday.
Lead Testing	Blood Lead - test at 12 & 24 months	One or more blood tests for lead poisoning BEFORE the 2nd birthday.
Well Child/Well Care Visits	Six visits 0-15 months	Six or more well-child visits BEFORE the child turns age 15 months
	Well Child Care	Members 3-6 years of age require an annual well child visit
	Well Care Adolescents	Members 12-21 years of age require a well-care visit with a PCP or an OB/GYN annually
Women's Care	Breast Cancer Screening	Women 40-69 years of age need an annual mammogram
	Cervical Cancer Screening	Women 21-64 years of age need an annual pap test
	Chlamydia Screening	Women 15-25 years of age, sexually active, need an annual test for Chlamydia
	Timeliness of Prenatal Care	A prenatal care visit in the first trimester or within 42 days of enrollment
	Postpartum Care	Postpartum visit on or between 21 and 56 days after delivery
	Frequency of Prenatal Care	Monthly or more often if recommended by medical provider
Diabetics	HbA1c testing	Members 18-75 years of age with diabetes HbA1c testing at least annually
	LDL-C Screening	Members 18-75 years of age with diabetes LDL-C testing at least annually
	Retinal Eye Exam	Members 18-75 years of age with diabetes Dilated Retinal Eye Exam at least annually
	Kidney Function/Nephropathy Monitoring	Members 18-75 years of age with diabetes Micro albumin testing at least annually
Obesity Prevention/Screening	Adult Body Mass Index (BMI) Assessment	Members 18-74 years of age need their body mass index (BMI) documented annually
	Children and Adolescents 2-17 years of age	Body Mass Index (BMI) percentile documented or plotted on a growth chart annually; AND Nutritional Counseling, education or referral for Nutrition education annually; AND Counseling for physical activity, education, or anticipatory guidance

Molina Healthcare

Provider Quick Reference Guide | IMPORTANT NUMBERS

APPEALS ADDRESS
15115 Park Row Blvd. Suite # 110
Houston, Texas 77084
Bexar, Harris, Dallas, Jefferson,
El Paso & Hidalgo Service Areas 866-449-6849
CHIP Rural Service Area 877-319-6826

BEHAVIORAL HEALTH SERVICES
..... 800-818-5837
BH Fax for Prior Authorization 866-617-4967
For Behavioral Health Services in Dallas Service Area
(STAR & STAR+PLUS), please call NorthSTAR at 888-800-6799

CONTRACTING
texasexpansioncontracting@molinahealthcare.com
- How to join the network
- Contract Clarifications
- Fee schedule inquires

CUSTOMER SERVICE (MEMBERS AND PROVIDERS)
- Claims Status
- Member Eligibility
- Benefit Verification
- Complaint & Appeals Status

Bexar, Harris, Dallas, Jefferson, El Paso &
Hidalgo Service Areas (Voice) 866-449-6849
..... (Fax) 281-599-8916
CHIP Rural Service Area ..... (Voice) 877-319-6826
..... (Fax) 281-599-8916

DENTAL SERVICES
Delta Dental Insurance Company 866-561-5891
Denta Quest 800-508-6775
MCNA Dental 800-494-6262

ELECTRONIC CLAIMS SUBMISSION VENDORS
- Payor Identification for all - 20554
- Availity, Zirmed, Practice Insight, SSI & EMDEON

MEDICAL MANAGEMENT
- Prior Notification
- Prior Authorization
- Referrals
- Disease Management

STAR+PLUS Service
Coordination Department ..... (Voice) 866-409-0039
..... (Fax) 866-420-3639

MOLINA COMPLAINTS ADDRESS
N.E. Loop 410, #200,
San Antonio, TX 78216
Bexar, Harris, Dallas, Jefferson,
El Paso & Hidalgo Service Areas 866-449-6849
CHIP Rural Service Area 877-319-6826

NURSE ADVICE LINE
- Clinical Support for Members

..... 888-275-8750 (English) or
..... 866-648-3537 (Spanish)

PAPER & CORRECTED CLAIMS ADDRESS
P.O. Box 22719
Long Beach, CA 90801

PHARMACY
Prior Authorization
Assistance/Inquiries
..... (Voice) 866-449-6849
..... (Fax) 888-487-9251

PROVIDER SERVICES
Bexar, Harris, Dallas, Jefferson,
El Paso & Hidalgo Service Areas 866-449-6849
CHIP Rural Service Area 877-319-6826

STAR+PLUS SERVICE COORDINATION
..... 866-409-0039
..... (Fax) 866-420-3639

VISION SERVICES:
(www.opticarevisionplans.com;
provrel@opticare.net)
..... 800-537-6697 (CHIP)
..... 866-492-9711 (STAR)
..... 877-832-4118 (STAR+PLUS)

MEDICAID CONTACTS

CHIP ELIGIBILITY 800-645-7164
CHIP MEMBER ENROLLMENT 800-647-6558
EARLY CHILDHOOD INTERVENTION 800-628-5115
EPORTAL TECHNICAL SUPPORT 866-449-6848
FAMILY PLANNING PROGRAM 512-458-7796
MEDICAL TRANSPORTATION PROGRAM (MTP)
STAR & STAR+PLUS 877-633-8747
MEDICAID HOTLINE 800-252-8263
MEDICAID PROGRAM MEMBER
Verification (NAIS) 800-925-9126
NPI # REQUEST
https://nppes.cms.hhs.gov 800-925-9126
STARLINK-MEDICAID MANAGED CARE HELPLINE
General Member Assistance 866-566-8989
STAR & STAR+PLUS PROGRAM ENROLLMENT
PCP Information
Plan Changes
Health Plan Information 800-964-2777
TEXAS HEALTH STEPS
STAR & STAR+PLUS 877-847-8377
TEXAS DEPARTMENT OF INSURANCE
HMO Division 512-322-4266
HMO Complaint 512-305-6745
Consumer Division 512-463-6500
Consumer Hotline 800-525-3439

TEXAS VACCINES FOR CHILDREN PROGRAM 800-252-9152

Please visit www.MolinaHealthcare.com

Molina Healthcare of Texas
2009 PREVENTIVE HEALTH GUIDELINES:
Immunization and Screening Recommendations for Healthy Children**, Adults, Seniors and Pregnancy

Ages 21 and older

Immunizations/Vaccines	Recommended age in years 21-39	40-49	50-64	≥ 65
Tetanus, diphtheria, pertussis (Td/Tdap)[13]: 1-dose Td booster every 10 years; substitute 1 dose of Tdap for Td.	✓	✓	✓	✓
Hepatitis A[19]: 2-doses for high risk individuals, as advised by clinician.	PD			
Hepatitis B[20]: 3-doses for high risk individuals, as advised by clinician.	PD			
Human Papillomavirus (HPV)[24]: 3-doses for females age ≤ 26 years.	✓			
Influenza[26]: 1-dose annually for age > 50 years and high risk population or as advised by clinician.	PD		✓	✓
Measles, Mumps, Rubella (MMR)[30]: 1-dose for adults born during or after 1957 who lack evidence of immunity; 1-2 doses for high-risk.		✓	PD	
Meningococcal[31]: 1-dose for high risk individuals or as advised by clinician. Revaccination after 5 years to high risk adults	PD			
Pneumococcal Polysaccharide[33]: 1-dose for age ≥ 65 years; 2-dose if vaccinated more than 5 years ago and were younger than 65 years of age at the time of primary vaccination.	PD			✓
Varicella (chickenpox)[42]: 2 doses for all adults without previous immunization or evidence of disease.		✓	PD	
Screenings/Laboratory Testing				
Abdominal Aortic Aneurysm (AAA) Screening[1]: one-time screening by ultrasonography in men aged 65 to 75 who have ever smoked.				✓
Breast Cancer Screening (mammography)[5]: every 1-2 years for women aged 40 and older.		✓	✓	✓
Cervical Cancer Screening (Pap smears)[6]: within 3 years of onset of sexual activity, then at least every 3 years thereafter.	✓	✓	✓	
Chlamydia Screening[7]: sexually active females aged ≤ 25 years, and females at risk.	✓	PD		
Colorectal Cancer Screening[9]: begin screening at 50 years of age; Fecal Occult Blood Testing (FOBT): annually; Sigmoidoscopy and double-contrast barium enema: every 5 years; Colonoscopy: every 10 years			✓	✓
Diabetes Screening (Adult Type 2)[12]: adults with hypertension or hyperlipidemia.	PD			
Gonorrhea Screening[14]: sexually active and at increased risk women, including those who are pregnant.	PD			
Height and Weight (body mass index)[17]: periodically screen for obesity.	✓	✓	✓	✓
High Blood Pressure/Hypertension Screening[22]: at least every 2 years or more for those with higher level of blood pressure.	✓	✓	✓	✓
HIV Testing[23]: persons at increased risk for infection and all pregnant women.	PD			
Lipid Disorder Screening (Cholesterol)[28]: men aged ≥ 35 years and women aged ≥ 45 years: every 5 years; if other CHD factors are present, then screen men aged 20 to 35 and women aged 20 to 45	✓	✓	✓	✓
Osteoporosis Screening[32]: women age 65 and older or begin at age 60 for women at increased risk.			PD	✓
Syphilis Screening[39]: persons at increased risk for infection and all pregnant women.	PD			
Tuberculosis (TB) Screening[40]: for high risk population	PD			
Vision and hearing[43]: in elderly adults.				✓
Counseling				
Accidental injury ; Alcohol; Coronary Heart Disease; Depression; Healthy diet/nutrition; Tobacco use prevention; STD and HIV prevention; Hypertension; Obesity and diabetes;				

PD – per Practitioner Discretion

For additional information about vaccines, vaccine supply and contraindications for immunization, please visit the National Immunization Program Website at www.cdc.gov/nip or call the National Immunization Hotline at 800 232-2522.

Guidelines are based on U.S. Preventive Services Task Force Recommendations (2006); American Academy of Pediatrics (2007); Recommended Immunization Schedule United States, 2007; American Academy of Pediatrics Immunization Schedule, 2007; Recommended Adult Immunization Schedule United States October 2006-September 2007; AAFP Summary of Policy Recommendations for Clinical Preventive Services Revision 6.2, August 2006; Guidelines for Perinatal Care, American College of Obstetricians, 5th edition (2002).

Approved by the Advisory Committee on Immunization Practices (ACIP) (www.cdc.gov/nip/ACIP), American Academy of Pediatrics (AAP) (www.aap.org), the American Academy of Family Physicians (AAFP) (www.aafp.org) and CDC National Center for HIV/STD/TB Prevention (www.cdc.gov/nchstp/od/nchstp.html)

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Molina Healthcare of Texas
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Healthy Children**, Adults, Seniors and Pregnancy

Pregnancy

Immunizations/Vaccines	PRENATAL VISITS: First Trimester 1-12 wks	Second Trimester 13-28 wks	Third Trimester > 28 wks	POSTPARTUM VISITS**
Tetanus, Diphtheria, Pertussis (Td/Tdap)[13]: Td booster during second and third trimester if previously vaccinated ≥ 10 years; if received Td < 10 years ago, Tdap during postpartum.		PD		
Influenza (Inactivated)[28]: 1-dose to all pregnant women in the second and third trimester during the flu season;	✓	✓	PD	
Meningococcal (MPSV4)[31]: high risk individuals	PD			
Screenings/Laboratory Testing				
Birth Defect Tests:				
• **Amniocentesis**[2]: between weeks 15 and 18 to screen for chromosomal disorders		✓		
• **Chorionic Villus Sampling (CVS)**[8]:before week 13 to screen for chromosomal disorders	✓			
• **Maternal serum multiple marker screening (neural tube defects)**[29]: during 16-18 weeks of gestation		✓		
Blood Pressure[22]: at first prenatal visit and periodically throughout the pregnancy	✓	✓	✓	
Blood Tests:				
• **Anemia (iron deficiency anemia)**[3]: during first prenatal visit.	✓	PD		
• **Diabetes screening**[12]: between 24 and 28 weeks of pregnancy.	PD	✓		
• **Hepatitis B (HBsAg)**[20]: during first trimester/prenatal visit.	✓	PD		
• **HIV**[23]: during first prenatal visit	✓			
• **Rh (D) Incompatibility**[36]: during first visit for all pregnant women; during 24-28 weeks of gestation for unsensitized Rh(D)–negative.	✓	PD		
• **Rubella Serology Screening**[37]: at first prenatal visit (susceptible pregnant women vaccinated during postpartum period)	✓			PD
• **Syphilis Screening**[39]: at first prenatal visit; repeat in the third trimester and at delivery for high-risk.	✓	PD		
Cervical Tests:				
• **Chlamydia Screening**[7]: all pregnant women aged 25 years and younger and others at risk.	✓			
• **Gonorrhea Screening**[14]: at first prenatal visit and at third trimester for continued risk factor.	✓		PD	
• **Group B streptococcus (GBS)**[15]: during third trimester.			✓	
Ultrasound exam[41]: during first trimester	✓	PD		
Urine Test:				
• **Asymptomatic Bacteriuria (Urine Test)**[4]: at 12-16 weeks of gestation or as recommended by your doctor	✓			
Counseling				
Accidental injury prevention; Alcohol; Breastfeeding; Coronary Heart Disease; Healthy diet/nutrition/vitamins and supplements (0.4 mg of folic acid a day to reduce the risk of neural tube defects); STD and HIV; Car seat safety; Tobacco use prevention;				

PD – per Practitioner Discretion ***Postpartum visits**: recommended within 21 – 56 days (3 to 8 weeks) following delivery.*

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NOTE: For all numbered items below THSteps guidance should be followed for individuals aged Birth through 20 years of age.

1. **Abdominal Aortic Aneurysm (AAA) Screening:** one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked lead to decreased AAA-specific mortality. AAFP and USPSTF make no recommendation for or against screening for AAA in men aged 65 to 75 years who have never smoked.
2. **Amniocentesis:** between 15 and 18 weeks of pregnancy for women ages 35 and older at risk for passing chromosomal disorders. A procedure in which a small amount of amniotic fluid and cells are withdrawn from the sac surrounding the fetus and tested.
3. **Anemia (iron deficiency anemia):** Iron deficiency anemia is defined as iron deficiency with a low hemoglobin or hematocrit value (abnormal values for serum ferritin, transferring saturation, and free erythrocyte protoporphyrin) *Pregnancy* – routine screening is recommended in asymptomatic pregnant women during first prenatal visit for iron deficiency anemia.
4. **Asymptomatic Bacteriuria (Urine Test):** screening recommended to all pregnant women for asymptomatic bacteriuria using urine culture at 12-16 weeks of gestation. Asymptomatic bacteriuria with urine culture reduces symptomatic urinary tract infections, low birth weight, and preterm delivery.
5. **Breast Cancer Screening (mammography):** women age 40 years and older are recommended to be screened for breast cancer with mammography every 1-2 years after counseling by their family physician regarding the potential risks and benefits of the procedures
   Breast Self-Examination (BSE): The AAFP concludes that the evidence is insufficient to recommend for or against teaching or performing routine BSE.
6. **Cervical Cancer Screening (Pap smears):** recommended to complete at least every 3 years to screen for cervical cancer for women who have ever had sex and have a cervix. The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer
7. **Chlamydia Screening:** recommended to all sexually active females age 25 years or younger and other asymptomatic females at increased risk for infection. *Pregnancy* – All pregnant women aged 25 years and younger and other at increased risk should be screened. Screening early in the pregnancy provides improved outcome, however, screening in the third trimester may be more effective at preventing transmission of chlamydia infection to the infant during birth.
8. **Chorionic Villus Sampling (CVS):** CVS before week 13 women ages 35 and older at risk for passing on certain chromosomal disorders, such as Down syndrome. A procedure in which a small sample of cells from the placenta is tested.
9. **Colorectal Cancer Screening:** recommended for men and women 50 years of age or older for colorectal cancer. Annual fecal occult blood testing (FOBT), 5-year internals for flexible sigmoidoscopy and double-contrast barium enema, and 10-year interval for colonoscopy are recommended.
10. **Dental caries:** primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months and through 16 years residing in areas with inadequate fluoride in the water supply (less than 0.6 ppm).
11. **Depression:** recommended in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up.
12. **Diabetes Screening (Adult Type 2):** recommended for type 2 diabetes in adults with hypertension or hyperlipidemia. Three tests are used to screen for diabetes: fasting plasma glucose (FPG); 2-hour post-load plasma glucose (2-hour PG), and hemoglobin A1C (HbA1c). *Pregnancy* – the level of sugar in your blood is measured to test for diabetes during 24 and 28 weeks of pregnancy.
13. **Diphtheria and Tetanus Toxoids and acellular Pertussis:**
    Pediatric (DTaP) – at 2, 4, 6 months. Fourth dose of DTaP may be administered as early age 12 month, but at least 6 months after the third dose. Final dose at age 4-6 years. Administer Tdap at age 11-12 years for those who have completed the recommended childhood DTP/DTaP series and have not received a Td booster dose (BOOSTRIX for 10 years of age and ADACEL for 11 years of age). Adolescents 13-18 years of age who missed the 11-12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP series. *Adults (Td/Tdap)* – recommended completing Td vaccine series if they haven't received primary series. A primary series for adults is 3-doses. Administer the first 2 doses at least 4 weeks apart and third dose 6-12 months after the second. Administer booster dose to adults who have completed a primary series and if the last vaccination was received ≥ 10 years previously. Tdap or tetanus and diphtheria (Td) vaccine may be used. Tdap should replace a single dose of Td for adults aged < 65 years who have not previously received a dose of Tdap (either in primary series, as a booster, or for wound management). One-time administration of 1-dose of Tdap with an interval as short as 2 years from a previous Td vaccination is recommended for close contacts of infants aged < 12 months and all health-care workers with direct patient contact.

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Pregnancy – if the person is pregnant and received the last Td vaccination ≥ 10 years ago, administer Td during the second or third trimester; if the pregnant individual received the last Td vaccination < 10 years, administer Tdap during the immediate postpartum period. One-time administration of 1-dose of Tdap with an interval as short as 2 years from a previous Td vaccination is recommended for postpartum women.

14. **Gonorrhea Screening:** recommended to all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection. Women under the age of 25, including sexually active adolescent are at highest risk. *Pregnancy* – Screening is recommended at the first prenatal visit for pregnant women who are in high risk group for gonorrhea infection. For pregnant women who are at continued risk, and for those who acquire a new risk factor, a second screening should be conducted during the third trimester.
15. **Group B streptococcus (GBS):** to prevent passing GBS to a baby during birth. Antibiotics can be during labor to help prevent the baby from being infected.
16. **Hearing:** routine screening for newborns or as recommended by a practitioner; recommended screening for elderly adults and counsel regarding the availability of treatment when appropriate.
17. **Height, weight, BMI (body mass index), head circumference:** periodic screening recommended to all children and adult patients; screen for obesity via body mass index (BMI) and offer intensive counseling and behavioral interventions to promote sustained weigh loss for obese adults.
18. **Hemoglobinopathies, Phenylketonuria (PKU), Thyroid Function abnormalities:** recommended screening test in neonates.
19. **Hepatitis A:** *Pediatric* – 2 doses for all children at 1 year of age (12-23 months); 2-doses in the series should be administered at least 6 months apart. Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits. *Adults* – Current vaccines should be administered in a 2-dose schedule at either 0 and 6-12 months, or 0 and 6-18months. If the combined hepatitis A and hepatitis B vaccine is used, administer 3 doses at 0, 1, and 6 months. Hepatitis A vaccine is recommended for adults with chronic liver disease and persons who receive clotting factor concentrates, men who have sex with men and persons who use illegal drugs, persons working with hepatitis A virus (HAV) – infected primates or with HAV in a research laboratory setting, persons working or traveling in areas where Hepatitis A is endemic and periodic outbreaks occur, and any person who would like to obtain immunity.
20. **Hepatitis B:** *Pediatric* – HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. Administer monovalent HepB to all new born prior to hospital discharge. (If mother is HBsAg-positive: administer HepB and 0.5 m: of Hepatitis B immune globulin (HBIG) within 12 hours of birth; If mother is HBsAg-negative, the birth dose can only be delayed with physician's order and mother's negative HBsAg laboratory report documented in the infant's medical record; If mother's HBsAg status is unknown, administer HepB within 12 hours of birth and determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG no later than age 1 week). Second-dose should be administered at age 1-2 months. Final-dose administered at age ≥ 24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of 3 or more doses in a licensed HepB series, at age 9-18 months. Four-dose is permissible when combination vaccines are given after the birth dose; if monovalent HepB is given after the birth, a dose at 4 months is not needed. *Catch-ups* – administer the 3-dose series to those who were not previously vaccinated; a 2-dose series of Recombivax HB is licensed for 11-15 years old. *Adults* – ***Hepatitis*** B vaccine is recommended to persons: 1) with end-stage renal disease, HIV infection, chronic liver disease, clotting factor concentrates; 2) who are exposed to blood, current or recent drug users, men who have sex with men, clients and staff of institutions for developmental disabilities, clients of STD clinics, international traveler to countries with high or intermediate prevalence of chronic HBV infection; and adult seeking protection from HBV infection. *Pregnancy* – All pregnant women should be routinely tested for HBsAg during first trimester, even if they have been previously vaccinated or tested. Women who are HBsAg positive should be referred to an appropriate case-management program to ensure that their infants receive timely post exposure prophylaxis follow-up.
21. **Hib (Haemophilus influenza type b)**: schedule includes 3 or 4 doses of Hib containing vaccine by age 2 years, depending on the specific vaccine. 4-dose schedule (at 2, 4, 6, and 12-15 months) should be used for the following vaccines: HibTiter®, ACTHib®, Tetramune®, or other Hib vaccines containing HbOC or PRP-T. 3-dose schedule (at 2, 4, and 12-15 months) should be used for following vaccines: PedvaxHib®, Comvax®, or other Hib vaccines containing PRP-OMP. TriHiBit® (DTaP/Hib) combination products should not be used for primary immunization, but can be used as boosters following any Hib vaccine in ≥ 12 months olds. Vaccine is not recommended for children aged ≥ 5 years.
22. **High Blood Pressure/Hypertension Screening:** recommended to adults aged 18 and older for high blood pressure every 2 years for person with SBP and DBP below 130 mHg and 85 mmHg, respectively, and more frequent intervals for screening those with blood pressure at higher levels.
23. **HIV Testing:** recommended to all adolescents, all pregnant women, and adults at risk for human immunodeficiency virus (HIV). *Pregnancy* – during first prenatal visit.

For additional information about vaccines, vaccine supply and contraindications for immunization, please visit the National Immunization Program Website at www.cdc.gov/nip or call the National Immunization Hotline at 800 232-2522.

Guidelines are based on U.S. Preventive Services Task Force Recommendations (2006); American Academy of Pediatrics (2007); Recommended Immunization Schedule United States, 2007; American Academy of Pediatrics Immunization Schedule, 2007; Recommended Adult Immunization Schedule United States October 2006-September 2007; AAFP Summary of Policy Recommendations for Clinical Preventive Services Revision 6.2, August 2006; Guidelines for Perinatal Care, American College of Obstetricians, 5th edition (2002).

Approved by the Advisory Committee on Immunization Practices (ACIP) (www.cdc.gov/nip/ACIP), American Academy of Pediatrics (AAP) (www.aap.org), the American Academy of Family Physicians (AAFP) (www.aafp.org) and CDC National Center for HIV/STD/TB Prevention (www.cdc.gov/nchstp/od/nchstp.html)

Adopted by Molina Healthcare of Texas 1/23/2008

24. **Human Papillomavirus (HPV) – (GARDASIL®):** administer to minimum age of 9 years; a complete series consists of 3 doses; first dose series to females at age 11-12 years; second dose should be administered 2 months after the first dose; the third dose should be administered 6 months after the first dose. Administer the 3-dose HPV vaccine series to females at 13-18 years if not previously vaccinated. HPV vaccination is recommended for all women aged ≤ 26 years who have not completed the vaccine series. HPV vaccine should be administered before exposure to HPV through sexual activity. Sexually active women should be vaccinated. *Pregnancy* – HPV vaccination is not recommended during pregnancy. If a woman is found to be pregnant after initiating the vaccination series, the remainder of the 3-dose should be delayed until after completion of the pregnancy.
25. **Inactivated Poliovirus (IPV):** Four dose series given at 2, 4, 6-18, and 4-6 years. First dose may be given as early as 6 weeks of age. The fourth dose of IPV is not recommended if the third dose is administered on or after the fourth birthday. DTaP-HepB-IPV combination vaccine (PEDIARIX) can be used for the 1st, 2nd, and 3rd doses of IPV if other components of the combination are not contraindicated. For children who received an all-IPV (Inactivated Poliovirus Vaccine) or all-OPV (Oral Poliovirus) series, a fourth dose is not necessary if third dose was administered at age ≥ 4 years. If both OPV and IPV were administered as part of a series, a total of 4 doses should be given, regardless of the child's current age.
26. **Influenza:** Pediatric **–** minimum age of 6 months for trivalent inactivated influenza vaccine (TIV) and minimum of 5 years for live, attenuated influenza vaccine (LAIV). All children aged 6-59 months and close contacts of all children aged 0-59 months are recommended to receive influenza vaccine. Annually recommended for children aged ≥ 59 months with risk factors. Children receiving TIV should receive 0.25 mL if aged 6-35 months or 0.5 mL if aged ≥ 3 years. *Adults* – recommended to adult who are resident of chronic care facilities, or suffer from chronic cardiopulmonary disorders, metabolic disease (including diabetes mellitus), hemoglobinopathies, immunosuppression, renal dysfunction, or are health care provider for the above. However, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with asplenia. Healthy, nonpregnant persons aged 5-49 years without high-risk medical conditions who are not contacts of severely immunocompromised persons in special care units can receive either intranasally administered vaccine (FluMist®) or inactivated vaccines. *Pregnancy* – vaccination with inactivated influenza vaccine is recommended for all women who are pregnant in the second and third trimester during the flu season (October – March). Women at high risk for pulmonary complication regardless of trimester.
27. **Lead Screening:** Consistent with recommendations of the CDC, children with identified risk factors should be screened at age one and again at age two; Screen children for blood lead at 12 and 24 months of age.
28. **Lipid Disorder Screening (Cholesterol):** recommended to routinely screen men aged 35 years and older and women aged 45 years and older for lipid disorder and treat abnormal lipids in people are at increased risk of coronary heart disease. Younger adults, men aged 20 to 35 and women aged 20 to 45, are recommended if they have other risk factors for coronary heart disease. Screening is recommended every 5 years and shorter interval for people who have lipid levels close to those warranting therapy. Screening includes measurement of total cholesterol and high-density lipoprotein cholesterol.
29. **Maternal serum alpha-fetoprotein (MSAFP):** recommended for all pregnant women at 16-18 weeks of gestation during prenatal care. Women with elevated MSAFP levels should received second test before 18 week of gestation. High risk pregnant women should be referred to specialized centers for appropriate diagnostic evaluation, including high-resolution ultrasound and amniocentesis. Folic acid supplementation at a dose of 4 mg/day beginning 1-3 months prior to conception and continuing through the first trimester is recommended for women planning pregnancy and was previously affected by neural tube defect. All women planning pregnancy take a daily multivitamin or multivitamin-multimineral supplement containing folic acid at a dose of 0.4-0.8 mg/day, beginning at least 1 month prior to conception and continuing through the first trimester.
30. **Measles, Mumps, Rubella (MMR):** *Pediatric* – minimum age of 12 months, except may be as young as 6 months of age in an outbreak or prior to international travel; first dose between 12-15 months and second dose at age 4-6 years. May be administered prior to age 4-6 years, provided ≥ 4 weeks have elapsed since the first dose and both disease are administered at age ≥ 12 months. *Adult* – ***Measles component:*** adults born during or after 1957 should receive ≥ 1 dose of MMR, unless they have medical contraindication, documentation of ≥ 1 dose, history of measles based on health-care provider diagnosis, or laboratory evidence of immunity. A second dose of MMR is recommended for adults who are at risk: have been recently exposed to measles; were previously vaccinated with killed measles vaccines; have been vaccinated with an unknown type during 1963-1967; students in postsecondary educational institutions; work in a health-care facility; travel internationally). ***Mumps component:*** adults born before 1957 are considered immune to mumps. Adults born during or after 1957 should receive 1-dose of MMR. A second dose of MMR is recommended for adults who are at risk. ***Rubella component:*** 1 dose of MMR vaccine to women whose rubella vaccination history is unreliable or who lack laboratory evidence of immunity. *Pregnancy* – Do not vaccinate women who are pregnant or who might become pregnant within 4 weeks of receiving vaccine. Women who do not have

For additional information about vaccines, vaccine supply and contraindications for immunization, please visit the National Immunization Program Website at www.cdc.gov/nip or call the National Immunization Hotline at 800 232-2522.

Guidelines are based on U.S. Preventive Services Task Force Recommendations (2006); American Academy of Pediatrics (2007); Recommended Immunization Schedule United States, 2007; American Academy of Pediatrics Immunization Schedule, 2007; Recommended Adult Immunization Schedule United States October 2006-September 2007; AAFP Summary of Policy Recommendations for Clinical Preventive Services Revision 6.2, August 2006; Guidelines for Perinatal Care, American College of Obstetricians, 5th edition (2002).

Approved by the Advisory Committee on Immunization Practices (ACIP) (www.cdc.gov/nip/ACIP), American Academy of Pediatrics (AAP) (www.aap.org), the American Academy of Family Physicians (AAFP) (www.aafp.org) and CDC National Center for HIV/STD/TB Prevention (www.cdc.gov/nchstp/od/nchstp.html)

Adopted by Molina Healthcare of Texas 1/23/2008

Molina Healthcare/Molina Medicare of Texas
Prior Authorization/Pre-Service Review Guide

Effective: 07/15/2012

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare/Molina Medicare Members.
Referrals to Network Specialists do not require Prior Authorization

Authorization required for services listed below.
Pre-Service Review is required for elective services.
Only covered services will be paid

- **All Non-Par providers/services:** services, including office visits, provided by non-participating providers, facilities and labs, except professional services for ER visit, approved Ambulatory Surgical Center or inpatient stay. ER visits do not require PA
- **Alcohol and Chemical Dependency Services**
- **All Inpatient Admissions:** Acute hospital, SNF, Rehab, LTACS, Hospice(notification only)
- **Behavioral Health Services:** - Inpatient, Partial hospitalization, Day Treatment, Intensive Outpatient Programs (IOP), ECT, and > 12 Office Visits/year for adults and 20 Office visits/year for children
- **Cardiac Rehabilitation, Pulmonary Rehabilitation, and CORF (Comprehensive Outpatient Rehab Facility services for Medicare only)**
- **Chiropractic Services**
- **Cosmetic, Plastic and Reconstructive Procedures in any setting:** which are not usually covered benefits include but are not limited to tattoo removal, collagen injections, rhinoplasty, otoplasty, scar revision, keloid treatments, and surgical repair of gynecomastia, pectus deformity, mammoplasty, abdominoplasty, venous injections, vein ligation, venous ablation or dermabrasion, botox injections, etc
- **Dental General Anesthesia:** > 7 years old or per state benefit (Not a Medicare covered benefit)
- **Dialysis:** notification only
- **Durable Medical Equipment/Orthotics/Prosthetics:**
  - >$500 allowed amount per line item or >$2000 total
  - C-PAP and Bi-PAP
  - All customized orthotics, prosthetics, wheelchairs and braces
  - Hearing Aids – including anchored hearing aids
  - Medicare Hearing Supplemental benefit: Contact Avesis at 800-327-4462
- **Enteral Formulas & Nutritional Supplements**
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing NOT related to pregnancy**
- **Home Healthcare: after 3 skilled nursing visits**
- **Home Infusion**
- **Outpatient Hospice & Palliative Care:** notification only.
- **Imaging:** CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms, intimal media thickness testing, three dimensional imaging
- **LTC Services (per state benefit)- e.g., Personal Attendant Services (PAS), Personal Care Services, Day Adult Health Services (DAHS). Not a Medicare covered benefit**
- **Neuropsychological Testing and Therapy**
- **Occupational Therapy, Physical Therapy and Speech Therapy after initial eval plus 6 visits. (Home or outpatient setting)** [An auth is not required for therapy listed on the ECI IFSP provided by an ECI provider (for children from birth through 35 months of age)]
- **Office-Based Surgical Procedures do not require auth except for Podiatry Surgical Procedures** (excluding routine foot care)
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** except for see attached**
- **Pain Management Procedures:** including sympathectomies, neurotomies, injections, infusions, blocks, pumps or implants, and acupuncture (Not a Medicare covered benefit)
- **Pregnancy and Delivery:** notification only
- **Sleep Studies**
- **All Specialty Pharmacy including, but not limited to:** Hemophilia drugs, Avastin, Enbrel, Lupron, Remicade, Avonex, Interferon, Xolair, Humira, Raptiva, Amevive, Synagis, Synvisc, growth hormone, monoclonal antibody, genomic preparations, etc. (except for specific state regulatory requirements)
- **Solid Organ and Bone Marrow Transplant Services:** including the evaluation (except Cornea transplants)
- **Transportation:** non-emergent ground and air ambulance
- **Unlisted CPT procedures (all),**
  - **miscellaneous codes >$500 billed charges per line item**
- **Wound Therapy including Wound Vacs and Hyperbaric Wound Therapy**

***STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with claim. (Medicaid benefit only)**

** Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:

The following procedures do NOT require PA if performed in a participating ASC or Outpatient Hospital setting:

Appendectomy	44950, 44970
AV Fistula	36831, 36832, 36833
Bladder Tumor	52234, 52235, 52240
Blood Patch	62273
Breast Biopsy	19120
Bronchoscopy	31622, 31623, 31624, 31625, 31626, 31627, 31628, 31629, 31630, 31631, 31632, 31633, 31635, 31636, 31637, 31638, 31640, 31641, 31643, 31645, 31646, 31656
Cardiac Cath	93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93462, 93463, 93464, 93530, 93531, 93532, 93533
Cardiovascular Intra-Arterial/Intra-Aortic Catheter	36100, 36120, 36140, 36147, 36148, 36160, 36200, 36215, 36216, 36217, 36218, 36245, 36246, 36247, 36248. Also please note that the following associated Aortography/Angiography procedures do not require authorization as well: 75600, 75605, 75625, 75630, 75650, 75658, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 75705, 75710, 75716, 75722, 75724, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75774, 75791
Cataract	66820, 66821, 66830, 66982, 66983, 66984
Cecostomy tube	49442
Cerclage during Pregnancy	59320
Colonoscopy	44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392
Cystourethroscopy	52270, 52275, 52276, 52265, 52260, 52000,52001, 52005
D&C	58120, 59812, 59820, 59821
Endometrial/Endocervical Sampling (biopsy)	58100
Gastrostomy Tube	49440, 49450, 43760, 43761, 49460
Gastrostomy Tube to Jejunostomy Tube	49446, 49452
GI Endoscopy	43234, 43235, 43236, 43237, 43238, 43239, 43240, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, 43256, 43257, 43258, 43259, 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272
Hardware Removal	20680, 20670
Inguinal Hernia	49505, 49507, 49520, 49521, 49525, 49650, 49651
Jejunostomy Tube	49441, 49451
Lacrimal Duct	68811, 68815, 68816
Lap Cholecystectomy	47563, 47564, 47562
Laryngoscopy	31505, 31510, 31511, 31512, 31513, 31515, 31520, 31525, 31526, 31527, 31528, 31529, 31530, 31531, 31535, 31536, 31540, 31541, 31545, 31546, 31560, 31561, 31570, 31571, 31575, 31576, 31577, 31578, 31579
Malignant Lesion	11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11640, 11641, 11642, 11643, 11644, 11646, 17260, 17261, 17262, 17263, 17264, 17266, 17270, 17271, 17272, 17273, 17274, 17276, 17280, 17281, 17282, 17283, 17284, 17286
Orchiopexy	54640
PICC line placement/ replacement	36568, 36569, 36582, 36584, 36589, 36590, 36598
PORT-A-CATH	36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36576, 36578
Sigmoidoscopy	45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345
Sterilization*	55250, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58600, 58605, 58611, 58615, 58671, 58940
Tonsillectomy/Adenoidectomy	42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836
TURP	52601, 52630
Tympanoplasty/ Myringotomy	69420, 69421, 69424, 69433, 69436, 69631, 69632, 69633, 69635, 69636, 69637, 69641, 69642, 69643, 69644, 69645, 69646

Important Information For Molina Healthcare/Molina Medicare

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT Lab or X-ray report/results)
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone or fax. Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition.

Providers can request a copy of the criteria used to review requests for medical services.

Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at 1-866-449-6849 (Bexar, Dallas, El Paso, Harris, Hidalgo & Jefferson Service Areas) or 1-877-319-6826 (CHIP Rural Service Area).

Important Molina Healthcare/Molina Medicare Information	
Prior Authorizations: 8:00 a.m. – 5:00 p.m. Phone: 1-866-449-6849 (Bexar, Dallas, El Paso, Harris, Hidalgo, & Jefferson Service Areas) 1-877-319-6826 (CHIP Rural Service Area) Fax: 1-866-420-3639 **Behavioral Health Authorizations:** Phone: 1-800-818-5837 Fax: 1-866-617-4967 For Behavioral Health Services in Dallas Service Area (STAR+PLUS), please call NorthSTAR at 1-888-800-6799 **Member/Provider Customer Service Benefits/Eligibility:** Phone: 1-866-449-6849 (Bexar, Harris & Dallas Service Areas) 1-877-319-6826 (CHIP Rural Service Area) Fax: 1-281-599-8916	**24 Hour Nurse Advice Line** English: 1-888-275-8750 [TTY: 1-866/735-2929] Spanish: 1-866-648-3537 [TTY: 1-866/833-4703] **Vision Care:** (www.opticarevisionplans.com provrel@opticare.net) Phone: 1-800-368-4790 (CHIP) 1-866-492-9711 (STAR) 1-877-832-4118 (STAR+PLUS) **Dental:** Liberty Dental Phone: 1-888-359-1084 (Bexar, Dallas, El Paso, Harris, Hidalgo & Jefferson Service Areas)

Providers may utilize Molina Healthcare's ePortal at: www.molinahealthcare.com

Available features include:

- Authorization submission and status
- Claims submission and status (EDI only)
- Download Frequently used forms
- Member Eligibility
- Provider Directory
- Nurse Advice Line Report

Molina Healthcare/Molina Medicare Prior Authorization Request Form

Phone Number: 1-866-449-6849 (Bexar, Dallas, El Paso, Harris, Hidalgo, & Jefferson Service Areas)
or 1-877-319-6826 (CHIP Rural Service Area)
Fax Number: 1-866-420-3639

Member Information

Plan: ☐ **Molina Medicaid** ☐ **Molina Medicare** ☐ **Other:**_____

Member's Name:_____ DOB: _____/_____/_____

Member's ID#:_____ Member Phone #: ( ) _____

Service Is: ☐ Elective/Routine ☐ Expedited/Urgent*

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

Referral/Service Type Requested		
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Rehab (PT, OT, & ST) ☐ Diagnostic Procedure ☐ Chiropractic ☐ Wound Care ☐ Infusion Therapy	☐ **Home Health** ☐ **DME** ☐ **In Office**

ICD-9 Code & Description:_____

CPT/HCPC Code & Description:_____

Number of visits requested:_____ Date(s) of Service:_____

Please send clinical notes and any supporting documentation

Provider Information

Requesting Provider Name: _____

Facility Providing Service: _____

Contact @ Requesting Provider's: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

For Molina Use Only:

Molina Healthcare Prior Authorization Request Form

Phone Number: 1-866-449-6849 (Bexar, Harris, Dallas, Jefferson, El Paso & Hidalgo Service Areas)
1-877-319-6826 (CHIP Rural Service Area)
Fax Number: 1-866-420-3639

Member Information

Plan: ☐ **Molina Medicaid** ☐ **Molina Medicare** ☐ **TANF** ☐ **Other**

Member's Name: _____ DOB: _____

Member's ID#: _____ Member Phone #: _____

Service Is: ☐ Elective/ Routine ☐ Expedited/Urgent*

***Definition of expedited/urgent is when the situation where the standard time frame or decision making process (up to 14 days per Molina's process) could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function.**

Referral/Service Type Requested

Inpatient	**Outpatient**	
☐ Surgical procedures	☐ Surgical Procedure	☐ **Home Health**
☐ ER Admits	☐ Rehab (PT, OT, & ST)	
☐ SNF	☐ Diagnostic Procedure	☐ **DME**
☐ Rehab	☐ Chiropractic	
☐ LTAC	☐ Wound Care	☐ **In Office**
	☐ Infusion Therapy	

Diagnosis Code & Description: _____

CPT/HCPC Code & Description: _____

Number of visits requested: _____ Date(s) of Service: _____

Please send clinical notes and any supporting documentation

Provider Information

Requesting Provider Name: _____

Facility Providing Service: _____

Contact @ Requesting Provider's: _____

Phone Number: _____ Fax Number: _____

For Molina Use Only:

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