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8.9 Re-Credentialing Requirements
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1.0 – Quick Reference Guide

1.1 Sendero Health Plans – Quick Reference Guide

Address

<table>
<thead>
<tr>
<th>Physical and Mailing Address</th>
<th>Internet Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>2028 East Ben White Blvd.</td>
<td><a href="http://www.senderohealth.com">www.senderohealth.com</a></td>
</tr>
<tr>
<td>Suite 510</td>
<td></td>
</tr>
<tr>
<td>Austin TX 78741</td>
<td></td>
</tr>
</tbody>
</table>

Department Phone Numbers

<table>
<thead>
<tr>
<th>Member Services</th>
<th>Medicaid STAR</th>
<th>CHIP</th>
<th>1-855-526-7388</th>
<th>1-855-526-7388</th>
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<tbody>
<tr>
<td>Medicaid and CHIP</td>
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<td>1-855-526-7388</td>
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</table>

Claims

<table>
<thead>
<tr>
<th>Medicaid and CHIP</th>
<th>Health Services Management Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-855-526-7388</td>
<td>1-855-895-0475</td>
</tr>
<tr>
<td></td>
<td>Fax 512-275-2862</td>
</tr>
</tbody>
</table>

Network Management

<table>
<thead>
<tr>
<th>Network Management</th>
<th>Behavioral Health HOT LINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-855-895-0475</td>
<td>1-888-287-5403 (CHIP)</td>
</tr>
<tr>
<td>Fax 512-901-9704</td>
<td>1-888-287-5402 (STAR)</td>
</tr>
</tbody>
</table>

Self-Referrals

PCP referral is not required when a participating network specialist is utilized for:

- Out-of-area emergency services
- Family planning services
- Texas Health Steps medical case management services for STAR Members
- Early Childhood Intervention (ECI) case management services
- Children and Pregnant Women (CPW) case management services
- School Health and Related Services (SHARS) program services
- Department of Assistive and Rehabilitative (DARS) case management services for STAR Members
- Department of State Health Services (DSHS) case management services for STAR Members
- Department of Aging and Disability Services (DADS) case management services for STAR Members

In-network-only, Self-referral for Covered Services – Paid by Sendero

- Behavioral health services
- Emergency room care
- Obstetric services
- Well-woman gynecological services
- Vision care, including covered eye glasses
### Billing/Claims

<table>
<thead>
<tr>
<th>Medicaid STAR and CHIP</th>
<th>Electronic Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mailing Address</strong></td>
<td>Clearinghouse of choice</td>
</tr>
<tr>
<td>Valence Health</td>
<td>EDI Payor ID: 36426</td>
</tr>
<tr>
<td>Attn: SENDERO CLAIMS</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 3869</td>
<td></td>
</tr>
<tr>
<td>Corpus Christi, TX 78463</td>
<td></td>
</tr>
</tbody>
</table>

*Please review Acceptance and Rejection Report from your Clearinghouse of choice – All claims received in through Emdeon to 3rd party payor*
CHIP and STAR
PRIOR AUTHORIZATION LIST
SENDERO HEALTH PLANS
EFFECTIVE 03/01/2012

Medical benefits and eligibility must be verified prior to requesting authorization. Admission notification and Prior Authorization requests can be submitted:

The following services must be prior-authorized before rendering the service:

<table>
<thead>
<tr>
<th>Inpatient/Skilled Nursing Facility Services</th>
<th>Behavioral Health</th>
<th>Surgeries/Procedures (Inpatient or Outpatient)</th>
<th>Outpatient Services/Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior authorization of an emergent, elective or scheduled admission is NOT required</td>
<td>Prior authorization of an emergent, elective or scheduled admission is NOT required.</td>
<td>Circumcision &gt;1 year of age</td>
<td>Bio-feedback</td>
</tr>
<tr>
<td>Facility is responsible for admission notification to Sendero</td>
<td>Facility is responsible for admission notification to Sendero</td>
<td>Cochlear Implants</td>
<td>Injectable drugs &gt; $500 AWP</td>
</tr>
<tr>
<td>Prior day admissions for surgical procedures</td>
<td>Behavioral Health outpatient treatments &gt;20 visits</td>
<td>Hyperbaric treatment for wound care</td>
<td>Sleep studies / sleep labs</td>
</tr>
<tr>
<td></td>
<td>Psychological and Neuropsychological Testing</td>
<td>Bariatric Surgery (STAR)</td>
<td>TMJ treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgeries with potential cosmetic indications (i.e., panniculectomies, blepharoplasties, etc...)</td>
<td>Synagis</td>
</tr>
<tr>
<td>Ancillary/Specialty Services</td>
<td>DME/Orthotics/Prosthetics</td>
<td>Radiology</td>
<td>Home Health</td>
</tr>
<tr>
<td>Chiropractic care &gt; 8 visits</td>
<td>DME (rental or purchase) and medical supplies &gt; $500 purchase price</td>
<td>CAT Scans, MRIs &amp; MRAs not provided in an inpatient or Emergency Room setting</td>
<td>Skilled nursing visits &gt; 3 visits</td>
</tr>
<tr>
<td>Organ or bone marrow transplants</td>
<td>Wound VACs</td>
<td>PET Scans/SPECT</td>
<td>PT, ST or OT (excluding initial evaluation)</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>Orthotics, Prosthetics or Dental devices purchase price &gt;$500 per item</td>
<td>Radiological procedures that require admission for observation</td>
<td>Infusion therapy</td>
</tr>
<tr>
<td>Notification only of Hospice Services</td>
<td>Hearing Aids</td>
<td>OB ultrasounds &gt;3</td>
<td>Private duty nursing</td>
</tr>
<tr>
<td>Treatment Related Services</td>
<td>Out of Network or Area Services</td>
<td>Transportation</td>
<td></td>
</tr>
<tr>
<td>Investigational or Experimental drugs or procedures</td>
<td>All out of network or out of area inpatient, outpatient hospital admissions, surgeries, procedures, referrals, evaluations, specialty services and/or treatments</td>
<td>Non-emergent ground and air ambulance services</td>
<td></td>
</tr>
<tr>
<td>New Technologies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implantable pumps &amp; devices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical trials covered by CMS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sendero Customer Services 1-855-526-7388     Network Management 1-855-895-0475
Health Services Dept.: 1-855-297-9191      (FAX 1-512-275-2862)
1.2 Other Organizations’ Telephone numbers

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Lead Poisoning</td>
<td>1-800-588-1248</td>
</tr>
<tr>
<td>CHIP application and enrollment assistance</td>
<td>1-877-543-7669 or 1-800-647-6558</td>
</tr>
<tr>
<td>Comprehensive Care Program</td>
<td>1-800-846-7470</td>
</tr>
<tr>
<td>Early Childhood Intervention (ECI) Care Line (STAR Only)</td>
<td>1-800-628-5115</td>
</tr>
<tr>
<td>Medicaid Client Hotline (Benefits)</td>
<td>1-800-252-8263</td>
</tr>
<tr>
<td>Medical Transportation Services (Medicaid)</td>
<td>1-877-633-8747</td>
</tr>
<tr>
<td>Pharmacy Questions - Navitus</td>
<td>1-877-908-6023</td>
</tr>
<tr>
<td>Texas Abuse Hotline</td>
<td>1-800-252-5400</td>
</tr>
<tr>
<td>Texas Vaccines for Children Program</td>
<td>1-800-252-9152</td>
</tr>
<tr>
<td>Texas Health Steps</td>
<td>1-877-847-8377</td>
</tr>
<tr>
<td>Finding Help in Texas/Eligibility and Benefits</td>
<td>2-1-1 or 1-877-541-7905</td>
</tr>
<tr>
<td>TMHP AIS Line (Automated Inquiry System)</td>
<td>1-800-925-9126 option 2</td>
</tr>
<tr>
<td>Women, Infant, Children (WIC)</td>
<td>1-800-942-3678</td>
</tr>
</tbody>
</table>
2.0 – Introduction

2.1 Background of Sendero Health Plans

Sendero Health Plans (Sendero) is a local non-profit corporation based in Austin, Texas and licensed as a community-based Health Maintenance Organization (HMO) that serves Central Texas. Sendero is sponsored by the Travis County Healthcare District, doing business as Central Health, which is providing organizational and financial resources to enable Sendero Health Plans to become a major player in improving health care access for people in Central Texas. Beginning March 2012, Sendero will provide services to the Medicaid STAR and CHIP population in Travis and surrounding counties of Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, and Williamson.

Mission Statement
Sendero is committed to providing comprehensive healthcare coverage and to arrange for innovative, high quality and cost-effective medical services for health plan Members within Central Texas.

Name Selection
Sendero means “path” in Spanish. Sendero Health Plans is your pathway to better health in Central Texas.

Provider Network
Sendero will develop collaborative relationships with physicians, hospitals and other healthcare providers to improve access, efficiency and quality of care for our Members. We are committed to understanding local provider’s requirements. As a non-profit corporation, Sendero Health Plans will reinvest any surplus earnings to strengthen local healthcare infrastructure and improve healthcare for people living in Central Texas. We are based in Austin with a local management team to serve Members and providers. We will work collaboratively with physicians and other providers to facilitate access and continuity of care.

Products
Under a contract with the Texas Health and Human Services Commission (HHSC), Sendero Health Plans functions as an administrator for the STAR/Medicaid managed care and Children’s Health Insurance Program (CHIP/CHIP Perinatal) programs in the eight county Travis Service Delivery Area.
STAR/Medicaid Managed Care

Sendero Health Plans is contracted with HHSC as one of the HMO’s in the Travis Service Delivery Area (SDA). The STAR program provides a full range of Medicaid health services to newborn, pregnant women, children, and adults.

Children’s Health Insurance Program

Sendero Health Plans will begin serving CHIP recipients in March 2012. The program is designed for families who earn too much money to qualify for Medicaid yet cannot afford to buy private insurance for their children. CHIP provides eligible children (up to age 19) with coverage for treatment for a full range of health services including regular checkups, immunizations, prescription drugs, lab tests, X-rays, hospital visits, and more. Sendero Health Plans is one of the HMO choices for a child with CHIP coverage in the Travis Service Delivery Area (SDA).

CHIP Perinatal

Sendero Health Plans will begin serving CHIP Perinatal members in March 2012. CHIP Perinatal provides care to unborn children of pregnant women with household income up to 200% of the federal poverty level (FPL) and who are not eligible for Medicaid. Once born, the child will receive benefits that are similar to the traditional CHIP benefits for the duration of the 12-month coverage period. Sendero Health Plans is one of the HMO choices for an unborn child / newborn with CHIP Perinatal coverage in the Travis Service Delivery Area (SDA).
2.2 Sendero’s Philosophy of Business

Sendero has established a working collaboration with its provider network; one that strives to improve access to care, efficiency in care and continued quality of care for our Members. We endeavor to make this approach gain Sendero the respect and cooperation of the provider community throughout the Travis Service Delivery Area (SDA). We encourage providers to be very involved, through the Medical Director and the Health Services Department, in review of clinical guidelines and in creating programs to benefit the Service Delivery Area. These strong and mutually beneficial relationships ensure excellence in the delivery of health care services to Sendero Members and the community at large.

2.3 Sendero’s Program Objectives

The program objectives of Sendero focus on:

- comprehensive well-child care, including childhood immunization
- case management opportunities to coordinate care
- ADHD, asthma and diabetes disease management programs to collaboratively improve control of these chronic conditions with affected Members
- early and continuous prenatal care for pregnant Members geared to improve birth outcomes
- effective behavioral health care services, including medication management
- outreach and care coordination for children with special health care needs

2.4 Sendero’s Material Subcontractors / Other Key Vendors

Sendero administers its own programs, manages all quality improvement processes, ensures compliance with the State contract, and oversees the development of its comprehensive network of providers and facilities. Sendero contracts with an Administrative Services Organization (ASO) to provide operational services and information management processes along with other subcontractor organizations to provide services. Subcontractors include:

- Corporate Printing – providing all non-marketing printed material for Providers and Members
- Navitus Health Solutions, LLC – to meet pharmacy needs for CHIP and STAR Members.
- Valence Health – providing Claims processing and adjudication, and Customer Services
- Westport Insurance Corporation – providing Reinsurance services for Sendero

Key Vendors include:

- Allied Management Group - providing Fraud and Abuse and Special Investigative Unit
- Avail – providing 24 hour Behavioral health hotline services.
- Bratton Law Firm – providing Subrogation Management services for Sendero
2.5 Role of Primary Care Provider

The primary care provider is the cornerstone for Sendero Health Plans. The primary care provider serves as the “Medical Home” for the Member. The “Medical Home” concept should help in establishing a relationship between the patient and provider, and ultimately better health outcomes. The primary care provider is responsible for the provision of all primary care services for the Sendero STAR, CHIP, and CHIP Perinatal Members. In addition, the primary care provider is responsible for facilitating referrals and authorization for specialty services to Sendero network providers, as needed. For more information on the responsibilities of the primary care provider, see “3.0 Guidelines for Providers” in this manual.

2.6 Role of the Specialty Care Provider

The Specialty Care provider collaborates with the primary care provider to deliver specialty care to STAR, CHIP, and CHIP Perinatal Members. A key component of the Specialist’s responsibility is to maintain ongoing communication with the Member’s primary care provider. Specialty providers are responsible to ensure necessary referrals/authorizations have been obtained prior to provision of services. For more information on the responsibilities of the Specialty Care provider, see “3.0 Guidelines for Providers” in this manual.

2.7 Role of the CHIP Perinatal Provider

The CHIP Perinatal provider establishes a relationship with the expectant mother in order to provide services to the unborn member to promote a healthy pregnancy and delivery. The Perinatal provider renders services such as prenatal visits, assessments, planning services, education and counseling along with coordination of routine prenatal laboratory testing. The CHIP Perinatal provider also prescribes medications to promote healthy pregnancy and provides attending services during hospitalization related to the delivery of the unborn child.

2.8 Role of the Pharmacy

The role of Navitus, the chosen pharmacy option for Sendero, is to provide an effective network of sites and pharmacy providers to provide access for members and providing prescription fulfillment while improving health and providing superior customer service in a manner that instills trust and confidence to Sendero.
members. Navitus and the PBM industry will be fully compliant and converted to NCPDP E.1 electronic eligibility verification by January 1, 2012

2.9 Network Limitations (e.g. Primary Care Providers, Specialists, OB/GYN)

Members are limited to the use of providers that are contracted with Sendero Health Plans. Exceptions can be made temporarily when continuity of care would be disrupted if the Member did not continue with an out-of-network provider. All out-of-network referrals must be approved by the Health Services department. For more information on referrals to out-of-network providers, see “3.0 Guidelines for Providers” below.

Members who are involved in an “active course of treatment” have the option of completing that course of treatment with their current provider regardless of whether the current provider is contracted with Sendero or terminates their contract with Sendero during the treatment phase. This option applies to Members who:

- Have pre-existing conditions
- Are in their 3rd trimester of pregnancy
- Are receiving care for an Acute medical condition
- Are receiving care for an Acute episode of a chronic condition
- Are receiving care for a life threatening illness, or
- Are receiving care for a disability

Members who fall into these categories will work with a Sendero Nurse Care Coordinator to transition services when it is appropriate to do so over a reasonable period of time as determined by the individual member’s situation. To contact a Nurse Care Coordinator, call Health Services at 1-855-297-9191.
3.0 – Guidelines for Providers

3.1 The Role and Responsibilities of the Primary Care Provider

Each Sendero STAR and CHIP Member must select a primary care provider. The role of the primary care provider is to render the following minimum set of primary care services in his/her practice, in conjunction with providing a medical home:

1. Routine office visits
2. Care for colds, flu, rashes, fever, and other general problems
3. Urgent Care within the capabilities of the Physician’s office
4. Periodic health evaluations, including Texas Health Steps examinations
5. Well baby and child care
6. Vaccinations, including tetanus toxoid injections
7. Allergy injections
8. Venipuncture and other specimen collection
9. Eye and ear examinations
10. Preventive care and education / access to second opinion for services
11. Nutritional counseling
12. Hospital visits if the physician has active hospital admitting privileges and/or if there is a hospital facility available in the immediate geographic area surrounding the physician’s office
13. Other covered services within the scope of the Physician provider’s Medical Practice
14. Based on evaluation and assessment, coordinate referrals to in network specialty care
15. Behavioral health screening and help to access to care if Member requests
16. May provide behavioral health related services within the scope of his/her practice

The physician provider must deliver the services listed above to Sendero Health Plans’ STAR and CHIP Members, unless specifically waived by the Health Plan. In addition to the above services, the primary care provider is required to:

- Coordinate all medically necessary care with other Sendero network providers as needed for each Member, including, but not necessarily limited to:
  - specialist physicians and ancillary providers
  - outpatient surgery
  - dental care
  - hospital admission
  - other medical services
- Follow Sendero procedures with regard to non-network provider referrals (see below) and applicable aspects of the Sendero medical management program outlined in “6.0 Medical Management” in this manual
- Be available to Members for urgent or emergency situations, either directly or through an on-call physician arrangement, on a 24 hour-a-day/7 day-a-week basis
- Have admitting privileges at an in-network hospital
● Maintain a confidential medical record for each patient
● Educate Members concerning their health conditions and their needs for specific medical care regimens or specialist referral and give information regarding advance directive as required
● Help Sendero in identifying and referring Members with chronic asthma, diabetes, attention deficit disorders or who are pregnant and would benefit from Sendero’s Whole Person Health Support (WPHS) programs. Referrals can be called in to Health Services at 1-855-297-9191.
● Cooperate with Sendero’s WPHS case management nurses by providing clinical information and collaborating with Sendero on case management efforts (such as education and provider follow up) to help members at risk for exacerbation, for compliance barriers or for unplanned hospitalizations when Members are determined appropriate for case management services.
● Participate in the Texas Vaccines for Children Program for the provision of immunization services to pediatric Members
● Maintain an open panel and accept new Members unless prior arrangements have been made with Sendero Health Plans
● When managing a Sendero STAR/Medicaid Member, be a Texas Health Steps provider or agree to refer to a Texas Health Steps provider and have an acceptable rate of completed Texas Health Steps exams and an acceptable immunization rate evidenced in the State’s immunization registry.
● Refer Members to the Women, Infant, Children (WIC) program and Early Childhood Intervention (ECI) program as appropriate.
● Inform member of their right to obtain medication from any Network pharmacy

Other Primary Care Provider Responsibilities
The primary care provider is responsible for collection of co-payments at the time of service for CHIP Members. Sendero CHIP Members are to be responsible for office co-payments and non-covered services (as applicable) at the time of service. According to the level of CHIP benefits (which are based on Federal Poverty Level) the amount of a Member’s co-payment will vary. The Member’s Identification Card will list the co-payments to be collected at the time of service or call CHIP toll free for assistance (877-543-7669). In no event shall the Member be billed for the difference between billed charges and fees paid by Sendero. (NOTE: There are no co-payments for services for the STAR Members.)

The primary care provider is responsible for verifying Member eligibility at the time of the office visit. This includes verification that the Member is seeing the primary care provider designated on their Sendero Member ID card. If the primary care provider’s office discovers that the Member has dual insurance coverage with a commercial insurance or CHIP/Medicaid, the office is responsible for notifying Sendero’s Customer Services.

Sendero requests that Members notify us in writing if they move, change their address or phone number – even if these are temporary situations. If a Member leaves the Travis Service Area, they may no longer be eligible. The Travis Service Area includes the counties of Bastrop, Burnett, Caldwell, Fayette, Hays, Lee, Travis, and Williamson.

Sendero does not impose any pre-existing condition limitations or exclusions, nor is there a requirement for Evidence of Insurability to join the Health Plan

If the primary care provider employs physician assistants, advanced practice nurses, or other individuals who assess the health care needs of the Members, the primary care provider must have written policies in place that
are implemented, enforced, and describe the duties of all such individuals in accordance with statutory requirements for licensure, delegation, collaboration, and supervision as appropriate.

**Interpreter/Translation Services**

If you have a Member who needs help with special language services including interpreters, please call Customer Services. Sendero is contracted with Language Services Associates, who can assist you with interpretation services in your office. Call **1-866-482-8230 CODE 31091** and provide the customer service representative at Language Services Associates with the following:

- Language needed
- Member Sendero ID number
- Physician’s first and last name

If you need an interpreter in the office when the Member sees you, please call, or have the Member call the Health Services department at least 48 hours before his/her appointment to schedule these services.

You can also contact Relay Texas for telephone interpreter service for deaf or hard of hearing Sendero Members by dialing 711 and requesting to communicate with the Member. This service is available for Texans 24 hours a day, 365 days a year. There are no restrictions imposed on Relay Texas calls.

### 3.2 Who Can Be a Primary Care Provider?

The following Sendero network provider types are eligible to serve as a primary care provider for STAR and CHIP Members:

- Pediatrician
- Family or General Practitioner
- Internist
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)
- Pediatric and Family Nurse Practitioners (PNP and FNP)
- Physician Assistants (PA) (under the supervision of a licensed practitioner)
- Obstetricians/gynecologists electing to be a Primary Care Provider
- Specialists, as approved by Sendero, willing to provide a medical home for specific Members with certain special health care needs or illnesses (see below)
3.3 OB/GYN Physician

Sendero Members are allowed to self-refer to a network OB/GYN for any of the well-woman services stated below. This information is clearly communicated to the Members in the Member Handbook. No referral is required.

*Sendero allows you to pick an OB/GYN but this doctor must be from within the same network as your Primary Care Provider.*

*ATTENTION FEMALE MEMBERS: You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:*

- One well-woman check-up each year
- Care related to pregnancy
- Care for any female medical condition
- Referral to specialist doctor within the network

The female STAR or CHIP Member may designate the OB/GYN physician as her primary care provider. The OB/GYN physician must agree to being designated as the primary care provider and must agree to abide by all the primary care provider requirements, including but not limited to, being available 24 hours a day, seven (7) days a week. A referral from an existing primary care provider is not required for the female Member to designate an OB/GYN physician as a primary care provider. The OB/GYN physician must be part of the Sendero network of providers, because Sendero limits a Member’s selection of OB/GYN providers to in-network providers.

**OB/GYN Responsibilities**

Once the obstetrical services provider diagnoses a Member’s pregnancy, the provider must notify Sendero Health Plans by using one of the following methods:

- completing the Sendero Pregnancy Notification Form (see Appendix A)
- completing a similar form containing the required information
- Notifying WPHS Case Management with the required information by calling 1-855-297-9191 or faxing Sendero at 512-275-2862.

Providers are not required to use the Sendero Pregnancy Notification form itself, but may provide the same information via some other form, such as the American College of Obstetricians and Gynecologists (ACOG) or Hollister high risk forms or other similar forms. If a health condition develops or is discovered during the self-referral episode of care that is likely to have an ongoing effect on the Member’s health and/or the Member’s relationship with or care from her primary care provider, the OB/GYN provider should provide a written report to the Member’s primary care provider unless the Member specifically requests that no such report be made.
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Sendero will make every effort not to disrupt an existing relationship for pregnant women who have already established a relationship with an OB/GYN provider at the time of their enrollment with the Health Plan. Newly enrolled pregnant members who are in their 3rd trimester (28 weeks gestation and beyond) will be allowed to remain with their established OB/GYN through the member’s post-partum checkup. If a member requests to change OB/GYN providers, she will be allowed to choose from any of Sendero’s in-network provider panel.

Sendero’s RN Care Coordinators are available to provide services to high risk pregnant women, and to be a resource for educational needs. If notified timely, the Care Coordinators can more effectively assist pregnant Members who have positive drug screening result, as these women frequently have premature births or newborns with complications.

Contact Case Management at 1-855-297-9191 if a high risk pregnant Member is identified.

Obstetrical providers must make appropriate referrals for applicable Members to WIC.

3.4 Other Specialists as Primary Care Provider

Sendero allows Members with chronic, disabling, or life-threatening illnesses to select a Specialist as their Primary Care Provider following a review and authorization by Sendero’s Medical Director. The request to utilize a Specialist in the capacity of a PCP must contain the following information:

- Certification by the Specialist of the medical need for the Member to utilize the Specialist as a PCP
- A Statement signed by the Specialist that he/she is willing to accept responsibility for the coordination of all of the Member’s health care needs, and
- Signature of the Member on the completed Specialist as a PCP Request form (Attachment D)

To be eligible to serve as a PCP, the Specialist must meet Sendero Health Plans’ Network requirements for PCP participation. A decision will be given to the requesting Specialist physician and Member in writing, within thirty (30) days of original request. If approved, the Specialist physician may serve as a primary care provider for specific Members and must be willing to provide all the services outlined above in The Role and Responsibilities of the Primary Care Provider paragraphs of this section, and if they meet the criteria stated below. Network Management will work with the specialty PCP to re-define their service agreement to reflect their new role as a PCP and will provide the specialist serving as a PCP with a copy of the current directory of participating specialist physicians and providers. If denied, the Member may appeal the decision following the appeal process defined in “ST5 Complaints & Appeals” or “CH4 Complaints & Appeals” in this manual.

The Specialist that has been chosen as a primary care provider by the Member must meet and agree to the following criteria:

1. The Specialist must be board certified or board eligible in their specialty and licensed to practice medicine or osteopathy in the State of Texas. (Board certification / eligibility may be waived in certain...
circumstances for Significant Traditional Providers or providers who have functioned long term in a field that is appropriate for the diagnosis of the Member with special health care needs.)

2. The Specialist must have admitting privileges at a network hospital.

3. The Specialist must agree to be the primary care provider for the Member. He/she will be contacted and informed of the Member’s selection. The Specialist must then sign the Specialist as a PCP Referral form (available by calling Network Management) for the Member with special needs that has made the request.

4. The Specialist must agree to abide by all the requirements and regulations that govern a primary care provider, including but not limited to:
   a. being available 24 hours a day, 7 days a week,
   b. administering immunizations as required, and
   c. acting as the medical home and coordinating care for this Member

The effective date of the Specialist functioning as the Member’s primary care provider will be the first of the month following the date the Specialist as a PCP Referral form is signed by the Medical Director. The effective date of the designation of the specialist as the member’s PCP may not be applied retroactively. Sendero will not reduce the amount of compensation owed to the original primary care physician for services provided before the date of the new designation.

3.5 Primary Care Provider Panel of Members

Open Panel of Members
Sendero desires all primary care providers to maintain an open panel and accept new Members that may select the primary care provider for medical care. Sendero understands that, from time to time, a primary care provider’s panel will become full and necessitate the primary care provider to close his or her panel.

Closing Primary Care Provider Panel of Members
Primary care providers must notify Sendero’s Network Management representative in writing if the primary care provider’s panel needs to be closed. The primary care provider’s written notice should include an explanation of why his/her panel needs to be closed. Sendero requests that primary care providers provide at least 30 days’ notice of the closure of their panel. Once the panel is closed, Sendero will not allow the primary care provider to selectively accept new Members unless the Member or siblings of the Member were existing Members of the primary care provider.
3.6 Primary Care Provider Panel Changes

Primary Care Provider Changes
Members have a right to change primary care providers up to three (3) times a year, but may receive Sendero authorization for a more frequent change as deemed necessary by Sendero. Sendero closely monitors primary care provider changes because such changes may disrupt the continuity of care and/or may indicate Member dissatisfaction with aspects of their care. Sendero will make every attempt to address a Member’s concerns prior to their making a primary care provider change and may even contact the primary care provider for help in resolving the Member’s issue if dissatisfaction with the current primary care provider is the cause for the Member requesting a primary care provider change.

If a Member requests to change primary care providers on or before the 5th of the month, the change will be retroactive to the first of the month. After the 5th of the month, the change will be effective on the first of the following month. The change of primary care provider will be expedited if the change is determined by Sendero to be in the best interest of the Member and/or the current primary care provider.

Sendero reserves the right to reassign a Member’s primary care provider or close a provider’s panel if, in Sendero’s sole determination, it is in the best interest of the Member.

Primary Care Provider-requested Removal of a Member from Panel
Primary care providers may request the removal of a Member from their panel in select situations. Sendero will work to resolve problems between the Member and the primary care provider before making the change. The following may be reasons for a primary care provider to request that a Member be removed from his/her panel:

- Member is consistently non-compliant with the primary care provider’s medical advice
- Member is consistently disruptive in the office
- Member consistently misses scheduled appointments without cause and/or without notice to the office

3.7 Primary Care Provider & Specialist Accessibility and Appointment Standards

Accessibility Standards
Primary care providers and Specialists serving as a primary care provider for certain Members must be available to Members 24 hours a day, 7 days a week. Your office is expected to answer phone calls during your routine office hours with after-hours telephone availability or arrangements as follows:

- Access to covering physician, or
- Answering service, or
- Triage service, or
- A voice message in English and Spanish that provides a second phone number that is answered or returned within 30 minutes of the Member leaving a message.
**Appointment Standards**

Primary care providers, Specialists serving as a primary care provider for certain Members, and Specialists must make appointments available to Members as follows:

<table>
<thead>
<tr>
<th>Event</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td>Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;</td>
</tr>
<tr>
<td>Urgent Care, including Urgent Specialty Care</td>
<td>Urgent care, including urgent specialty care must be provided within 24 hours of request;</td>
</tr>
<tr>
<td>Routine Primary Care</td>
<td>Routine primary care must be provided within 14 days of request;</td>
</tr>
<tr>
<td>Initial Outpatient Behavioral Health Visits</td>
<td>Initial outpatient behavioral health visits must be provided within 14 days of request;</td>
</tr>
<tr>
<td>Outpatient Behavioral Health Treatment following a Behavioral Health Inpatient Admission</td>
<td>Behavioral Health outpatient treatment must occur within 7 days from the date of discharge following an inpatient Behavioral Health stay.</td>
</tr>
<tr>
<td>Routine Specialty Care Referrals</td>
<td>Routine specialty care referrals must be provided within 30 days of request;</td>
</tr>
<tr>
<td>Initial Prenatal Visits</td>
<td>Prenatal care must be provided within 14 days of request, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days or immediately, if an emergency exists;</td>
</tr>
<tr>
<td>Preventive Health Services for Adults</td>
<td>Initial outpatient visits must be provided within 14 days of request;</td>
</tr>
<tr>
<td>Preventive Health Services for Children, including Well-Child Checkups</td>
<td>Preventive health services for children, including well-child checkups should be offered to Members in accordance with the American Academy of Pediatrics (AAP) periodicity schedule. Sendero follows the Texas Health Steps Program modifications to the AAP periodicity schedule. For newly enrolled Members under age 21, overdue or upcoming well-child checkups, including Texas Health Steps medical checkups, should be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 60 days of enrollment for all other eligible child Members.</td>
</tr>
<tr>
<td>Member Access to Primary Care Provider</td>
<td>Members are able to reach their primary care provider twenty-four (24) hours a day, seven (7) days a week, either by answering service or by coverage of another physician. Primary care provider (or covering physician) should call the Member within 30 minutes of the Member contacting the answering service.</td>
</tr>
</tbody>
</table>
### Event | Requirement
--- | ---
A Member’s Travel Requirements to Reach a Primary Care Provider or General Hospital | A Member is not required to travel in excess of thirty (30) miles to reach a primary care provider or general hospital.

A Member’s Travel Requirements To Secure An Initial Contact With A Referral Specialist, Specialty Hospital, Psychiatric Hospital, Or Diagnostic And Therapeutic Services | A Member is not required to travel in excess of seventy-five (75) miles to secure an initial contact with a referral specialist, specialty hospital, psychiatric hospital, or diagnostic and therapeutic services (if one is available).

Wait Times | Members should not wait longer than 45 minutes in the office waiting room prior to being taken to the examination room. Members should not wait more than 15 minutes to be seen by a provider after being taken to an examination room.

### 3.8 Primary Care Provider Referrals to Other Providers

#### Primary Care Provider Referrals to Network Providers

The Sendero PCP to In-Network Specialist Referral / Authorization Form or the Texas Authorization/Referral Form (see Appendix A of this manual) should be filled out and given to the Member when referring the Member to specialists or other ancillary providers for medically necessary services within the Sendero Health Plans’ network. You should explain to the member that the specialist may not see the member without this form. The member needs to give this form to the specialist so that the specialist knows that the member is being referred by you, why the member is being referred, what the expectations are for the visit, and how many visits are being allowed.

#### Primary Care Provider Referrals to Non-network Providers

In rare situations, the primary care provider may believe that the most medically appropriate referral for a specific Member with a unique medical condition is to a non-network provider. Referral to non-network providers must be referred to the Health Services department for review and pre-authorization. Health Services must be given a written justification stating member specific reasons for Out-Of-Network care. For pre-authorization of a non-network referral, the primary care provider must contact the Health Services Department by calling 1-855-297-9191, faxing a request to 512-275-2862, or complete an online referral on the SenderoHealth.com provider portal. Once the request for Out-of-Network care is received, it will be reviewed by Sendero’s Medical Director and sent to Network Management.

### 3.9 Members Right to Self-Referral
Sendero Members have the right to make a self-referral for certain services. Unless otherwise specified, self-referral is permitted for both STAR and CHIP Members. Members may self-refer for:

**In-network or Out-of-network Self-referral**

- Out-of-area emergency services
- Family planning services
- Dental services for STAR Members 20 years of age and older
- Texas Health Steps medical case management services for STAR Members can be reached by calling Texas Health Steps toll-free 1-877-847-8377 (1-877-THSTEPS) Monday to Friday from 8 a.m. to 8 p.m., Central Time.
- Early Childhood Intervention (ECI) case management services for infants and toddlers with developmental disabilities can be reached by calling the DARS Inquiries Line at 1-800-628-5115 or send an email message to dars.inquiries@dars.state.tx.us. For the hearing impaired call, TDD/TTY 1-866-581-9328.
- Children and Pregnant Women (CPW) case management services 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 help them gain access to medical, social, educational and other health-related services. CPW can be reached by calling the Texas Health Steps Outreach and Information Hotline: 1-877-847-8377 Monday to Friday from 8 a.m. to 8 p.m., Central Time.
- School Health and Related Services (SHARS) program services enables school districts in Texas to obtain federal Medicaid reimbursement for certain health-related services provided to Medicaid-eligible children with disabilities enrolled in special education. Current SHARS services include: assessment, audiology, counseling, school health services, medical services, occupational therapy, physical therapy, psychological services, speech therapy, special transportation and personal care services. These services must be provided by qualified professionals under contract with or employed by the school district/ssa. Furthermore, the school district/ssa’s must be enrolled as Medicaid providers in order to bill Medicaid. To refer to SHARS for case management, a provider should write a prescription for the Member’s school for each service needed (PT, OT, SLP, etc.)
- Department of Assistive and Rehabilitative (DARS) case management services for STAR Members such as those with disabilities and / or developmental delays. For information on Early childhood intervention services, Rehabilitation services, Services for people who are deaf or hard of hearing, Services for people who are blind or visually impaired, Disability determination services, contact DARS at 1-800-628-5115 or TTY 1-866-581-9328 or via the web at DARS.Inquiries@dars.state.tx.us
- Department of State Health Services (DSHS) case management services for STAR Members such as those with chronic or infectious diseases, and newborn screening can be reached at 1-800-252-8023.
- Department of Aging and Disability Services (DADS) case management services for STAR Members such as those age 21 and older who would qualify medically and financially for nursing facility care, or individuals with disabilities who are not self-sufficient and who might otherwise be subject to unnecessary institutionalization or to abuse, neglect or exploitation. DADS can be reached at 1-800-458-9858

**In-network-only Self-referral for Covered Services – Paid by Sendero**

- Behavioral health services
- Emergency room care
3.10 Responsibilities of Specialists

Specialists’ Responsibilities
Except as outlined above in the Members Right to Self-Referral paragraphs of this section, specialists should provide only the services outlined in a valid referral from the Member’s primary care provider or other authorized provider. Non-network specialists must have received pre-authorization from the Network Services department of Sendero.

When rendering services pursuant to a valid referral, the specialist is responsible to:

- provide the services requested in the referral
- educate the Member with regard to findings and/or next steps in treatment
- coordinate further services with the Primary Care Physician or provider and provide such services as authorized
- provide a written report of findings and recommendations to the Primary Care Physician or provider
- submit a claim for services to Sendero within 95 days of the date of service

If the Specialist provider employs physician assistants, advanced practice nurses, or other individuals who assess the health care needs of the Members, the Specialist provider must have written policies in place that are implemented, enforced, and describe the duties of all such individuals in accordance with statutory requirements for licensure, delegation, collaboration, and supervision as appropriate.

Before seeing any Sendero Member, the Specialist provider is obligated to always:

- Confirm that the Member is an eligible Member and has a valid referral form from the primary care provider.
- Adhere to the Sendero accessibility standards for obtaining appointments.
- Collect the applicable co-payment for office visit from the CHIP Member. (There is no co-payment for STAR Members or CHIP Perinatal members.)
- Send a report to the Member’s Primary Care Provider within seven (7) working days after the date of the member’s evaluation or service.
- Consult with the Member’s Primary Care Provider concerning any additional specialty care or service needed by the Member that is not included with the referral. This can be done during or after the Member’s visit to the Specialist, but must be done prior to providing any additional specialty care or service that is not included on the Referral Form.

- Obstetric services
- Well-woman gynecological services
- Vision care, including covered eye glasses
If the Specialist office discovers that the Member has dual insurance coverage with a commercial insurance or CHIP/Medicaid, the office is responsible for notifying Sendero Customer Services.

If the Member needs mental health or substance abuse services, the Specialist may refer to an in-network provider for the mental health benefits. Sendero holds individual contracts with Psychiatrists and therapists to provide these services. Pre-authorization may be required prior to seeing this Behavioral Health provider. Call Health Services at 1-855-297-9191 for an authorization, or for any questions regarding mental health benefits.

Specialist providers must also comply with the Sendero policies and procedures included in this Manual.

**Hospital Responsibilities**

There is a list of planned hospital admissions that require prior authorization. Admissions will be coordinated by the Member’s primary care provider or a network specialty provider involved in the Member’s care.

Hospital admission for Emergent services should be communicated to Sendero within 24 hours of the admission by calling or faxing the Health Services Department at the numbers listed below. The Health Services Department may request specific clinical information for discharge planning activities and/or for review.

**Ancillary Provider Responsibilities**

Ancillary providers such as home health agencies, rehabilitative services providers, durable medical equipment providers, and similar providers may only supply services as authorized by Sendero. It is the responsibility of the referring physician to provide any required physician orders to the ancillary provider.

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### 3.11 Pharmacy Provider Responsibilities

**Pharmacy providers are required to provide services to members according to these 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 or other insurance benefits

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### 3.12 Credentialing and Responsibilities of Mid-Level Practitioner

Mid-level practitioners include nurse practitioners and physician assistants. Mid-level practitioners who have continuous physician oversight are not credentialed by Sendero. Mid-level practitioners who work independently and may be within a Rural Health Clinic, or Federally Qualified Health Clinic are credentialed by Sendero and must:
provide an application to the health plan, along with information identifying the medical director who provides oversight
• ensure that the medical director providing oversight completes an application and forwards it to Sendero, so that he/she may complete the credentialing process
• be credentialed by the health plan
• follow all regulations required by the State of Texas regarding collaborating physician oversight
• have the collaborating physician sign the Sendero form understanding requirements of oversight of the mid-level practitioner

Mid-level practitioners may be primary care providers, if they meet all the requirements as directed by their Texas licensing board to be an independent practitioner. Questions regarding the practitioner services may be directed to the Network Management number below.

3.13 Marketing Guidelines Affecting Providers

All health plan marketing activities targeting STAR and CHIP Members must be pre-approved by Health and Human Services Commission (HHSC). This includes marketing activities by providers that are targeted at STAR and CHIP enrollees. The following guidelines and prohibitions apply to marketing activities of STAR and CHIP providers.

<table>
<thead>
<tr>
<th>Permitted Activities</th>
<th>Prohibited Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Providers may inform patients of all health plans in which they participate.</td>
<td>1. Providers are not allowed to stock, reproduce or handle program enrollment forms. As stated in #6 under permitted activities. Providers can distribute application forms to uninsured children, just not the enrollment form.</td>
</tr>
<tr>
<td>2. Providers may inform their patients of the benefits, services, and specialty care services offered through the health plans in which they participate.</td>
<td>2. Providers CANNOT help people in filling out the program enrollment forms or in making a decision on selecting a health plan.</td>
</tr>
<tr>
<td>3. At the patients’ request, providers may give patients the information necessary to contact a particular health plan.</td>
<td>3. Non-health related materials or banners that are for a specific health plan (even if the provider is contracted with the health plan) are NOT allowed in provider offices.</td>
</tr>
<tr>
<td>4. Providers may distribute or display written health educational materials (see definition below) or health related posters (no larger than 16” by 24”) developed by the health plan so long as they do so for ALL health plans in which the provider participates. These materials may have the health plan’s name, logo and phone number on them.</td>
<td>4. Providers may not make false, misleading or inaccurate statements related to services, benefits, providers, or potential providers of any health plan.</td>
</tr>
<tr>
<td>5. Providers may display plan stickers (no larger than 5” by 7”) indicating they participate with a particular Health Plan so long as they display</td>
<td>5. Provider may not recommend one health</td>
</tr>
</tbody>
</table>
**Permitted Activities** | **Prohibited Activities**
--- | ---
stickers by ALL contracted MCOs. These stickers cannot indicate anything more than that the “health plan is accepted or welcome”. Stickers MUST display the applicable STAR and/or CHIP logo. | plan over another.

6. Providers may distribute application booklets to families of uninsured children and may help with completing the application.

7. Providers may direct patients to enroll in STAR or CHIP programs by calling the state Administrative Service Contractor.

**DEFINITION:** Health Education Materials are materials produced by the health plan or a third party that contains information related to health (i.e. immunization, diabetes, heart disease, birth control, prenatal care, Texas Health Steps screenings, nutrition, health education classes, etc.) and DOES NOT include announcements of health fairs, materials that are specific to a given health plan, or materials that are specific to STAR/Medicaid or CHIP programs.

### 3.14 Medical Records

**Maintenance of Records**
All Sendero providers are required to maintain a written or electronic medical record that complies with the standards of the health care industry and with the requirements of applicable federal, state and local laws, rules and regulations. Records must be:

- Individual to each patient
- A complete and accurate representation of all medical services, counseling and patient education provided by the provider including ancillary services
- Maintained in an orderly and legible fashion
- Kept secured to ensure the maintenance of confidentiality and be accessible only to practice employees and eligible persons as permitted by law
- Maintained pursuant to procedures of confidentiality that comply with the Health Insurance Portability and Accountability Act (HIPAA)
- Made available to the patient according to the written policies and procedures
- Made available to appropriate parties allowed to view such records pursuant to HIPAA and other relative federal, state and local laws, rules and regulations

**Electronic Medical Records**
Providers, who use electronic medical recording keeping within their office, must have a system that conforms to all the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Health
Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act (collectively referred to as “HIPAA Requirements”) and other federal and state laws.

**Forms Required by Sendero**

Sendero does not require any health-plan-specific forms to be maintained in a provider’s medical records. The forms used by each provider are determined solely by the provider, but must be sufficient to document all treatment, counseling and education services to Members in an orderly, efficient and complete manner.

**Sendero and HHSC Requests for Medical Records**

Sendero and HHSC may from time to time request copies of medical records related to the treatment of Sendero STAR or CHIP Members. Such requests for records will generally be for the purposes of (1) assessing or evaluating aspects of the STAR and CHIP managed care programs, (2) responding to legislative or regulatory inquiries or purposes, (3) responding to complaints or appeals filed by Members or providers, or (4) quality improvement and/or utilization management functions. All providers are required to make available copies of applicable records at no cost to Sendero or HHSC if the request comes from:

- HHSC or other federal or state entities of competent jurisdiction.
- Sendero as a direct result of a request for records from HHSC or other federal or state entities of competent jurisdiction.
- Sendero pursuant to the health plan’s utilization management pre-authorizations requested by the provider.
- Sendero in relation to a quality review.
- Sendero or the State as a direct result of a Fraud, Waste, and Abuse investigation.

**Confidentiality**

All providers must maintain written policies and procedures with regard to maintaining the confidentiality of medical records in a manner consistent with federal, state and local laws, rules and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act.

Sendero will maintain complete confidentiality with regard to medical records that may be requested from providers. Sendero’s policies and procedures for confidentiality shall at all times be compliant with federal, state and local laws, rules and regulations, including HIPAA and HITECH.

### 3.15 Changes in Provider Addresses or Contact Information or Opening of New Office Locations

All network providers are required to notify Sendero and HHSC’s administrative services contractor in writing of any changes in office address or in relevant contact information. Changes in office address should be received by Sendero at least thirty (30) days prior to the change. This includes notifying Sendero when a provider is leaving a group practice or joining another group practice or an employed provider is leaving a group practice.
In addition, all network providers must notify Sendero upon opening of new offices where Sendero’s STAR or CHIP Members may be treated OR upon engaging new physician or mid-level practitioners who may be involved in the treatment of Sendero’s STAR or CHIP Members. New office locations are subject to site review before they are eligible to receive reimbursement. New providers or mid-level practitioners joining an existing group practice may have expedited credentialing and will be reimbursed at the rates of the contracted group.

The Sendero Provider Information Form (PIF) can be located on the website and used for notification of changes to practice location or panel.

### 3.16 Cultural Sensitivity

Sendero places great emphasis on the wellness of its Members and recognizes that a large part of health care delivery is treating the whole person and not just a medical condition. Sensitivity to differing cultural influences, beliefs and backgrounds can improve a provider’s relationship with Members and in the health and wellness of the patients themselves. Sendero encourages all providers to be sensitive to varying cultures in the community. Following is a list of principles for Sendero’s network providers demonstrating the knowledge, skills and attitudes related to cultural sensitivity in the delivery of health care services to Sendero members:

**KNOWLEDGE of cultural sensitivity:**
- Provider’s self understanding of race, ethnicity and influence.
- Understanding historical factors impacting the health of minority populations
- Understanding the particular psycho-social stressors relevant to minority patients.
- Understanding the cultural differences within minority groups.
- Understanding the minority patient status within a family life cycle and inter-generational conceptual framework in addition to a personal developmental network.
- Understanding the differences between "culturally acceptable" behavior of psycho-pathological characteristics of different minority groups.
- Understanding indigenous healing practices and the role of religion in the treatment of minority patients.
- Understanding the cultural beliefs of health and help seeking patterns of minority patients.
- Understanding the health service resources for minority patients.
- Understanding the public health policies and its impact on minority patients and communities.

**SKILLS** for demonstrating cultural sensitivity:
- Ability to interview and assess minority patients based on a psychological, social, biological, cultural, political, and spiritual model.
- Ability to communicate effectively with the use of cross-cultural interpreters.
- Ability to diagnose minority patients with an understanding of cultural differences in pathology.
- Ability to avoid under diagnosis or over diagnosis.
- Ability to formulate treatment plans that are culturally sensitive to the patient and family's concept of health and illness.
- Ability to utilize community resources (churches, community based organizations, self-help groups, school programs)
- Ability to provide therapeutic and pharmacological interventions, with an understanding of the cultural differences in treatment expectations and biological response to medication.
- Ability to ask for consultation.

**ATTITUDES demonstrating cultural sensitivity:**
- Respect the "survival merits" of immigrants and refugees.
- Respect the importance of cultural forces.
- Respect the holistic view of health and illness.
- Respect the importance of spiritual beliefs.
- Respect and appreciate the skills and contributions of other professional and paraprofessional disciplines.
- Be aware of transference and counter transference issues.

### 3.17 Reporting Fraud, Waste, or Abuse by a Provider or Member

For information regarding reporting Fraud, Waste or Abuse, see “10.0 – Fraud, Waste or Abuse” in this Manual.

### 3.18 Termination of Provider Participation

**Provider-requested Termination**

As outlined in each provider’s contract, a provider retains the right to terminate his/her participation in the Sendero network for any reason. If a provider desires to terminate his/her service agreement with Sendero, a written notice to Sendero is required either ninety (90) days prior to the desired effective date of the termination or in accordance with the time frames outlined in the provider’s contract with Sendero. Sendero will honor requests for termination, but may work with the provider to see if some other alternative can be identified to prevent network termination. In the event of a conflict between this rule and the provider’s contract, the contract will prevail.

**Sendero-requested Termination**

Sendero will follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with you as a provider. At least 30 days before the effective date of the proposed termination of your contract, Sendero will provide a written explanation to you indicating the reasons for termination. Sendero may immediately terminate a provider contract if the provider presents imminent harm to Member health, actions against a license or practice, fraud or malfeasance.
Within 60 days of the termination notice date, you may request a review of Sendero’s proposed termination by an advisory review panel, except in a case in which there is imminent harm to Member health, an action against a private license, fraud or malfeasance. The advisory review panel will be composed of physicians and providers, as those terms are defined in §843.306 Texas Insurance Code, including at least one representative in your specialty or a similar specialty, if available, appointed to serve on Sendero’s Quality Improvement Committee or Provider Advisory Subcommittee. The decision of the advisory review panel must be considered by Sendero but is not binding on Sendero. Sendero must present to you, on request, a copy of the recommendation of the advisory review panel and Sendero’s determination.

According to your agreement with Sendero Health Plans, you are entitled to sixty (60) days advance written notice of our intent to terminate your agreement for cause. The agreement also states that it will terminate immediately and without notice under certain circumstances. If we give you a sixty (60) day notice of intended termination or if your agreement terminates immediately without notice, and the cause for termination is based on concerns regarding competence or professional conduct as the result of formal peer review, you may appeal the action pursuant to this procedure. This procedure is available only if we are terminating your agreement for the reasons stated above.

You may not offer or give anything of value to an officer or employee of HHSC or the State of Texas in violation of state law. A “thing of value” means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Sendero may terminate this Network Provider contract at any time for violation of this requirement.

Notice of Proposed Action
Sendero Health Plans will give you notice that your agreement has terminated or is about to terminate, and the reason(s) for the termination. The notice will either accompany your sixty (60) day notice of termination, or be given at the time your agreement terminates immediately without notice.

Upon termination of your agreement with Sendero, you may request reinstatement by special notice (registered or certified mail) within thirty (30) days of receiving the notice of termination to Sendero’s Medical Director. You should include any explanation or other information with your request for reinstatement. Sendero’s Medical Director will appoint a committee to review your request, and any information or explanation provided within thirty (30) days of receipt. The committee will recommend an initial decision to the Sendero Board of Directors to reaffirm your agreement, reaffirm with sanctions, or to revoke your contract as a Sendero network provider.

Decision
Within ten (10) days of receiving the committee’s recommendations, Sendero will, by special notice in registered or certified mail, inform you of our decision on your request for reinstatement. This decision will be final.

Sendero will work with Members currently receiving care from you to transition to other providers within the Sendero network pursuant to the Transition of Care policy. This transition will occur based on the individual
termination situation (upon completion of the Notice of Action process, your appeal or immediately) depending on the reasons for termination of the contract.

3.19 Member Materials

From time to time, Sendero sends various communications to Members. These materials are produced at or below the 6th grade reading level to ensure that they can be understood by all Members regardless of their educational level. Providers are encouraged to make available Member notices and general information about their practice in a similar form to ensure that Members understand the information. This does not apply to health education materials that are provided to Members.
4.0 – Emergency Services

4.1 Definitions: Routine, Urgent and Emergent Services

**Routine**
Routine care is defined as health care for covered preventive and medically necessary Health Care Services that are non-emergent or non-urgent, such as a well child visit, a chronic condition status visit or an annual physical examination.

**Urgent Care**
Urgent care is defined as when a Member needs to be seen, evaluated and treated within 24 hours. An urgent need may be for illness or injury that is non-life threatening.

**Emergent Care**
Emergency care is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, serious disfigurement, or in the case of a pregnant woman, serious jeopardy to the health of the fetus.

“Emergency services” and “emergency care” means health care services provided in an in-network or out-of-network hospital emergency department or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize medical conditions. Emergency services also include, but are not limited to, any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency condition exists.

Some conditions that may require taking the Member to the Emergency Room include:

- Incessant infant crying
- Excessive, uncontrolled bleeding
- Epiglottitis
- High fever
- Pneumonia
- Loss of consciousness
- Kidney stones
- Referral from primary care provider to ER (regardless of diagnosis)
- Mental Health conditions where the Member is a threat to themselves or others
- Fracture
- Severe laceration
- Status asthmatic
- Urinary tract infection, pyelonephritis
- Concussion
- Loss of respiration
- Convulsions
- Poisoning
- Overdose situations
- Severe abdominal pain
- Chest pain
4.2 Prudent Layperson Standards at Sendero

Sendero Health Plans’ standards regarding Prudent Layperson comply with the Texas Administrative Code definition for emergency services. See definition of Emergent Care above.

4.3 Out of Network Emergency Services

Out of network emergency services are covered by Sendero. Any services rendered are reimbursed at the usual and customary rate. Members who must use emergency services while out of the service area are encouraged to contact their primary care provider as soon as possible and advise them of the emergent situation.

4.4 Emergency Transportation

Emergency transportation, such as ambulance service, is covered by Sendero. Emergency transportation is defined as transportation to an acute care facility, when there is a life and death situation. Ambulance service companies are to submit claims to Sendero for reimbursement.

4.5 Emergency Services Outside the Service Area

If a Member is injured or becomes ill while temporarily outside of the service area, the Member should contact his / her primary care provider and follow his / her or the covering physician’s instructions, unless the condition is life-threatening. If the condition is life-threatening, as determined by a prudent layperson, the Member may go to the nearest emergency facility. The Member should notify Sendero of the incident within 48 business hours (or the primary care provider should notify the Sendero within 24 hours or the next business day) after learning of the out-of-area emergency. An authorization number will be issued based on medical criteria, for inpatient services. Emergency room services do not require authorization. If the Member is admitted to an out-of-area hospital, the Sendero Health Services Department, in conjunction with the primary care provider, will monitor the Member’s condition with the out-of-area attending physician. Sendero will help the primary care provider in arranging for follow up care upon the member’s return to the service area when medically appropriate.
4.6 Emergency Dental Services

Medical Emergency Dental Services:

Sendero 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 craniofacial anomalies

CHIP Emergency Dental Services:

Sendero 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 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 craniofacial anomalies
5.0 – Behavioral Health Services

5.1 Definition of Behavioral Health

Behavioral health covered services are services for the treatment of mental, emotional or chemical dependency disorders or any combination of these diagnoses. Substance abuse includes drug and alcohol abuse, and the detoxification and withdrawal treatment that may be required.

5.2 Primary Care Provider Requirements for Behavioral Health

Primary care providers must screen, evaluate, refer, and/or treat any behavioral health problems and disorders for Sendero. The primary care provider may provide behavioral health services within the scope of its practice. Timely and appropriate patient assessment and referral are essential components for the treatment of behavioral health issues.

Sendero has a comprehensive network of behavioral health service providers for the treatment of mental health and drug and alcohol abuse issues.

5.3 Sendero Behavioral Health Services Program

Behavioral Health Services are covered services for the treatment of mental emotional disorders and for chemical dependency disorders for both STAR (under the age of 21) and CHIP Members of Sendero. STAR Members over age 21 also have treatment for chemical dependency disorders as a covered benefit.

Primary care providers are responsible for coordinating Members’ physical and behavioral health care, including making referrals to in-network Behavioral Health providers when necessary. In addition, primary care providers must adhere to screening and evaluation procedures for the detection and treatment of, or referral for any known or suspected behavioral health problems or disorders. Providers should follow generally accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies, such as the National Institute of Health. Primary care providers may provide behavioral health related services within the scope of their practice.

- All services which require pre-authorization related to behavioral health must be coordinated through Sendero.
- For mental health services not covered by STAR/Medicaid, the Member must access local resources. Please refer the member to Sendero’s RN Care Coordinators in Health Services at 1-855-297-9191 to help in locating these resources.
● A list of local resources for behavioral health care alternatives outside of network providers is available through the following public resources:
  o The local Department of Health Services offices
  o The local Public Library
  o The Finding Help in Texas website-- www.211texas.org/211 – or toll free at 2-1-1.

Community Mental Health Centers will accept patients with the primary diagnosis of schizophrenia, bi-polar or severe major depression, along with many other behavioral health diagnoses (ADD, ADHD, post-traumatic stress disorder, etc.). The following CMHCs serve Members in the Travis Service Delivery Area as follows:

**Austin Travis County Integral Care (formerly Austin Travis County MHMR Center)**
1430 Collier St.
Austin, TX 78704
Crisis Phone: 512-472-4357
Main Phone: 512-447-4141
Website: http://www.integralcare.org/

Counties Served: Travis

**Bluebonnet Trails Community MHMR Center**
1009 Georgetown St.
Round Rock, TX 78664
Crisis Phone: 800-841-1255
Main Phone: 512-255-1720
Website: http://www.bluebonnetmhmr.org/

Counties Served: Bastrop, Burnet, Caldwell, Fayette, Lee, and Williamson

**Hill Country Community MHMR Center**
819 Water St., Ste. 300
Kerrville, TX 78028
Crisis Phone: 877-466-0660
Main Phone: 830-792-3300
Website: http://www.hillcountry.org/

Counties Served: Hays
5.4 Sendero’s 24-hour/7 Days a Week Behavioral Health Crisis Hotline

Sendero Health Plans subcontracts for a crisis hotline to Avail Solutions, which is available 24 hours a day / 7 days a week at:

1-888-287-5402 for STAR Members
1-888-287-5403 for CHIP Members

These numbers are listed on the Member’s ID card. The crisis hotline provides a Crisis Intervention Specialist who is available to screen the needs of the Member and direct the Member for an initial psychiatric or therapist evaluation. An authorization is not required for initial evaluation. Once a Member is seen, it is the responsibility of the contracted provider to fax a completed Texas Referral Authorization Form (Attachment A) to the Primary Care Physician.

The following circumstances indicate that a referral to a physician is recommended:

- The Member is receiving psychoactive medication for an emotional or behavioral problem or condition.
- The Member has significant medical problems that impact his/her emotional well-being.
- The Member is having suicidal and/or homicidal ideations.
- The Member has delirium, amnesia, a cognitive disorder, or other condition for which there is a probable medical (organic) etiology.
- The Member has a substance use disorder such as substance-induced psychosis, substance induced mood disorder, substance induced sleep disorder, etc.
- The Member has or is likely to have a psychotic disorder, major depression, bipolar disorder, panic disorder, or eating disorder.
- The Member is experiencing severe symptoms or severe impairment in level of functioning or has a condition where there is a possibility that a pharmacological intervention will significantly improve the Member’s condition.
- The Member has another condition where there is a significant possibility that somatic treatment would be of help. Conditions include dysthymia, anxiety, adjustment disorders, post-traumatic stress disorders, and intermittent explosive disorders.
- The Member has a substance abuse problem.

5.5 Covered Behavioral Health Services

The following services are available to all STAR and CHIP Members:

- Inpatient Substance Abuse Treatment Services
- Outpatient Substance Abuse Treatment Services
The following services are available to all STAR Members under the age of 21 years of age and to all CHIP members:

- Inpatient Mental Health Services
- Outpatient Mental Health Services

Behavioral Health Inpatient Facilities must ensure that a seven (7) day follow-up appointment is made prior to Member discharge from an inpatient stay.

For details about behavioral health covered benefits see “ST2 STAR/Medicaid Covered Services” or “CH2 Covered Services” in this manual.

### 5.6 Referral Authorizations for Behavioral Health Services

Sendero Members do not require referrals from their primary care providers for initial evaluation or follow-up behavioral health treatment from an in-network Behavioral Health provider. Pre-authorization is only required for Psychological testing. Primary care providers may provide Behavioral Health Services for Members, if it is within the scope of his/her practice.

### 5.7 Pre-authorization

Prior authorization is required for > 20 visits for outpatient treatments. Prior authorization of an emergent, elective or scheduled admission is NOT required. The Behavioral Health Hotline is available for members 24/7 by calling Avail Solutions at 1-888-287-5402 for STAR and 1-888-287-5403 for CHIP. Psychological testing requires pre-authorization. This may be obtained by the provider faxing a prior-authorization for psychological testing form to the Health Services Department for approval prior to testing being initiated. (See the fax number at the bottom of this page.)

### 5.8 Triage and Initial Assessment

Sendero has clinicians available 24 hours a day, seven days a week to help Members with referrals to practitioners, facilities, urgent or emergent care and crisis calls. Sendero’s RN Care Coordinators or a Crisis Intervention Specialist (through the Behavioral Health Crisis Hotline) helps Members with clinical determinations, urgent and emergent care, crisis calls and referrals to facilities. The goal of the referral and triage process is to provide accurate information and referrals to appropriate providers. During the workday, call Sendero’s RN Care Coordinators at 1-855-297-9191 for assistance. After hours, on weekends and on holidays, a Crisis Intervention Specialist can be reached at:
5.9 Concurrent Review

Sendero’s RN Care Coordinators conduct concurrent review via telephone on all Members admitted to inpatient mental health hospitalizations, inpatient detoxification, chemical dependency rehabilitation, partial hospitalization and intensive outpatient treatment. Concurrent review includes review of medical necessity, discharge planning and researching, and coordinating alternatives to inpatient care. RN Care Coordinators use Milliman Care Guidelines and/or InterQual Criteria to help with all concurrent review determinations. A Medical Director is available to review difficult cases and reviews all potential denials or questionable cases. The purpose of the concurrent review function is to continue coordination of patient care with the treating facility or provider to determine the best course of treatment for the Member.

5.10 Retrospective Review

Retrospective reviews are conducted upon request to determine the medical necessity of treatment that was rendered without pre-authorization. Sendero’s RN Care Coordinators have the authority to approve all treatment that meets the Milliman/InterQual Criteria and to refer cases they are not able to authorize or questionable cases to the Medical Director for review.

5.11 Case Management

Sendero’s Whole Person Health Support (WPHS) program addresses a Member’s longitudinal course of care including continuity and coordination among practitioners and sites of care both within behavioral health and between behavioral health and physical health. WPHS includes helping Members to access behavioral health care within the most efficient time frame by the most appropriate practitioner or in the most appropriate treatment setting. This includes helping and encouraging Members to have seven (7) and thirty (30) day follow-up after an inpatient stay for behavioral health illness. It is necessary to promote efficient use of benefits to maximize Member and family access to necessary care. In addition, Sendero has implemented intensive case management for Members who have been identified as high risk due to diagnosis, multiple admissions, life threatening suicide attempts or who require additional services and have complicating factors that, without concentrated intervention coordinated by Sendero, would result in further deterioration in the severity of illness. To speak with a nurse about a Member or to make a referral for WPHS for a member, please call Sendero’s Health Service’s Department at 1-855-297-9191.
5.12 Utilization Decisions

Consistency of Application of UM Criteria
Sendero uses Milliman Care Guidelines and InterQual Criteria for all utilization management decisions. The criteria are applied by utilization and case management staff and by the Medical Director. All pre-authorization, concurrent, and retrospective review decisions as well as appeal determinations will reference the appropriate medical necessity criteria and indicate why the criteria were met or not met.

Denials
The Medical Director reviews all potential denials related to behavioral health diagnoses. A physician makes all medical necessity denial determinations for inpatient mental health and chemical dependency partial hospitalization, and intensive structured outpatient. The Medical Director may contact the provider requesting services for additional information or to discuss alternatives to care. The provider requesting services may request to consult with the Medical Director. The Medical Director will make at least two (2) attempts to contact the Member’s provider regarding a denial. Members and providers receive written notification of all denials. Denial notifications include the reason for the denial and instructions for requesting an appeal.

Appeals
For more information regarding appeal process, contact Network Management at the phone number below, or refer to “ST5 Complaints & Appeals” or “CH4 Complaints & Appeals” in this manual.

5.13 Responsibilities of Behavioral Health Providers

Behavioral health providers and/or physical health providers, who are treating a behavioral health condition, are responsible for appropriate referrals to the Texas Department of Protective and Regulatory Services (TDPRS) for suspected or confirmed cases of abuse.

They are also responsible to assure that any necessary pre-authorization activities take place and for the following:

- Assure the release of information consent form is signed by the Member.
- Refer Members with known or suspected physical health problems or disorders to the primary care provider for examination and treatment.
- Only provide physical health if a behavioral health provider is already rendering treatment for behavioral health conditions.
- Ensure that the patients know of, and are able to avail themselves of, their rights to execute Behavioral Health Advance Directives.
- Assure All STAR and CHIP Members that receive inpatient psychiatric services are scheduled for outpatient follow up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge.
- Have policies and procedures in place on how to follow-up on Member missed appointments.
• Contact Members who have missed appointments within 24 hours to reschedule appointments.
• Make available to primary care providers behavioral health assessment instruments.
• Communicate with the Member’s primary care provider, if OK with the Member, treatment plans and progress to achieving treatment plan.
• Refer the Member for needed lab and ancillary services if not available in the provider’s office.

5.14 7 Day Follow-up After Inpatient Behavioral Health Admission

Members must be scheduled for a seven (7) day follow-up appointment at time of discharge from an inpatient Behavioral Health admission. These follow-up appointments are monitored by the Quality Improvement Committee, as well as through Health and Human Services Commission (HHSC). Behavioral Health providers need to ensure that these appointments are scheduled and kept.

Member’s appointments are followed by an RN Care Coordinator. Members who miss appointments are attempted to be contacted to reschedule.

Members with a behavioral health diagnosis are also monitored for readmission to an inpatient mental health facility. Results of these reports and focused studies are available to providers upon request.

5.15 DSM-IV Coding Requirements

Behavioral health documentation and referral requests should include DSM-IV multi-axial classifications. Subsequently, behavioral health claims should be filed using the applicable and appropriate DSM-IV diagnostic code to define the patient’s condition being treated. The DSM-IV is the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

5.16 Laboratory Services for Behavioral Health Providers

Behavioral Health providers should facilitate provision of in-office laboratory services for behavioral health patients whenever possible, or at a location that is within close proximity to the Behavioral Health provider’s office. Providers may refer Members to any network independent laboratory for needed laboratory services with an appropriate laboratory order/prescription. Sendero does not require a referral for Members to have lab work done.
5.17 Court-ordered Services and Commitments

A Member under the age of 19 who has been ordered to receive treatment under the provisions of Chapter 573 or 574 of the Texas Health and Safety Code must receive the services ordered by that court of competent jurisdiction. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. The Member cannot appeal the commitment through the complaint or appeals process. Sendero is responsible for covering court-ordered commitments.

5.18 Confidentiality of Behavioral Health Information

The provider is required to obtain consent for disclosure of information from the Member in order to permit the exchange of clinical information between the behavioral health provider and the Member’s primary care provider.

If the Member refuses to sign a release of information, documentation will need to indicate that they refused to sign. In addition, the provider will document the reasons for declination in the medical record.
6.0 – Medical Management

6.1 Utilization Management Program

Utilization Management is a set of activities performed by Sendero to ensure that medically necessary services are coordinated for Members in an efficient and timely manner and that appropriate health care services are available to Members. Utilization Management activities are retrospective, concurrent and prospective. All Utilization Management activities are performed by Registered Nurses and clinicians under the supervision of the Medical Director.

Philosophy of Utilization Management
It is the goals of the Utilization Management Program to:

- Assure access to appropriate levels of care
- Promote disease prevention and wellness
- Provide high-quality, cost-effective services for all Members
- Have satisfied Members and providers

We strive to assure the Member is receiving the appropriate care at the appropriate time and work proactively on the Member’s behalf with the Sendero network providers to make certain that the Member is maintaining his/her optimal level of health and well-being.

Utilization Review Criteria
The screening criteria used for medical necessity determination by Sendero Health Plans include Milliman Care Guidelines and/or InterQual Criteria and other guidelines from recognizable resources, as necessary. Other resources may be, but are not limited to, the National Heart, Lung and Blood Institute (NHLBI), the Agency for Health Care Policy and Research (AHCPR), National Institute of Health (NIH), American Academy of Pediatrics (AAP), National Coverage Determinations (NCD), or internally developed guidelines. The screening criteria used are objective, clinically valid, compatible with established principles of health care, and are flexible enough to deviate from the normal, when justified, on a case-by-case basis. Each case will be reviewed individually, for special circumstances that may cause deviation from the standard.

6.2 Management of Utilization

Concurrent Inpatient Review
Concurrent inpatient reviews are conducted to ensure that services rendered to the Member are medically necessary, meet Milliman/InterQual Criteria, are provided in the appropriate environment, and that continuity of care is appropriately planned for discharge.
Determinations on appropriateness of care and of hospitalization are made by reviewing information in the medical record and through discussions with the attending physician. The following criteria must be met:

1. Documentation in the medical record must indicate that the medical condition requires continuous daily monitoring by the facility staff and by the provider that cannot be provided at a less restrictive setting.
2. The Member’s condition cannot be managed safely at another level of care (such as outpatient, home health care, etc.)
3. Continued stay criteria for both intensity of service and severity of illness must be present and documented in the medical record for each day of confinement.

It is the responsibility of the attending / admitting physician to ensure that hospital admissions are certified and that authorized lengths of stay are extended, as indicated.

If Milliman/InterQual Criteria is not met, or transfer to an alternative level of care is medically appropriate, the Medical Director reviews the information and, if necessary, discusses the case with the attending physician prior to making a determination of whether continued hospitalization is authorized.

If Concurrent Review indicates a discharge and / or transfer of care is appropriate:

- The Health Services Department RN Care Coordinator is available to help the attending physician with arranging discharge and transfer of patients from acute care facilities to other facilities, such as rehabilitation, or home health care.
- Daily on-site, faxed or telephone reviews are usually conducted for inpatient cases in acute care, rehabilitation, and short-term facilities. The frequency and intensity of the reviews are based on the severity of illness and care required by the patient.
- Discharge plans will be discussed with the attending physician as needed.
- If the hospitalization is deemed not medically necessary, the Member, the primary care provider, and the hospital will be notified regarding denial of services beyond a specified date.

Information regarding the expedited appeal process may be obtained by calling Sendero Health Services department, or for more information, refer “ST5 Complaints & Appeals” or “CH4 Complaints & Appeals” in this manual.

**Retrospective Review**

Retrospective reviews may be conducted on any claim without an authorization, partial hospitalizations, and emergency room treatment, out of area treatment, admissions or Member reimbursement. The reviews are conducted to ensure that services rendered to the patient are medically necessary, provided in the appropriate environment and contractually covered.

The process includes the following steps:

- When the claim in question is received, the provider is notified within fifteen (15) days that the claim has been received and that it is under review.
- Specific parts of the medical record are requested from the provider.
If records are not received with thirty (30) days, the claim is considered denied. The provider is notified of the denial, the reason for the denial and the appeal process.

When records are received, a decision is made within thirty (30) days using the following criteria:

- medical appropriateness, timeliness, and necessity
- established medical criteria
- plan benefits

Once a decision is made, the provider is notified of the results.

If the provider disagrees with the results, he / she may appeal according to appeals requirements included “ST5 Complaints & Appeals” or “CH4 Complaints & Appeals” in this manual.

**Discharge Planning**

Discharge planning refers to all aspects of planning for post-hospital needs and ensuring the continuity of quality medical care in an efficient and cost-effective manner, and should begin prior to admission. Discharge planning activities include provisions for and/or referrals to services required in improving and maintaining the patient’s health and welfare following discharge.

Sendero’s Health Services RN Care Coordinators work with the attending physician and staff, the Member, the Member’s family, and other health care professionals to ensure continuity of care after discharge. It is recognized that discharge planning is a process which requires multidisciplinary involvement to achieve the greatest success. Consequently, input is sought from all healthcare professionals such as nurses, physical therapists, as well as any other ancillary staff and services.

Anticipated discharge needs should be discussed with the Health Services Department prior to admission, or as early as possible in the admission. Upon notification, each admission will receive an anticipated length of stay that indicates the estimated discharge date.

To facilitate discharge planning for Members in the hospital, call the Health Services Department. The Health Services Department RN Care Coordinator may help in:

- Arranging home health services and durable medical equipment (DME)
- Admissions / transfers to other facilities
- Coordinating medical transportation
- Questions on benefits or coverage
- Authorization and arrangement of transfer of out-of-area patients
- Information and referral to community resources

### 6.3 Referrals

**Members with Special Health Care Needs**

Members with special health care needs may need several referrals to meet their health care needs. These Members may need direct access to a Specialist provider. Members with special health care needs may have a standing referral to a Specialty Physician as approved by the Medical Director.
Referral Procedure
When a referral to a Sendero Specialist or ancillary facility is necessary, the following steps should be taken:

- The primary care provider selects a Specialist from the Sendero network panel.
- The primary care provider arranges for services with the Specialist in the usual manner including coordination of pertinent clinical information and then issues a referral. A referral form is sent to the specialist by using either the Sendero Referral logo form or the Texas Authorization and Referral Form in Appendix A of this manual or online via the internet.
- The Specialist will examine and treat the Member (as requested by the primary care provider) and document recommendations and treatment. The Specialist should keep the primary care provider continually informed of findings and treatment plans.
- The Specialist will submit a claim form to Sendero. For further details regarding claim filing, please see “7.0 Billing and Claims” in this manual.
- If the Member requires additional services not directly associated with the diagnosis in the referral, the Specialist must contact the primary care provider prior to rendering the additional care to coordinate these services.

Primary Care Provider Referrals to Specialists
A Member’s referral is usually initiated during an office visit to the primary care provider. Referrals usually include visits to the Specialist through the Member’s enrollment period.

Referrals should be issued prior to the visit to the Specialist (with the exception of emergency room and behavioral health initial evaluation).

Specialist to Specialist Referrals
When a specialist wishes to refer to another specialist they need to refer the patient back to the primary care provider to initiate the physician to physician referral. Specialists can, however refer patients for in network ancillary services that fall under the scope of their practice. (For example, an Orthopedic Specialist can make a referral for Physical Therapy or Occupational Therapy.) Specialists should ensure that the primary care providers are kept informed of the results of any examinations and any additional treatment recommended.

Self-Referral Services
Members are allowed to self-refer, without a primary care provider referral, for the following services:
- Emergency care
- Routine vision care, other than surgery form a Network Therapeutic Optometrist or Ophthalmologist
- OB/GYN care
- Behavioral Health Services
- Texas Health Steps examinations (STAR Members only)
- Family Planning (STAR Members only)

Out-of-Network Referrals
Request for services by non-contracted providers, out of area / out of network services require Pre-authorization by the Health Services Department. The pre-authorization will require that the requesting provider submit the
clinical rationale to Sendero for specific needed services to this out-of-network specialist that cannot be provide by any in-network specialist.

Non-participating Specialist care requires **Pre-authorization** by the Health Services Department. A request for Out-of Network services can be initiated by calling Sendero’s Health Service’s Department at 1-855-297-9191 or by faxing a request with the appropriate documentation to justify the request to 1-512-275-2862.

**Physician-requested Second Opinions and Member-requested Second Opinions**
Second opinions requested by either the Member or the physician do not require pre-authorization. For questions regarding a second opinion request, contact the Health Services Department.

**Results of Not Obtaining Pre-authorization**
Cases that require pre-authorization and in which pre-authorization was not obtained are subject to denial. Appeal information can be found in “ST5 Complaints & Appeals” or “CH4 Complaints & Appeals” in this manual.

**Appealing Non-Payment for Lack of Referral**
Information on how to appeal can be found in “ST5 Complaints & Appeals” or “CH4 – Complaints & Appeals” in this manual.

**Online Referrals and Authorization Processes**
Request for authorization of outpatient services can be initiated on line. Once you have accessed [www.SenderoHealth.com](http://www.SenderoHealth.com), click on the link for the Provider Portal … Once in the Provider section of the website, select the link on the left for creating an Online Referral or for initiating the pre-authorization process depending on your need. <Instructions and links will be documented once HHSC has approved Sendero’s website … estm 11/2/2011>.

**Faxing Paper Referrals and Authorization Requests**
Providers may fax the Sendero Authorization and Referral Form or the Texas Authorization and Referral Form (in Appendix A) to the Health Services Department at 512-275-2862.

**Obtaining Referral and Authorization Forms**
Forms are available online as well as from the Health Services Department by clicking on the following link <pending HHSC approval> or by typing the web address into your browser.

### 6.4 Pre-Authorization

**Overview**
Sendero Health Plans requires notification only for most planned admissions and procedures so that discharge planning can be facilitated timely. For certain admissions and / or procedures (such as those that may be interpreted as “cosmetic” in nature), Sendero does require pre-authorization. A list of these situations can be located in Appendix A of this manual or by accessing the list via this internet link to Sendero’s website, <pending HHSC approval>. The pre-authorization process is used to evaluate the medical necessity of a
procedure or course of treatment, appropriate level of service and the length of confinement prior to the delivery of services. The clinical information provided aids in the medical review of the request.

Sendero provides prospective, concurrent, and retrospective utilization review services. All services that require pre-authorization must be phoned or faxed to the Health Services Department utilizing either the Sendero Authorization and Referral Form or the Texas Authorization and Referral Form included in Appendix A of this manual. The request may be submitted via the internet as well.

Failure to obtain pre-authorization may result in non-payment of claims and encounters.

Members may request reconsideration of benefit determinations in accordance with the medical appeals process. Physicians are responsible for making medical treatment decisions in consultation with their patients. Any denial of pre-authorization based on lack of medical necessity or documentation of such, will be made by the Medical Director.

All decisions made by the Health Services Department are subject to appeal using the provider appeal process as described in “ST5 Complaints & Appeals” or “CH4 Complaints & Appeals” in this Manual.

Protocols and procedure for obtaining Pre-authorization
The physician (primary care provider or Specialist) initiates a pre-authorization using the same procedure as requesting a referral, by calling or by faxing either the Sendero Authorization and Referral Form or the Texas Authorization and Referral Form (see Appendix A) to Sendero’s Health Services Department and providing the same demographic and clinical information as required for a referral as stated above. Pre-authorizations can also be initiated over the internet and provider offices with internet access have been instructed in this procedure. Provider offices interested in additional information on entering web based requests can call Network Management at the phone number listed on the bottom of this page.

Definition of Admissions:
Elective Admission: Elective, or pre-planned, admissions generally include elective surgeries and admissions for elective treatment that requires an acute care setting for management.

Observation Admission: Observation admissions are intended for use when it is necessary for a Member to be monitored for a longer period of time post-operatively, or if the member has known risk factors or medical conditions requiring frequent monitoring by the nursing staff. Observation is authorized for up to 72 hours following Medicare guidelines. If the decision to keep the patient beyond 72 hours, the hospital or the attending physician should contact Sendero within one (1) business day.

Direct Urgent Admissions: Urgent admissions are defined as those admissions that take place upon direct referral from a physician’s office or when the Member is directed by a physician to go to the hospital. The facility is required to notify Sendero within 24 hours or next business day of the admission.

Emergency Admissions: An emergency admission usually occurs directly from a hospital emergency facility following evaluation and stabilization of a medical condition of recent onset and severity. These admissions may occur after regular business hours. The facility must contact the Health Services Department within 24 hours or the next business day.
Services Requiring Pre-authorization
For Pre-authorization, contact the Health Services Department at the number at the bottom of this page, or via the internet.

Please notify the Health Services Department at least three to five (3-5) business days prior to rendering the service to allow time for Sendero to complete the pre-authorization review process.

All elective surgeries are performed on the day of admission unless, based on medical necessity, the Health Services Department has approved the admission the day prior to surgery.

6.5 Vision Services
Sendero Health Plans offers vision services through a contracted vendor. This vendor is OptiCare Managed Vision. The vision benefit includes a routine eye exam, and eyewear. Vision services that are for medical conditions of the eye require Primary Care Physician’s referral to an Ophthalmologist. Questions regarding the routine vision benefit and services should be directed to OptiCare at 1-877-615-7720 for CHIP and STAR.

6.6 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 is not available. This applies to non-preferred drugs on the Preferred Drug List and any drug that is affected by a clinical or prior authorization edit and would need prescriber prior approval.

6.7 Chiropractic Services
Chiropractic services are available for Members. Visits do not require a referral from the member’s primary care physician nor pre-authorization unless they exceed 8 visits. The services are limited to treatment for spinal subluxation only. For pre-authorization, call or fax the Sendero Authorization and Referral Form or the Texas Authorization and Referral Form (see Appendix A) to Sendero’s Health Services Department to the numbers listed at the bottom of this page. Requests may also be made online via our website www.senderohealth.com.

6.8 Transplant Services
Providers who are caring for Members under consideration for transplant services must notify Sendero. An RN Care Coordinator will become involved with this Member and follow them through the pre-transplant and final
transplantation process. Sendero requires pre-authorization for admission to any transplant facility. Any nationally recognized facility will be evaluated for approval based on the medical necessity of services for the Member. For prior approval and to notify of potential transplantation, contact the Sendero Health Services Department at the phone number at the bottom of this page.

### 6.9 Case Management Program

Sendero provides case management services for catastrophic medical cases or for specific types of health care services through the Whole Person Health Support (WPHS) program which can be contacted at 1-855-297-9191. Case management activities are performed by Sendero Health Services’ RN Care Coordinators. The RN Care Coordinator works closely with the Member's primary care provider to monitor the Member's health by tracking and reviewing the Member's utilization trends (inpatient admissions, office visits, pharmacy, etc.). The RN Care Coordinator determines whether coordination of services will result in more appropriate and cost effective care through treatment plan intervention and helps develop a proposed treatment plan. Members may be referred to the Whole Person Health Support program by calling into Health Services at 1-855-297-9191, completing a WPHS Referral form (Appendix A) and faxing it to 1-512-275-2862, or entering a referral online at [www.SenderoHealth.com](http://www.SenderoHealth.com). Referrals are accepted by any person or provider with a concern, such as:

- A child's family/self-referral
- Customer Services Referral
- Behavioral Health Referral
- Member Satisfaction Surveys
- State developed Assessment tool
- Primary Care Provider/ Provider Referral
- Community/ External Agency Referral
- Analysis of claims utilization reports
- Administrator Contract for any State program

Patients with high risk diagnoses or conditions may trigger WPHS intervention. Sendero’s WPHS program involves the Member, family or significant others, physicians, social services, community resources and facility team members, all of whom contribute to decisions regarding care.

When appropriate, the Care Coordinator refers the Member and family to public health resources. A partial listing of these resources may include the following:

- Texas Health and Human Services Commission (HHSC)
- Supplemental Nutrition Assistance Program (SNAP)
- Women, Infants, and Children Program (WIC)
- Early Childhood Intervention Program (ECI)
- Texas Department of State Health Services (DSHS)
- Texas Department of Aging and Disability Services (DADS)
- Local School Districts as appropriate
- Texas Information and Referral Network (2-1-1, TIRN)
- Texas Department of Rehabilitative Services (DARS)
● Other child-serving civic & religious organizations and consumer & advocacy groups.

● March of Dimes

● American Heart Association

● American Lung Association

The Care Coordinator arranges social services, community services and other services as needed, including DME.

For more information regarding Sendero’s WPHS case management program or for additional information on the community agencies, contact Sendero’s Health Services Department at 1-855-297-9191.

6.10 Disease Management Programs

Disease Management Programs are largely retrospective oversight of high risk medical conditions. Disease management is designed to prevent exacerbation of symptoms that might result in hospitalization. Disease management is also designed to help Members with specific illnesses deal more effectively with their disease or condition to as to improve their quality of life. Sendero’s Disease Management programs are a component of the Whole Person Health Support (WPHS) program.

Currently, Sendero offers WPHS Programs for Attention Deficit Hyperactivity Disorders (and related conditions), Asthma, Diabetes, and high risk pregnancy. These services are designed to increase patient knowledge regarding their health, their disease process, nutrition, medication and importance of compliance with the introduction of community resources available to them. If you encounter a Member that you feel would benefit from one of these programs, please contact the Health Services Department by phone at 1-855-297-9191, by completing a referral form (Appendix A) and faxing it to 1-512-275-2862 or by submitting a Referral form on line at www.SenderoHealth.com. An RN Care Coordinator will be available to help in facilitating the physician based treatment plan in a collaborative effort with the Member’s various healthcare providers to help in improving or maintaining the wellbeing of the Member.

6.11 Practice Guidelines

Sendero Health Plans utilizes the American Academy of Pediatrics Practice Guidelines, as guidelines for care for the pediatric Members. In addition, Sendero uses the asthma practice guidelines from the National Heart Lung and Blood Institute. The immunization guidelines are followed as recommended by the American Academy of Pediatrics as are the ADHD Practice Guidelines. Sendero’s guidelines for management of Diabetes vary depending on the age of the individual and the pregnancy status. Questions regarding practice guidelines may be directed to the Health Services Department. See Clinical and Preventative Care Guidelines in Appendix C.
7.0 – Billing and Claims

7.1 What is a Claim?
A claim is a request for payment. Sendero uses the standard CMS-1500 (professional) and CMS-1450 (UB04 institutional) paper claim forms OR the ANSI-837 format for electronic claims submission for medical and behavioral health claims.

7.2 What is a Clean Claim?
A clean claim is defined as a claim submitted by a physician or provider for medical care or health care services rendered to a Member, with the data necessary for Sendero to adjudicate and accurately report the claims. A clean claim must meet all requirements for accurate and complete data as defined in the 837 transaction guide.

Once a clean claim is received, Sendero is required, within the thirty (30) day claim payment period to:

- Pay the claim in accordance with the provider contract, or
- Deny the entire claim, or part of the claim, and notify you why the claim or part of the claim was not paid.

7.3 Electronic Claims Submission: ANSI-837
Sendero accepts claims via 837 electronic claims submission utilizing Emdeon as our clearinghouse acceptance point. EDI Payor ID = 36426. Please verify that your current clearinghouse can be accepted by Emdeon or contact your Provider Relations Representative for assistance.

7.4 Submitting Paper Claims to Sendero
Paper claim forms are mailed to:

Sendero Health Plans
ATTN: CLAIMS
P.O. Box 3869
Corpus Christi, TX 78463
### 7.5 Timeliness of Billing

Claims and/or encounters must be submitted as follows:

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Timely Billing Parameter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Claims submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format</td>
<td>95 days from <strong>DATE OF SERVICE</strong></td>
</tr>
<tr>
<td>Ancillary Services Claims submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format</td>
<td>95 days from <strong>DATE OF SERVICE</strong></td>
</tr>
<tr>
<td>Ancillary Services Claims for services that are billed on a monthly basis submitted on a CMS-1500 or using the professional ANSI-837 electronic claim format (e.g. home health or rehabilitation therapy)</td>
<td>95 days from the <strong>LAST DAY OF THE MONTH</strong> for which services are being billed</td>
</tr>
<tr>
<td>Outpatient Hospital Services billed on the CMS-1450 (UB04 institutional claim form) or using the institutional ANSI-837 electronic claim format</td>
<td>95 days from the <strong>DATE OF SERVICE</strong></td>
</tr>
<tr>
<td>Inpatient Hospital Services claims billed on the CMS-1450 (UB04 institutional claim form) or using the institutional ANSI-837 electronic claim format</td>
<td>95 days from the <strong>DATE OF DISCHARGE</strong></td>
</tr>
</tbody>
</table>

Claims not submitted in accordance with the above noted deadlines may be denied.

**Please do not submit a duplicate claim from original submission date prior to thirty (30) days for electronic claims, and forty-five (45) days for paper claims.**

### 7.6 Timeliness of Payment

Sendero will pay all clean claims submitted in the acceptable formats as previously detailed within thirty (30) days from the date of receipt or the date that the claim is deemed “clean”. Should Sendero fail to pay the provider within the thirty days, the provider will be reimbursed the interest on the unpaid claim at a rate of 1.5% per month (18% annum) for every month the claim remains unpaid.

Sendero will pay all clean electronic pharmacy claims submitted in the acceptable format within eighteen (18) days from the date of receipt or the date that the claim is deemed “clean”. Should Sendero fail to pay the provider within the eighteen (18) days, the provider will be reimbursed the interest on the unpaid claim at a rate of 1.5% per month (18% annum) for every month the claim remains unpaid.
### 7.7 Coding Requirements: ICD9 and CPT/HCPCS Codes

**Professional Medical Claims:** Sendero requires the use of ICD9 diagnosis codes and CPT or HCPCS procedure codes.

**Emergency Professional Services Claims:** Sendero requires the use of ICD9 diagnosis codes and CPT or HCPCS procedure codes.

**Inpatient Institutional Claims:** Sendero requires the use of ICD9 diagnosis codes and either ICD9 or CPT surgical procedure codes. Line item charges must be coded with UB04 Revenue Codes.

**Outpatient Institutional Claims:** Sendero requires the use of ICD9 diagnosis codes, HCPCS codes for applicable line item charges and the corresponding UB04 Revenue Code, and either ICD9 or CPT surgical procedure codes.

**Emergency Institutional Claims:** Sendero requires the use of ICD9 diagnosis codes, HCPCS codes for applicable line item charges and the corresponding UB04 Revenue Code, and either ICD9 or CPT surgical procedure codes.

**Dental Claims:** Dental services are provided through a Dental Management Organization (DMO) for the majority of Sendero members. Sendero will pay claims for Medicaid clients who are adults age 21 and older and pregnant women under the plan’s Value Added Services. Please call Customer Services number listed below or contact the State’s DMO by calling 1-866-561-5891 for questions concerning benefits and billing.

**Prescription Drug Claims:** All pharmacy / drug claims should be submitted thru Navitus Health Solutions or call Navitus Customer Care 1-877-908-6023. Claims forms are available at [www.navitus.com](http://www.navitus.com) Claims can be submitted to:
- Navitus Health Solutions
- Operations division – claims
- P.O. Box 999
- Appleton, WI 54912-0999

### 7.8 E&M Office Visits Billing Requirements

Sendero follows standard E&M coding guidelines as promulgated by the Centers for Medicare and Medicaid Services (CMS).
7.9 E&M Consult Billing Requirements

Sendero follows standard coding and billing requirements for consults (CPT codes 99241-99275).

7.10 Emergency Services Claims

If emergency care is needed, it should be provided immediately in accordance with the procedures described in “4.0 - Emergency Services” in this manual. Services provided in an emergency situation will be reimbursed in accordance with the Hospital’s or provider’s agreement with Sendero. Non-participating providers and hospitals that provide Emergency care to Medicaid Members will be paid according to the Texas Medicaid allowable fee schedule. Providers within the service area who are non-participating will be paid according to the out of network Medicaid allowable fee schedule.

7.11 Use of Modifier 25

Sendero will accept modifier 25 codes when submitted in accordance with the following requirements:

- Modifier 25 is used on a valid CPT or HCPCS procedure code to indicate that the identified service was provided as a distinctly separate service from other similar services furnished on the same date of service.

  **EXAMPLE:** Providing an age-appropriate health screening on the same day as a sick visit.

  | Sick Visit | Select the appropriate E&M Office Visit Code |
  | Preventive Screen | Select the age-appropriate preventive E&M Code and affix the 25 modifier. |

- Providers may use the modifier 25 when billing an E&M code with another significant procedure on the same day. The modifier 25 should be affixed to the E&M code only. The medical record should clearly support the significance and distinctiveness of the associated procedure.

- The modifier 25 may also be used to bill a preventive health screen, or Texas Health Steps exam, performed on the same day as a sick visit. The modifier 25 should be affixed to the preventive screen code.

The Sendero Fraud, Waste and Abuse (FWA) special investigative unit monitors modifier 25 billings. Occasional chart audits are performed to comply with our FWA program requirements.
7.12 Billing for Assistant Surgeon Services

Sendero provides coverage for Assistant Surgeon services authorized in accordance with Sendero policies for certain CPT codes.

7.13 Billing for Capitated Services

Capitated providers are required to submit encounter claims for all capitated services. Sendero accepts encounter data on the CMS-1500 form or the professional ANSI-837 electronic format. The forms should be completed in the same manner as a claim.

For a complete list of capitated services along with applicable carve outs and allowables please refer to your provider contract.

7.14 Billing for Immunization and Vaccine Services

*Childhood Immunizations:* Primary care providers who furnish immunization services for children are required to enroll with the Texas Vaccine for Children (TVFC) program. The program provides vaccines for childhood immunization. Sendero does not reimburse for vaccines, but will reimburse primary care providers for the administration of the vaccine(s).

*Adult Immunizations:* Sendero covers adult immunization services. Providers may bill for both the vaccine (using the appropriate HCPCS code) and for vaccine administration.

7.15 Billing for Texas Health Steps (Medicaid STAR only) or Well Child Visit Services

Texas Health Steps providers are required to submit claims for all Texas Health Steps services in the acceptable formats previously detailed. Additionally, Texas Health Steps providers must send all Texas Health Steps newborn screen to the Texas Department of State Health Services (DSHS), Bureau of Laboratories or a DSHS certified lab. Texas Health Steps providers must include detailed identifying information for all screened newborn Members and the Member’s mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up. Billing for services outside of the Periodicity schedule listed in “ST4 – Texas Health Steps Program” or “CH3 – Well Child Visits” in this manual will only be paid for exceptions listed in that section. The website link to access the THSteps Periodicity Schedule is www.dshs.state.tx.us/thsteps/Periodicity-Schedule-THSteps_bw.doc.
7.16 Billing for Deliveries and Newborn Services

Sendero requires separate claim forms for mothers and babies. Every effort should be made to bill claims with the appropriate Medicaid ID Number. However, since there may be a delay in obtaining a Medicaid number for a newborn, Sendero accepts billing for newborns using the mother’s Sendero ID # affixed with an “A” at the end. If the mother gave birth to multiple newborns, sequentially use “A”, “B”, “C”, etc. and submit a separate claim for each newborn.

EXAMPLE 1: Mother delivers a single live child.

Mother = 12345678
Newborn = 12345678A

EXAMPLE 2: Mother delivers twins.

Mother = 87654321
Newborn 1 = 87654321A
Newborn 2 = 87654321B

Claim forms that reflect combined charges for both a mother and a newborn will be rejected or will be subject to denial.

7.17 Billing for Outpatient Surgery Services

A limited number of Outpatient Surgeries require pre-authorization which are outlined in Appendix A. To ensure payment for any of these surgeries, include the authorization number on your submitted claim. An authorization may be obtained by submitting a request via our web site at www.senderohealth.com, by faxing a request to the Health Services Department at 512-275-2862 or by contacting the Health Services Department at the phone number below.

Physician Claims: Submit the claim on the standard CMS-1500 or using the acceptable ANSI-837 professional electronic format. The applicable CPT-coded surgical procedure code(s) must be identified.

Facility Claims: Claims from hospitals, ambulatory surgery centers or other facilities where outpatient surgery may be performed, must be submitted on the CMS-1450 (UB04) form of using the acceptable ANSI-837 institutional electronic format, with the applicable ICD9 surgical procedures code(s), date of the surgery, itemized charges, and associated CPT/HCPCS procedure codes.
7.18 Billing for Hospital Observation Services

Facilities are eligible to receive reimbursement for Observation Admissions congruent with CMS rules (up to 72 hours). Sendero considers an observation claim to be an outpatient claim. In the itemized charges section of the claim form, a line showing the UB Revenue Code should be shown with the number of hours of observation. In cases where an observation stay is converted to inpatient, the facility should notify the Health Services Department at the phone number below. Labor and Delivery Observation Stays require notification.

7.19 Coordination of Benefits (COB) Requirements

Sendero utilizes a third party vendor to verify COB status on all Sendero Health Plans Members. Verified information obtained through this process will take precedence on all claim processing. For more information on other coverage please contact Customer Services. For further information on COB claims, please contact your Network Management Representative.

Sendero is the payer of last resort. Providers must bill all other carriers and receive payment or denial prior to billing Sendero.

Other Payer Makes Payment: In cases where the other payer makes payment, the CMS-1500, CMS-1450, or applicable ANSI-837 electronic format claim must reflect the other payer information and the amount of the payment received.

Other Payer Denies Payment: In cases where the other payer denies payment, or applies their payment to the Member’s deductible, a copy of the applicable denial letter or Explanation of Payment (EOP) must be attached with the claim that is submitted to Sendero.

7.20 Billing Members

Balance billing is billing the Member for the difference between what a provider charges and what Sendero or any other insurance company has already paid. Providers are not allowed to “balance bill” Sendero Members except as noted below. All covered services are included within the payment made by Sendero and the residual balance of covered charges must be written off as a contractual allowance. Providers are prohibited from billing or collecting any amount from a Medicaid STAR Member for Health Care Services. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service. The following table illustrates circumstances concerning billing Members.
## Member Billing Situations

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>PLAN PAYS NOTHING</th>
<th>PLAN PAYS CONTRACTED RATE</th>
<th>PLAN PAYS USUAL &amp; CUSTOMARY</th>
<th>PROVIDER CAN BILL MEMBER if an Advance Beneficiary Notice and Private Pay Form was Executed Prior to Rendering the Services</th>
<th>PROVIDER CANNOT BALANCE BILL MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN NETWORK</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Authorized</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Authorized</td>
<td>✓</td>
<td></td>
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<tr>
<td><strong>OUT-OF-NETWORK</strong></td>
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<tr>
<td>Authorized</td>
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<td>✓</td>
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<tr>
<td>Not Authorized</td>
<td>✓</td>
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<tr>
<td><strong>EMERGENCY CARE</strong></td>
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<tr>
<td>In Network</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-Of-Network</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Covered Services</td>
<td>✓</td>
<td></td>
<td></td>
<td>See “STAR – B – STAR/Medicaid Covered Services” or “CHIP – B – Covered Services” in this manual</td>
<td></td>
</tr>
</tbody>
</table>

**Co-pay Amounts for STAR/Medicaid Members:** There are **no co-payments** for STAR/Medicaid Members.

**Co-pay Amounts for CHIP Members:** Providers may collect co-pay amounts from CHIP Members as outlined below or on the Member’s CHIP identification card.

**Co-pay Amounts for CHIP Perinatal Members:** There are **no co-payments** for CHIP Perinatal Members.

### 7.21 Collecting from or Billing CHIP Members for Co-pay Amounts

Some CHIP Members have co-pay amounts for certain services. The Members’ Sendero identification card will indicate the co-pay amounts for these specific services. Only valid co-pay amounts can be collected from CHIP Members.

For a list of when a co-pay applies, refer to Chapter 4.0 of this Provider Manual.
7.22 Billing Members for Non-covered Services

Providers may not bill Members for non-covered services UNLESS the provider has obtained a signed Member Acknowledgement Statement or a Private Pay Form (see Appendix A) from the Member or guarantor prior to furnishing the non-covered service. These forms must be maintained in the provider’s records and made available to Sendero, HHSC, or agents of HHSC upon request.

- **Member Acknowledgement Statement Form**

  The provider obtains and keeps a written Member Acknowledgement Statement, signed by the Member, when a Member agrees to have services provided that are not a covered benefit for STAR/Medicaid or CHIP. By signing this form, the Member agrees to have the services rendered, and agrees to personally pay for the services. (See Appendix A for a copy of this form.)

- **Private Pay Form Agreement**

  The provider obtains and keeps a written Private Pay Form Agreement, signed by the Member, when the Member agrees to have services provided as a private paying patient. By signing this form, the Member agrees to pay for all services, and the provider will not submit a claim to Sendero. (See Appendix A for a copy of this form.)

7.23 Providers Required to Report Credit Balances

Providers are required to report credit balances on accounts of Sendero Members within 60 days of the credit balance occurring on the account, if the credit balance was caused by:

(a) Receiving payment from both Sendero and another payer, or
(b) Receiving duplicate payment from Sendero.

7.24 Filing an Appeal for Non-payment of a Claim

All claim appeals must be filed within 120 days of the date of the Explanation of Payment (EOP). To submit an appeal regarding claim payment, please submit a completed claim form, a copy of the EOP with the claim in question, and a written explanation of your appeal which should identify as “Administrative Claims Appeal” or “Corrected Claim” for appropriate processing to:
7.25 Claims & Appeals Questions

For questions regarding claims, please contact Sendero Customer Services at the phone number at the bottom of this page.

7.26 Electronic Funds Transfer (EFT)

For your convenience, Sendero is pleased to offer Electronic Funds Transfer (EFT) as a method of receipt to claims payment. You may authorize Sendero to present credit entries into a bank account with minimal paperwork. A copy of the EFT form can be obtained in this Provider Manual or on the Sendero website at www.senderohealth.com or by calling your Provider Relations Representative. (See Appendix A for a copy of this form.)
8.0 – Sendero Quality Program

8.1 Sendero’s Quality Improvement Program (QIP)

Sendero Health Plans’ Quality Improvement Program actively monitors and evaluates services provided to health plan enrollees. The program is designed to assist Members of Sendero Health Plans in receiving appropriate, timely, and quality services rendered in settings suitable to their individual needs while promoting primary preventive care in an effort to achieve optimal wellness.

Authority for the program is received from the Sendero Health Plans’ Board of Directors. The Board of Directors receives annual reports concerning the operation of the program from the Quality Improvement Committee.

Annually, a Quality Improvement (QI) Work Plan is developed to identify areas to monitor for the coming year. The QI Work Plan includes monitoring and evaluating the structure, process, and outcomes of the health plans delivery system. The Sendero Health Plans’ Board of Directors approves the QI Work Plan.

8.2 Sendero’s Provider Quality Measures

The Annual QI Work Plan includes ongoing specific quality measures that directly involve providers. Other areas may be added throughout the year. These measures include, but are not limited to, reviews of:

- Accessibility and Availability of Providers.
- Complaints from Members and Providers
- Emergency Room utilization
- Quality of Care Focused Studies (Diabetes and Asthma)
- MRSA claims
- Texas Health Steps and Well-Child exams
- Cervical Cancer Screening
- Perinatal Care
- Member and Provider Satisfaction surveys
- Review of Denials and Appeals
- Continuity of Care reviews
- Medical and Behavioral Utilization Statistics

Sendero Health Plans monitors after hours accessibility and appointment availability of providers twice a year. Providers are expected to follow the standards as defined “3.0 – Guidelines for Providers” in this Provider Manual.
8.3 Sendero’s HEDIS® Measurements

Sendero Health Plans is required by the Health and Human Services Commission (HHSC) to conduct certain defined HEDIS® measurements. Health Employer Data Information Sets (HEDIS®) are specified criteria defined by the National Committee for Quality Assessment (NCQA), the national accrediting agency for Health Maintenance Organizations (HMOs). The HHSC defined criteria includes, but are not limited to, the following:

- evaluation of well child examinations
- use of appropriate medications for Members with asthma
- mental health follow-up appointments following hospitalization (at 7 days and 30 days)
- prenatal and postpartum care

Sendero provides encounter data to the HHSC-contracted External Quality Review Organization (EQRO). The EQRO evaluates all STAR and CHIP health plan claims and produces health plan report cards and HEDIS® data. For more information regarding HEDIS® criteria, and monitoring, contact Network Management at the number below.

8.4 Sendero’s Quality Improvement Committee

Sendero Health Plans has a Quality Improvement (QI) Committee which is responsible for oversight and ensuring that quality processes and quality of care is provided to all Members. This committee is comprised of Pediatricians, Specialists, the Sendero Health Plans’ CEO, the QI Manager, the Subcommittee Chairmen and other ad hoc Members as needed. All Sendero Subcommittees report to the QI Committee. Subcommittee chairmen provide updates at each QI Committee meeting. The QI Committee reviews and approves the annual QI Work Plan. Each committee meeting consists of review of areas associated with the work plan. In addition, all policies and procedures for Sendero are reviewed and approved by this committee. The QI Committee reports to the Sendero Health Plans’ Board of Directors.

8.5 How to Get Involved in Sendero’s Quality Program

All providers are encouraged to participate in Sendero’s Quality Program. This includes participation in the QI Committee. For more information on how to participate in the Quality Program and/or the QI Committee, contact the QI Manager at 512-978-8085.
8.6 Provider Report Cards

Sendero Health Plans prepares individual provider report cards that evaluate each provider’s performance as it relates to the care of the Members. The information is compiled from claims and utilization data and is compared to like providers so that a peer to peer assessment can be completed. For more information regarding the report card, the provider may contact Network Management at the number at the bottom of this page.

8.7 Confidentiality

Each physician contracted with Sendero Health Plans (Sendero) must implement and maintain a policy which acts to ensure the confidentiality of patient information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Only healthcare providers treating a Member and essential Sendero employees involved in the coordination of a Member’s care are permitted access to medical records and Member-specific information. Essential personnel are defined as those with “a need to know”. All Member-specific information shall be maintained in a secure area both in the provider’s office and at the Sendero corporate and operational offices.

Verbal and written exchange of Member-specific information is permitted when used for purposes of treatment, payment or operational procedures. Some examples of these purposes may be:

- During professional conferences, consultations and reports that are required as part of the Sendero Utilization Management or Quality Improvement programs.
- Between essential Sendero staff and the healthcare providers involved in the Member’s care.
- Healthcare providers include primary care providers, specialists, behavioral health providers and other persons involved in the direct care for a Member at in- and out-patient facilities.

Only pertinent and essential health information will be communicated. The general rule of “the least amount of information required to accomplish the task” shall be followed in all cases.

All Sendero records are the property of Sendero Health Plans. They may be removed from the Sendero jurisdiction and safe-keeping only in accordance with recognized statues of law, including but not limited to, court order or subpoena.

Copies of hospital medical records of Sendero Members are released according to the policies and procedures of the Medical Records Department of the particular institution and their contract with Sendero.

Copies of the physician office medical records may be released in compliance with state and federal regulations, and the terms of the individual physician’s or group’s contract with Sendero.

Unauthorized release of confidential information by an employee or agent of Sendero will result in disciplinary action, in compliance with Sendero Health Plans’ Confidentiality Policy.
Confidential information relating to a Member, including HIV/AIDS information will not be disclosed or published without the prior written consent of the patient, parent, family, or legal guardian.

Any information that is no longer required confidential information is completely destroyed (i.e. shredded, etc.).

### 8.8 Focused Studies and Utilization Management reporting requirements

In conjunction with the QI Work Plan, Sendero Health Plans conducts focused studies to look at the quality of care. Examples of focused studies would be those regarding diabetes care and treatment, and asthma care and treatment.

The QI Work Plan is developed annually, and focused studies may be added at this review.

Other Utilization Management reports that are produced monthly and reviewed at the Provider Advisory Subcommittee and the Behavioral Health Subcommittee meetings, as well as the QI Committee are as follows:

- Review of admissions and admission/1,000 Members (Medical and Behavioral Health)
- Review of bed days and bed days/1,000 Members (Medical and Behavioral Health)
- Average length of stay for inpatient admissions (Medical and Behavioral Health)
- ER utilization and health services utilization/1,000 Members
- Denials and appeals
- Other reports as needed to evaluate utilization of services by Membership

For information on any of the above reports, or to see one of these reports, contact the Health Services Director for Sendero at **512-978-8176**.
9.0 – Credentialing and Re-credentialing

9.1 Credentialing and Re-credentialing Oversight

The Provider Advisory Subcommittee (PAS) is led by Sendero’s Medical Director. One of its functions is to review and approve credentialing files of providers who apply to the Sendero Health Plans network. The Subcommittee meets as often as necessary to complete provider credentialing and re-credentialing activities. There are contemporaneous dated and signed minutes that reflect all Provider Advisory Subcommittee activity. Reports are then made to the Quality Improvement Committee. The main scope of the committee is to ensure that competent qualified practitioners and providers are included in Sendero Health Plans’ network and to protect the Members from professional incompetence. The Quality Improvement Committee and the Sendero Health Plans’ Board of Directors review all activities of the Provider Advisory Subcommittee related to the credentialing and the re-credentialing of providers for the Sendero network. If you are interested in the PAS, please contact the Health Services Director at 512.978.8176 for more information.

9.2 Provider Site Reviews

Site visits may be conducted at the offices of primary care providers, OB/GYN physicians, and high volume individual behavioral health providers, by your local Network Management Representative prior to initial credentialing at Sendero Health Plans. In addition, site visits will be conducted at any time for cause, including a complaint made by a Member or another external complaint made to Sendero Health Plans.

High volume behavioral health providers and all psychiatrists, any behavioral health group or clinic of ten (10) or more practitioners, and all Community Mental Health centers may also have a site visit conducted prior to initial credentialing with Sendero Health Plans.

The site visit review will consist of at least the following components:

- Physical Structure and Surroundings
- Provider Accessibility
- Provider Availability
- Confidentiality processes
- Treatment Areas
- Patient Education / Patient Rights
- Medical Record Review

For Rural Health Clinics, if a Nurse Practitioner or Physician Assistant is the main provider, additional criteria are reviewed that includes:
Evidence of current state licensure for the Nurse Practitioner (Advance Practice Nurse) and Physician Assistant;
Evidence of protocols or orders in place to provide medical authority and prescriptive authority;
Verification that these protocols or orders are signed by the Medical Director and reviewed annually;
Evidence that the Medical Director has visited at least once every ten (10) days; and
Evidence that the Nurse Practitioner or Physician Assistant has given a daily report to the Medical Director if there are complications.

The physician and office are notified of the results of the review by registered letter, with any deficiencies identified. Physician office site visits that do not achieve a score on the assessment of 85% compliance or higher will be written as failing the visit score. The physician’s office will be made aware of the deficiency, and will be given a time frame to make corrections. Another site visit will be conducted within six months from the date of the deficient visit. The provider’s office will be given feedback of the site visit findings as they work towards correcting areas of non-compliance.

### 9.3 Required Office Policies & Procedures

Sendero Health Plans requires that network providers have Policies & Procedures in place for:

- **Advance Directives**: Sendero requests that information on Advance Directives be provided to any Sendero Member 18 years of age or older.

- **Oversight of Mid-Level Practitioners**: Sendero requires that policies defining the role of the Mid-Level Practitioner in providing health care within their scope of practice be in place at the provider’s office.

- **Medical Record Confidentiality**: Sendero requests that the provider’s office implement and maintain a policy which acts to ensure the confidentiality of patient information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- **Release of Records**: The provider’s office must have a policy in place directing its staff to follow a specific process that is HIPAA compliant for release of records.

- **Informed Consent and ID**: A written policy and procedure must be in place for confirming the identification of a member and obtaining consent for treatment prior to rendering services.

- **Maintenance of Medical Records**: The office should have a written policy regarding the safeguard against loss, destruction, or unauthorized use of any medical records.
9.4 Re-Credentialing Requirements

The following updated information is required for re-credentialing. Sendero’s Network Management representative will request the following information for the re-credentialing process.

- Current Texas medical license;
- Current DEA license;
- Current DPS license;
- Clinical privileges at the primary network admitting facility;
- Malpractice/Liability insurance declaration page with minimum coverage of $200,000/$600,000 or as required by the primary admitting facility and expiration date*;
- National Practitioner Data Bank inquiry;
- Board certification if newly certified or recertified since last credentialing;
- Sanction inquiry (Medicare and Medicaid);
- Any additional medical diplomas and/or certificates; and
- Malpractice history.

* Failure to provide Malpractice/Liability Insurance will result in immediate termination of the Provider Service Agreement.

Disputes from participating providers denied participation in the Health Plan will be addressed through the Health Plans’ formal credentialing appeals process, in a timely manner.

In addition, Sendero Health Plans must be notified by the provider whenever any of the following occurs:

- Malpractice settlements
- Any disciplinary actions taken (i.e. from hospital where physician has privileges, from state medical board, etc.)
- Change in malpractice coverage
- Loss of medical license
10.0 – Fraud, Waste or Abuse

REPORTING FRAUD, WASTE OR ABUSE BY A PROVIDER OR CLIENT
MEDICAID MANAGED CARE AND CHIP

Do you want to report Fraud, Waste or Abuse?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care provider, or a person getting benefits is doing something wrong. Doing something wrong could be fraud, waste or abuse, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren’t given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid or CHIP ID.
- Using someone else’s Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To Report Fraud, Waste or Abuse, chose 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 Fraud, Waste or Abuse” to complete the online form; or
- You can report directly to your health plan
  o Sendero Health Plans
    2028 East Ben White, Suite 510
    Austin, TX 78741
    o 1-855-297-9191

To report fraud, waste or abuse, gather as much information as possible.

- When reporting a provider (a doctor, dentist, counselor, etc.) include:
  o Name, address, and phone number of provider
  o Name and address of the facility (hospital, nursing home, home health agency, etc.)
  o Medicaid number of the provider and facility, if you have it
  o Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  o Names and phone numbers of other witnesses who can help in the investigation
  o Dates of events
  o Summary of what happened.
• When reporting someone who receives benefits such as a Member, include:
  o The person’s name
  o The person’s date of birth, Social Security number, or case number if you have it
  o The city where the person lives
  o Specific details about the fraud, waste or abuse.
Texas STAR Program
ST1 – Eligibility of Members

ST 1.1 HHSC Determines Eligibility

The Texas Health and Human Services Commission (HHSC) are responsible for determining CHIP and STAR/Medicaid eligibility. For information regarding eligibility, contact HHSC’s STAR hotline at 1-800-964-2777.

For other help, call Sendero’s Customer Services at 1-855-526-7388.

ST 1.2 Role of Enrollment Broker

HHSC uses an Enrollment Broker to receive and process applications for STAR/Medicaid and CHIP. The enrollment broker cannot authorize or determine eligibility. The role of the enrollment broker is to ensure that all required documentation and forms are gathered. Once eligibility is determined by HHSC, the enrollment broker mails out welcome letters and information on the available health plans in each area. The enrollment broker receives each Member’s plan and primary care provider selection documentation and notifies health plans of their new Members.

ST 1.3 General Eligibility for STAR/Medicaid

Beginning June 2011, the Texas Health and Human Services Commission (HHSC) introduced a new system that uses digital technology to streamline the process which includes a new card that all STAR Members will receive. This card is their new “Your Texas Benefits Medicaid ID card” which will take the place of the monthly Medicaid Form 3087. Also in the new process is an online website where Medicaid providers can get up-to-date information on a Member’s eligibility and history of services and treatments paid by Medicaid. The enrollment period will remain for a six month period for Medicaid Members. The STAR ID card includes the Member’s name and ID number, Managed care program enrolled in, Date card was issued, Health plan names and phone numbers and other billing and pharmacy information.

If a STAR Member loses their “Your Texas Benefits Medicaid card” and needs proof of eligibility, HHSC staff can generate a Temporary Medicaid Eligibility Verification Form (Form 1027-A). Members must apply for the temporary form in person at an HHSC benefits office.

If a Member becomes temporarily (for six months or less) ineligible for Medicaid and regains eligibility status during the initial six-month timeframe, the Member will be automatically re-enrolled in the health plan they were in when eligibility was lost. The Member at this time may choose to switch plan.
The geographic area served by Sendero Health Plans is a mandatory enrollment area. All persons eligible for Medicaid in the Temporary Aide to Needy Families (TANF) category or in the child categories, must enroll in a health plan and select a primary care provider who participates in that health plan’s network.

**ST 1.4 Span of Eligibility (Members’ Right to Change Health Plans)**

You can change health plans by calling the Texas MEDICAID MANAGED CARE Program Helpline at 1-800-964-2777. However, you **cannot** change from one health plan to another health plan while you are in the hospital as a patient.

If you call 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 you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you ask to change plans on or before April 15, the change will take place on May 1.
- If you ask to change plans after April 15, the change will take place on June 1.

**ST 1.5 Disenrollment from Health Plan**

**STAR/Medicaid**

A request to remove a Member from the health plan must be forwarded to HHSC. Providers must provide adequate documentation to justify disenrollment, and there must be sufficient compelling circumstances to warrant disenrollment. The provider cannot make this request as retaliatory action against the Member. The primary care provider or other provider must submit medical records to justify the request. All requests and documentation will be forward to HHSC to make the determination. HHSC has the final decision authority.
## ST2 – STAR/Medicaid Covered Services

### ST 2.1 STAR/Medicaid Managed Care Covered Services

Sendero Health Plans is required to provide specific medically necessary services to its STAR Members. The following table provides an overview of benefits. Please refer to the current *Texas Medicaid Provider Procedure Manual* available at [www.tmhp.com](http://www.tmhp.com) and the bi-monthly Texas Medicaid Bulletin for a more inclusive listing of limitations and exclusions.

**ALL out-of-network services (other than emergency services) require prior authorization by the Health Services Department at Sendero Health Plans.**

<table>
<thead>
<tr>
<th>Covered benefit</th>
<th>Authorization/Notification Required</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Ambulance Services                     | • *No authorization required for emergent transport*  
                                                • Authorization required for non-emergent transport                                     |                                                                          |
| Audiology Services                     | • Cochlear implants and augmentative devices require authorization                                 | Hearing aids for Members under age 21 are provided through TMHP and not Sendero |
| Behavioral Health Services             | Authorization is required for:  
                                                • Facility is responsible for in patient admission notification  
                                                • Outpatient treatment >20 visits  
                                                • Psychological and Neuropsychological testing  
                                                • Prior auth of an emergent, elective or scheduled admission is NOT required | Please see the Behavioral Health section of this manual for further guidelines. |
| Chiropractic Services                  | • Chiropractic visit > 8 visits                                                                     | Limited to spinal subluxation, only.                                     |
| Dialysis                               | • Notification is required                                                                           |                                                                          |
| Durable Medical Equipment (DME) and Supplies | • Rental or purchase of DME and medical supplies >$500 (purchase price)  
                                                        • Wound VACs  
                                                        • Orthotics or Prosthetics purchase price >$500 per item | Use of in-network supplier required                                       |
| Emergency Services                     | No authorization required                                                                            |                                                                          |
| Family Planning Services               | No authorization required                                                                            | Members may access any family planning provider without network restriction.  
                                                • Annual family planning visit must include correct family planning modifier |
| Home Health Care Services               | • Skilled nursing visits > 3 visits  
                                                • PT / ST / OT > 8  
                                                • Infusion therapy  
                                                • Private duty nurse | Use of in-network provider / supplier required                              |
<table>
<thead>
<tr>
<th>Covered benefit</th>
<th>Authorization/Notification Required</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Hospital Services                   | • Facility is responsible for notification of ALL inpatient admissions.  
• Prior authorization of an emergent, or scheduled admission is NOT required. | • Inpatient admissions for childbirth does not require authorization unless the length of stay exceeds two (2) days for vaginal delivery of four (4) days for C/Section |
| Laboratory                          | No authorization for in-network provider labs                                                         |                                                                           |
| Medical Checkups                    | No authorization required                                                                            | • Checkups for Members under the age of 21 are covered under the Texas Health Steps Program |
| Optometry and Vision                | • Routine eye exams are provided through subcontractor – OptiCare Managed Vision. Contact OptiCare for specific information | • Contact phone number: 1-866-838-7614                                    |
| Oral Evaluation and Fluoride Varnish| No authorization required                                                                            | • For ages six (6) through thirty-five (35) months as part of the Texas Health Steps visit |
| Podiatry                            | No authorization required                                                                            |                                                                           |
| Prenatal Care                       | No authorization required                                                                            | • Please submit Sendero’s Pregnancy Notification Form                      |
| Primary Care Services               | No authorization required                                                                            |                                                                           |
| Radiology, Imaging, and X-rays      | • Authorization required for CAT Scans, MRA/MRA not provided in an inpatient or Emergency Room setting  
• PET Scans/SPECT  
• Radiological procedures that require admission for observation  
• OB ultrasounds >3 | No other authorization required if performed at in-network facility and in-network provider |
| Specialty Physician Services        | Referral from the PCP is required  
Authorization is required only for  
• Chiropractic care > 8 visits  
• Organ or bone marrow transplants |                                                                           |
| Therapies – Physical, Speech,      | Authorization required for PT, ST or OT > 8 visits                                                 | Prior authorization not required for initial evaluation                   |
| Occupational                        |                                                                                                      |                                                                           |
| Texas Health Steps                  | No authorization required                                                                            |                                                                           |
| Transplantation of organs and       | Prior Authorization is required                                                                       |                                                                           |
| tissues                             |                                                                                                      |                                                                           |

**STAR/Medicaid Program Limitations and Exclusions**
Refer to the Texas Medicaid Provider Procedures Manual and the bi-monthly Texas Medicaid Bulletin for the most current information regarding Program limitations and exclusions. The following is the list as of 2011, of limitations and exclusions: (This list is not all inclusive.)

- Autopsies.
- Biofeedback therapy.
- Care and treatment related to any condition for which benefits are provided or available under Workers’ Compensation laws.
- Cellular therapy.
- Chemolase injection (chymodiactin, chymopapain).
- Custodial care.
● Dentures or endosteal implants for adults.
● Ergonovine provocation test.
● Excise tax.
● Fabric wrapping of abdominal aneurysms.
● Hair analysis.
● Heart–lung monitoring during surgery.
● Histamine therapy–intravenous.
● Hyperthermia.
● Hysteroscopy for infertility.
● Immunizations or vaccines unless they are otherwise covered by Texas Medicaid. (These limitations do not apply to services provided through the THSteps Program.)
● Immunotherapy for malignant diseases.
● Infertility.
● Inpatient hospital services to a client in an institution for tuberculosis, mental disease, or a nursing section of public institutions for the mentally retarded.
● Inpatient hospital tests that are not specifically ordered by a physician/doctor who is responsible for the diagnosis or treatment of the client’s condition.
● Intragastric balloon for obesity.
● Joint sclerotherapy.
● Keratoprosthesis/refractive keratoplasty.
● Laetrile.
● Mammoplasty for gynecomastia.
● Obsolete diagnostic tests.
● Oral medications, except when billed by a hospital and given in the emergency room or the inpatient setting (hospital take-home drugs or medications given to the client are not a benefit).
● Orthotics (except CCP).
● Outpatient and nonemergency inpatient services provided by military hospitals.
● Outpatient behavioral health services performed by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, non-LCSW social worker, or psychological associate (excluding a Masters-level licensed psychological associate [LPA]) regardless of physician or licensed psychologist supervision.
● Oxygen (except CCP and home health).
● Parenting skills.
● Payment for eyeglass materials or supplies regardless of cost if they do not meet Texas Medicaid specifications.
● Payment to physicians for supplies is not an allowable charge. All supplies, including anesthetizing agents such as Xylocaine, inhalants, surgical trays, or dressings, are included in the surgical payment.
● Podiatry, optometric, and hearing aid services in long term care facilities, unless ordered by the attending physician.
● Private room facilities except when a critical or contagious illness exists that results in disturbance to other patients and is documented as such when it is documented that no other rooms are available for an emergency admission, or when the hospital only has private rooms.
● Procedures and services considered experimental or investigational.
- Prosthetic and orthotic devices (except CCP).
- Prosthetic eye or facial quarter.
- Psychiatric services:
  - Outpatient behavioral health services for which no prior authorization has been given.
  - Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services.
- Quest test (infertility).
- Recreational therapy.
- Review of old X-ray films.
- Routine cardiovascular and pulmonary function monitoring during the course of a surgical procedure under anesthesia.
- Separate fees for completing or filing a Medicaid claim form. The cost of claims filing is to be incorporated in the provider’s usual and customary charges to all clients.
- Services and supplies to any resident or inmate in a public institution.
- Services or supplies for which benefits are available under any other contract, policy, or insurance, or which would have been available in the absence of Texas Medicaid.
- Services or supplies for which claims were not received within the filing deadline.
- Services or supplies not reasonable and necessary for diagnosis or treatment.
- Services or supplies not specifically provided by Texas Medicaid.
- Services or supplies provided in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body Member, or when prior authorized for specific purposes by TMHP (including removal of keloid scars).
- Services or supplies provided outside of the U.S., except for deductible and coinsurance portions of Medicare benefits as provided for in this manual.
- Services or supplies provided to a client after a finding has been made under utilization review procedures that these services or supplies are not medically necessary.
- Services or supplies provided to a Texas Medicaid client before the effective date of his or her designation as a client, or after the effective date of his or her denial of eligibility.
- Services payable by any health, accident, other insurance coverage, or any private or other governmental benefit system, or any legally liable third party.
- Services provided by an interpreter (except sign language interpreting services requested by a physician).
- Services provided by ineligible, suspended, or excluded providers.
- Services provided by the client’s immediate relative or household Member.
- Services provided by Veterans Administration facilities or U.S. Public Health Service Hospitals.
- Sex change operations.
- Silicone injections.
- Social and educational counseling except for certain health and disability related and counseling services.
- Sterilization reversal.
- Sterilizations (including vasectomies) unless the client has given informed consent 30 days before surgery, is mentally competent, and is 21 years of age or older at the time of consent. (This policy complies with 42 CFR §441.250, Subpart F.)
• Take-home and self-administered drugs except as provided under the vendor drug or family planning pharmacy services.
• Tattooing (commercial or decorative only).
• Telephone calls with clients or pharmacies (except as allowed for case management).
• Thermogram.
• Treatment of flatfoot conditions for solely cosmetic purposes and the prescription of supportive devices (including special shoes), the treatment of subluxations of the foot.

**Spell of Illness Limitation Removed**
In the traditional Medicaid program, the Spell of Illness Limitation is defined as thirty (30) days of inpatient hospital care, which may accrue intermittently or consecutively. After thirty (30) days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the patient has been out of an acute facility for sixty (60) consecutive days. This limitation does **NOT** apply to Sendero Health Plans’ STAR Members.

**Annual Limit Does NOT Apply**
$200,000 annual limit on inpatient services does not apply for STAR Members.

**Adult Annual Examination**
An annual adult physical exam is an additional benefit for STAR Members 21 years and older. The annual adult well exam may be received in addition to the Member’s annual GYN visit for females. The Member does not need a referral from the primary care provider for the annual GYN visit.

**Unlimited Medically Necessary Prescription Drugs for Adults**
STAR Members who are 21 years of age or older receive unlimited medically necessary prescription drugs. The elimination of the three (3) prescription limit per month for adult clients enrolled in STAR allow the provider greater flexibility in treating and managing a Member’s healthcare needs.

### ST 2.2 Sendero’s Value Added Services

In addition to the standard benefits for STAR Members, Sendero Health Plans provides certain Value Added Services including:

<table>
<thead>
<tr>
<th>Value Added Service</th>
<th>STAR Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Line</td>
<td><strong>SERVICE:</strong> Sendero has available to STAR Members a 24 hour a day, 365 days per year nurse advice line. Members can access the nurse line via a toll-free telephone number. The nurse line can assist Members with various health-related questions, as well as provide guidance as to when to access emergency facilities.</td>
</tr>
<tr>
<td>Value-added Vision Services</td>
<td><strong>SERVICE:</strong> $100 above the Medicaid allowable per 24 month period for corrective eyewear. <strong>LIMITATION:</strong> The benefit is limited only as it applies to frequency and Members who are 2 years or older.</td>
</tr>
<tr>
<td>Value Added Service</td>
<td>STAR Program</td>
</tr>
<tr>
<td>-----------------------------------------</td>
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</tr>
<tr>
<td>Temporary Cell Phone</td>
<td><strong>SERVICE:</strong> Sendero will provide pre-programmed cell phones to pregnant Members who are determined to be high-risk. This service will permit these Members to be in touch on both inbound and outbound call with Sendero’s Health Services RN Care Coordinator and the PCP/OB in order to ask questions and receive advice, be reminded of appointments, arrange for transportation and to contact 911 in case of emergency. <strong>LIMITATION:</strong> As it applies only to female Members who are determined high-risk, limited to use during pregnancy and immediate postpartum period.</td>
</tr>
<tr>
<td>Gifts for New Mothers</td>
<td><strong>SERVICE:</strong> Sendero will provide up to $50 worth of health items for pregnant Members who complete at least eight (8) prenatal visits to their OB during pregnancy. At least 1 gift will be for Member. <strong>LIMITATION:</strong> As it applies only to pregnant Members and the completion of the minimum required number of eight (8) prenatal appointments while a Member of Sendero.</td>
</tr>
<tr>
<td>Sports/School Physicals</td>
<td><strong>SERVICE:</strong> Sendero will reimburse its contracted PCP for an annual sports/school physical for children up to age 19 at the PCP’s contracted rate. <strong>LIMITATION:</strong> Only limitation is under age 19</td>
</tr>
<tr>
<td>Extra Help with Getting a Ride</td>
<td><strong>SERVICE:</strong> Sendero will arrange transportation to physician appointments. <strong>LIMITATIONS:</strong> plan reserves the right to determine medical necessity</td>
</tr>
<tr>
<td>Extra Dental Benefits Pregnant Women</td>
<td><strong>SERVICE:</strong> Sendero will pay for up to $250 in dental services each year for pregnant member. <strong>LIMITATIONS:</strong> value limited to $250 and for pregnant members only</td>
</tr>
</tbody>
</table>

**ST 2.3 Family Planning Services**

Family Planning services, including sterilization, are covered STAR Member benefits. These services can be provided by any qualified HHSC approved family planning provider (regardless of whether or not the provider is in network for Sendero) without the prior approval from the PCP or Sendero. Family planning providers must deliver family planning services in accordance with the HHSC Family Planning Service Delivery Standards. Family planning services are preventive health, medical, counseling and educational services that assist Members in managing their fertility and achieving optimal reproductive and general health. Family planning services must be provided by a physician or under physician supervision.

In accordance with the provider agreement, family planning providers must assure clients, including minors, that all family planning services are confidential and that no information will be disclosed to a spouse, parent, or other person without the client’s permission. Health care providers are protected by law to deliver family planning services to minor clients without parental consent or notification.
Only family planning patients, not their parents, their spouses or other individuals, may consent to the provision of the family planning services. However, counseling should be offered to adolescents, which encourages them to discuss their family planning needs with a parent, adult family member, or other trusted adult.

Sterilization services are a benefit for members who are at least 21 years of age when the consent form is signed. In the event that a Sendero Member aged 21 years or older chooses sterilization, providers must use the current state-approved sterilization consent form and complete at least thirty (30) days prior to the procedure, with some exceptions related to emergency surgery and premature delivery. These forms and instructions are available in both English and Spanish at www.tmhp.com by clicking on the Family Planning link under the Provider section.

Providers may fax the completed form to Sendero Health Services Department at the fax number at the bottom of this page, or simply include the form with the completed claim form.

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**ST 2.4 Non-Urgent Medical Transportation Services**

The Health and Human Services Commission provides medical transportation services for STAR patients that have no other means of transportation for medical and dental appointments. The transportation program will utilize the most cost-effective method of transportation that does not endanger a patient’s health, to include an ambulance or wheelchair van.

To request medical transportation services, a Member should contact the transportation program at: 1-877-633-8747. To arrange for transportation, call at least 48 hours in advance of the office visit, Monday through Friday, 8 a.m. to 5 p.m.

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**ST 2.5 Coordination with Non-Medicaid Managed Care Covered Services:**

Non-Medicaid Managed Care Services include the following:

**Dental Services**

Beginning March 1, 2012 STAR and CHIP dental services are offered through a managed care model program for eligible recipients. Dental services are discussed in “ST4 – Texas Health Steps Program” or “CH2 – Covered Services” in this Provider Manual. For more information see the value added services listed for STAR and CHIP.

**Texas Agency Administered Programs and Case Management Services**

Texas Department of Family and Protective Services (DFPS): Sendero’s network of providers coordinates with DFPS (and associated foster parents) to ensure that the at-risk population, both children in custody and not in custody of DFPS, receive the services they need. Children who are served by DFPS may transition into and out
of Sendero more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the Service Area. During the transition period and beyond, providers must:

- Provide medical records to DFPS
- Schedule medical and behavioral health appointments within 14 days unless requested earlier by DFPS
- Participate, when requested by DFPS, in planning to establish permanent homes for Members
- Refer suspected cases of abuse or neglect to DFPS

For help with Member and DFPS, providers should call Sendero’s Health Services Department.

**Essential Public Health Services**

Sendero is required through its contractual relationship with HHSC to coordinate with Public Health Entities regarding provision of services for essential public health services. Providers must assist Sendero in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunizations as defined by State Law.
- Assisting in notifying or referring to the local Public Health Entity, as defined by state law, any communicable disease outbreaks involving Members
- Referring to the local Public Health Entity for TB contact investigation and evaluation and preventive treatment of person whom the Member has come into contact
- Referring to the local Public Health Entity for STD/HIV contact investigation and evaluation and preventive treatment of persons whom the Member has come into contact
- Referring for Women, Infant, and Children (WIC) services and information sharing
- Assisting in the coordination and follow up of suspected or confirmed cases of childhood lead exposure
- Reporting of immunizations provided to the statewide ImmTrac Registry including parental consent to share data
- Cooperating with activities required of public health authorities to conduct the annual population and community based needs assessment
- Referring lead screening tests to the Texas Department of State Health Services. To report lead poisoning, provider can complete the applicable form for Children or Adults and fax it to 512.776-7699, or call DHSH at 512-776-7269 or toll free at 1-800-588-1248. The following information must be reported: child’s name, address, date of birth, sex, race and ethnicity; blood lead level concentration, test date, name and telephone number of testing laboratory; whether the sample was capillary or venous blood; and the name and city of the attending physician.

Sendero’s RN Care Coordinators can help organize services with the Member, the Member’s primary care provider and the public health entity. In cases where services are coordinated and subject to applicable laws, rules and regulations concerning confidentiality of certain health information, the public health entity is requested to provide a written report to the primary care provider concerning the services provided by the public health entity.
Early Childhood Intervention (ECI) Case Management/Service Coordination

The Texas Department of Assistive and Rehabilitative Services (DARS) oversees the Early Childhood Intervention program for the State of Texas. Case management and service coordination are provided to children from birth to three (3) years with a developmental disability and/or developmental delay. Eligibility for the program is determined by 1) a delay in one or more area of development; 2) atypical development in which children perform within their appropriate age arrange on test instruments, but whose patterns of development are different from their peers, and 3) a medically diagnosed condition that has a high probability of resulting in a developmental delay. The PCP will receive a copy of Individualized Family Service Plan (IFSP) for our Members from ECI. PCP’s are encouraged to refer Members with disabilities or developmental delays, birth to three (3) years of age, to ECI for services. For more information about ECI or to refer a child, call the DARS Inquiries Line at 1-800-628-5115.

SHARS

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as School Health and Related Services (SHARS). This is a joint program of the Texas Education Agency and the Texas Health and Human Services Commission (HHSC). SHARS allows local school districts / shared services arrangements (SSAs) to obtain Medicaid reimbursement for certain health-related services provided to students in special education. The program is for children under age 21 with disabilities who need audiology services, medical services, occupational therapy, physical therapy, psychological services, speech therapy, school health services, assessment and counseling. If you have questions regarding School Health and Related Services program/policy issues, please call the TMHP Contact Center at 1-800-925-9126.

Mental Health Targeted Case Management

Individuals served through the Texas Department of State Health Services (DSHS) Mental Health and Substance Abuse (MHSA) program are eligible for services including advocacy, assessment, linkage, monitoring, crisis intervention, and referral and planning and coordination of services. Priority population include: substance abuse, mental retardation, autism, pervasive development disorder, children at risk of removal from preferred environment, children determined by the school system to have a serious emotional disturbance, children at risk of disruption of the preferred living situation due to psychological symptoms or those with a functional impairment – GAF (Global Assessment Function) of 50 or below.

Providers may obtain information through the MHSA website www.dshs.state.tx.us/MHSA or by contacting Network Management.

Mental Health Rehabilitation:
Rehabilitative services are covered when provided to persons, regardless of age, who have a single severe mental disorder excluding mental retardation.

Texas Department of Assistive and Rehabilitative Services (DARS)

DARS may provide additional case management services for the blind and visually impaired Members. This is limited to one contact per client, per month. The main office in Austin may be contacted at 1-800-252-5204 or by visiting their website at http://www.dars.state.tx.us/dbs/.
Tuberculosis Services Provided by DSHS Approved Provider

All confirmed or suspected cases of Tuberculosis must be referred to the Infectious Disease Control Unit of the DSHS using the forms and procedures for reporting TB adopted by DSHS. Sendero will assist providers in referring to the Local Tuberculosis Control Health Authority within 1 day of diagnosis for a contact investigation. The provider must document the referral to the local health authority in the Member’s medical records that may be reviewed by DSHS and the local authority. Providers should notify Sendero on any referral made to the local health authority.

Sendero must coordinate with the local health authority to ensure that Members with confirmed or suspected TB have a contact investigation and receive directly observed therapy. Sendero will report any Member who is non-compliant, drug-resistant, or who is or may be posing a health threat to DSHS or the local authority. Sendero will cooperate with the local health authority in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Health and Safety Code.

DADS Hospice Services

The Department of Aging and Disability Services (DADS) manages the Hospice Program through provider enrollment contracts with hospice agencies. Coverage of services follow the amount duration and scope of services specified in the Medicare Hospice Program. Hospice pays for services related to the treatment of the client’s terminal illness and for certain physician services (not the treatments). Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

Texas Health Steps Case Management

Texas Health Steps Case Management for Children & Pregnant Women 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 help them gain access to medical, social, educational and other health-related services. The Texas Health Steps phone number is 1-877-847-8377 (877-THSTEPS). Providers can call in a request, complete the referral form and fax it to Texas Health Steps SSU at 512-533-3867, or contact a regional contracted provider. Sendero Health Plans Whole Person Health Support program can also help these members attain the care they need. If you or the member or parent would prefer, you can contact a contracted Case Management vendor in our service area. A current list of these licensed and contracted vendors can be found at www.dshs.state.tx.us/caseman/hsr7.shtm.

ST 2.6 Pharmacy/Navitus

Sendero Health Plans has an arrangement with Navitus Health Solutions, a pharmacy benefit management company to administer pharmacy benefits for the STAR program. For questions related to the formulary, “How to” find a list of covered drugs, “How to” find a preferred drug list, the process for requesting a prior authorization (PA), prescription over-rides, quantity limits, brand necessity or formulary exceptions, please contact Navitus at 877-908-6023 or access the Navitus website through www.senderohealth.com.

NAVITUS SUPPORTS E-PRESCRIBING FOR MEDICAID
• Navitus provides point of care information available through Surescripts
  • Eligibility confirmation
  • Daily updates to eligibility facilitator
  • Medication history
  • Formulary and PDL benefit confirmation
  • Formulary “alternative” drug list
  • Formulary lists will be updated no less frequently than weekly
• Navitus expects pharmacies to have ability to accept e-prescriptions and facilitate refills with prescribers

**DME**

Navitus will encourage Texas Medicaid Network Pharmacies to become Medicaid-enrolled durable medical equipment (DME) providers with the MCO’s in their Service Areas.

**ST 2.7 OB/GYN**

Sendero allows you to pick an OB/GYN provider but this doctor must be in-network.

**ATTENTION FEMALE MEMBERS**

You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:

• One well-woman checkup each year
• Care related to pregnancy
• Care for any female medical condition
• Referral to a specialist doctor within the network
ST3 – Alberto N

ST 3.1 Alberto N First Partial Settlement Agreement

The Alberto N First Partial Settlement Agreement requires Sendero to notify Members when Sendero is reducing, denying, or terminating a requested Medicaid service on the basis that the service is not medically necessary or federal financial participation is not available, and when Sendero receives incomplete prior authorization requests. Notices must substantially conform to the sample notices in the HHSC Uniformed Managed Care Manual and must be written at a sixth grade reading level with the exception of citations, medical terms, policy, or law. This process only applies to STAR/Medicaid Members under the age of 21.

Notification for Reduction, Denial, Termination of Services Due to no Federal Financial Participation

The notice informing the Member of a reduction, denial, or termination of a requested service because there is no federal financial participation for the requested service shall:

(a) state that this is the basis;
(b) contain an explanation of the basis for Sendero’s decision, applying the state or federal law to the individual’s particular request; and
(c) cite the particular federal law that prohibits federal financial participation for the requested service.

All notices required under this Agreement pursuant to the above paragraph must contain:

- The dates, type, and amount of service requested;
- A statement of what action Sendero intends to take (i.e., a reduction, denial, or termination of services);
- The basis for the intended action;
- An explanation of the basis for Sendero’s decision, applying the state and/or federal law to the individual’s request;
- A cite to the particular federal law that prohibits federal financial participation for the requested service;
- A toll-free number for the individual’s use in seeking additional information regarding the intended action, for requesting help understanding the notice, and for requesting a fair hearing;
- Information about accessing medical case management; and
- An explanation of:
  - The individual’s right to a fair hearing;
  - The number of days and date by which the fair hearing must be requested;
  - The individual’s right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesman;
  - The right to either a written, telephonic, or in-person hearing;
  - The right to examine, at a reasonable time before the date of the hearing, the contents of the case file, and any and all documents to be used by Sendero at the hearing; and,
  - The circumstances under which services will be continued if a hearing is requested.
Notification for Reduction, Denial, Termination of Services Not Medically Necessary

The notice informing the Member of a reduction, denial, or termination of a requested service, based on a determination that the requested service is not medically necessary, shall:

(a) State that this is the basis;
(b) Contain an explanation of the medical basis for Sendero’s decision, applying Sendero’s policy or the accepted standards of medical practice to the individual Member’s particular medical circumstances; and
(c) Cite the particular state and federal law that supports, or the change in state or federal law that requires, the intended action.

All notices required under this Agreement pursuant to the above paragraph must contain:

- The dates, type, and amount of service requested;
- A statement of what action the Agency intends to take (i.e., a reduction, denial, or termination of services);
- The basis for the intended action;
- An explanation of the medical basis for the Agency’s decision, applying the Agency’s policy or the accepted standards of medical practice to the individual’s particular medical circumstances;
- A cite to the particular state and federal law that supports, or the change in state or federal law that requires, the intended action;
- A toll-free number for the individual’s use in seeking additional information regarding the intended action, for requesting help understanding the notice, and for requesting a fair hearing;
- Information about accessing medical case management; and,
- An explanation of:
  - The individual’s right to a fair hearing;
  - The number of days and date by which the fair hearing must be requested;
    - The individual’s right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesman;
  - The right to either a written, telephonic, or in-person hearing;
  - The right to either examine, at a reasonable time before the date of the hearing, the contents of the case file and any and all documents to be used by the Agency at the hearing, and
  - The circumstances under which services will be continued if a hearing is requested.

Notification for Incomplete Prior Authorizations

When a request for prior authorization is submitted to Sendero or its contractor with incomplete specific documentation/information: Sendero or its contractor will return the request to the Medicaid provider with a letter describing the documentation that needs to be submitted, or when possible, Sendero or its contractor will contact the Medicaid provider by telephone and obtain the information necessary to complete the prior authorization process. If the documentation/information is not provided within sixteen (16) business hours of its request to the Medicaid provider, a letter will be sent to the Member explaining that the request cannot be acted upon until the documentation/information is provided, along with a copy of the letter sent to the Medicaid provider describing the documentation/information that needs to be submitted. If the documentation/information is not provided to Sendero or its contractor within seven (7) days of its letter to the Member, a notice will be
sent to the Member informing the Member of its denial of the requested service due to the incomplete documentation/information, and providing the Member an opportunity to request a fair hearing.

**ST 3.2 Alberto N Second Partial Settlement Agreement**

The Alberto N Second Partial Settlement Agreement requires Sendero to send notification to Members regarding denied nursing services and denied private duty nursing services. This applies to STAR/Medicaid Members under the age of 21.

**Denied Nursing Services**

When the Agency or its Contractor determines that the requested nursing services are not nursing services and that the documentation may support authorization of personal care services, the notice denying the nursing services will describe the basis for this determination, in accordance with the paragraph titled Notification for Reduction, Denial, Termination of Services Not Medically Necessary (paragraph 18 of the Partial Settlement Agreement effective April 19, 2002). The notice will include template language briefly describing the Personal Care Services benefit and where and how to request prior authorization for Personal Care Services. The template language to be used is as follows:

“The medical information received may support authorization of Personal Care Services. Personal Care Services are support services provided to Medicaid Beneficiaries under 21 year of age who require assistance with activities of daily living and health related functions because of a physical, cognitive, or behavioral limitation related to their disability to chronic health condition. For more information and to find out how to obtain Personal Care Services for a Medicaid Beneficiary under 21 years of age, you should contact Sendero Health Plans.”

**Denied Private Duty Nursing Services**

When Sendero determines that the services requested do not support a request for Private Duty Nursing services because the services could be provided on a per-visit basis through Home Health Skilled Nursing services, the notice denying the Private Duty Nursing services will describe the basis for this determination, in accordance with the paragraph titled Notification for Reduction, Denial, Termination of Services Not Medically Necessary (paragraph 18 of the Partial Settlement Agreement effective April 19, 2002). The notice will include template language briefly describing the Home Health Skilled Nursing services benefit and where and how to request prior authorization for Home Health Skilled Nursing services. The template language to be used is as follows:

“The medical information received may support authorization of Home Health Skilled Nursing services. Home Health Skilled Nursing services are nursing services provided on a per-visit basis. Home Health Skilled Nursing services may be provided to meet acute care needs or on an ongoing basis to meet chronic needs. For more information and to find out how to obtain Home Health Skilled Nursing services, you should contact Sendero Health Plans.”
ST4 – Texas Health Steps Program

**ST 4.1 What is the Texas Health Steps Program?**

Texas Health Steps is a special health care program for young adults, and teens, birth through age 20. Texas Health Steps is identified in federal law as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service. These checkups are important and Members should set up an appointment with their primary care provider within 45 days of becoming a Sendero Health Plans’ Member. Even if a child looks and feels well, a Texas Health Steps checkup can find problems before they get worse and harder to treat. For information regarding the Texas Health Steps program, see the *Texas Medicaid Provider Procedures Manual* current edition which is available online at http://www.tmhp.com/Pages/Medicaid/Medicaid_THSteps_Program_Info.aspx.

A Texas Health Steps medical checkup includes:

- Comprehensive health and development history (mental and physical)
- Comprehensive unclothed physical exam
- Appropriate immunizations
- Laboratory tests appropriate to age and risk
- Health Education/Anticipatory Guidance

**ST 4.2 How Can I Become a Texas Health Steps Provider?**

To become a Texas Health Steps provider, you will need to enroll through the Texas Medicaid and Healthcare Partnership (TMHP). Enrollment as a Texas Health Steps provider is separate from general Medicaid provider enrollment. Go to the website link to Provider Enrollment Support for Territory 7 at: http://www.tmhp.com/Pages/ProviderEnrollment/PE_Reg_7_Support.aspx.
**ST 4.3 Finding a Texas Health Steps Provider**

If you are not a Texas Health Steps provider, you may locate an in-network Texas Health Steps provider by reviewing your Sendero Provider Directory.

**ST 4.4 Texas Health Steps Periodicity Schedule**

Providers are required to follow the STAR/Medicaid Texas Health Steps periodicity schedule, to complete Texas Health Steps exams. This information may be found in the Texas Medicaid Provider Procedures Manual at [http://www.dshs.state.tx.us/thsteps/providers.shtm](http://www.dshs.state.tx.us/thsteps/providers.shtm)

**ST 4.5 Eligibility for Texas Health Steps Exam**

STAR/Medicaid Members are periodically eligible for a Texas Health Steps exam. The Member’s new Medicaid ID card will indicate that the Member is currently eligible. Verification of benefits and eligibility will assist to identify if a Member has eligibility for the particular service, such as eye exam, eye glasses, hearing aid, and medical services.

**ST 4.6 Timely Texas Health Steps Exam**

Sendero would like to ensure Medicaid enrollees get a timely Texas Health Steps exam within the year of their birthday or enrollment date. If the Members birth date/eligible date is past and you do not have record of a Texas Health Steps exam and the parent does not indicate they had one elsewhere, you do not need to wait for the indication on the enrollment state card, or for the Member to have a reminder letter from the state. Perform the exam, and Sendero will pay for those services. Sendero will be implementing provider incentive programs to acknowledge your cooperation with the Texas Health Steps program as the Patient Centered Medical Home approach to primary care continues to expand.

**ST 4.7 Exams outside the Texas Health Steps Periodicity Schedule**

Exams provided when a Texas Health Steps statement does not indicate a medical checkup is due, must be billed as an exception to the periodicity schedule. The claim must be submitted with the appropriate modifier. Payment will be made for these exceptions if the services are provided under the following categories:
- Medically necessary (such as developmental delay or suspected abuse)
- Environmental high risk (such as a sibling of a child with elevated blood lead)
- Required to meet state or federal exam requirements for Head Start, day care, foster care, or pre-adoption
- Required for dental services provided under general anesthesia

**ST 4.8 Texas Health Steps Exams for Newborns**

Inpatient newborn examinations are counted as Texas Health Steps medical checkups and must include all the necessary components. The required components of the initial newborn checkup are:

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

**ST 4.9 Immunization Requirements for Children**

Immunization requirements for children are defined on the Texas DSHS website at [http://www.dshs.state.tx.us/immunize/Schedule/schedule_child.shtml](http://www.dshs.state.tx.us/immunize/Schedule/schedule_child.shtml) Providers are required to participate with the Texas Vaccines for Children Program. (See next page.)

**ST 4.10 Children of Migrant Farm workers**

Children of Migrant Farm workers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is considered an exception to periodicity.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor is it considered an accelerated service. It is considered a late checkup.
**ST 4.11 Texas Vaccines for Children (TVFC) Program**

The Texas Vaccines for Children Program provides free vaccines to STAR/Medicaid children who are younger than 19 years of age. TVFC automatically covers all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC). To obtain free vaccine, the provider must enroll in the TVFC program through Department of State Health Services (DSHS). Vaccine is ordered through regional state offices. A TVFC provider may not charge for the vaccine itself, but is permitted to charge a reasonable administration fee. For more information, contact DSHS at 800-252-9152 or 512-776-7284, or Network Management at the phone number listed below. See application form in Appendix A of this manual.

**ST 4.12 Texas Health Steps Lab and Testing Supplies**

Specific laboratory tests required as part of the Texas Health Steps exam must be submitted to the Department of State Health Services (DSHS) laboratory. Because these laboratory tests must be processed at the DSHS Laboratory, they cannot be billed as separate claims on the same date of service as a medical checkup. The tests that must be sent to the DSHS lab are Hemoglobin; Chlamydia, gonorrhea, and lead. The initial blood lead test may be done by point-of-care testing in the providers office, and billed for reimbursement. The following tests may be performed at a lab of the provider's choice: hyperlipidemia, type 2 diabetes, syphilis, or HIV.

All newly enrolled Texas Health Steps providers receive a startup package of forms and supplies. Included in this startup package are blood specimen collection supplies. Additional supplies may be requested from DSHS Laboratory Services via fax at 1-512-776-7672 or via their website at: http://www.dshs.state.tx.us/lab/mrs_forms.shtm

**ST 4.13 Texas Health Steps Dental Screenings**

Pediatric (birth through age 20) dental services for STAR Members are covered under the Texas Health Steps program. Routine dental exams and services are available beginning at age six (6) months and once every six (6) months thereafter. These dental services are covered by the Texas Health Steps Dental Program through HHSC. Members can self-refer to participating dentists in the Texas Health Steps Dental Program. Neither a referral from the primary care provider nor authorization from Sendero is necessary for routine dental services.

**ST 4.14 Dental-oral Evaluation and Fluoride Varnish (OEFV)**

Dental-oral evaluation and fluoride varnish is covered by Sendero when provided in the PCP office for children from 6 to 35 months of age. Oral evaluation and fluoride varnish (OEFV) in the medical home has been
established to support the dental home concept. The oral evaluation and fluoride varnish application must be performed during a Texas Health Steps medical exam.

A dental evaluation includes the following:

- Intermediate oral evaluation (must be done by a physician, nurse practitioner or physician assistant who has been certified by DSHS to perform OEFV)
- Fluoride varnish application
- This application may be delegated to nurses or medical assistants
- Referral to a dental home beginning at six (6) months of age.

In conjunction with a Texas Health Steps medical checkup, utilize CPT code 99429 with U5 modifier when billing fluoride varnish. The oral evaluation/fluoride varnish must be billed with one of the following medical checkup codes – 99381, 99382, 99391, or 99392.

Federally Qualified Health Centers (FQHC) should refer to the Texas Medicaid Provider Procedures Manual for further instructions on billing.

**ST 4.15 Texas Health Steps Vision**

Each Texas Health Steps checkup includes a vision screen based on the periodicity schedule. The Texas Health Steps Program provides one (1) eye examination per state fiscal year (September through August) and eyeglasses every two (2) years. Any diagnosed conditions or abnormalities of the eye that require additional services beyond the scope of an exam for refractive errors must be referred back to the Member’s primary care provider. Vision providers who render additional services, beyond refractive exams, must have a prior authorization. Routine eye exams are provided through Sendero Health Plans’ subcontractor, OptiCare Managed Vision. For information, please call OptiCare at 1-866-838-7614.

**ST 4.16 Referral for Services Identified During a Texas Health Steps Exam**

Referrals for services identified during a Texas Health Steps exam would occur as any other referral process. Contact the Health Services Department for more information regarding the referral process at the number listed at the bottom of this page.

**ST 4.17 Outreach to Members for Texas Health Steps Exams**

Sendero has an Outreach Call Center to help in making the Texas Health Steps appointments for STAR Members. The call center helps in the following:
• Attempt to contact Members who are due for a Texas Health Steps exam.
• Attempt to contact new Members who are due for a Texas Health Steps exam.
• Once contacted, the Call Center will conference call the Member’s primary care provider’s office to help in scheduling the appointment, while the Member is on the line.
• The Call Center will send out an appointment reminder letter to the Member once the appointment is made.
• If unable to reach Member/parent by telephone, the Call Center will send them a postcard to remind them to call their primary care provider to schedule their child’s Texas Health Steps visit that is due.
• In addition, the Call Center helps Migrant Farm Worker’s children with acceleration of services prior to leaving the area, if needed.

The Call Center reaches out to help schedule Texas Health Steps appointments for Members that are due for a visit.

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**ST 4.18 Pregnancy Notification Requirements**

*Pregnant STAR/Medicaid Members*

Sendero Health Services Department should be notified as soon as the Member is determined to be pregnant, as well as advised of any high risk factors. This will allow the RN Care Coordinators to work collaboratively with the physician and provide proactive case management in order to help in maintaining a healthy full term pregnancy.

*Obtaining Pregnancy Notification Forms*

Supplies of Pregnancy notification forms are available to provider’s offices, or see Appendix A of this manual. Contact Network Management at the phone number at the bottom of this page for information regarding these forms. These forms may be completed and faxed to the Health Services Department at 512-275-2862 to notify Sendero of a Member’s pregnancy.
ST5 – Complaints & Appeals

ST 5.1 Introduction

Sendero has established procedures for the handling and resolution of complaints and appeals. If a provider or Member is not satisfied with the resolution of a complaint, an appeal can be filed. Sendero Customer Services is available to assist those persons requiring assistance with the filing of a complaint or appeal. It is Sendero’s goal to resolve all complaints. A Member or provider may initiate the complaint process either by telephone, in person, or in writing, expressing the details of the concerns. Providers may submit complaints to Sendero or to HHSC regarding STAR Members. Sendero would prefer that complaints come to the Sendero Quality Department before going to a state agency.

ST 5.2 What is a Complaint?

A complaint is a verbal or written expression of dissatisfaction with Sendero Health Plans concerning a process within the health plan. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the provider. It is anticipated that the majority of the verbal and written complaints would be resolved with Sendero.

ST 5.3 What is an Appeal?

There are three (3) types of appeals. They are:

- **Complaint Appeal** is an appeal that occurs when the complainant is not satisfied with the outcome of the complaint review. This is not a medical necessity determination appeal.
- **Adverse Medical Determination Appeal** is an appeal that occurs when there has been a denial of benefit because of lack of medical necessity.
- **Expedited Appeal** is an appeal at an expedited rate that occurs when the usual timeframe for appeal response may jeopardize the Member’s health. This expedited appeal may occur for a complaint or an adverse medical determination appeal.

ST 5.4 STAR Program: Complaints & Appeals

Filing a Complaint

A provider, Member, or someone acting on behalf of a Member, may file a complaint by calling Customer Services. A Member advocate is available to help with filing the complaint. A complaint may also be filed
with the Health and Human Services Commission (HHSC) at 1-800-252-8263. A complaint may be filed orally, or in writing. A complaint form will be sent to the complainants who file a verbal complaint. To file a verbal complaint, the Member should call 1-877-220-6376. An acknowledgement letter will be sent within five (5) days of receiving the complaint, with a complaint form, if applicable.

All complaints are reviewed and a response sent within thirty (30) days of receipt of the complaint.

**Complaint Appeal**

If the provider, Member, or someone acting on behalf of the Member (“Appellant”), is not satisfied with the response of the complaint, they may file an appeal. Information regarding the appeal of the complaint decision is included with the decision response. The appeal must be in writing. Appeal decisions are made within thirty (30) days of receiving the appeal. Included in the appeal letter is the process used to make the determination.

**Member Appeal Process for Denial of Services**

STAR/Medicaid Members have the right to appeal when services are denied. Listed below are common questions and processes that will provide information regarding this appeal course of action.

- **How will I find out if services are denied?**
  Members and providers are notified of denials by a letter. If the denial is a medical necessity denial, the Medical Director issuing the denial will attempt to contact the requesting provider prior to rendering his decision to obtain additional information or discuss the situation with him/her. A denial letter is sent out within three (3) days of the Medical Director making the decision.

- **What can I do if Sendero denies or limits my Member’s request for a covered service?**
  The Member, provider, or someone acting on behalf of the Member may file an appeal when a denial occurs. (See the Appeal of an Adverse Determination below for how to file this appeal.)

Members also have a right to request an appeal for denial of payment for services in whole or in part.

- **Can Someone from Sendero Help Me File an Appeal?**
  Members needing help with filing the appeal should call the STAR Customer Services toll free number and request this help. A Member Advocate will be available to help the Member. This includes help with filing an Expedited Appeal.

**Appeal of Adverse Determination for STAR Member**

The provider, Member, or someone acting on behalf of the Member (“Appellant”) has thirty (30) days from the date on the denial letter to appeal the determination. This may be requested verbally or in writing. If the request is received verbally, we will ask that this appeal be put in writing. If the provider is requesting the appeal, the Member, or someone acting on behalf of the Member, must sign this appeal. If more than ten (10) days is needed to appeal this denial, this must be requested. Sendero may grant up to an additional fourteen (14) days to appeal this denial.

Sendero will send an acknowledgement letter within five (5) days of receiving the appeal. Sendero will complete the appeal review within thirty (30) days from receipt of the written appeal. If Sendero needs additional time for the review to obtain additional information, we will notify the appellant with the
rationale for needing more time. Please note that Appeals for denials of service for not being a covered benefit is a complaint, not an appeal for adverse determination.

Members may be required to pay the cost of services furnished while the appeal is pending, if services were delivered before approval was given.

In order to ensure that there is continuity of current authorized services, the Member, provider, or someone acting on behalf of the Member, should file the appeal on or before the later of: (a.) ten (10) days following the mailing of the notice of Action, or (b.) the intended effective date of the proposed Action.

**Expedited Appeal for STAR Member**

An expedited appeal can be requested when a decision needs to be made quickly based on the health status of the Member, and taking time for the standard appeal process could jeopardize the life or health of the Member. Requests can be made verbally or in writing. A Member advocate can help the Member with this process. For more information, or to request an expedited appeal, contact Customer Service at 855-526-7388. Once the expedited appeal is received, a decision will be made within one business day from receipt.

Sendero will make every effort to honor the Member’s request for an expedited appeal. If the rationale for request does not meet the definition of an expedited appeal (decision warranted quickly due to the Member’s critical health outcome), Sendero may deny the request to expedite the review. If this happens, the provider may intervene on the Member’s behalf and discuss the situation with the Medical Director. The provider should contact the Medical Director by calling Health Services at the number shown on this page.

**State Fair Hearing Information**

- **Can I ask for a State Fair Hearing?**

If you, as the 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 representing you. A provider may be your representative. You or your representative must ask for the fair hearing within 90 days of the date on the health plan’s letter that tells of the decision you are challenging. 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 call Health Services at the number on the bottom of this page or send a letter to the health plan at:

Sendero Health Plans  
ATTN: Complaint/Appeal Department  
Suite 510  
2028 E Ben White Blvd  
Austin TX 78741

If you ask for a fair hearing within 10 days from the time you get the hearing notice from the health plan, you have the right to keep getting the service(s) the health plan denied, at least until the final hearing decision is made. If you do not request a fair hearing within 10 days from the time you get the hearing notice, 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 one week or more before the date of the fair 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.
ST6 – STAR/Medicaid Member Rights and Responsibilities

ST 6.1 Member Rights

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.

2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another health plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose your health plan and your primary care provider from the choices you are given.
   b. Be told how to change to any health plan you want that is available in your area and to change your primary care provider from that health plan’s network without any penalty.
   c. Change your primary care provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your primary care provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b. Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.

5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals 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 the process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
b. Get medical care in a timely manner.
c. Be able to get in and out of a health care provider’s office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them, including obtaining medication from any Network pharmacy.

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

8. You have a right to know the 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 co-payments or any other amounts for covered services.

**ST 6.2 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 and Medicaid policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan 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 relating to your health status with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health.
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
a. Work as a team with your provider in deciding what health care is best for you;
b. Understand how the things you do can affect your health.
c. Do the best you can to stay healthy.
d. Treat providers and staff with respect.

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.
Texas CHIP Program
CH1 – Eligibility of Members

CH 1.1 HHSC Determines Eligibility

The Texas Health and Human Services Commission (HHSC) is responsible for determining CHIP eligibility. For information regarding eligibility, contact HHSC CHIP hotline at 1-800-647-6558.

For other help, call Sendero Health Plans’ Customer Services at 1-855-526-7388.

CH 1.2 Role of Enrollment Broker

HHSC uses an Enrollment Broker to receive and process applications for CHIP. The enrollment broker cannot authorize or determine eligibility. The role of the enrollment broker is to ensure that all required documentation and forms are gathered. Once eligibility is determined by HHSC, the enrollment broker mails out welcome letters and information on the available health plans in each area. The enrollment broker receives each Member’s plan and primary care provider selection documentation and notifies health plans of their new Members.

CH 1.3 General Eligibility for CHIP

Children under age 19 and whose family’s income is below 200% of the federal poverty level (FPL) are eligible to enroll in the CHIP program if they do not qualify for STAR/Medicaid coverage. The four CHIP eligibility categories are:

- At or below 100% of FPL
- 101% to 150% of FPL
- 151% to 185% of FPL
- 186% to 200% of FPL

CHIP enrollment period is a twelve (12) month period. Prior to the end of the eligibility period, Members are sent re-enrollment packets to complete and return to the enrollment broker. Determination of coverage is made by the state Administrative Services Contractor. Members should complete the necessary forms and return as soon as possible to the enrollment broker to prevent lapses in coverage. Physicians should encourage Members to re-enroll.

Children of families with Group Health Insurance or Medicaid coverage for the children are NOT eligible for the CHIP program.
Pregnant Members are no longer automatically dis-enrolled from CHIP and placed in Medicaid. Health plans notify the enrollment broker when a CHIP Member is pregnant and a re-determination for Medicaid eligibility occurs. This process can take up to an average of 60 days, and Member ID card may not be available from plan, immediately.

There is no spell of illness limitation for CHIP Members.

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**CH 1.4 Span of Eligibility (Members’ Right to Change Health Plans) - CHIP**

Members are allowed to make health plan changes under the following circumstances:

- For any reason within the first ninety (90) days of enrollment in CHIP
- For cause at any time
- During the annual re-enrollment period

Requests are forwarded to HHSC, who makes the final determination. For more information, contact the CHIP Helpline at **1-800-647-6558**.

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**CH 1.5 Disenrollment from Health Plan**

Disenrollment may occur if a Member loses CHIP eligibility. A CHIP Member can lose CHIP eligibility for the following reasons:

- “Aging-out” when the Member turns 19
- Failure to re-enroll by the end of the 12 month coverage period
- Change in health insurance status, i.e., a Member enrolls in an employer sponsored health plan
- Death of a Member
- Member permanently moves out of the state
- 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 requests, in writing, the voluntary disenrollment of a child

Providers may not request that a Member be disenrolled from the health plan, and from managed care, without good cause. The provider cannot make this request due to retaliatory action against the Member.

Sendero can also request a Member be disenrolled from Sendero for the following reasons:

- Fraud or intentional material misrepresentation
- Fraud in the use of services or facilities
- Misconduct that is detrimental to safe plan operations and the delivery of services
Failure to establish a satisfactory patient/physician or patient/provider relationship

Child no longer lives or resides in the service area

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

All requests are forwarded to HHSC, who makes the final decision.

**CH 1.6 Pregnancy Notification Requirements – CHIP**

If a provider identifies a CHIP Member as being pregnant, he/she should notify Health Services Department **immediately** so as to ensure that the Member receives the highest level of coverage available. Many pregnant CHIP teenagers and their newborns, up to age one year, will qualify for Medicaid. Since the Medicaid Program now provides a much more comprehensive scope of services for both the pregnant teen and their newborn, it is in the best interest of the pregnant teen to receive Medicaid coverage as early as possible. For this reason, it is critical that providers notify Sendero immediately upon learning about a CHIP teenager’s pregnancy. Sendero will notify the HHSC that the CHIP Member is pregnant. Pregnant CHIP teenagers who are Medicaid eligible will be transferred from CHIP to Medicaid by HHSC.

For CHIP Members who are not Medicaid eligible, Sendero will be responsible to cover the costs of the delivery; however, the provider must immediately notify Sendero about the delivery. Newborns of CHIP Members do not automatically become CHIP Members. Upon notification by the provider, Sendero will refer the newborn to Medicaid to determine eligibility. Newborns deemed not eligible for Medicaid, will be enrolled in CHIP as determined by HHSC.

Providers are encouraged to submit a Pregnancy Notification Form to Sendero, so that we are apprised of this pregnant Member, and can get the Member enrolled in High Risk OB Case Management as appropriate.
CH2 – Covered Services

CH 2.1 Medically Necessary Services

What does medically necessary mean?

Covered services for CHIP Members must meet the CHIP definition of "Medically Necessary."

"Medically Necessary" means:

1. Physical Health Care Services 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 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. not experimental or investigational; and
   g. not primarily for the convenience of the Member or Provider.

2. Behavioral Health Services that are:
   a. reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
   b. provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
   c. not experimental or investigative; and
   d. not primarily for the convenience of the Member or Provider.
## CH 2.2 CHIP Covered Services

<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>Description of Benefit</th>
<th>Limitations</th>
<th>Co-Pay</th>
</tr>
</thead>
</table>
| Inpatient General Acute and Inpatient Rehabilitation Hospital Services | Services include:  
- Hospital - given doctor 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 not given free-of-charge to the patient and their administration  
- X-rays, imaging and other radiological tests (facility technical component)  
- Laboratory and pathology services (facility technical component)  
- Machine diagnostic tests (EEGs, EKGs, etc.)  
- Oxygen services and inhalation therapy  
- Radiation and chemotherapy  
- Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care  
- In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarian section  
- Hospital, doctor and related medical services, such as anesthesia, associated with dental care  
- Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:  
  - dilation and curettage (D&C) procedures;  
  - appropriate provider administered medications;  
  - ultrasounds; and  
  - histological examination of tissue samples.  
- Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:  
  - cleft lip and/or palate; or  
  - severe traumatic skeletal and/or congenital craniofacial deviations; or  
  - Requires Notification for non-emergency care and following stabilization of an emergency condition  
  - Requires authorization for out-of-network facility and doctors services as well as for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by cesarian section | Requires Notification for non-emergency care and following stabilization of an emergency condition  
Requires authorization for out-of-network facility and doctors services as well as for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by cesarian section | Applicable level of inpatient co-pay applies |
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<th>Type of Benefit</th>
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<th>Co-Pay</th>
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|                | - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.  
  - Surgical implants  
  - Other artificial aids including surgical implants  
  - Inpatient services for mastectomy and breast reconstruction include:  
    - all stages of reconstruction on the affected breast;  
    - surgery and reconstruction on the other breast to produce symmetrical appearance; and  
    - treatment of physical complications from the mastectomy and treatment of lymphedemas.  
  - Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.                                                                 |             |                                                                        |
| Skilled Nursing Facilities (Includes Rehabilitation Hospitals) | Services include, but are not limited to, the following:  
  - Semi-private room and board  
  - Regular nursing services  
  - Rehabilitation services  
  - Medical supplies and use of appliances and equipment furnished by the facility | Requires authorization and doctor prescription | Co-pays do not apply |
| Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center | Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:  
  - X-ray, imaging, and radiological tests (technical component) if performed in an Emergency Room setting  
  - Laboratory and pathology services (technical component)  
  - Machine diagnostic tests  
  - Ambulatory surgical facility services  
  - Drugs, medications and biologicals  
  - Casts, splints, dressings  
  - Preventive health services  
  - Renal dialysis  
  - Respiratory Services  
  - Radiation and chemotherapy  
  - Blood or blood products not offered 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 offered in a licensed ambulatory surgical facility.  
  - Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: | May require prior authorization and doctor prescription | Applicable level of co-pay applies to prescription drug services  
<p>|                                                                          |                                                                        | Co-pays do not apply to preventive services |</p>
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<th>Type of Benefit</th>
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<th>Limitations</th>
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<td>- dilation and curettage (D&amp;C) procedures;</td>
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<td>- appropriate provider administered medications;</td>
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<td>- ultrasounds; and</td>
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<td>- histological examination of tissue samples.</td>
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<td></td>
<td>- Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:</td>
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<td>- cleft lip and/or palate; or</td>
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<td>- severe traumatic skeletal and/or congenital craniofacial deviations; or</td>
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<td>- severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
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<td>- Surgical implants (excluding pumps and/or devices)</td>
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<td>- Other artificial aids including surgical implants</td>
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<td>- Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:</td>
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<td>- all stages of reconstruction on the affected breast;</td>
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<td>- surgery and reconstruction on the other breast to produce symmetrical appearance; and</td>
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<td>- treatment of physical complications from the mastectomy and treatment of lymphedemas.</td>
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<td>- Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit</td>
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<td>Doctor / Doctor Extender</td>
<td>Services include, but are not limited to the following:</td>
<td>May require authorization for specialty services</td>
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<tr>
<td>Professional Services</td>
<td>- American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)</td>
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<td>- Doctor office visits, inpatient and outpatient services</td>
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<td>- Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation</td>
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<td>- Medications, biologicals and materials administered in doctor’s office</td>
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<td>- Allergy testing, serum and injections</td>
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<td>- Professional component (in/outpatient) of surgical services, including:</td>
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<td>- Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care</td>
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<td>- Administration of anesthesia by doctor (other than surgeon) or CRNA</td>
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<td>- Second surgical opinions</td>
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<td></td>
<td>- Same-day surgery performed in a hospital without an over-night stay</td>
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</table>

Applicable level of co-pay applies to office visits
Co-pays do not apply to preventive visits or to prenatal visits after the first visit
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<thead>
<tr>
<th>Type of Benefit</th>
<th>Description of Benefit</th>
<th>Limitations</th>
<th>Co-Pay</th>
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</thead>
</table>
| Invasive diagnostic procedures such as endoscopic examination | ▪ Hospital-based doctor services (including doctor-performed technical and interpretative components)  
▪ Doctor and professional services for a mastectomy and breast reconstruction include:  
  - all stages of reconstruction on the affected breast;  
  - surgery and reconstruction on the other breast to produce symmetrical appearance; and  
  - treatment of physical complications from the mastectomy and treatment of lymphedemas. |                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                   |
| In-network and out-of-network doctor 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 | ▪ Doctor services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation.  
▪ Doctor services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Doctor services associated with miscarriage or non-viable pregnancy include, but are not limited to:  
  - dilation and curettage (D&C) procedures;  
  - appropriate provider administered medications;  
  - ultrasounds; and  
  - histological examination of tissue samples.  
▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:  
  - cleft lip and/or palate;  
  - severe traumatic skeletal and/or congenital craniofacial deviations; or  
  - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. |                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                   |

**Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies**

Covered services include DME (equipment that 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 help in the treatment of a medical condition, including, but not limited to:

- Requires prior authorization and doctor prescription  
- $20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap)

Co-pays do not apply
<table>
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<tr>
<th>Type of Benefit</th>
<th>Description of Benefit</th>
<th>Limitations</th>
<th>Co-Pay</th>
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<tbody>
<tr>
<td></td>
<td>➢ Orthotic braces and Orthotics</td>
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<td>➢ Dental devices</td>
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<td></td>
<td>➢ Prosthetic devices such as artificial eyes, limbs braces, and external breast prostheses</td>
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<td>➢ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease</td>
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<td>➢ Other artificial aids including surgical implants</td>
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<td>➢ Hearing aids</td>
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<td></td>
<td>➢ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.</td>
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<td>➢ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements</td>
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<tr>
<td>Home and Community Health Services</td>
<td>Services that are provided in the home and community, including, but not limited to:</td>
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<td></td>
<td>➢ Home infusion</td>
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<td>➢ Respiratory therapy</td>
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<td>➢ Visits for private duty nursing (R.N., L.V.N.)</td>
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<td>➢ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).</td>
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<td>➢ Home health aide when included as part of a plan of care during a period that skilled visits have been approved</td>
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<td>➢ Speech, physical and occupational therapies.</td>
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<td></td>
<td>➢ Requires prior authorization and doctor prescription</td>
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<td>Co-pays do not apply</td>
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<td>➢ Services are not intended to replace the child's caretaker or to provide relief for the caretaker</td>
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<td></td>
<td>➢ Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services</td>
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<tr>
<td></td>
<td>➢ Services are not intended to replace 24-hour inpatient or skilled nursing facility services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Mental Health Services</td>
<td>Mental health services, including care for serious mental illness, furnished in a free-standing psychiatric hospital, in psychiatric units of general acute care hospitals and in state operated facilities.</td>
<td></td>
<td>Applicable level of inpatient co-pay applies</td>
</tr>
<tr>
<td></td>
<td>➢ Does not require prior authorization.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Does not require Primary Care Provider referral.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Neuropsychological and psychological testing DO require Prior Authorization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Benefit</td>
<td>Description of Benefit</td>
<td>Limitations</td>
<td>Co-Pay</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Outpatient Mental Health Services**  | Mental health services, including for serious mental illness, provided on an outpatient basis, including but not limited to:  
  - The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.  
  - Medication management  
  - Rehabilitative day treatments  
  - Residential treatment services  
  - Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment)  
  - Skills training (psycho-educational skill development) | - Does not require prior authorization for the first 20 visits, then pre-authorization is required.  
  - Does not require Primary Care Provider referral.  
  - Neuropsychological and psychological testing DO require Prior Authorization  
  - When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.  
  - A Qualified Mental Health Professional – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or doctor and provides services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services. | Applicable level of co-pay applies to office visits.                                                                                   |
| **Inpatient Substance Abuse Treatment Services** | Inpatient substance abuse treatment services include, but are not limited to inpatient and residential substance abuse treatment services including detoxification, crisis stabilization, and 24-hour residential rehabilitation programs. | - Does not require prior authorization.  
  - Does not require Primary Care Provider referral. | Applicable level of inpatient co-pay applies |

**Note:**
- The limitations and co-pay requirements may vary based on the specific provider and service type. Always consult with the provider for the most accurate information.
<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>Description of Benefit</th>
<th>Limitations</th>
<th>Co-Pay</th>
</tr>
</thead>
</table>
| Outpatient Substance Abuse Treatment Services | Outpatient substance abuse treatment services include, but are not limited to:  
- Prevention and intervention services that are offered by doctor and non-doctor providers, such as screening, assessment and referral for chemical dependency disorders.  
- Intensive outpatient services  
- Partial hospitalization  
- Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day.  
- Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training. | - Does not require prior authorization for the first 20 visits, then pre authorization is required.  
- Does not require Primary  
- 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) | Applicable level of co-pay applies to office visits. |
| Rehabilitation Services            | Habilitation (the act 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 | Requires pre-authorization after the 8th visit and a physician’s prescription | Co-pays do not apply |
| Hospice Care Services              | Services include, but are not limited to:  
- Palliative care, including medical and support services, for children who have six months or less to live, to keep patients comfortable during the last weeks and months before death  
- Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services. | - Requires notification only  
- Services apply to the hospice diagnosis  
- Up to a maximum of 120 days with a 6 month life expectancy  
- Patients electing hospice services may cancel this election at anytime | Co-pays do not apply |
<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>Description of Benefit</th>
<th>Limitations</th>
<th>Co-Pay</th>
</tr>
</thead>
</table>
| **Emergency Services, including Emergency Hospitals, Doctors, and Ambulance Services** | Health plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include:  
- Emergency services based on prudent layperson definition of emergency health condition  
- Hospital emergency department room and ancillary services and doctor 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 or hospitals meeting equivalent levels of care for emergency services  
- Emergency ground, air or water transportation  
- Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts. | May require authorization for post-stabilization services or equipment                                                                                                                                   | Applicable co-pays apply to non-emergency room visits.                                                                           |
| **Transplants**                                    | Covered services include:  
- Using up-to-date Medicare and/or 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 | Requires Notification prior to placing on transplant list.                                                                                                                                         | Co-pays do not apply                                                                                                               |
| **Vision Benefit**                                 | Covered services include:  
- One examination of the eyes to find 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.  
- Requires pre-authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. | Applicable level of co-pay applies to office visits billed for refractive exam                                                   |
| **Chiropractic Services**                          | Covered services do not require doctor prescription and are limited to spinal subluxation                                                                                                                              | Requires pre-authorization for more than 8 visits. Any Benefit Limit?                                                                                                                       | Applicable level of co-pay applies to chiropractic office visits         |
| **Tobacco Cessation Programs**                     | Covered up to $100 for a 12-month period limit for a plan-approved program                                                                                                                                              |  
- Does not require prior authorization  
- Health Plan defines plan-approved program  
- May be subject to formulary requirements. | Co-pays do not apply                                                                                                                   |
CH 2.3 CHIP Member Prescriptions

CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

CH 2.4 EXCLUSIONS for CHIP Benefits

- 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 that are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for employment, flight clearance, camps, insurance or court
- Dental devices solely for cosmetic purposes
- Private duty nursing services performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and doctor 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 offered 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 (routine foot care does not include treatment injury or complications of diabetes)
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
• Custodial care (care that helps a child with the activities of daily living, such as help in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or given by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice.

• Housekeeping

• Public facility services and care for conditions that federal, state, or local law requires be given in a public facility or care given while in the custody of legal authorities

• Services or supplies received from a nurse, that do not require the skill and training of a nurse

• Vision training and vision therapy

• Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Doctor/ Primary Care Provider

• Donor non-medical expenses

• Charges incurred as a donor of an organ when the recipient is not covered under this health plan

• Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

CH 2.4 DME/SUPPLIES – for CHIP Programs

<table>
<thead>
<tr>
<th>SUPPLIES</th>
<th>COVERED</th>
<th>EXCLUDED</th>
<th>COMMENTS/MEMBER CONTRACT PROVISIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ace Bandages</td>
<td>++ ++ X</td>
<td></td>
<td>Exception: If given by and billed through the clinic or home care agency it is covered as an incidental supply.</td>
</tr>
<tr>
<td>Alcohol, rubbing</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Alcohol, swabs (diabetic)</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply not covered, unless RX given at time of dispensing.</td>
</tr>
<tr>
<td>Alcohol, swabs</td>
<td></td>
<td>X</td>
<td>Covered only when received with IV therapy or central line kits/supplies.</td>
</tr>
<tr>
<td>Ana Kit Epinephrine</td>
<td></td>
<td>X</td>
<td>A self-injection kit used by patients highly allergic to bee stings.</td>
</tr>
<tr>
<td>Arm Sling</td>
<td></td>
<td>X</td>
<td>Dispensed as part of office visit.</td>
</tr>
<tr>
<td>Attends (Diapers)</td>
<td></td>
<td>X</td>
<td>Coverage limited to children age 4 or over only when prescribed by a doctor and used to give care for a covered diagnosis as outlined in a treatment care plan</td>
</tr>
<tr>
<td>Bandages</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Basal Thermometer</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Batteries – first</td>
<td></td>
<td>X</td>
<td>For covered DME items</td>
</tr>
<tr>
<td>Batteries – replacement</td>
<td></td>
<td>X</td>
<td>For covered DME when replacement is necessary due to normal use.</td>
</tr>
<tr>
<td>Betadine</td>
<td></td>
<td>X</td>
<td>See IV therapy supplies.</td>
</tr>
<tr>
<td>Books</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Clinitest</td>
<td></td>
<td>X</td>
<td>For monitoring of diabetes.</td>
</tr>
<tr>
<td>Colostomy Bags</td>
<td></td>
<td></td>
<td>See Ostomy Supplies.</td>
</tr>
<tr>
<td>Communication Devices</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Contraceptive Jelly</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply. Contraceptives are not covered under the plan.</td>
</tr>
<tr>
<td>Cranial Head Mold</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dental Devices</td>
<td></td>
<td>X</td>
<td>Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td></td>
<td>X</td>
<td>Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.</td>
</tr>
<tr>
<td>Diapers/ Incontinent Briefs/Chux</td>
<td></td>
<td>X</td>
<td>Coverage limited to children age 4 or over only when prescribed by a doctor and used to give care for a covered diagnosis as outlined in a treatment care plan</td>
</tr>
<tr>
<td>SUPPLIES</td>
<td>COVERED</td>
<td>EXCLUDED</td>
<td>CONTRACT PROVISIONS</td>
</tr>
<tr>
<td>--------------------------------</td>
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<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>X</td>
<td></td>
<td>Contraceptives are not covered under the plan.</td>
</tr>
<tr>
<td>Diastix</td>
<td></td>
<td>X</td>
<td>For monitoring diabetes.</td>
</tr>
<tr>
<td>Diet, Special</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Distilled Water</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dressing Supplies/Central Line</td>
<td>X</td>
<td></td>
<td>Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.</td>
</tr>
<tr>
<td>Dressing Supplies/Decubitus</td>
<td>X</td>
<td>+</td>
<td>Able to get coverage only if receiving covered home care for wound care.</td>
</tr>
<tr>
<td>Dressing Supplies / Peripheral IV Therapy</td>
<td>X</td>
<td></td>
<td>Able to get coverage only if receiving home IV therapy.</td>
</tr>
<tr>
<td>Dressing Supplies/Other</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dust Mask</td>
<td></td>
<td>X</td>
<td>Custom made, post inner or middle ear surgery</td>
</tr>
<tr>
<td>Ear Molds</td>
<td>X</td>
<td></td>
<td>Able to get coverage when used with a covered DME.</td>
</tr>
<tr>
<td>Electrodes</td>
<td>X</td>
<td></td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Enema Supplies</td>
<td></td>
<td>X</td>
<td>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.</td>
</tr>
</tbody>
</table>
| Enteral Nutrition Supplies     | X       |          | Exception: Able to get 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 doctor and authorized by plan.) Doctor documentation to justify prescription of formula must include:  
  - Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product  
  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 people 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 of whether these regular food products are taken orally or parenterally. |
| Eye Patches                    | X       |          | Covered for patients with amblyopia.                                                |
| Formula                        |         | X        |                                                                                     |
| Gloves                         |         | X        | Exception: Central line dressings or wound care given 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 doctor and used to give 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         |         | X        | Able to get coverage when used during covered home care for wound care.            |
### CH 2.5 Sendero’s Value Added Services

In addition to the standard benefits for CHIP noted above, Sendero Health Plans provides certain value added services for Members. Sendero’s value added services for Members with CHIP coverage are:

<table>
<thead>
<tr>
<th>SUPPLIES</th>
<th>COVERED</th>
<th>EXCLUDED</th>
<th>COMMENTS/MEMBER CONTRACT PROVISIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td></td>
<td></td>
<td>care.</td>
</tr>
<tr>
<td>Irrigation Sets, Urinary</td>
<td>X</td>
<td></td>
<td>Able to get coverage for person with an indwelling urinary catheter.</td>
</tr>
<tr>
<td>IV Therapy Supplies</td>
<td>X</td>
<td></td>
<td>Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.</td>
</tr>
<tr>
<td>K-Y Jelly</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Lancet Device</td>
<td>X</td>
<td></td>
<td>Limited to one device only.</td>
</tr>
<tr>
<td>Lancets</td>
<td></td>
<td></td>
<td>Able to get coverage for person with diabetes.</td>
</tr>
<tr>
<td>Med Ejector</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needles and Syringes/Diabetic</td>
<td></td>
<td></td>
<td>See Diabetic Supplies</td>
</tr>
<tr>
<td>Needles and Syringes/IV and Central Line</td>
<td></td>
<td></td>
<td>See IV Therapy and Dressing Supplies/Central Line.</td>
</tr>
<tr>
<td>Needles and Syringes/Other</td>
<td>X</td>
<td></td>
<td>Able to get coverage if a covered IM or SubQ medication is being administered at home.</td>
</tr>
<tr>
<td>Normal Saline</td>
<td></td>
<td></td>
<td>See Saline, Normal</td>
</tr>
<tr>
<td>Novopen</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>X</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Parenteral Nutrition/Supplies</td>
<td>X</td>
<td></td>
<td>Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.</td>
</tr>
<tr>
<td>Saline, Normal</td>
<td></td>
<td>X</td>
<td>Eligible for coverage:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>a) when used to dilute medications for nebulizer treatments;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b) as part of covered home care for wound care;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>c) for indwelling urinary catheter irrigation.</td>
</tr>
<tr>
<td>Stump Sleeve</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Stump Socks</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Suction Catheters</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Syringes</td>
<td></td>
<td></td>
<td>See Needles/Syringes.</td>
</tr>
<tr>
<td>Tape</td>
<td></td>
<td></td>
<td>See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.</td>
</tr>
<tr>
<td>Tracheostomy Supplies</td>
<td>X</td>
<td></td>
<td>Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.</td>
</tr>
<tr>
<td>Under Pads</td>
<td></td>
<td></td>
<td>See Diapers/Incontinent Briefs/Chux.</td>
</tr>
<tr>
<td>Unna Boot</td>
<td>X</td>
<td></td>
<td>Eligible for coverage when part of wound care in the home setting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Incidental charge when applied during office visit.</td>
</tr>
<tr>
<td>Urinary, External Catheter &amp; Supplies</td>
<td>X</td>
<td></td>
<td>Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the Primary Care Provider and approved by the plan.</td>
</tr>
<tr>
<td>Urinary, Indwelling Catheter &amp; Supplies</td>
<td>X</td>
<td></td>
<td>Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.</td>
</tr>
<tr>
<td>Urinary, Intermittent</td>
<td></td>
<td>X</td>
<td>Cover supplies needed for intermittent or straight catherization.</td>
</tr>
<tr>
<td>Urine Test Kit</td>
<td></td>
<td>X</td>
<td>When decided to be medically necessary.</td>
</tr>
<tr>
<td>Urostomy supplies</td>
<td></td>
<td>X</td>
<td>See Ostomy Supplies.</td>
</tr>
<tr>
<td>Value Added Service</td>
<td>CHIP Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Line</td>
<td>SERVICE: Sendero will make available to CHIP Members a 24 hour a day, 365 days per year nurse advice line. Members will be able to access the nurse line via a toll-free telephone number. The nurse line will be able to assist Members with various health-related questions, as well as provide guidance as to when to access emergency facilities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value-added Vision Services</td>
<td>SERVICE: $100 above the Medicaid allowable per 24 month period for corrective eyewear. LIMITATION: The benefit is limited only as it applies to frequency and Members who are 2 years or older.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporary Cell Phone</td>
<td>SERVICE: Sendero will provide pre-programmed cell phones to pregnant Members who are determined to be high-risk. This service will permit these Members to be in touch on both inbound and outbound call with the Plan’s health Service care coordinator and the PCP/OB in order to ask questions and receive advice, reminded of appointments, arrange for transportation and to contact 911 in case of emergency. LIMITATION: As it applies only to female Members who are determined high-risk and during the pre, peri and immediate post natal period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gifts for New Mothers</td>
<td>SERVICE: Sendero will provide up to $50 worth of health items for pregnant Members who complete at least eight (8) prenatal visits to their OB during pregnancy. At least 1 gift will be for Member. LIMITATION: As it applies only to pregnant Members and the completion of the minimum required number of eight (8) prenatal appointments while a Member of Sendero.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sports/School Physicals</td>
<td>SERVICE: Sendero will reimburse its contracted PCP for an annual sports/school physical for children up to age 19 at the PCP’s contracted rate. LIMITATION: Only limitation is under age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra Help with Getting a Ride</td>
<td>SERVICE: Sendero will help arrange transportation to physician appointments beyond those services covered by the MTP program LIMITATIONS: plan reserves the right to determine medical necessity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra Dental Benefits Pregnant Women</td>
<td>SERVICE: Sendero will pay for up to $250 in dental services each year for pregnant member LIMITATIONS: value limited to $250 and for pregnant members only</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**CH 2.6 Coordination with Non-CHIP Covered Services:**

Non-CHIP covered services include the following:

**Dental Services**  
Beginning March 1, 2012 CHIP dental services are offered through a managed care model program for eligible recipients. Dental services are discussed “CH2 - Covered Services” in this Provider Manual.

**Texas Agency Administered Programs and Case Management Services**  
Texas Department of Family and Protective Services (DFPS):  
Sendero’s network of providers coordinates with DFPS (and associated foster parents) to ensure that the at risk population, both children in custody and not in custody of DFPS, receive the services they need. Children who are served by DFPS may transition into and out of Sendero more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the Service Area. During the transition period and beyond, providers must:

- Provide medical records to DFPS
- Schedule medical and behavioral health appointments within 14 days unless requested earlier by DFPS
- Participate, when requested by DFPS, in planning to establish permanent homes for Members
- Refer suspected cases of abuse or neglect to DFPS

For help with Member and DFPS, providers should call Sendero’s Health Services Department.

**Essential Public Health Services**  
Sendero is required through its contractual relationship with HHSC to coordinate with Public Health Entities regarding provision of services for essential public health services. Providers must assist Sendero in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunizations as defined by State Law.
- Assisting in notifying or referring to the local Public Health Entity, as defined by state law, any communicable disease outbreaks involving Members
- Referring to the local Public Health Entity for TB contact investigation and evaluation and preventive treatment of person whom the Member has come into contact
- Referring to the local Public Health Entity for STD/HIV contact investigation and evaluation and preventive treatment of persons whom the Member has come into contact
- Referring for Women, Infant, and Children (WIC) services and information sharing
- Assisting in the coordination and follow up of suspected or confirmed cases of childhood lead exposure
- Reporting of immunizations provided to the statewide ImmTrac Registry including parental consent to share data
- Cooperating with activities required of public health authorities to conduct the annual population and community based needs assessment
Referring lead screening tests to the TDH Laboratory (for levels 40 or higher) at the Texas Department of State Health Services. To report lead poisoning, provider can complete the applicable form for Children or Adults and fax it to 512.458-7699, or call DHSH at 512-458-7269 or toll free at 1-800-588-1248. The following information must be reported: child’s name, address, date of birth, sex, race and ethnicity; blood lead level concentration, test date, name and telephone number of testing laboratory; whether the sample was capillary or venous blood; and the name and city of the attending physician.

Sendero’s Care Coordinators can help organize services with the Member, the Member’s primary care provider and the public health entity. In cases where services are coordinated and subject to applicable laws, rules and regulations concerning confidentiality of certain health information, the public health entity is requested to provide a written report to the primary care provider concerning the services provided by the public health entity.

**Early Childhood Intervention (ECI) Case Management/Service Coordination**
The Texas Department of Assistive and Rehabilitative (DARS) Rehabilitative Services oversees the Early Childhood Intervention program for the State of Texas. Case management and service coordination are provided to children from birth to three (3) years with a developmental disability and/or developmental delay. Eligibility for the program is determined by 1) a delay in one or more area of development; 2) atypical development in which children perform within their appropriate age range on test instruments, but whose patterns of development are different from their peers, and 3) a medically diagnosed condition that has a high probability of resulting in a developmental delay. The PCP will receive a copy of Individualized Family Service Plan (IFSP) for Members from ECI. PCP’s are encouraged to refer Members with disabilities or developmental delays, birth to three (3) years of age, to ECI for services. For more information about ECI or to refer a child, call the DARS Inquiries Line at 1-800-628-5115.

**Mental Health Targeted Case Management**
Individuals served through the Texas Department of State Health Services (DSHS) Mental Health and Substance Abuse (MHSA) program are eligible for services including advocacy, assessment, linkage, monitoring, crisis intervention, and referral and planning and coordination of services. Priority population include: substance abuse, mental retardation, autism, pervasive development disorder, children at risk of removal from preferred environment, children determined by the school system to have a serious emotional disturbance, children at risk of disruption of the preferred living situation due to psychological symptoms or those with a functional impairment – GAF (Global Assessment Function) of 50 or below. Providers may obtain information through the MHSA website www.dshs.state.tx.us/MHSA or by contacting Network Management.

**Mental Health Rehabilitation:**
Rehabilitative services are covered when provided to persons, regardless of age, who have a single severe mental disorder excluding mental retardation.

**Texas Department of Assistive and Rehabilitative Services (DARS)**
DARS may provide additional case management services for the blind and visually impaired Members. This is limited to one contact per client, per month. The main office in Austin may be contacted at 1-800-252-5204 or by visiting their website at http://www.dars.state.tx.us/dbs/.
Tuberculosis Services Provided by DSBS Approved Provider

All confirmed or suspected cases of Tuberculosis must be referred to the Infectious Disease Control Unit of the DSBS using the forms and procedures for reporting TB adopted by DSBS. Sendero will assist providers in referring to the Local Tuberculosis Control Health Authority within 1 day of diagnosis for a contact investigation. The provider must document the referral to the local health authority in the Member’s medical records that may be reviewed by DSBS and the local authority. Providers should notify Sendero on any referral made to the local health authority.

Sendero must coordinate with the local health authority to ensure that Members with confirmed or suspected TB have a contact investigation and receive directly observed therapy. Sendero will report any Member who is non-compliant, drug-resistant, or who is or may be posing a health threat to DSBS or the local authority. Sendero will cooperate with the local health authority in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Health and Safety Code.

DADS Hospice Services

The Department of Aging and Disability Services (DADS) manages the Hospice Program through provider enrollment contracts with hospice agencies. Coverage of services follow the amount duration and scope of services specified in the Medicare Hospice Program. Hospice pays for services related to the treatment of the client’s terminal illness and for certain physician services (not the treatments). Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

CH 2.7 Pharmacy/Navitus

Sendero Health Plans has an arrangement with Navitus Health Solutions, a pharmacy benefit management company to administer pharmacy benefits for the STAR program. For questions related to the formulary, preferred drug list, prescription over-rides, quantity limits, brand necessity or formulary exceptions, please contact Navitus at 877-908-6023 or access the Navitus website through www.senderohealth.com.

NAVITUS SUPPORTS E-PRESCRIBING FOR MEDICAID

- Navitus provides point of care information available through Surescripts
  - Eligibility confirmation
    - Daily updates to eligibility facilitator
  - Medication history
  - Formulary and PDL benefit confirmation
  - Formulary “alternative” drug list
  - Formulary lists will be updated no less frequently than weekly
- Navitus expects pharmacies to have ability to accept e-prescriptions and facilitate refills with prescribers
DME

Navitus will encourage Texas Medicaid Network Pharmacies to become Medicaid-enrolled durable medical equipment (DME) providers with the MCO’s in their Service Areas.

CH 2.8 Co-Pay Information for CHIP Members

The following table lists the CHIP co-payment schedule according to family income. No co-payments are paid for preventive care such as well-child or well-baby visits or immunizations.

The Sendero CHIP Member ID card lists the co-payments that apply to the Member. The Member must present this ID card when the Member receives services from your office. You are required to collect the co-pay as part of the office visit.

<table>
<thead>
<tr>
<th>Federal Poverty Levels</th>
<th>Office Visits</th>
<th>Emergency Room Visits</th>
<th>Inpatient Hospitalizations</th>
<th>Prescription Generic Drugs</th>
<th>Prescription Brand Drugs</th>
<th>Once a Year Reporting Caps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native Americans</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>At or Below 100%</td>
<td>$3</td>
<td>$3</td>
<td>$10</td>
<td>$0</td>
<td>$3</td>
<td>1.25% cap of family yearly income</td>
</tr>
<tr>
<td>101%-150%</td>
<td>$5</td>
<td>$5</td>
<td>$25</td>
<td>$0</td>
<td>$5</td>
<td>1.25% cap of family yearly income</td>
</tr>
<tr>
<td>151%-185%</td>
<td>$12</td>
<td>$50</td>
<td>$50</td>
<td>$8</td>
<td>$25</td>
<td>2.5% cap of family yearly net income</td>
</tr>
<tr>
<td>186%-200%</td>
<td>$16</td>
<td>$50</td>
<td>$100</td>
<td>$8</td>
<td>$25</td>
<td>2.5% cap of family yearly net income</td>
</tr>
</tbody>
</table>

CH 2.9 OB/GYN

Sendero allows you to pick an OB/GYN but this doctor must be in the same network as your Primary Care Provider.

ATTENTION FEMALE MEMBERS

You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:
- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- Referral to a specialist doctor within the network
CH3 – Well Child Exams

CH 3.1 What is a Well Child Exam?
Well Child Exams are for children’s health checkups. These checkups are important and Members should set up an appointment with their primary care provider within 45 days of becoming a Sendero Member. Even if a child looks and feels well, he or she may still have a problem. Well Child Exams can help in many ways. Some of the things done in a medical checkup are:

- Physical exam, measuring height and weight;
- Hearing and eye check;
- Checking for a good diet;
- Immunizations (when needed);
- Blood tests (when needed)
- TB test

CH 3.2 Periodicity Schedule and Immunization Requirements

Providers are required to follow the periodicity schedule as defined by the American Academy of Pediatrics (AAP) and/or the Centers for Disease Control and Prevention. A copy of the periodicity schedule is available online at [http://www.dshs.state.tx.us/thsteps/providers.shtm](http://www.dshs.state.tx.us/thsteps/providers.shtm). Providers are required to participate with the Texas Vaccines for Children Program (TVFC).

CH 3.3 Texas Vaccines for Children (TVFC) Program

The Texas Vaccines for Children Program provides free vaccines to CHIP members who are younger than 19 years of age that are routinely recommended according to the American Academy of Pediatrics (AAP) immunization schedule. To obtain free vaccine, the provider must enroll in the VFC program through Department of State Health Services (DSHS). There is no reimbursement to providers for vaccines available from TVFC although reimbursement is available for the administration of the vaccines. For more information, contact DSHS at 800-252-9152 or 512-776-7284, or Network Management at phone number below.
CH4 – Complaints & Appeals

CH 4.1 Introduction
Sendero Health Plans has established procedures for the handling and resolution of complaints and appeals. If a provider or Member is not satisfied with the resolution of a complaint, an appeal can be filed. Sendero Customer Services is available to assist those persons requiring assistance with the filing of a complaint or appeal. It is Sendero’s goal to resolve all complaints. A Member or provider may initiate the complaint process either by telephone, in person, or in writing, expressing the details of the concerns. Providers may submit complaints to Sendero or to the Texas Department of Insurance. Sendero would prefer that complaints come to the Sendero Quality Improvement team before going to a state agency.

CH 4.2 What is a Complaint?
A complaint is a verbal or written expression of dissatisfaction with Sendero Health Plans concerning a process within the health plan. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the provider. It is anticipated that the majority of the verbal and written complaints would be resolved with Sendero.

CH 4.3 What is an Appeal?
There are three (3) types of appeals. They are:

- **Complaint Appeal** is an appeal that occurs when the complainant is not satisfied with the outcome of the complaint. This is not a medical necessity determination appeal.
- **Adverse Medical Determination Appeal** is an appeal that occurs when there has been a denial of benefit because of lack of medical necessity.
- **Expedited Appeal** is an appeal at an expedited rate that occurs when the usual timeframe for appeal response may jeopardize the Member’s health. This expedited appeal may occur for a complaint or an adverse medical determination appeal.

CH 4.4 CHIP Program: Complaints & Appeals

What should I do if I have a Complaint?
A provider, Member, or someone acting on the behalf of the Member (“Complainant”) may initiate the complaint process either by telephone, in person, or in writing, expressing the details of the concerns.
Who do I call?
To initiate by telephone, the Complainant should call Customer Service at the number shown at the bottom of this page. The customer service representative will try to resolve the issue immediately. If the issue cannot be resolved during this phone call, the CSR will help the Complainant complete the Complaint Form and will route the issue to the appropriate department.

Can someone from Sendero help me file a Complaint?
If the Complainant needs help with filing the complaint, they should request this when calling Customer Services. Someone within SENDERO will help the complainant. (CHIP Members may call Customer Services at 1-877-451-5598 or 694-6780 to file a complaint.)

If a complaint is verbal (i.e. by telephone or in person), the Sendero representative receiving the initial communication will request that the complainant submit the complaint in writing, when possible. A Sendero Complaint Form will be sent to the complainant.

The Sendero Complaint Form can be found in Appendix A of this Manual. The mailing address and fax number where complaints may be directed is as follows:

Sendero Health Plans  
ATTN: Member Advocate  
Suite 510  
2028 E. Ben White Blvd.  
Austin, TX, 78741  
Fax Number – 512.275.2862

How long will it take to process my Complaint?
A written acknowledgement will be sent within five (5) business days, confirming receipt of the complaint. Sendero will resolve all complaints within thirty (30) calendar days from receipt of complaint. The Complainant will be sent a complaint resolution letter summarizing the results of the issue presented and setting out the complaint appeal process and timeframes for appeal.

If I am not satisfied with the outcome, who else can I contact? (How to file a Complaint Appeal)

If the Complainant is not satisfied with the complaint resolution, an appeal may be filed. An appeal must be filed within thirty (30) days of the date on the resolution letter. The resolution letter will provide information regarding the right to appeal before a Complaint Appeal Panel. In addition to appealing the response to Sendero, the Complainant has the right to contact the Texas Department of Insurance by calling 1-800-252-3439, or write them at P.O. Box 149104, Austin, Texas 78714-9104, if he/she is not satisfied with Sendero’s resolution.

CHIP Member Appeal Process for Denial of Services
CHIP Members have the right to appeal when services are denied. Listed below are common questions and procedure that will provide information regarding this appeal process.
What can I do if Sendero denies or limits my patient’s request for a covered service?
If the Member, provider, or someone acting on behalf of the Member, is denied a request for a covered service by Sendero, they may file an appeal to Sendero. (See the process below for filing an Appeal of Adverse Determination.)

How will I be notified if services are denied?
If the requested service is not able to be approved due to lack of medical necessity, the Medical Director will attempt to contact the requesting provider and discuss the situation with him/her prior to denying the service(s). A denial letter is sent out within three (3) days of the Medical Director making his/her coverage decision.

Can Someone from Sendero Help Me File an Appeal?
Members needing help with filing the appeal should call Customer Services toll free number and request this help. A Member Advocate will be available to help the Member. This includes help with filing an Expedited Appeal.

Appeal of Adverse Determination for CHIP Member

If the Sendero Medical Director determines that requested services do not meet medical necessity criteria, then coverage for medical services may be denied. The provider, Member or someone acting on behalf of the Member ("Appellant") is entitled to request the appeal process through Sendero Health Plans. The denial letter sent to the provider and Member will outline the process, along with the appropriate forms, to initiate the appeal. An appeal may be submitted orally or in writing. If the appeal is submitted orally, an appeal form will be sent with the acknowledgement letter for the Appellant to complete and return to Sendero. Appellant must submit the appeal in writing, signed by the Member or Member’s representative.

An acknowledgement letter will be sent to the Appellant within five (5) days of receipt of the appeal. The appeal will be reviewed by a Medical Director or physician designee who did not participate in the original denial and a decision will be rendered within thirty (30) days of receipt of the appeal. The decision letter will include the rationale for the decision, the name of the Specialist provider that may have helped in the decision, whether the denial has been overturned, partially overturned or upheld. If partially overturned or upheld, the appellant will receive information regarding the second level appeal process to have the issue reviewed by an Independent Review Organization. Appellant may request help with filing the 2nd level appeal by contacting Customer Services at the phone number at the bottom of this page.

Expedited Appeal for CHIP Member

A provider, Member or someone acting on behalf of the Member may request an expedited appeal if they believe the Member’s life or health could be jeopardized by the time frames involved in the normal appeal process. Appellant may file the request orally or in writing. In addition, the Appellant may request help in filing the appeal. They should contact Customer Services and request the help. Someone within Sendero will provide that help. During an expedited appeal, a health care provider who has not previously reviewed the case will review the appeal. The expedited appeal will be completed no later than one (1) working day following the day on which the appeal, including all information necessary to complete the appeal, is made to Sendero. If the appeal involves a life-threatening disease or condition for which the likelihood of death is probable if the course of treatment of the disease or condition is interrupted, the Appellant may request the case be directly forwarded.
to an Independent Review Organization (IRO), through the Texas Department of Insurance. The process must be initiated by Sendero, so the proper forms should be completed and submitted to Sendero as soon as possible – a Member Advocate is available to help the appellant complete the form.

Sendero will make every effort to honor the Appellant’s request for an expedited appeal. If the rationale for request does not meet the definition of an expedited appeal (decision warranted quickly due to the Member’s critical health outcome), Sendero may deny the request to expedite the review. If this happens, the provider may intervene on the Member’s behalf and discuss the situation with the Medical Director. The provider should contact the Medical Director by calling Health Services at the number shown at the bottom of this page. In the event the request for the appeal to be expedited does not meet criteria to be expedited, the appeal will be processed within the standard appeal process timeframes.

**Independent Review Organization Appeal through TDI for CHIP Members**

CHIP Members may request an appeal directly to an Independent Review Organization (IRO) through the Texas Department of Insurance (TDI). An IRO is an outside organization assigned by TDI to review the health plan’s denial of services.

Direct appeals to the IRO are available for those cases that involve a life-threatening disease or condition for which the likelihood of death is probable if the course of treatment for the disease or condition is interrupted. In addition, CHIP Members have the right to request an IRO for non-life threatening disease or conditions after exhausting Sendero’s internal appeal process.

Sendero must initiate this process. To request an IRO, the Appellant should contact Health Services at the phone number at the bottom of the page. Sendero will provide the Appellant with the necessary forms that must be completed and returned to Sendero. Sendero will send the request to TDI, who will appoint the IRO to review the case within one (1) business day of receipt of the request. TDI will notify the Appellant and Sendero who was appointed as the IRO. Sendero will then submit all required documentation to the IRO within three (3) business days. The IRO will make a decision within five (5) days from the date they receive the information from Sendero for life threatening situations, or within fifteen (15) days for non-life threatening situations. Decisions of the IRO are final and binding. Sendero will abide by the decision of the IRO, and will incur all expenses of the IRO review.
CH5 – CHIP Member Rights and Responsibilities

CH 5.1 Member Rights

1. You have a 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 that 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. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months and the health plan must continue paying for those services. Ask your plan about how this works.

10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.

11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to the CHIP Perinatal.

12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.

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

15. You have the right to be treated fairly by your health plan, doctors, hospitals and other providers.

16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

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

19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

**CH 5.2 Member Responsibilities**

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.

2. You must become involved in the doctor's decisions about your child's treatments.

3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.

4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.

5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.

6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers’ co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.

8. You must report misuse of CHIP services by health care providers, other Members, or health plans.
Texas CHIP Perinatal
CP1 – Eligibility of Members

CP 1.1 HHSC Determines Eligibility

The Texas Health and Human Services Commission (HHSC) is responsible for determining CHIP Perinatal eligibility. For information regarding eligibility, contact HHSC CHIP hotline at 1-800-647-6558.

For other help, call Sendero Customer Services at 1-877-451-5598.

CP 1.2 Role of Enrollment Broker

HHSC uses an Enrollment Broker to receive and process applications for CHIP Perinatal. The enrollment broker cannot authorize or determine eligibility. The role of the enrollment broker is to ensure that all required documentation and forms are gathered. Once eligibility is determined by HHSC, the enrollment broker mails out welcome letters and information on the available health plans in each area. The enrollment broker receives each Member’s plan and primary care provider selection documentation and notifies health plans of their new Members.

CP 1.3 General Eligibility for CHIP Perinatal

Unborn children of pregnant women who:

- Have a household income greater than 185% FPL and at or below 200% FPL.
- Have a household income at or below 200% FPL but do not qualify for Medicaid because of immigration status.

Women who are U.S. citizens or qualified immigrants with household income at or below 185% FPL may be eligible for coverage under Medicaid’s pregnant women program.

Pregnant Members are no longer automatically dis-enrolled from CHIP and placed in Medicaid. The member or provider should notify the enrollment broker when an uninsured or CHIP patient is pregnant and a re-determination for CHIP Perinatal or Medicaid eligibility occurs through HHSC. This process can take up to 60 days.

There is no spell of illness limitation for CHIP Perinatal Members.
• A CHIP Perinatal newborn whose birthdate on or after September 1, 2010, and 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 Perinatal newborn will continue to receive coverage through CHIP Perinatal as a “CHIP Perinatal Newborn” if: (1) born before September 1, 2010, or (2) if born on or after September 1, 2010, to a family with an income above 185% to 200% FPL.

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

• If the mother of the CHIP Perinatal newborn lives in an area with more than one CHIP/CHIP Perinatal MCO, and does not select an MCO within 15 calendar days of receiving the enrollment packet, the CHIP Perinatal newborn 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 the CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member’s health plan. 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, (2) the end of the traditional CHIP Program members’ enrollment period. In the 10th month of the CHIP Perinatal 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 Perinatal Newborn’s and the CHIP Program members’ information. Once the child’s CHIP Perinatal coverage expires, the child will be added to his or her siblings’ existing CHIP program case.

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**CP 1.4 Span of Eligibility (Members’ Right to Change Health Plans) – CHIP Perinatal**

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

• o for any reason within 90 days of enrollment in the CHIP Perinatal; and

• o for cause at any time.

Requests are forwarded to HHSC, the Administrative Services Contractor, who makes the final determination. For more information, contact the CHIP Helpline at **1-800-647-6558**.

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**CP 1.5 Disenrollment from Health Plan**

Disenrollment may occur if a Member loses CHIP Perinatal eligibility. A CHIP Perinatal Member can lose eligibility for the following reasons:

• Change in health insurance status, i.e., a Member enrolls in an employer sponsored health plan
- Death of a Member
- Member permanently moves out of the state
- Member or authorized representative requests voluntary disenrollment in writing

Providers may not request that a Member be disenrolled from the health plan, and from managed care, without good cause. The provider cannot make this request due to retaliatory action against the Member.

Sendero can also request a Member be disenrolled from Sendero for the following reasons:

- Fraud or intentional material misrepresentation
- Fraud in the use of services or facilities
- Misconduct that is detrimental to safe plan operations and the delivery of services
- Failure to establish a satisfactory patient/physician or patient/provider relationship
- Member no longer lives or resides in the service area

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

All requests are forwarded to HHSC, who makes the final decision.
CP2 – Covered Services

CP 2.1 Medically Necessary Services

What does medically necessary mean?

Covered services for CHIP Perinatal Members must meet the CHIP Perinatal definition of "Medically Necessary."

"Medically Necessary" means:

2. Health Care Services 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 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. not experimental or investigational; and
   g. not primarily for the convenience of the Member or Provider.

2. Behavioral Health Services that are:
   e. reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
   f. provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
   g. not experimental or investigative; and
   h. not primarily for the convenience of the Member or Provider.
## CP 2.2 CHIP Perinatal Covered Services

<table>
<thead>
<tr>
<th>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</th>
<th>Services include, but are not limited to, the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Hospital-provided Physician or Provider services</td>
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<tr>
<td>□ Semi-private room and board (or private if medically necessary as certified by attending)</td>
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<tr>
<td>□ General nursing care</td>
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<td>□ Special duty nursing when medically necessary</td>
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<td>□ ICU and services</td>
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<td>□ Patient meals and special diets</td>
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<tr>
<td>□ Operating, recovery and other treatment rooms</td>
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<tr>
<td>□ Anesthesia and administration (facility technical component)</td>
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<tr>
<td>□ Surgical dressings, trays, casts, splints</td>
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<tr>
<td>□ Drugs, medications and biologicals</td>
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<tr>
<td>□ Blood or blood products that are not provided free-of-charge to the patient and their administration</td>
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<tr>
<td>□ X-rays, imaging and other radiological tests (facility technical component)</td>
<td></td>
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<tr>
<td>□ Laboratory and pathology services (facility technical component)</td>
<td></td>
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<tr>
<td>□ Machine diagnostic tests (EEGs, EKGs, etc.)</td>
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<tr>
<td>□ Oxygen services and inhalation therapy</td>
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<tr>
<td>□ Radiation and chemotherapy</td>
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<tr>
<td>□ Access to DSHE-designated Level III perinatal centers or Hospitals meeting equivalent levels of care</td>
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<tr>
<td>□ 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.</td>
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<tr>
<td>□ Hospital, physician and related medical services, such as anesthesia, associated with dental care</td>
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<tr>
<td>□ Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:</td>
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<tr>
<td></td>
<td>□ dilation and curettage (D&amp;C) procedures;</td>
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<td></td>
<td>□ appropriate provider-administered medications;</td>
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<td></td>
<td>□ ultrasounds, and</td>
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<td></td>
<td>□ histological examination of tissue samples</td>
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<tr>
<td>□ Surgical implants</td>
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<tr>
<td>□ Other artificial aids including surgical implants</td>
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</tbody>
</table>

For CHIP Perinatals in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit.

For CHIP Perinatals in families with incomes above 185% to 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy.

Services include:
- Operating, recovery and other treatment rooms
- Anesthesia and administration (facility technical component)

Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).

Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
- dilation and curettage (D&C) procedures;
- appropriate provider-administered medications;
- ultrasounds, and
- histological examination of tissue samples.
- Inpatient services for a mastectomy and breast reconstruction include:
  - all stages of reconstruction on the affected breast;
  - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
  - surgery and reconstruction on the other breast to produce symmetrical appearance; and
  - treatment of physical complications from the mastectomy and treatment of lymphedemas.
- Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit
- Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
  - cleft lip and/or palate; or
  - severe traumatic skeletal and/or congenital craniofacial deviations; or
  - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth
  - or its treatment.

<table>
<thead>
<tr>
<th>Skilled Nursing Facilities (Includes Rehabilitation Hospitals)</th>
<th>Services include, but are not limited to, the following:</th>
<th>Not a covered benefit.</th>
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</thead>
<tbody>
<tr>
<td>- Semi-private room and board</td>
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<tr>
<td>- Regular nursing services</td>
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<tr>
<td>- Rehabilitation services</td>
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<tr>
<td>- Medical supplies and use of appliances and equipment furnished by the facility</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center</th>
<th>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:</th>
<th>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:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- X-ray, imaging, and radiological tests (technical component)</td>
<td>- Laboratory and pathology services (technical component)</td>
<td>- X-ray, imaging, and radiological tests (technical component)</td>
</tr>
<tr>
<td>- Laboratory and pathology services (technical component)</td>
<td>- Machine diagnostic tests</td>
<td>- Laboratory and pathology services (technical component)</td>
</tr>
<tr>
<td>- Machine diagnostic tests</td>
<td>- Ambulatory surgical facility services</td>
<td>- Machine diagnostic tests</td>
</tr>
<tr>
<td>- Drugs, medications and biologicals</td>
<td>- Emergency services</td>
<td>- Drugs, medications and biologicals that are medically necessary</td>
</tr>
<tr>
<td>- Casts, splints, dressings</td>
<td>- Preventive health services</td>
<td>- prescription and injection drugs.</td>
</tr>
<tr>
<td>- Physical, occupational and speech therapy</td>
<td>- Respiratory services</td>
<td>- Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not</td>
</tr>
<tr>
<td>- Renal dialysis</td>
<td>- Radiation and chemotherapy</td>
<td>supported.</td>
</tr>
<tr>
<td>- Respiratory services</td>
<td>- Medical supplies and use of appliances and equipment furnished by the facility</td>
<td></td>
</tr>
</tbody>
</table>

- Skilled Nursing Facilities
- Rehabilitation Hospitals
- Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center)
- Ambulatory Health Care Center
- Blood or blood products that are not provided free-of-charge to the patient and the administration of these products.
- Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  - dilation and curettage (D&C) procedures;
  - appropriate provider-administered medications;
  - ultrasounds, and
  - histological examination of tissue samples.
- 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
- Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:
  - all stages of reconstruction on the affected breast;
  - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
  - surgery and reconstruction on the other breast to produce symmetrical appearance; and
  - treatment of physical complications from the mastectomy and treatment of lymphedemas.
- Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit
- Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
  - cleft lip and/or palate; or
  - severe traumatic skeletal and/or congenital craniofacial deviations; or
- Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.

limited to:
- dilation and curettage (D&C) procedures;
- appropriate provider-administered medications;
- ultrasounds, and
- histological examination of tissue samples.

1. Laboratory and radiological services are limited to services that directly relate to antepartum care and/or the delivery of the covered CHIP Perinatal until birth.
2. Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or non-viable pregnancy.
3. Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis.
4. Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RH immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.
5. Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.
<table>
<thead>
<tr>
<th>Physician/Physician Extender</th>
<th>Services include, but are not limited to, the following:</th>
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<tbody>
<tr>
<td></td>
<td>• medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:</td>
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<tr>
<td></td>
<td>□ cleft lip and/or palate; or</td>
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<tr>
<td></td>
<td>□ severe traumatic skeletal and/or congenital craniofacial deviations; or</td>
</tr>
<tr>
<td></td>
<td>□ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prenatal Care and Pre-Pregnancy Family Services and Supplies</th>
<th>Not a covered benefit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include:</td>
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<tr>
<td>(1) One (1) visit every four (4) weeks for the first 28 weeks or pregnancy;</td>
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<tr>
<td>(2) one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and</td>
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<tr>
<td>(3) one (1) visit per week from 36 weeks to delivery.</td>
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</tbody>
</table>

More frequent visits are allowed as Medically Necessary. Benefits are limited to:

Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician’s files and is subject to retrospective review.

Visits after the initial visit must include:

□ interim history (problems, marital status, fetal status);

□ physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and

□ laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rh immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
<table>
<thead>
<tr>
<th><strong>Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies</strong></th>
<th>S$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:</th>
<th>Not a covered benefit.</th>
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</thead>
<tbody>
<tr>
<td>- Orthotic braces and orthotics</td>
<td>- Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses</td>
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<tr>
<td>- Dental devices</td>
<td>- Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease</td>
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<tr>
<td>- Hearing aids</td>
<td>- Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A)</td>
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<tr>
<td><strong>Home and Community Health Services</strong></td>
<td>Services that are provided in the home and community, including, but not limited to:</td>
<td>Not a covered benefit.</td>
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<tr>
<td></td>
<td>- Home infusion</td>
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<td></td>
<td>- Respiratory therapy</td>
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<td></td>
<td>- Visits for private duty nursing (R.N., L.V.N.)</td>
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<td></td>
<td>- Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).</td>
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<td>- Home health aide when included as part of a plan of care during a period that skilled visits have been approved.</td>
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<td>- Speech, physical and occupational therapies.</td>
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<td></td>
<td>- Services are not intended to replace the CHILD’S caretaker or to provide relief for the caretaker</td>
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<td>- Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services</td>
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<td></td>
<td>- Services are not intended to replace 24-hour inpatient or skilled nursing facility services</td>
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<tr>
<td><strong>Inpatient Mental Health Services</strong></td>
<td>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:</td>
<td>Not a covered benefit.</td>
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<tr>
<td></td>
<td>- Neuropsychological and psychological testing.</td>
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<td></td>
<td>- When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination</td>
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<tr>
<td></td>
<td>- Does not require PCP referral</td>
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<tr>
<td>Outpatient Mental Health Services</td>
<td>Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:</td>
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<td>- The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility</td>
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<td>- Neuropsychological and psychological testing</td>
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<td></td>
<td>- Medication management</td>
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<td>- Rehabilitative day treatments</td>
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<td></td>
<td>- Residential treatment services</td>
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<td></td>
<td>- Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment)</td>
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<td></td>
<td>- Skills training (psycho-educational skill development)</td>
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<tr>
<td></td>
<td>- When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination</td>
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<td></td>
<td>- A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DHS-contracted Local Mental Health Authority or a separate DHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services</td>
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<td>- Does not require PCP referral</td>
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<tr>
<td>Inpatient Substance Abuse Treatment Services</td>
<td>Services include, but are not limited to:</td>
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<td></td>
<td>- Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs</td>
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<tr>
<td></td>
<td>- Does not require PCP referral</td>
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<tr>
<td>Outpatient Substance Abuse Treatment Services</td>
<td>Services include, but are not limited to, the following:</td>
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<tr>
<td></td>
<td>- Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.</td>
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<td>- Intensive outpatient services</td>
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<td></td>
<td>- Partial hospitalization</td>
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<td></td>
<td>Not a covered benefit.</td>
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<tr>
<td></td>
<td>Not a covered benefit.</td>
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<tr>
<td><strong>Intensive outpatient services</strong></td>
<td>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 four to 12 weeks, but less than 24 hours per day.</td>
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<tr>
<td><strong>Outpatient treatment service</strong></td>
<td>Defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training.</td>
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<tr>
<td><strong>Does not require PCP referral</strong></td>
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</tbody>
</table>

| **Rehabilitation Services** | Services include, but are not limited to, the following: |
| **Habilitation** | (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: |
| **Physical, occupational and speech therapy** | |
| **Developmental assessment** | |
| **Not a covered benefit.** | |

| **Hospice Care Services** | Services include, but are not limited to: |
| **Palliative care** | including medical and support services, for those children who have six (6) months or less to live, to keep patients comfortable during the last weeks and months before death. |
| **Treatment services** | including treatment related to the terminal illness. |
| **Up to a maximum of 120 days** | with a 6 month life expectancy. |
| **Patients electing hospice services** | May cancel this election at anytime. |
| **Services apply to the hospice diagnosis.** | |
| **Not a covered benefit.** | |

| **Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services** | MCO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. |
| **Covered services** | but are not limited to, the following: |
| **Emergency services** | based on prudent layperson definition of emergency health condition. |
| **Hospital emergency department room and ancillary services and physician services 24 hours a day, seven (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 or hospitals meeting equivalent levels of care for emergency services.** | |
| **MCO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery.** | Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. |
| **Emergency services based on prudent layperson definition of emergency health condition.** | |
| **Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child.** | |
| **Stabilization services related to the labor with delivery of the covered.** | |
CP 2.3 EXCLUSIONS for CHIP Perinatal Member Benefits

- For CHIP Perinatal Members in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth.
- 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 labor or threatened labor, miscarriage or non-viable pregnancy, and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or postpartum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery.
- Prostate and mammography screening.
● Elective surgery to correct vision
● Gastric procedures for weight loss
● Cosmetic surgery/services solely for cosmetic purposes
● Out-of-network services not authorized by the Health Plan except for emergency care related to the labor with delivery of the covered unborn child.
● Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
● 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
● Charges incurred as a donor of an organ

**CP 2.4 DME/SUPPLIES – for CHIP Perinatal Newborn Members**

**Note:** DME/SUPPLIES are not a covered benefit for CHIP Perinatal Members (Unborn Child).

<table>
<thead>
<tr>
<th>SUPPLIES</th>
<th>COVERED</th>
<th>EXCLUDED</th>
<th>COMMENTS/MEMBER CONTRACT PROVISIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ace Bandages</td>
<td></td>
<td>X</td>
<td>Exception: If given by and billed through the clinic or home care agency it is covered as an incidental supply.</td>
</tr>
<tr>
<td>Alcohol, rubbing</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Alcohol, swabs</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply not covered, unless RX given at time of dispensing.</td>
</tr>
<tr>
<td>(diabetic)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol, swabs</td>
<td></td>
<td>X</td>
<td>Covered only when received with IV therapy or central line kits/supplies.</td>
</tr>
<tr>
<td>Ana Kit Epinephrine</td>
<td></td>
<td>X</td>
<td>A self-injection kit used by patients highly allergic to bee stings.</td>
</tr>
<tr>
<td>SUPPLIES</td>
<td>COVERED</td>
<td>EXCLUDED</td>
<td>COMMENTS/MEMBER CONTRACT PROVISIONS</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------</td>
<td>----------</td>
<td>----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Arm Sling</td>
<td>X</td>
<td></td>
<td>Dispensed as part of office visit.</td>
</tr>
<tr>
<td>Attends (Diapers)</td>
<td>X</td>
<td></td>
<td>Coverage limited to children age 4 or over only when prescribed by a doctor and used to give care for a covered diagnosis as outlined in a treatment care plan</td>
</tr>
<tr>
<td>Bandages</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Basal Thermometer</td>
<td>X</td>
<td></td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Batteries – first</td>
<td>X</td>
<td></td>
<td>For covered DME items</td>
</tr>
<tr>
<td>Batteries – replacement</td>
<td>X</td>
<td></td>
<td>For covered DME when replacement is necessary due to normal use.</td>
</tr>
<tr>
<td>Betadine</td>
<td>X</td>
<td></td>
<td>See IV therapy supplies.</td>
</tr>
<tr>
<td>Books</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Clinitest</td>
<td>X</td>
<td></td>
<td>For monitoring of diabetes.</td>
</tr>
<tr>
<td>Colostomy Bags</td>
<td></td>
<td></td>
<td>See Ostomy Supplies.</td>
</tr>
<tr>
<td>Communication Devices</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Contraceptive Jelly</td>
<td>X</td>
<td></td>
<td>Over-the-counter supply. Contraceptives are not covered under the plan.</td>
</tr>
<tr>
<td>Cranial Head Mold</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dental Devices</td>
<td>X</td>
<td></td>
<td>Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>X</td>
<td></td>
<td>Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.</td>
</tr>
<tr>
<td>Diapers/Incontinent Briefs/Chux</td>
<td>X</td>
<td></td>
<td>Coverage limited to children age 4 or over only when prescribed by a doctor and used to give care for a covered diagnosis as outlined in a treatment care plan</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>X</td>
<td></td>
<td>Contraceptives are not covered under the plan.</td>
</tr>
<tr>
<td>Diastix</td>
<td>X</td>
<td></td>
<td>For monitoring diabetes.</td>
</tr>
<tr>
<td>Diet, Special</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Distilled Water</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dressing Supplies/Central Line</td>
<td>X</td>
<td></td>
<td>Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change</td>
</tr>
<tr>
<td>Dressing Supplies/Decubitus</td>
<td>X</td>
<td></td>
<td>Able to get coverage only if receiving covered home care for wound care.</td>
</tr>
<tr>
<td>Dressing Supplies/Peripheral IV Therapy</td>
<td>X</td>
<td></td>
<td>Able to get coverage only if receiving home IV therapy.</td>
</tr>
<tr>
<td>Dressing Supplies/Other</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dust Mask</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ear Molds</td>
<td>X</td>
<td></td>
<td>Custom made, post inner or middle ear surgery</td>
</tr>
<tr>
<td>Electrodes</td>
<td>X</td>
<td></td>
<td>Able to get coverage when used with a covered DME.</td>
</tr>
<tr>
<td>Enema Supplies</td>
<td></td>
<td>X</td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Enteral Nutrition Supplies</td>
<td>X</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>Eye Patches</td>
<td>X</td>
<td></td>
<td>Covered for patients with amblyopia.</td>
</tr>
</tbody>
</table>
| Formula                  |         | X        | Exception: Able to get 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 doctor and authorized by plan.) Doctor documentation to justify prescription of formula must include:  
  - Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrosomy, or disease resulting in malabsorption that requires a medically necessary nutritional product  
  Does not include formula:   |
<table>
<thead>
<tr>
<th>SUPPLIES</th>
<th>COVERED</th>
<th>EXCLUDED</th>
<th>COMMENTS/MEMBER CONTRACT PROVISIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food thickeners, baby food, or other regular grocery products that can be blended 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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloves</td>
<td>X</td>
<td></td>
<td>Exception: Central line dressings or wound care given by home care agency.</td>
</tr>
<tr>
<td>Hydrogen Peroxide</td>
<td>X</td>
<td></td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Hygiene Items</td>
<td>X</td>
<td></td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Incontinent Pads</td>
<td>X</td>
<td></td>
<td>Coverage limited to children age 4 or over only when prescribed by a doctor and used to give care for a covered diagnosis as outlined in a treatment care plan.</td>
</tr>
<tr>
<td>Insulin Pump (External) Supplies</td>
<td>X</td>
<td></td>
<td>Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.</td>
</tr>
<tr>
<td>Irrigation Sets, Wound Care</td>
<td>X</td>
<td></td>
<td>Able to get coverage when used during covered home care for wound care.</td>
</tr>
<tr>
<td>Irrigation Sets, Urinary</td>
<td>X</td>
<td></td>
<td>Able to get coverage for person with an indwelling urinary catheter.</td>
</tr>
<tr>
<td>IV Therapy Supplies</td>
<td>X</td>
<td></td>
<td>Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.</td>
</tr>
<tr>
<td>K-Y Jelly</td>
<td>X</td>
<td></td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Lancet Device</td>
<td>X</td>
<td></td>
<td>Limited to one device only.</td>
</tr>
<tr>
<td>Lancets</td>
<td>X</td>
<td></td>
<td>Able to get coverage for person with diabetes.</td>
</tr>
<tr>
<td>Med Ejector</td>
<td>X</td>
<td></td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Needles and Syringes/Diabetic</td>
<td>X</td>
<td></td>
<td>See Diabetic Supplies.</td>
</tr>
<tr>
<td>Needles and Syringes/IV and Central Line</td>
<td>X</td>
<td></td>
<td>See IV Therapy and Dressing Supplies/Central Line.</td>
</tr>
<tr>
<td>Needles and Syringes/Other</td>
<td>X</td>
<td></td>
<td>Able to get coverage if a covered IM or SubQ medication is being administered at home.</td>
</tr>
<tr>
<td>Normal Saline</td>
<td>X</td>
<td></td>
<td>See Saline, Normal.</td>
</tr>
<tr>
<td>Novopen</td>
<td>X</td>
<td></td>
<td>Over-the-counter supply.</td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>X</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Parenteral Nutrition/Supplies</td>
<td>X</td>
<td></td>
<td>Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.</td>
</tr>
<tr>
<td>Saline, Normal</td>
<td>X</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Stump Sleeve</td>
<td>X</td>
<td></td>
<td>See Needles/Syringes.</td>
</tr>
<tr>
<td>Stump Socks</td>
<td>X</td>
<td></td>
<td>See Needles/Syringes.</td>
</tr>
<tr>
<td>Suction Catheters</td>
<td>X</td>
<td></td>
<td>See Needles/Syringes.</td>
</tr>
</tbody>
</table>
SUPPLIES | COVERED | EXCLUDED | COMMENTS/MEMBER CONTRACT PROVISIONS
--- | --- | --- | ---
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.
Umma 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 Primary Care Provider 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 Catheter & Supplies | X | | Cover supplies needed for intermittent or straight catherization.
Urine Test Kit | X | | When decided to be medically necessary.
Urostomy supplies | | | See Ostomy Supplies.

**CP 2.5 Sendero’s Value Added Service**

In addition to the benefits included in the CHIP Perinatal, Sendero provides certain value added services for Members. The Sendero value added services are:

<table>
<thead>
<tr>
<th>Value Added Service</th>
<th>CHIP Perinatal NEWBORN Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Line</td>
<td>SERVICE: Sendero will make available to the caregivers of CHIP Perinatal Newborn Members a 24 hour a day, 365 days per year nurse advice line. Caregivers will be able to access the nurse line via a toll-free telephone number. The nurse line will be able to assist the Caregiver with various health-related questions, as well as provide guidance as to when to access emergency facilities for the newborn member.</td>
</tr>
<tr>
<td>Extra Help with Getting a Ride</td>
<td>SERVICE: Sendero will help arrange transportation to physician appointments for the Perinatal Newborn beyond those services covered by the MTP program LIMITATIONS: plan reserves the right to determine medical necessity</td>
</tr>
</tbody>
</table>

In addition to the benefits for the CHIP Perinatal Member (unborn child), Sendero provides certain value added services for mother of the unborn Member. The Sendero value added services are:

<table>
<thead>
<tr>
<th>Value Added Service</th>
<th>CHIP Perinatal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Line</td>
<td>SERVICE: Sendero will make available to CHIP Perinatal expectant mothers a 24 hour a day, 365 days per year nurse advice line. Members will be able to access the nurse line via a toll-free telephone number. The nurse line will be able to assist Members with various health-related questions, as well as provide guidance as to when to access emergency facilities.</td>
</tr>
<tr>
<td>Value Added Service</td>
<td>CHIP Perinatal</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Temporary Cell Phone</td>
<td>SERVICE: Sendero will provide pre-programmed cell phones to pregnant Members who are determined to be high-risk. This service will permit these Members to be in touch on both inbound and outbound call with the Plan’s health Service care coordinator and the PCP/OB in order to ask questions and receive advice, reminded of appointments, arrange for transportation and to contact 911 in case of emergency. LIMITATION: As it applies only to female Members who are determined high-risk for the duration of their pregnancy and the immediate postpartum period.</td>
</tr>
<tr>
<td>Gifts for New Mothers</td>
<td>SERVICE: Sendero will provide up to $50 worth of health items for pregnant Members who complete at least eight (8) prenatal visits to their OB during pregnancy. At least 1 gift will be for Member. LIMITATION: As it applies only to pregnant Members and the completion of the minimum required number of eight (8) prenatal appointments while a Member of Sendero.</td>
</tr>
<tr>
<td>Extra Help with Getting a Ride</td>
<td>SERVICE: Sendero will help arrange transportation to physician appointments. LIMITATIONS: plan reserves the right to determine medical necessity</td>
</tr>
<tr>
<td>Extra Dental Benefits Adults Age 20 and Older and Pregnant Women</td>
<td>SERVICE: Sendero will pay for up to $250 in dental services each year for pregnant member. LIMITATIONS: value limited to $250 and for pregnant members only</td>
</tr>
</tbody>
</table>

**CP 2.6 NON-CHIP Perinatal Covered Services (non-Capitated Services)**

Non-CHIP Perinatal Covered Services include the following:

*Texas Agency Administered Programs and Case Management Services*

Texas Department of Family and Protective Services (DFPS):

Sendero’s network of providers coordinates with DFPS (and associated foster parents) to ensure that the at risk population, both children in custody and not in custody of DFPS, receive the services they need. Children who are served by DFPS may transition into and out of Sendero more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the Service Area. During the transition period and beyond, providers must:

- Provide medical records to DFPS
- Schedule medical and behavioral health appointments within 14 days unless requested earlier by DFPS
- Participate, when requested by DFPS, in planning to establish permanent homes for Members
- Refer suspected cases of abuse or neglect to DFPS

For help with Member and DFPS, providers should call Sendero’s Health Services Department.
**Essential Public Health Services**

Sendero is required through its contractual relationship with HHSC to coordinate with Public Health Entities regarding provision of services for essential public health services. Providers must assist Sendero in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunizations as defined by State Law.
- Assisting in notifying or referring to the local Public Health Entity, as defined by state law, any communicable disease outbreaks involving Members
- Referring to the local Public Health Entity for Tuberculosis contact investigation and evaluation and preventive treatment of person whom the Member has come into contact
- Referring to the local Public Health Entity for Sexually Transmitted Diseases and HIV contact investigation, evaluation and preventive treatment of persons whom the Member has come into contact
- Referring for Women, Infant, and Children (WIC) services and information sharing
- Assisting in the coordination and follow up of suspected or confirmed cases of childhood lead exposure
- Reporting of immunizations provided to the statewide ImmTrac Registry including parental consent to share data
- Cooperating with activities required of public health authorities to conduct the annual population and community based needs assessment
- Referring lead screening tests to the Department of State Health Services (for levels 40 or higher). To report lead poisoning, provider can complete the applicable form for Children or Adults and fax it to 512-776-7699, or call DSHS at 512-776-7269 or toll free at 1-800-588-1248. The following information must be reported: child’s name, address, date of birth, sex, race and ethnicity; blood lead level concentration, test date, name and telephone number of testing laboratory; whether the sample was capillary or venous blood; and the name and city of the attending physician.

Sendero’s RN Care Coordinators will help organize services with the Member, the Member’s primary care provider and the public health entity. In cases where services are coordinated and subject to applicable laws, rules and regulations concerning confidentiality of certain health information, the public health entity is requested to provide a written report to the primary care provider concerning the services provided by the public health entity.

**Early Childhood Intervention (ECI) Case Management/Service Coordination**

The Texas Department of Assistive and Rehabilitative Services oversees the Early Childhood Intervention program for the State of Texas. Case management and service coordination are provided to children from birth to three (3) years with a developmental disability and/or developmental delay. Eligibility for the program is determined by 1) a delay in one or more area of development; 2) atypical development in which children perform within their appropriate age arrange on test instruments, but whose patterns of development are different from their peers, and 3) a medically diagnosed condition that has a high probability of resulting in a developmental delay. The PCP will receive a copy of Individualized Family Service Plan (IFSP) for our Members from ECI. PCP’s are encouraged to refer Members with disabilities or developmental delays, birth to three (3) years of age, to ECI for services. For more information about ECI or to refer a child, call the DARS Inquiries Line at 1-800-628-5115.
Mental Health Targeted Case Management

Individuals served through the Texas Department of State Health Services (DSHS) Mental Health and Substance Abuse (MHSA) program are eligible for services including advocacy, assessment, linkage, monitoring, crisis intervention, and referral and planning and coordination of services. Priority population include: substance abuse, mental retardation, autism, pervasive development disorder, children at risk of removal from preferred environment, children determined by the school system to have a serious emotional disturbance, children at risk of disruption of the preferred living situation due to psychological symptoms or those with a functional impairment – GAF (Global Assessment Function) of 50 or below. Providers may obtain information through the MHSA website: www.dshs.state.tx.us/MHSA or by contacting Network Management.

Texas Department of Assistive and Rehabilitative Services (DARS)

DARS may provide additional case management services for the blind and visually impaired Members. This is limited to one contact per client, per month. The main office in Austin may be contacted at 1-800-252-5204 or by visiting their website at http://www.dars.state.tx.us/dbs/.

Tuberculosis Services Provided by DSHS Approved Provider

All confirmed or suspected cases of Tuberculosis must be referred to the Infectious Disease Control Unit of the DSHS using the forms and procedures for reporting TB adopted by DSHS. Sendero will assist providers in referring to the Local Tuberculosis Control Health Authority within 1 day of diagnosis for a contact investigation. The provider must document the referral to the local health authority in the Member’s medical records that may be reviewed by DSHS and the local authority. Providers should notify Sendero on any referral made to the local health authority.

Sendero must coordinate with the local health authority to ensure that Members with confirmed or suspected TB have a contact investigation and receive directly observed therapy. Sendero will report any Member who is non-compliant, drug-resistant, or who is or may be posing a health threat to DSHS or the local authority. Sendero will cooperate with the local health authority in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Health and Safety Code.

DADS Hospice Services

The Department of Aging and Disability Services (DADS) manages the Hospice Program through provider enrollment contracts with hospice agencies. Coverage of services follow the amount duration and scope of services specified in the Medicare Hospice Program. Hospice pays for services related to the treatment of the client’s terminal illness and for certain physician services (not the treatments). Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

CP 2.7 Pharmacy/Navitus

The CHIP Perinatal newborn’s prescriptions and the CHIP Perinatal mother’s prenatal vitamins are covered by the CHIP Perinatal. Sendero Health Plans has an arrangement with Navitus Health Solutions, a pharmacy benefit management company to administer pharmacy benefits for the CHIP Perinatal. For questions related to the formulary, preferred drug list, prescription over-rides, quantity limits, brand necessity or formulary
exceptions, please contact Navitus at 877-908-6023 or access the Navitus website through www.senderohealth.com.
The only drugs eligible for are listed in the current Texas listing of National Drug Codes. Sendero will assist its Members with medication management through the primary care providers and/or Specialists.

**NAVITUS SUPPORTS E-PRESCRIBING FOR MEDICAID**

- Navitus provides point of care information available through Surescripts
  - Eligibility confirmation
  - Daily updates to eligibility facilitator
- Medication history
- Formulary and PDL benefit confirmation
- Formulary “alternative” drug list
- Formulary lists will be updated no less frequently than weekly
- Navitus expects pharmacies to have ability to accept e-prescriptions and facilitate refills with prescribers

**DME**

Navitus will encourage Texas Medicaid Network Pharmacies to become Medicaid-enrolled durable medical equipment (DME) providers with the MCO’s in their Service Areas.

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**CP 2.8 Co-Pay Information for CHIP Perinatal Members**

There are no co-payments for CHIP Perinatal Members or CHIP Perinatal Newborn Members.

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**CP 2.9 OB/GYN**

Sendero allows you to pick an OB/GYN but this doctor must be in the same network as your Primary Care Provider.

**ATTENTION FEMALE MEMBERS**

- You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you care related to your current pregnancy
CP3 – Well Child Exams

Well Child Exams are for children’s health checkups. These checkups are important and Members should set up an appointment with their primary care provider within 45 days of becoming a Sendero Member. Even if a child looks and feels well, he or she may still have a problem. Well Child Exams can help in many ways. Some of the things done in a medical checkup are:

- Physical exam, measuring height and weight;
- Hearing and eye check;
- Checking for a good diet;
- Immunizations (when needed);
- Blood tests (when needed)
- TB test

CP 3.1 Periodicity Schedule and Immunization Requirements

Providers are required to follow the periodicity schedule as defined by the American Academy of Pediatrics (AAP) and/or the Centers for Disease Control and Prevention. Providers are required to participate with the Texas Vaccines for Children Program (TVFC).

CP 3.2 Texas Vaccines for Children (TVFC) Program

The Texas Vaccines for Children Program provides free vaccines to CHIP members who are younger than 19 years of age that are routinely recommended according to the American Academy of Pediatrics (AAP) immunization schedule. To obtain free vaccine, the provider must enroll in the TVFC program through Department of State Health Services (DSHS). There is no reimbursement to providers for vaccines available from TVFC although reimbursement is available for the administration of the vaccines. For more information, contact DSHS at 800-252-9152 or 512-776-7284 or Network Management at phone number below.
CP4 – Complaints & Appeals

CP 4.1 Introduction

Sendero has established procedures for handling and resolving complaints and appeals. If a provider or Member is not satisfied with the resolution of a complaint, an appeal can be filed. Sendero Customer Services is available to assist those persons requiring assistance with the filing of a complaint or appeal. It is Sendero’s goal to resolve all complaints. A Member or provider may initiate the complaint process either by telephone, in person, or in writing, expressing the details of the concerns. Providers may submit complaints to Sendero or to the Texas Department of Insurance. Sendero would prefer that complaints come to the Sendero Quality Improvement Department before going to a state agency.

CP 4.2 What is a Complaint?

A complaint is a verbal or written expression of dissatisfaction with Sendero Health Plans concerning a process within the health plan. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the provider. It is anticipated that the majority of the verbal and written complaints would be resolved with Sendero.

CP 4.3 What is an Appeal?

There are three (3) types of appeals. They are:

- **Complaint Appeal** is an appeal that occurs when the complainant is not satisfied with the outcome of the complaint. This is not a medical necessity determination appeal.
- **Adverse Medical Determination Appeal** is an appeal that occurs when there has been a denial of benefit because of lack of medical necessity.
- ** Expedited Appeal** is an appeal at an expedited rate that occurs when the usual timeframe for appeal response may jeopardize the Member’s health. This expedited appeal may occur for a complaint or an adverse medical determination appeal.

CP 4.4 CHIP Perinatal: Complaints & Appeals

What should I do if I have a Complaint?

A provider, Member, or someone acting on the behalf of the Member (“Complainant”) may initiate the complaint process either by telephone, in person, or in writing,expressing the details of the concerns.
Who do I call?
To initiate by telephone, the Complainant should call Customer Service at the number shown at the bottom of this page. The customer service representative (CSR) will try to resolve the issue immediately. If the issue cannot be resolved during this phone call, the CSR will help the Complainant complete the Complaint Form and will route the issue to the appropriate department.

Can someone from Sendero help me file a Complaint?
If the Complainant needs help with filing the complaint, they should request this when calling Customer Services. Someone within Sendero will help the complainant. If a complaint is verbal (i.e. by telephone or in person), the Sendero representative receiving the initial communication will request that the complainant submit the complaint in writing. A Sendero Complaint Form will be sent to the complainant. The Sendero Complaint Form can be found in Appendix A of this Manual. The mailing address and fax number where complaints may be directed is as follows:

    Sendero Health Plans  
    ATTN: Member Advocate  
    Suite 510  
    2028 E. Ben White Blvd.  
    Austin, TX, 78741

Fax Number – 512.275.2862

How long will it take to process my Complaint?
A written acknowledgement will be sent within five (5) business days, confirming receipt of the complaint. Sendero will resolve all complaints within thirty (30) calendar days from receipt of complaint. The Complainant will be sent a complaint resolution letter summarizing the results of the issue presented and setting out the complaint appeal process and timeframes for appeal.

If I am not satisfied with the outcome, who else can I contact? (How to file a Complaint Appeal)
If the Complainant is not satisfied with the complaint resolution, an appeal may be filed. An appeal must be filed within thirty (30) days of the date on the resolution letter. The resolution letter will provide information regarding the right to appeal before a Complaint Appeal Panel. In addition to appealing the response to Sendero, the Complainant has the right to contact the Texas Department of Insurance by calling 1-800-252-3439, or write them at P.O. Box 149104, Austin, Texas 78714-9104, if he/she is not satisfied with Sendero’s resolution.

CHIP Perinatal Member Appeal Process for Medical Necessity Denial of Services
CHIP Perinatal Members have the right to appeal when services are denied based on lack of medical necessity. Listed below are common questions and processes that will provide information regarding this appeal process.

- What can I do if Sendero denies or limits my patient’s request for a covered service?
  If the Member, provider, or someone acting on behalf of the Member, is denied a request for a covered service by Sendero, they may file an appeal to Sendero. (See the process below for filing an Appeal of Adverse Determination.)
- **How will I be notified if services are denied?**
  The Member and provider will be notified of the denial of services within three days of the Sendero Medical director rendering the decision via a letter. If the denial is a medical necessity denial, the Medical Director issuing the denial will attempt to contact the requesting provider and discuss the situation with him/her prior to denying the services. A denial letter is sent out within three (3) days of making the decision.

- **Can Someone from Sendero Help Me File an Appeal?**
  Members needing help with filing the appeal should call Customer Services toll free number at the number below and request this help. A Member Advocate will be available to help the Member. This includes help with filing an Expedited Appeal.

### Appeal of Adverse Determination for CHIP Member

If the Sendero Medical Director determines that requested services do not meet medical necessity criteria, then medical services may be denied. The provider, Member or someone acting on behalf of the Member (“Appellant”) is entitled to request the appeal process through Sendero Health Plans. The denial letter sent to the provider and Member will outline the process, along with the appropriate forms, to initiate the appeal. An appeal may be submitted orally or in writing. If the appeal is submitted orally, an appeal form will be sent with the acknowledgement letter for the Appellant to complete and return to Sendero. Appellant must submit the appeal in writing, signed by the Member or Member’s representative.

An acknowledgement letter will be sent to the Appellant within five (5) days of receipt of the appeal. The appeal will be reviewed by a Medical Director or physician designee who did not participate in the original denial, and a decision will be rendered within thirty (30) days of receipt of the appeal. The decision letter will include the rationale for the decision, the name of the Specialist provider that may have helped in the decision, whether the denial has been overturned, partially overturned or upheld. If partially overturned or upheld, the appellant will receive information regarding the second level appeal process to have the issue reviewed by an Independent Review Organization. Appellant may request help with filing the 2nd level appeal by contacting Customer Services at the phone number at the bottom of this page.

### Expedited Appeal for CHIP Perinatal Member

A provider, Member or someone acting on behalf of the Member may request an expedited appeal if they believe the expectant mother, the unborn Member or the newborn’s life or health could be jeopardized by the time frames involved in the normal appeal process. Appellant may file the request orally or in writing. In addition, the Appellant may request help in filing the appeal. They should contact Customer Services and request the help. Someone within Sendero will provide that help. During an expedited appeal, a health care provider who has not previously reviewed the case will review the appeal. The expedited appeal will be completed no later than one (1) working day following the day on which the appeal, including all information necessary to complete the appeal, is made to Sendero. If the appeal involves a life-threatening disease or condition for which the likelihood of death is probable if the course of treatment of the disease or condition is interrupted, the Appellant may request the case be directly forwarded to an Independent Review Organization (IRO), through the Texas Department of Insurance. The process must be initiated by Sendero, so the proper forms should be completed and submitted to Sendero as soon as possible – a Member Advocate is available to help the appellant complete the form.
Sendero will make every effort to honor the Appellant’s request for an expedited appeal. If the rationale for request does not meet the definition of an expedited appeal (decision warranted quickly due to the Member’s critical health outcome), Sendero may deny the request to expedite the review. If this happens, the provider may intervene on the Member’s behalf and discuss the situation with the Medical Director. The provider should contact the Medical Director by calling Health Services at the number shown at the bottom of this page. In the event the request for the appeal to be expedited does not meet criteria to be expedited, the appeal will be processed within the standard appeal process timeframes.

**Independent Review Organization Appeal through TDI for CHIP Members**

CHIP Perinatal Members may request an appeal directly to an Independent Review Organization (IRO) through the Texas Department of Insurance (TDI). An IRO is an outside organization assigned by TDI to review the health plan’s denial of services.

Direct appeals to the IRO are available for those cases that involve a life-threatening disease or condition for which the likelihood of death is probable if the course of treatment for the disease or condition is interrupted. In addition, CHIP Members have the right to request an IRO for non-life threatening disease or conditions after exhausting Sendero’s internal appeal process.

Sendero must initiate this process. To request an IRO, the Appellant should contact Health Services at the phone number at the bottom of the page. Sendero will provide the Appellant with the necessary forms that must be completed and returned to Sendero. Sendero will send the request to TDI, who will appoint the IRO to review the case within one (1) business day of receipt of the request. TDI will notify the Appellant and Sendero who was appointed as the IRO. Sendero will then submit all required documentation to the IRO within three (3) business days. The IRO will make a decision within five (5) days from the date they receive the information from Sendero for life threatening situations, or within fifteen (15) days for non-life threatening situations. Decisions of the IRO are final and binding. Sendero will abide by the decision of the IRO, and will incur all expenses of the IRO review.
CP 5.1 Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child’s health plan, doctors, hospitals and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered and/or medically necessary. You have the right to know about the people in the health plan who decides those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child’s life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child’s health care.
8. You have the right to speak to your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals and other providers.
10. You have the right to talk to you Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child’s doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

CP 5.2 Member Responsibilities

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities:
1. You must try to follow healthy habits. Stay away from tobacco and alcohol and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child’s care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Perinatal Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
Appendix A
- Universal Authorization/Referral Form / Sendero Authorization and Referral Form
- Pregnancy Notification Form
- Specialist Acting as a PCP Request Form
- Medicaid “Your Texas Benefits ID” card
- Complaint Form
- Provider Information Form (PIF)
- Prior Authorization List – page 10
- Electronic Fund Transfer (EFT)
- Whole Person Health Support Referral Form
- Sendero STAR ID Card
- Sendero CHIP ID Card
- Sendero CHIP Perinate ID Card
**Universal Authorization/Referral Form/Sendero Authorization & Referral Form**

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**Texas Referral/Authorization Form**

Please fill out form completely in blue or black ink. Refer to instruction sheet.

*This referral does not guarantee payment. Please contact health plan to verify member eligibility and covered benefits.*

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**HEALTH PLAN NAME:** [Input Field]

**DATE:** [Input Field]

**PATIENT INFO**

**Patient name**

**Last name**

**First name**

**Middle initial**

**DOB:** [Input Field]

**Sex:** [Input Field]

**MD/EO**

**Phone #:** [Input Field]

**Member ID #:** [Input Field]

**Member Social Sec. #:** [Input Field]

**OFFICIAL**

**REFERRED BY**

**Physician name**

**Last name**

**First name**

**Middle initial**

**Provider #:** [Input Field]

**PCP/SCP/HOSPITAL**

**Fax #:** [Input Field]

**Contact name:** [Input Field]

**Phone #:** [Input Field]

**REFERRED TO**

**Provider name**

**Last name**

**First name**

**Middle initial**

**Specialty type**

**Provider/Facility #:** [Input Field]

**Facility name**

**Facility #:** [Input Field]

**Facility #:** [Input Field] (Required for ER/CC, Therapy, and Outpatient services.)

**COMMENTS/CLINICAL HISTORY**

**Clinical information attached:** [Y/N] [Input Field]

**# of pages:** [Input Field]

**PHYSICIAN SIGNATURE**

The information contained in this form is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the authorized agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

**HEALTH SERVICES RESPONSE**

**Approved as requested:** [Y/N]

**Authorization #:** [Input Field]

**Expiration date:** [Input Field]

**Days authorized:** [Input Field]

**Medical Director Review:** [Y/N]

**Pending Info:** [Y/N]

**No referral needed:** [Y/N]

**Denied:** [Y/N]

**Approved with modification:** [Y/N]

**NOTES**

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**Revised 12-15-00**

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Sendero Customer Services 1-855-526-7388 Network Management 1-855-895-0475

Health Services Dept.: 1-855-297-9191 (FAX 1-512-275-2862)
Texas Referral/Authorization Form

Instruction Sheet

Please fill out completely in blue or black ink.

Sendero Customer Services 1-855-526-7388
Network Management 1-855-895-0475
Health Services Dept.: 1-855-297-9191 (FAX 1-512-275-2862)
## Sendero Referral/Authorization Form

Please fill out form completely in blue or black ink. Refer to instruction sheet.

This referral does not guarantee payment. Please contact health plan to verify member eligibility and covered benefits.

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**PATIENT INFO**

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<td><strong>Member Social Sec. #</strong></td>
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**REFERRED TO LOCATION**

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**COMMENTS/CLINICAL HISTORY**

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**PHYSICIAN SIGNATURE**

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**HEALTH SERVICES RESPONSE**

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<td><strong>Pending Info.</strong></td>
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**Requested**

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<td><strong>Requested End date</strong></td>
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**ICD-9/DSM4/Diagnosis**

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<td><strong>Follow-up</strong></td>
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<td><strong>Number of visits</strong></td>
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**SPECIFIC SERVICES REQUESTED**

**Refer to specific plan instructions. Certification/authorization guidelines must be followed.**

- Behavioral Health
- Dialysis
- DME/Prosthesis/Splints
- Case Mgmt.
- Health Educ.
- Home Care
- Injections and IV Therapy
- Maternity Services
  - EDC
  - Vaginal
  - C-Section
- Lab/Pathology
- Radiology/Imaging
- Therapy: Indicate # of visits
  - Physical
  - Cardiac
  - Rehab
  - Speech
  - Occupational Visits/Week
- Surgery (CPT4 code)
- Assistant Surgeon

**TO AUTHORIZE ONLY**

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<tr>
<td><strong>Other Specific Services, Include CPT4, Medicare Local or HCPCE codes here</strong></td>
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# Pregnancy Notification Form

Please submit the following information to Sendero Health Plans after the initial prenatal visit to:

- **FAX:** 512-275-2862
- **Call:** 512-973-8100
- **Mail:** Sendero Health Plans
  Suite 510
  2028 East Ben White Boulevard
  Austin, TX 78741

<table>
<thead>
<tr>
<th>MEMBER’S NAME:</th>
<th>DATE OF BIRTH:</th>
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<tbody>
<tr>
<td>Member’s Medicaid ID#:</td>
<td>Member’s Phone #:</td>
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<tr>
<td>Member’s Address:</td>
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- **Member’s Mental Status:**
  - Single
  - Partnered
  - Married
  - Separated
  - Divorced
  - Widowed
- **OB’s Name:**
- **OB’s Phone #:**
- **Office Contact Person:**
- **Office Fax #:**
- **Gravida/Para/AB/Stillbirth:**
- **Delivery Hospital:**

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<tr>
<th>Due Date by Sonogram:</th>
<th>Due date by Dates:</th>
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- **Risk Factors / Significant Medical History:**
  - Age
  - Weight
  - Multiple birth
  - HIV / STD / Infection
  - Kidney Disease
  - Heart Disease
  - Drugs / Alcohol
  - Tobacco abuse
  - Previous preterm labor / delivery
  - Previous miscarriage / SAB / Stillbirth
  - Anemia
  - Pre-eclampsia / eclampsia
  - Diabetes
  - High Blood Pressure
  - Seizures
  - Depression / Anxiety
  - Homelessness
  - Victim of abuse

| Date of first appt with this | # Weeks gestation |
| Physician’s office: | at first office visit: |
| Previous Prenatal Care: | Location of Previous Prenatal Care: |
| Date of first Prenatal Visit for this pregnancy: | # Weeks gestation at first prenatal visit: |
| Comments / Concerns: | Any special needs: |

**Standard Length of Stay:**
- Two nights following a vaginal delivery and four nights following a Cesarean section.
- Please call 512-973-8100 if your patient’s medical condition warrants a longer stay.

Sendero Health Plans
Suite 510, 2028 E. Ben White Blvd., Austin, TX 78741
512-973-8100

WSN#P021
# Specialist Acting as a PCP Request Form

![Sendero Health Plans Logo]

## Request by Specialist to act as a PCP

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<th>Guardian Name:</th>
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<tr>
<th>Member/Guardian Address:</th>
<th>Member/Guardian Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PCP on Record</th>
<th>PCP's Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist Requesting PCP Status</th>
<th>Specialist's Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member’s Diagnosis(es)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical &amp; Historical Data supporting requested action:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

---

I hereby request to serve as a Sendero Primary Care Physician for the above named member. I accept all responsibility for coordination of all of this member’s health care needs and will follow all requirements of a Sendero Primary Care Physician pursuant to any and all contractual obligations.

**Specialist Signature**

**Member’s Reason for Request**

**Member Signature**

**Approved**:  
- Yes  
- No

**Effective Date**:  
“Note the effective date will not be retroactive”

**Medical Director Signature**:  
**Date**:  

<table>
<thead>
<tr>
<th>Date Sent to Provider Relations</th>
<th>Date Sent to Customer Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Director Signature</th>
<th>Health Services Manager Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Confirming PCP change)</td>
<td></td>
</tr>
</tbody>
</table>

NM-SPPCP08
Medicaid “Your Texas Benefits ID” Card

Your Texas Benefits
MEDICAID CARD

Information for Medicaid Providers

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) clients have been getting in the mail every month.
- An online 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

What information is on the 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:
- Client 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 those in the Medicaid Limited program.

The back of the card has:
- A statewide toll-free number that clients can call if they need help or have questions about using the card.
- A website (www.YourTexasBenefits.com) where clients 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.

For more information visit:
www.YourTexasBenefitsCard.com
Complaint Form

Formal Complaint Notification

Date: 
To: 
From: 

Department: Customer Service

| Member Complaint: | 
|-------------------|---|
| Caller Name: | Caller Contact Number: |
| Member Name: | Member ID Number: |
| Provider Name: | Provider Phone Number: |

OR

| Provider Complaint: | 
|---------------------|---|
| Caller Name: | Caller Contact Number: |
| Member Name: | Member ID Number: |
| Provider Name: | Provider Phone Number: |

Formal Complaint Description Received in Customer Service:
### Provider Information Form (PIF)

**Providers can complete and submit this form to update their provider data file. Please type all of the information on this form. Email, fax or mail the completed form and any additional documentation to:**

Email: laura.fiero@senderohealth.com  
Fax: (512) 901-9704  
Sendero Health Plans, Attn: Network Manager, 2028 East Ben White Blvd., Ste 510, Austin, TX 78741

**Provider Name:** As noted in the Provider Directory  
**Date:**

<table>
<thead>
<tr>
<th>TYPE OF ADDS / CHANGES DOCUMENTED (Check Appropriate Box)</th>
<th>PCP Panel Status: (2 wk notice req)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Add New Provider</td>
<td>□ Do not list in Directory</td>
</tr>
<tr>
<td>□ Change of address</td>
<td>□ Closing Panel</td>
</tr>
<tr>
<td>□ Change of Provider Status, to include Effective Date (e.g., termination from plan, moved out of area)</td>
<td>□ Opening Panel</td>
</tr>
<tr>
<td>□ Call Covering Physician</td>
<td>□ Accepting existing patients only</td>
</tr>
<tr>
<td>(Please indicate in the comments section)</td>
<td></td>
</tr>
<tr>
<td>□ Other (please indicate in the comments section)</td>
<td></td>
</tr>
</tbody>
</table>

**Physician National Provider Identifier (NPI):**

<table>
<thead>
<tr>
<th>Physical Address:</th>
<th>The Physical address cannot be a PO Box Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street:</td>
<td>City:</td>
</tr>
<tr>
<td>County:</td>
<td>State:</td>
</tr>
<tr>
<td>Fax Number:</td>
<td>Zip Code:</td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
</tr>
</tbody>
</table>

**Email address:**

<table>
<thead>
<tr>
<th>Secondary Physical Address:</th>
<th>The Physical address cannot be a PO Box Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street:</td>
<td>City:</td>
</tr>
<tr>
<td>County:</td>
<td>State:</td>
</tr>
<tr>
<td>Fax Number:</td>
<td>Zip Code:</td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
</tr>
</tbody>
</table>

**Accounting/Mailing Address:** All Providers who make changes to the Accounting/Mailing address Must submit a copy of the W-9 form along with this PIF.

| Street:                     | City:                                         |
| County:                     | State:                                        |
| Fax Number:                 | Zip Code:                                     |
| Telephone:                  |                                               |

**Provider Demographic/Directory Information:** Do not

<table>
<thead>
<tr>
<th>Languages Spoken other than English:</th>
<th>Office Hours by Location</th>
</tr>
</thead>
</table>

**Specialty:**

<table>
<thead>
<tr>
<th>Tax ID Number:</th>
<th>Effective Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name: As Reported to the IRS:</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

<table>
<thead>
<tr>
<th>Provider Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

| Provider Representative (update per office contact): | Date: |

NM-PIF05 - 02/22/10
Instructions for Completing the Provider Information Form (PIF)

Form should be typed and forwarded to the Network Services team (see contact information below). No updates will be done without initial review by Network Services Team.

Signatures:
- The Provider's signature is required on the Provider Information Form for any update involving change to billing ID, or panel closing.
- A signature by the authorized representative of a practice or facility is acceptable for all other requested changes. Provider Rep may submit changes to demographic data and add of provider to practice.

Tax Identification Number (TIN):
- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers in a group cannot change the TIN.
- The W-9 form is required for all name and TIN changes.

General:
- Email, Fax or Mail the completed form to:

  laura.fierro@senderohealth.com

  Fax: (512) 901-9704

Sendero Health Plans
Attn: Network Manager
2028 East Ben White Blvd, Ste 510
Austin, Tx 78741

---

Internal Use Only

<table>
<thead>
<tr>
<th>Current provider id#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add / Change requested by:</td>
</tr>
<tr>
<td>Department:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Add / Change loaded by: Name:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Add / Change filed by: Name:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

NM-PIF05 - 02/22/10
Electronic Fund Transfer (EFT)

SENDERO HEALTH PLANS
Electronic Funds Transfer (EFT) Authorization Agreement

Type of Authorization (check one): __ NEW __ CHANGE

Tax Payer ID# (TIN) ____ ____ - ____ ____ ____ ____ ____

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>9-digit Medicaid ID # (TIN #)</th>
<th>Provider NPI Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Accounting Address</td>
<td>Phone Number</td>
<td>FAX Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bank Name</th>
<th>ABA/Transit Number (bank routing number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank Street Address</td>
<td>Account Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bank City/State/Zip</th>
<th>Provider e-Mail Address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Bank Phone Number</th>
<th>Type of Account (check only one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Checking</td>
</tr>
</tbody>
</table>

PLEASE ATTACH A VOIDED CHECK.

I (we) hereby authorize Sendero Health Plans (Sendero) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If Sendero erroneously deposits funds into my (our) account, I (we) authorize Sendero to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle.

I (we) agree to comply with all certification and credentialing requirements of Sendero and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by Sendero or its authorized affiliate(s) or subcontractor(s). I (we) understand that payment of claims will be made from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through Sendero in accordance with applicable state and federal laws, rules, and regulations.

Authorizing Signature ____________________________ Date Signed ____________

Printed Name ____________________________ Title of Signatory ____________________________

Please provide a response to the following question: For the convenience of having direct deposit, are you willing to download your remittance advices directly from a web site and print them in your own office rather than receive a hard copy EOB/EOP in the mail?

RETURN THIS FORM TO:
Sendero Health Plans
ATTN: Provider Relations Department
2028 E. Ben White Blvd., Suite 510
Austin, TX 78741

NM-EFT06
### Whole Person Health Support Referral Form

**WHOLE PERSON HEALTH SUPPORT REFERRAL FORM**

Please fax to Sendero’s Health Services Department at 1-855-275-2862

#### REReferral

<table>
<thead>
<tr>
<th>Referral</th>
<th>Referral Source (Please check one):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>☐ Health Care Provider ☐ Community Agency ☐ School</td>
</tr>
<tr>
<td></td>
<td>☐ Health Plan ☐ Member/Parent ☐ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Referral Source</th>
<th>Address of Referral Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number for Referring Source:</th>
<th>Fax Number for Referring Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

**Are other providers involved in care?**

☐ No ☐ Yes, who?

---

#### MEMBER INFORMATION

<table>
<thead>
<tr>
<th>MEMBER Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOB:</th>
<th>☐ Male ☐ Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MEMBER ID #:</th>
<th>Describe Medical / Health Condition / Risk or High-Risk Pregnancy Condition:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Name (if Member is under 18):</th>
<th>Language Preference:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address:</th>
<th>City:</th>
<th>ZIP:</th>
<th>County:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Numbers:</th>
<th>Home:</th>
<th>Work:</th>
<th>Cell:</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

---

#### OTHER DIAGNOSES AFFECTING MEMBER

<table>
<thead>
<tr>
<th>DIAGNOSIS #1</th>
<th>DIAGNOSIS #2</th>
<th>DIAGNOSIS #3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When Diagnosed?</th>
<th>☐ No ☐ Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>On medications?</th>
<th>☐ No ☐ Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sees a specialist?</th>
<th>☐ No ☐ Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Any labs for this?</th>
<th>☐ No ☐ Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Any other needs or concerns about this diagnosis?</th>
<th></th>
</tr>
</thead>
</table>

---

### ADDITIONAL INFORMATION

**Reason for Referral/Need for case management:**

---

**Priority Status of Referral:**

☐ Urgent (needs to be contacted within 2 working days)

☐ Standard (needs to be contacted within 7 working days)

---

Please Submit Referral Form to Sendero’s Health Services Department via:
phone 1-855-297-9191, fax 1-512-275-2862 or online at [www.senderohealth.com](http://www.senderohealth.com)
**Sendero STAR ID card**

**FRONT**

**BACK**

---

Important Information / Información Importante:

- 24/7 Member Services / Departamento de Servicios para Miembros: 1-855-526-7388
- TTY for hearing impaired / TTY para personas con discapacidades auditivas: 1-800-565-8280
- 24/7 Behavioral Health Hotline / Líneas de Servicios de Salud Mental: 1-888-287-5402
- Vision Services / Servicios para la vista: 1-877-816-7730

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours.

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 las 24 horas.

NOTICE TO PROVIDER: The member whose name appears on the face of this card is covered by Sendero Health Plans for STAR services. For provider billing or UM questions, call 1-855-526-7388. The UM FAX number is 512-275-2862.

Submit Claims to: Sendero Health Plans, PO Box 39389, Corpus Christi, TX 78439

Pharmacy Only: Call 1-877-908-8023

BIM: 610024
PCN: MCC
Rx FRP: SNO

Rev: 3/12
**Sendero CHIP ID card**

![Sendero CHIP ID card](image)

**FRONT**

**Important Information/Información Importante**

- 24/7 Member Services/Departamento de Servicios para Miembros: 1-866-626-7388
- TTY for hearing impaired/TTY para personas con discapacidad auditiva: 1-800-855-2580
- 24/7 Behavioral Health Hotline/Línea de Servicios de Salud Mental: 1-888-287-6403
- Vision Services/Servicios para la Vista: 1-877-816-7730

In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours.

**NOTICE TO PROVIDER**: The member whose name appears on the face of this card is covered by Sendero Health Plans for CHIP services. For provider billing or UM questions, call 1-866-526-7388. The UM FAX number is 512-275-2802.

Submit Claims to: Sendero Health Plans, PO Box 9999, Corpus Christi, TX 78469

Pharmacy Only: Call 1-877-908-6023

BIN: 610032     PCN: MCD     RxGRP: SND

**BACK**

---

**Sendero Customer Services 1-855-526-7388**  **Network Management 1-855-895-0475**  
**Health Services Dept.: 1-855-297-9191**  **(FAX 1-512-275-2862)**
**Sendero CHIP Perinate ID card**

![Sendero CHIP Perinate ID card image](image_url)

**Children's Health Insurance Program (CHIP)**

**Member Name:**

**Member ID:**

**Effective Date:**

**Hospital Facility Billing:**

[variable data depending on poverty level]

Submit Professional Claims to: Sendero Health Plans, PO Box 3069, Corpus Christi, TX 78486

Member Service Phone #: 1-855-526-7388

**FRONT**

**Important Information/Información Importante**

24/7 Member Services/Departamento de Servicios para Miembros: 1-855-526-7388

TTY for hearing impaired/TTY para personas con discapacidad auditiva: 1-800-866-2880

**Directions for what to do in an emergency**

In case of emergency call 911 or go to the closest emergency room.

In caso de emergencia, llame al 911 o vaya al sala de emergencias más cercanas.

**NOTICE TO PROVIDER:** The member whose name appears on the face of this card is covered by Sendero Health Plans for CHIP services. For provider billing or UM questions, call 1-855-526-7388. The UM fax number is 512-275-2862.

Pharmacist Only. Call 1-877-406-6023.

**BIN:** 818022

**PCN/MCD:** PA, GRP, SNID

Rev 3/12

**BACK**
Appendix B
Provider Complaints and Appeals

A. Sendero has established the following process for receiving, resolving, tracking and reporting all provider indications of dissatisfaction.

1. A complaint(s) from a provider is received at Sendero either through telephone contact or through a written complaint.
   a. If the Provider calls into Sendero, he/she will be warm transferred to the Network Management Manager
   b. If a complaint is received in writing, the complaint will be forwarded to the Network Management Manager

2. All complaints must be submitted in writing. If received telephonically, Sendero will refer the provider to the Sendero web portal to download the Provider Complaint Form (Attachment A) or will fax or mail the form to the provider to complete. The complaint will then be logged onto the Provider Complaint Tracking tool (Attachment B) with the following data elements:
   a. The date the Complaint was received;
   b. Provider name and NPI number
   c. Where the complaint was received
   d. Provider phone number
   e. Provider name
   f. Provider contact person/caller
   g. A detailed description of the complaint

B. The Network Management Manager will review each complaint from a provider and investigate the concerns expressed by the provider. The Network Management Manager will collaborate with department leadership of units involved in the complaint to establish a resolution for the provider that is consistent with all applicable regulatory, accrediting and contract statutes.

C. The Network Management Manager will send a written notice to the provider outlining the findings of her review. The notice to the provider will include the opportunity for and an explanation of how the provider can pursue a Formal Desk Review through HHSC if he/she is not satisfied with the review outcome within Sendero. If after completing Sendero’s internal review process, the provider believes they did not receive full due process, they may file a complaint or inquiry at HPM_complaints@hhsc.state.tx.us or:

Texas Health and Human Services Commission
Provider Complaints
Health Plan Operations, H-320
PO Box 85200
Austin, Texas 78708

D. After the Formal Desk Review, Sendero’s Network Management Manager will send a FDR final determination notice (Attachment D) to the provider with the outcome of the review noting that the provider has exhausted all review procedures available through Sendero Health Plans.
Appendix C
Sendero Health Plans
Preventive Care Guidelines List
2012-2014

- Advisory Council on Immunization Practices (ACIP): Summary of Recommendations for Adult Immunizations (Age 19 and older)
- Centers for Disease Control and Prevention: Recommended Adult Immunization Schedule
- Institute for Clinical Systems Improvement: Preventive Services for Children and Adolescents
- THSteps Medical Checkup Periodicity Schedule for Infants, Children and Adolescents
- U.S. Preventive Services Task Force Recommendations: Adult Preventive Care Guidelines: Ages 21 through 64

These are available online at www.senderohealth.com or please call 1-855-895-0475 to request a copy.
Sendero Health Plans

Clinical Practice Guidelines List
2012-2014

- Access and Availability Standards
- Adult Depression: Institute for Clinical System Improvement and Michigan Quality Improvement Consortium Guidelines
- Asthma Guidelines: Institute for Clinical System Improvement
- Attention Deficit Hyperactivity Disorder Clinical Guidelines: America Academy of Pediatrics
- Diabetes Clinical Guidelines for Children and Adults: Texas Diabetes Council
- Management of Common Breast Problems: American College of Obstetrics and Gynecologist
- Medical Record Review Tool and Guidelines for Primary Care Provider, Specialist, OB-GYN and Behavioral Health
- Overweight Management Adults and Children: Texas Diabetes Council
- Routine Prenatal Care Guidelines: Institute for Clinical System Improvement

These are available online at www.senderohealth.com or please call 1-855-895-0475 to request a copy.