

Your child.
Our care. Smart Plan.

Seton Health Plan CHIP

A member of the  **Seton** Family of Hospitals

PROVIDER MANUAL

CHILDREN'S HEALTH INSURANCE PROGRAM

Provider Services 1-512-324-3125

SHPProviderservices@seton.org

Travis Service Delivery Area Includes the Following Counties
Bastrop, Burnet, Caldwell, Hays, Lee, Fayette, Travis, and Williamson

**SETON HEALTH PLAN - CHIP
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WELCOME TO SETON HEALTH PLAN - CHIP

Welcome to the SETON HEALTH PLAN! Seton Health Plan (SHP) is a licensed Texas health maintenance organization that is dedicated to provide quality care to its members. We are committed to providing you with information that will assist you in treating your patients.

Seton Health Plan is the health plan for Children's Health Insurance Program (CHIP) members in the Travis Service Delivery Area. CHIP is a gateway plan that requires the member to choose a Primary Care Physician (PCP). The PCP coordinates the member's health care services including preventive care and refers the member to specialists and other health care providers as needed.

This provider manual is designed to inform you of Seton Health Plan's policies and procedures and address any questions that you may have.

If you have questions that are not addressed in this manual, please, call our Member Services Department for member related questions, the Medical Management Department regarding authorization or referral questions, or the Provider Relations Department for Provider Relations issues. A telephone listing of the various departments and departmental functions is located in the front of this manual.

We would like to hear from you. If you have a suggestion on how we can improve this manual, please contact the SETON HEALTH PLAN Provider Relations department. Your input is valuable and will enable us to better inform you of Seton Health Plan's policies and procedures.

Thank you for choosing to participate with the Seton Health Plan. For questions, please call Provider Relations at 512/324-3125 or email us at shpproviderservices@seton.org.

**SETON HEALTH PLAN – Children’s Health Insurance Program (CHIP)
Contract Briefing Sheet**

Plan Name: Seton Health Plan - CHIP
Effective Date: May 1, 2000

Claims Address: Seton Health Plan - CHIP
PO Box 15507
Austin, TX 78761-5507 **OR** VIA THIN: SHPCH

Claims Inquiry: (877) 451-5601 **OR** VIA Seton.Net (if you are signed up for Physician Self-Service Center access)

Medical Management: (512) 420-2777 Fax (512) 420-2798
(877) 451-5628 Toll free Fax (866) 272-2542

Provider Relations: (512) 324-3125 Fax (512) 324-3359
Email Address: SHPProviderservices@seton.org

Eligibility/Benefit (877) 451-5601 **OR** VIA Seton. Net (if you are signed up
Verification: for Physician Self-Service Center access)

**Behavioral Health/
Substance Abuse
UM & Eligibility:** Tejas Behavioral Health Care (800) 852-7691

Behavioral Health Claims: Tejas Behavioral Health Care
PO Box 3216
Austin, TX 78764
Phone (512) 445-7702
Fax (512) 445-7708

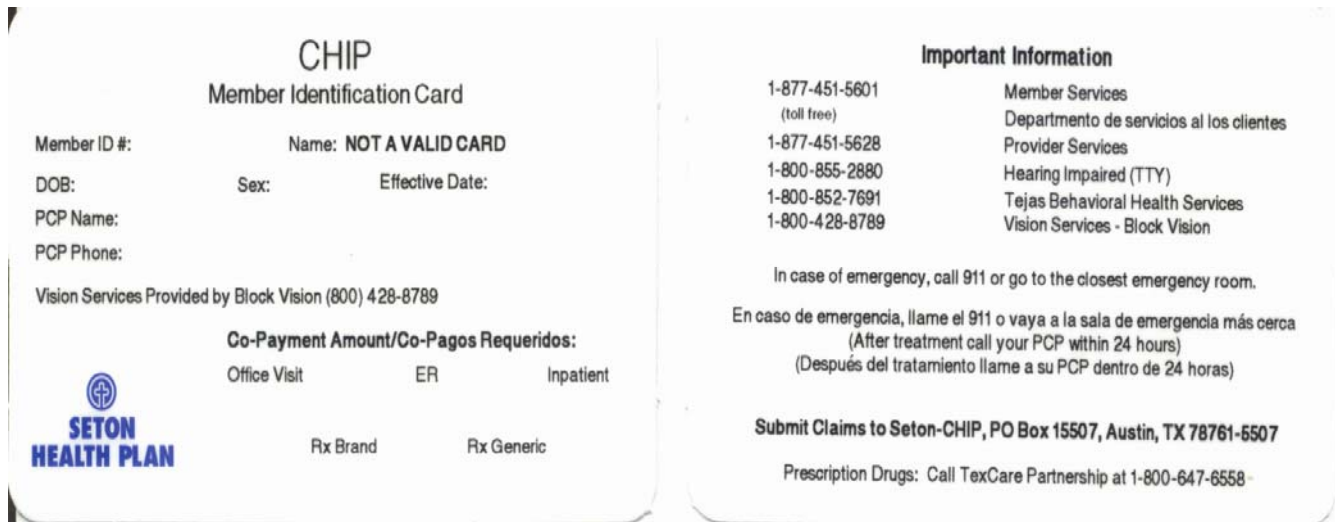
Compensation:

- No balance billing except for co-payment, coinsurance, deductibles, and non-covered services.
- Bills must be submitted no later than ninety (90) days after the date of service.
- Bills are to be submitted on a HCFA 1500 containing all the data requested on the HCFA 1500 or via EDI using HIPAA compliant format
- Appeals/reconsiderations must be received within 90 days from the original EOB.

Laboratory Services: Clinical Pathology Labs
Seton HealthCare Network Labs
CLIA waived tests performed in provider’s office

Radiology Services: In-Office Facilities
Seton HealthCare Network Facilities
Austin Radiological Association

**SETON HEALTH PLAN-CHIP INSURANCE
CARD EXAMPLE**



TO OBTAIN INFORMATION ON COMPANIES, COVERAGE, RIGHTS, OR COMPLAINTS YOU MAY ALSO CONTACT THE TEXAS DEPARTMENT OF INSURANCE AT:

(800) 252-3439

OR

WRITE THE TEXAS DEPARTMENT OF INSURANCE AT:

**TEXAS DEPARTMENT OF INSURANCE
PO BOX 149104
AUSTIN, TEXAS 78714-9104
FAX# (512) 475-1771**

SETON HEALTH PLAN -CHIP OBJECTIVES & GUIDELINES

Texas has roughly 1.4 million uninsured children, one of the highest percentages of uninsured children in the United States. Seton Health Plan is the administrator for the Children's Health Insurance Program (CHIP) in Central Texas. The Seton Health Plan CHIP provides health care to its members through a network of physicians, hospitals, and other healthcare professionals. Our goal at Seton Health Plan is to keep the children enrolled in our health plan healthy and to make sure that these members receive the proper treatment if they become sick or injured.

Under the benefit guidelines of Seton Health Plan CHIP, members must select a Primary Care Physician (PCP) from the participating network. The PCP is responsible for coordinating members' health care services. Thus, the PCPs will coordinate referrals to those Specialty Care Physicians (Specialist/ SCP) who are part of Seton Health Plan's network of providers. The following is a quick reference to remember the basic guidelines and procedures involved in the Seton CHIP plan:

- Members do not have out-of-network benefits.
- Refer to member ID card for Co-payment amount.
- Referrals are always required from the Primary Care Physician to the Specialty Care Physician in order for the specialty services to be considered covered benefits. If the provider believes referral to a out of network provider is the best course of care for the member, then the provider is required to provide justification to Seton Health Plan CHIP for the referral.
- Members must see their Primary Care Physician in order to obtain a referral for specialty care. The only exception is that of a female enrollee self-referring to an In-network OB/GYN physician annually – no referral is needed in this case. This means a female member has the right to select an OB/GYN without a referral from her PCP. The access to health care services of an OB/GYN includes:
 - one well-woman check-up per year;
 - care related to pregnancy;
 - care for any female medical condition; and
 - Referral to a special doctor (specialist) within the network.
- If Seton Health Plan has deemed a service as not medically necessary, the service may not be covered even if the member's PCP has requested a referral for the procedure. Please call Medical Management if you have questions regarding this matter at (512) 420-2777.

- Seton Health Plan CHIP providers must obtain Pre-certification for procedures that require authorization through the Medical Management Department. The department can be reached at (512) 420-2777 or (877) 451-5601. For services that require authorization please refer to the Prior AUTH Grid in the FORMS section of this manual.

SETON HEALTH PLAN - CHIP PROVIDER ROLES & RESPONSIBILITIES

ROLE OF PRIMARY CARE PROVIDER (PCP) & RESPONSIBILITIES

CHIP primary care providers will act as the “medical homes” for enrolled members. Primary care providers have the responsibility to develop a physician/patient relationship based on trust and cooperation. Seton Health Plan (SHP) expects the primary care provider to provide accessible, comprehensive and coordinated care as consistently as possible to all enrolled members. This continuity of care strengthens the positive relationship between the member and provider.

At the time of enrollment in CHIP the member will select a primary care provider (PCP). The member will be able to access their primary care provider by referring to their name and telephone number on the CHIP identification card. The PCP agrees to be the principal caregiver for members who select them and render care directly or through managing referrals to specialists to meet the medical/health care needs of each member. The PCP is expected to provide services to all eligible members in the same manner and quality as those services provided to all other members.

Key factors in the success of the medical home are the role of case management in facilitating coordinated comprehensive care. SHP’s case management system includes a strong team approach between SHP and the contracted primary care providers to utilization and referral management, especially of complex cases, and emphasizes efforts to manage utilization at the most appropriate level of care. It also includes policies and procedures that address the non-clinical issues which are important to a member's overall health. These include a range of health education and promotion activities, in-depth orientations for new members, aggressive efforts to encourage members to schedule initial health assessments and supportive approaches to re-scheduling missed appointments.

Central to the success of SHP’s case management approach is the role of the primary care provider. The primary care provider as care manager assesses health care needs, develops treatment plans, coordinates specialty care, ensures follow-up for referrals and documents services provided to members. Integral to the care manager role is coordination of direct service delivery with case management work in a team process in which the physician works closely with other medical and health professionals as part of a health care

team. The primary care provider will use linkages with other community providers to manage the overall medical and health needs of the individual.

Supporting the primary care provider is a team of SHP staff from the Medical Services and Member Services Departments. The Utilization Management staff helps the primary care provider evaluate, observe and assure the continuity, quality and appropriateness of care. They help coordinate length of stay and discharge planning, considering the range of alternative treatment methods or settings that are available. They may also

SPECIALTY CARE PROVIDER ROLE & RESPONSIBILITIES

Seton Health Plan (SHP) has established a network of Specialty Care Providers to provide health care services for those members in need of specialty care. All visits to a specialist require a referral. Services requested or provided must be within the member's plan as a covered benefit. Specialists who determine a need for another specialist's opinion, unanticipated services, or additional visits must contact the member's PCP or the Medical Management department for a referral. If the specialist requests a service that is listed on the prior authorization list, the specialist must contact the Medical Management department to obtain authorization for the requested procedure.

Seton Health Plan (SHP) providers who provide services as a participating specialist are required to the following:

- Keep a record of the member's health and of care provided;
- Accept referral of a member in accordance with the services and number of visits and/or time frame requested by the PCP;
- Send a report to the referring PCP upon completion of the consultation. Should additional visits be needed, beyond those specified on the referral form, a new referral request must be made of either the PCP or SHP's Utilization Management;
- Provide copies of x-ray and laboratory results and other health record information to the members PCP as appropriate;
- Refer members to participating providers within the guidelines of the referral process completed by the PCP and Utilization Management;
- Arrange for admission of the member to the hospital when appropriate;
- Return the member to the care of the SHP PCP as soon as medically feasible;
- Maintain and operate his/her office in a manner protective of the health and safety of his/her personnel and the member in accordance with Texas Department of Health standards.

Specialists have the following responsibilities with regard to referrals:

- Only provide the services requested by the Primary Care Physician

- There is no need to wait for a referral number to be called or faxed back to your office (as long as the specialist is in-network and listed in the provider directory.)
- You may call Member Services to verify that the PCP has made a referral to your office.
- Inform the PCP of test results, recommended treatment, and treatment progress in a timely manner;
- Inform the member's PCP of any additional services or procedures needed;
- Notify the member's PCP if the Specialist feels that the member needs to see additional specialists;
- Obtain authorization for services from the SHP Medical Management department.
- Collaborate with the member's family to develop continuing treatment plans and identify the resources necessary to implement them. Nurse case managers within the Medical Services Department will monitor catastrophic, chronic or problem cases.

PROVIDER EXPECTATIONS:

As a Seton Health Plan provider you have the right to expect the following:

- Respect;
- Confidentiality;
- In service training:
 - Annual training for providers and their staff regarding requirements of the contract, special needs of members, covered services, contract requirements, quality assurance, performance improvement program, and referral policy.
- Training within 30 days for newly contracted provider on active status
- Information about changes in policies, procedures and plan benefits;
- Consideration of your suggestions;
- Timely processing of claims;
- Timely resolutions of appeals and grievances;
- Accurately representation in Seton Health Plan directories or publications.

PROVIDER OBLIGATIONS:

As a Seton Health Plan (SHP) participating provider you are committing to the following:

- Provide services only as medically necessary in accordance with generally accepted medical, surgical, and scientific practices and standards prevailing at the time of treatment;
- Accessible to SHP members in a manner which ensures continuity of care, that includes emergency access via telephone on the following basis: twenty-four (24) hours per day, seven (7) days per week, three hundred sixty five (365) days per year;

- Maintain licensures and other pertinent applicable credentials as required by law and medical standards at your own expense;
- Cooperate with SHP's Medical Director or designee in the review and supervision of the quality of care administered to Plan members;
- Cooperate and comply with SHP's quality management requirements
- Maintain and preserve all records including but not limited to medical and billing records of covered services to SHP members as required by law and medical standards;
- Provide medical histories, financial, administrative and other records of SHP members as requested by SHP or SHP's designee (SHP is committed to respecting the confidentiality of members and providers, thus such information shall be used to assure the quality of care and cost effectiveness of services), this information should not be released to anyone unless the provider has been authorized to do so by the SHP;
- Treat all members with respect and not differentiate or discriminate because of sex, race, color, age, religion, disability, marital status, sexual orientation, or source of payment;
- Notify SHP (within 10 days if not sooner) of any change in your practice, including but not limited to a change of group affiliation, name, address, telephone number, type of practice, willingness to accept new patients, languages spoken and/or any other change.
- If a PCP, provide behavioral health services within the scope of your practice.

Twenty Four (24) Hour & After Hours Availability

Providers are required to be accessible to Seton Health Plan (877) 451-5601 members in a manner which ensures continuity of care, that includes emergency access via telephone on the following basis: twenty-four (24) hours per day, seven (7) days per week, three hundred sixty five (365) days per year.

An answering service may be used after hours only if the PCP returns a call within thirty (30) minutes. The following are acceptable and unacceptable after-hours phone arrangements for availability of PCPs.

Acceptable:

(1) Office phone is answered after hours by an answering service, which can contact the PCP, or another designated medical practitioner.

(2) Office phone is answered after office hours by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the provider has designated.

(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner.

Unacceptable:

- (1) Office phone is only answered during office hours.
- (2) Office phone is answered after hours by a recording, which tells patients to leave a message.
- (3) Office phone is answered after hours by a recording which directs patients to go to the Emergency Room for any services needed.

MEDICAL RECORD DOCUMENTATION

The medical record shall reflect all aspects of a member's care, including ancillary services. The member's medical record must be maintained in a chronological, legible manner. Emergency Room visits and follow-ups are to be included in the record. Immunizations must be documented, including immunizations received from other sources. Other information to be included in medical records is as follows: telephone advice, broken appointments, and medication refills. The medical record shall also include documentation of the reason why a member is referred to a non Seton Health Plan CHIP provider.

Electronic medical records shall conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws

MEMBER CAPACITY CHANGES

All participating primary care providers (PCPs) may treat an unlimited number of members, so long as accessibility and quality of care is not jeopardized.

If a provider wishes to limit the number of members the provider is treating, the provider must notify the Seton Health Plan (SHP) in writing of their desire to close their practice to new managed care members. SHP will indicate in the quarterly Provider Directory update that the practice has been closed to new members.

If a provider wishes to re-open their practice to new members, the provider must notify the SHP in writing of their desire to re-open their practice to new members. SHP will indicate in the quarterly Provider Directory update that the provider is open to new managed care members.

PROVIDERS TERMING NON-COMPLIANT PATIENTS

Seton Health Plan (SHP) recognizes that there may be situations where a member and physician fail to establish an effective or therapeutic provider-patient relationship. In the case of a member demonstrating repeated non-compliance with the clinical treatment plan, the provider may

request that the member be terminated from that provider's practice. The provider should forward a written request to the SHP Medical Director and include documentation of the specific non-compliance and how the provider has addressed the issue. The SHP Medical Director may request a review of the case by the Quality Improvement Committee. SHP will respond to the requesting provider within thirty (30) days of the receipt of the request.

SPECIALIST AS A PCP

Under certain circumstances, including but not limited to a patient having a chronic, disabling, or life-threatening illness, a specialist may be authorized to act as a member's Primary Care Physician (PCP). Specialty areas may include Cardiology, Oncology, Nephrology and Pulmonary Disease. Other specialists treating members with serious medical conditions may be approved at the discretion of the Seton Health Plan Medical Director. The PCP will provide primary care services and will arrange for specialty and hospital care as necessary. As the PCP, the provider is responsible for all routine care and for coordinating the referrals with other providers to meet the member's medical needs. The PCP will meet SHP's requirements for PCP participation (TIC Art. 20A.09). In order for a specialist to act as a PCP, the patient must submit a written request to the Medical Management department stating the need for care by the specialist as well as a statement signed by the specialist indicating his/her interest in serving as the PCP. This written request will be reviewed by the Seton Health Plan Medical Director and either approved or denied. Both the patient and provider are informed by letter within thirty (30) days of the request (28TAC 11.900(b)). The effective date of the designation of the specialist as the PCP may not be retroactively applied (TIC Art.20A.09 (a)(3)(F)).

COORDINATION WITH NON-CHIP COVERED SERVICES

There are other services not covered through the health plan but are available to CHIP members through other state programs. Health Plan providers should make every effort to coordinate with these resources in order to maximize the CHIP member's benefit. These programs include:

- Texas Agency Administered Programs and Case Management Services
- Essential Public Health Services

SETON HEALTH PLAN ACCESSIBILITY STANDARDS

Access to timely health care services for every member is a primary concern of Seton Health Plan. Each office is required to assure appropriate available appointments based on the Provider-to-Member ratio assigned under the contract. Each office must maintain adequate telephone systems to handle the patient volume enrolled within the practice/clinic.

All participating Seton Health Plan providers are required to ensure availability and accessibility of care to members and adhere to the appointment standards outlined below:

- **Waiting time for appointments for urgent care:**

SHP participating providers are required to schedule urgent care appointments with members within twenty- four (24) hours of request. The request for services is evaluated and the urgency assessed to determine the nature of the problem and the need for urgent treatment. Contingent on the nature of the medical problem, the member should be triaged to the appropriate level of care.

- **Waiting time for appointments for emergency care:**

Emergency care must be available immediately to all members. SHP will review ER usage by the PCP's members and coordinate education to members about more appropriate access to care of necessity.

- **Waiting time for appointments for routine care:**

SHP PCP's are required to ensure that routine patient care will be available within two (2) weeks of request.

- **Waiting time for first pre-natal visit:**

All pre-natal visits for a pregnant member must be made available within two (2) weeks of request.

- **Waiting time for Newborns:**

Newborns must be seen within two (2) weeks of enrollment and consistent with the American Academy of Pediatric Guidelines.

- **Waiting time for appointment with specialists:**

The estimated average time for routine and urgent visits for specialists is described below

- Urgent Care: within 24 hours of request
- Routine Care: within 2 weeks of request
- Prenatal Care: within 2 weeks of request

NOTE: Each PCP office maintains a tracking system to document time compliance. The SHP Medical Management Department reviews the Member Service logs quarterly to note trends or patterns related to access and reports the findings to the Seton Health Plan Medical Quality Improvement Committee.

SETON HEALTH PLAN - CHIP Member Enrollment and Dis-enrollment

How does a child enroll in CHIP?

CHIP eligibility is determined through the CHIP application process managed for the state of Texas by an administrative services contractor. Currently that contractor is MAXIMUS. Once eligibility is determined by MAXIMUS the member is enrolled for a continuous twelve (12) month span of eligibility beginning at the 1st of the month.

WHEN DOES A MEMBER NEED TO RE-ENROLL?

About two (2) months before it is time to renew a child's CHIP coverage, he/she will receive a notice from Children's Health Insurance Program. To re-enroll in the CHIP plan members must complete and submit their re-enrollment packet to MAXIMUS. If the family does not complete the renewal packet and return it immediately they may miss the renewal deadline and the child could experience a lapse in coverage.

WHAT ARE SOME OF THE REASONS A MEMBER WOULD BE DIS-ENROLLED FROM CHIP?

Members may be dis-enrolled from CHIP for a number of reasons. They may age out of the program because they turned 19. They may become eligible for coverage through other programs like Medicaid. They may no longer qualify for CHIP due to income and other eligibility factors. If you need additional information regarding a member's termination please contact member services.

If a member is dis-enrolled Providers may not take retaliatory action against the member.

VERIFICATION OF MEMBER ELIGIBILITY

Providers are responsible for requesting current eligibility information from the member by asking the member to produce their Seton Health Plan CHIP Identification Card. Providers should make a copy of the ID card for their records. Members participating with Seton Health Plan CHIP are provided with a Identification Card, which lists the Primary Care Provider's name or Clinic name. This ensures that the person is eligible at the time the services are provided.

If a person insists he or she is eligible for a SHP CHIP plan but cannot produce a current Identification Card, providers should check with Seton Health Plan Member Services (877) 451-5601 to verify eligibility. Providers are advised to document this contact with SHP in their records.

WHAT IF A FEMALE MEMBER BECOMES PREGNANT WHILE UNDER MY CARE?

Call Seton Health Plan Member services at 1-877-451-5601 as soon as you know you have a pregnant CHIP member. Seton Health Plan CHIP will call Children's Health Insurance Program to tell them this member is pregnant. Children's Health Insurance Program may notify her regarding potential eligibility for Medicaid. Children's Health Insurance Program will send out information on how to apply for Medicaid. If this member is potentially eligible for Medicaid, she must apply for Medicaid. If she is determined to be Medicaid eligible, she is no longer eligible for CHIP.

If she is deemed not eligible for Medicaid, the Children's Health Insurance Program will extend her eligibility period, if her eligibility would otherwise expire. Her CHIP coverage will continue during her pregnancy. Her coverage continues through the end of the second full month of the baby's birth.

Seton Health Plan offers classes to help CHIP members through the pregnancy. Other classes prepare them for when the baby comes home.

CHANGING HEALTH PLANS

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

SPECIAL ACCESS REQUIREMENTS

Each office is required to ensure compliance with applicable State and Federal regulations for handicapped access.

INTERPRETER / TRANSLATION SERVICES

Some providers have language capability for Spanish speaking members. Seton Health Plan will assist offices with other language interpreters when requested. For assistance, the provider should:

1. Identify the language used by the member.
2. Provide the member with a phone or have a speakerphone available for use by both the member and the provider during the conference call.
3. Call our Member Service Department at (877) 451-5601.

Seton Health Plan has contracted with the AT&T Language Line and ASL Services for visual communication for CHIP members. If an interpreter is required to be present during a member's appointment, please call the Member Services department for assistance. Relay Texas is a service established by the Public Utility Commission of Texas to provide telephone

interpreting service between people who can hear and those who are deaf, hard-of-hearing, deaf-blind and speech-impaired. Members that cannot use a regular telephone can communicate with the provider through a Relay Texas Agent who will serve as an interpreter. The Relay Texas phone number is 800/735-2989.

If you have a member who is deaf, or who is the child of a parent or guardian who is deaf, Seton Health Plan will coordinate with your office to provide an interpreter for the visit.

Please consider the reading/grade level of the member or parent/guardian. As a rule of thumb any documentation you provide to the member should not exceed a sixth grade reading level.

Please be culturally sensitive to members and or parents/guardians. Some action or words you use may be interpreted by the member and or parent/guardian in the wrong way. If you need additional information about cultural sensitivity please contact provider relations at 512/324-3125

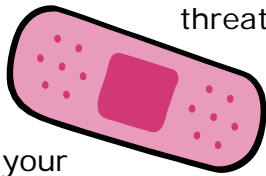
ROUTINE, URGENT, & EMERGENCY MEDICAL CARE

Definitions

ROUTINE MEDICAL CARE is when a member gets a check up or annual physical at your office. Sometimes, if a CHIP member has had surgery, you may tell him/her to come back to your office for a follow-up check up. That is also routine care.

A CHIP member should be able to get Routine Medical Care by calling the PCP's office and the PCP should make appointment within two weeks of when you call.

URGENT MEDICAL CARE is when your child is sick, but it is not life threatening. This might be a sore throat or if you think your child may have an ear infection. You should call the PCP and make an appointment. Do not go to the Emergency Room for Urgent Medical Care. The PCP should make appointment within 24 hours of when you call.



EMERGENCY MEDICAL CARE is a covered CHIP service. "Emergency" and "emergency condition" means a medical condition of 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 the child's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- placing the child'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.

If a member presents in your office and you or your staff feel that the patient is presenting an emergent condition please call 911. Emergency Transportation, via Emergency Medical Services Ambulance, helicopter, boat or airplane is a covered benefit of CHIP and is not subject to network restrictions.

HOW

Here



CAN A CHIP MEMBER GET A RIDE TO YOUR OFFICE?

are some suggestions of how a member can to get to your office if he/she doesn't have a car:

Capitol Metro. Most Seton Health Plan doctors in Austin have offices on or very close to bus routes. A member may have to pay the usual Capitol Metro fares if they take the bus.

Capitol Metro Special Transit Services. In Austin and Round Rock, Capitol Metro has special buses and cars for people with disabilities or other special needs. A member might qualify to use this service. You can suggest they call Member Services and we can help you find out. (Advance reservation is required). Or you can call Capitol Metro at 478-9647. Or call free from any pay phone by dialing 1-800-474-1201.

Capital Area Rural Transportation System (CARTS). If a CHIP member lives outside the city limits of Austin or Round Rock or in Bastrop, Burnet, Caldwell, Hays or Fayette County, CARTS will assist them in getting transportation to your doctor. Call them to make a reservation at 1-800-456-7433 or 478-7433.

SETON HEALTH PLAN – CHIP BEHAVIORAL HEALTH PROVIDERS

BEHAVIORAL HEALTH PROVIDER RESPONSIBILITIES

A CHIP Enrollee has behavioral health benefits, too. Mental health visits are covered. Substance abuse treatment is also covered. A member can go to a behavioral health provider without getting a referral from your PCP. But the provider must be in our network. The Provider Directory lists all of the behavioral health providers in our network.

Seton Health Plan (SHP) has contracted with Tejas Behavioral Health (Tejas) to provide Behavioral health services its CHIP members. Members may access behavioral health services directly by contacting Tejas at (800) 852-769. All behavioral health services must be a covered benefit as listed in the CHIP Evidence of Coverage and Scope of Benefits (a copy is provided later in this manual).

Definition of Behavioral Health

Behavioral Health is the broad area of health care dealing with those illnesses and disorders catalogued in the DSM-IV-TR, the current diagnostic manual for psychiatry.

Seton Health Plan providers who provide services as a participating behavioral health providers (Tejas) are required to the following:

- Keep a record of the member's health and of care provided;
- Accept referral of a member in accordance with the services and number of visits and/or time frame requested by the PCP;
- Send a report to the referring PCP upon completion of the consultation. Should additional visits be needed, beyond those specified on the referral form, a new referral request must be made of the PCP and Seton Health Plan's Utilization Management;
- Continuing consultation between the PCP and the behavioral health provider may be oral and/or written.
- Return the member to the care of the Seton Health Plan's PCP as soon as medically feasible.

Referral from the Member's Primary Care Physician

When the primary care physician decides the member requires behavioral health services the PCP may direct the member to access behavioral health

services directly by contacting Tejas at (800) 852-7691.

BEHAVIORAL HEALTH PROVIDER PROCESSES

Coordination of Care

POLICY: In order to facilitate the coordination of essential, effective, and appropriate care between participating behavioral healthcare providers, Primary Care Physicians, specialty service providers or the general medical delivery system, including the local mental health authority; behavioral health providers are required to send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the primary care physician, with the member's or the member's legal guardian's consent.

Primary care Physician (PCP): A physician who is identified by the patient as being principally responsible for delivering the patient's general medical care. PCP's are typically Internists, Family Practitioners, General Practitioners, Pediatricians, or Obstetrician/Gynecologists.

Vital Patient Information: Clinical and demographic patient information, which facilitates the coordination of essential, effective, and appropriate care. Vital patient information includes the patient's name, participating behavioral healthcare provider's name, credential, address, and phone number; findings from the psychiatric assessment including the DSM-IV diagnosis; and essential elements of the treatment plan.

PROCEDURE:

1. Release of Information

A signed release of information form must be obtained from the patient by the participating behavioral healthcare provider before releasing vital patient information to the PCP or other service provider.

- The participating behavioral healthcare provider will first discuss the rationale for coordination of care with the patient.
- The participating behavioral healthcare provider is encouraged to use the Authorization for Release of Information or PCP Release of Information Form.
- The participating behavioral healthcare provider will retain a signed copy of the Release of Information in the patient's case file.
- Notification of the PCP or other service providers by the Participating Behavioral Healthcare Provider
- The participating behavioral healthcare provider shall forward vital patient information to the requesting party.
- Vital patient information shall be sent to the PCP or other service

provider within 5 business days of obtaining the signed release of information form. Providers will weigh the clinical urgency of sharing vital patient information with other clinical/medical professionals when deciding how soon to forward the information within this 5-day period.

2. The participating behavioral healthcare provider shall retain a copy of the initial patient information that has been sent to the requestor of the information.

3. Requests for Additional Information by the Primary Care Physician:
The participating behavioral healthcare provider will honor requests for additional vital patient information from the PCP or other service providers within the parameters of conditions described in the Release of Information Form on the next page.

**TEJAS BEHAVIORAL HEALTH SERVICES
AUTHORIZATION FOR THE RELEASE
OF CONFIDENTIAL INFORMATION**

Patient Parent or Guardian's Name

Address

Authorize **Provider** Name

Address

To disclose to **Provider** Name

Address

The following information:

For the following purpose:

This authorization may be withdrawn at any time in writing except to the extent that the program or person that is to make this disclosure has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. This release of information expires on _____ or in _____ days following completion or termination of treatment, except for information to be released or exchanged for purposes of a claim for benefit payment(s). If it is a claim for benefits, this release of information expires upon termination of coverage under the insurance policy or benefit plan or the final determination of the claim, if later.

Executed this _____ day of _____, 20_____

(PARENT, GUARDIAN if REQUIRED) Witness

To The Recipient of Confidential Information

If the information disclosed to you relates to substance abuse treatment, these records' confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rule restricts any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient's records

BEHAVIORAL HEALTH PROVIDER DOCUMENTATION

Medical Records Documentation and Referral Information (required documenting using the DMS-IV multi-axial classifications)

The clinical record is an important element in the delivery of quality treatment because it documents the information of assessment and treatment of services. Clinical records should include documentation of all contacts regarding the patient, relevant financial and legal information, consents for release of information, release of information to the Primary Care Physician, a signed copy of the Statement of Patient's Rights and Responsibilities, the prescribed medications with refill dates and quantities and any other information from other professionals and/or agencies. Member diagnoses must be recorded in the multi-axial format (Axes I-V) as described in the DSM-IV-TR.

Providers are responsible for maintaining an adequate clinical record for each patient and furnishing TBHS with a treatment plan at the proper pre-defined visit intervals. Providers are also responsible for furnishing updates when requested to facilitate quality patient management and utilization review. Providers are also requested to contact TBHS when an episode of care has ended whether it is by mutual decision or not. A form is provided for your use to fax to TBHS for notification that the episode of care has ended for a patient.

Clinical records are to be maintained by the provider for at least 7 years following case closure. These records may be maintained in a secured, off-site setting, but must be retrievable within 48 hours of request.

As part of our ongoing quality management program, clinical records may be audited to assure the quality and consistency of providers' documentation, as well as the appropriateness of patient treatment.

Procedures for follow-up on missed appointments

No Show Appointments

A "no show" is defined as a failure to appear for a scheduled appointment and without notification to the provider at least 24 hours in advance. No show appointments must be recorded in the member record. In addition, providers should immediately attempt to contact and re-appoint the member. In the event of 2 consecutive no show appointments or other unexpected termination of treatment, the provider should notify TBHS UM that the member did not attend their scheduled appointment so that TBHS may contact the member and assess the need for ongoing care.

Follow-up from Inpatient Care Discharge

Follow-up after hospitalization is one of the most important markers that TBHS and its health plan partners monitor in an effort to help members

remain stable and to prevent relapse after discharge. Follow-up within 7 days after discharge from inpatient services is required by TBHS and is monitored closely by the National Committee for Quality Assurance, which has developed and maintains the Health Plan Employer Data and Information Set (HEDIS). Even more importantly, increased compliance with this measure has been proven to decrease readmission and helps minimize no-shows at your practice. While a member is in an inpatient facility receiving acute care services, TBHS Care Managers work with the facility's treatment team to make arrangements for continued care with outpatient Network Clinician. If a member does not keep their outpatient appointment after discharge, please inform TBHS as soon as possible. When a member does not keep their appointment, a member of the Care Management Department will begin outreach services to the member. If the member is designated as an intensive care management member according to risk criteria such as significant diagnosis or readmission history, the follow-up specialist will also call periodically after the ambulatory follow-up treatment link is established to monitor compliance with continued care.

The practitioner or facility must obtain authorization for treatment within twenty-four (24) hours after a member request services by calling the Care Management department.

Assessment Instruments for Behavioral Health services – PCP usage

Tejas Behavioral Health relies on the "MacArthur Initiative Depression Tool Kit" which is intended to help Primary care Providers recognize and manage Depression. The complete kit is available for review on-line at <http://www.depression-primarycare.org/>. The Kit includes tools to assist with:

- Recognizing and diagnosing depression;
- Educating patients about depression, assessing treatment preferences, engaging their participation and explains the process of care;
- Using evidence-based guidelines and management tools for treating depression; and
- Monitoring patient response to treatments.

TEJAS BEHAVIORAL HEALTH SERVICES CONSENT TO RELEASE MEDICAL RECORDS

Please complete the following consent of medical release. This release will allow your provider to coordinate your care with your Primary Care Physician (PCP).

Patient Name: _____ Patient number: _____

Address: _____

Dates of Treatment: _____ Date of Birth: _____ SS#: _____

This consent authorizes Tejas to release or disclose information from the medical records of the above named patient to:

Physician Name: _____ Phone #: _____

Address: _____

Check the items that apply:

- Assessments
- Evaluations
- Progress Notes
- Treatment Plans
- Medication Information
- Transfer/Discharge Information
- Substance Abuse Information
- AIDS Information/HIV Status
- Other: _____

The purpose for this disclosure is: _____

This consent to disclose may be revoked at any time, but the revocation will not affect any action that has already been taken in accordance with the consent. The consent, unless revoked sooner, will expire one (1) year from the date of the signature.

Client _____
Date

Parent/Guardian _____
Date

Legally Authorized Representative _____
Date

Relationship _____

Staff Member _____
Date

Witness _____
Date

Court Ordered Commitments

Includes inpatient psychiatric services, up to annual limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, or placements as a Condition of Probation as authorized by the Texas Family Code. 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.

Includes outpatient psychiatric services, up to annual limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, or placements as a Condition of Probation as authorized by the Texas Family Code. 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.

Quality Management

Providers will be expected to comply with the quality assurance/methods improvement requirements of the SHP program regarding medical records review and utilization management reporting requirements. Providers will be expected to participate in focus studies as required by the accrediting agencies, or studies selected by Seton Health Plan.

SETON HEALTH PLAN - CHIP MEMBER RIGHTS & RESPONSIBILITIES

MEMBERS HAVE THE RIGHT TO:

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. This means that 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 about whether a service is covered and/or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If your child is confirmed to have 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 confirmed to have 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 or 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. You have a right to emergency services when you need them 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 few dollars depending on your income. This is called "co-payment."
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 say 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.

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. Try to follow healthy habits, such as, encourage your child to exercise, to stay away from tobacco, and to eat a healthy diet.
2. Become involved in the doctor's decisions about your child's treatments.
3. 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, try first to resolve it using the health plan's complaint process.
5. 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, try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. To pay your doctor and other providers co-payments that you owe them.
8. Report misuse of CHIP by health care providers, other CHIP members, or CHIP health plans

Member's Right to Self-Refer to an OB/GYN Provider.

Seton Health Plan CHIP DOES NOT LIMIT OB/GYN Services to LIMITED PROVIDER NETWORKS. Seton Health Plan CHIP does not limit your selection of an OB/GYN to your PCP's network.

ATTENTION FEMALE MEMBERS

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

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

Client Acknowledgment Statement

A provider may bill a Seton Health Plan member for a service that has been denied as not medically necessary or not a covered benefit only if **both** of the following conditions are met:

- The member requests the specific service or item, and
- The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

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

A Spanish version of the Client Acknowledgement is furnished in the Provider Enrollment and Responsibilities section of the Texas Medicaid Provider Procedures Manual.

Member Private Pay Agreements

There are health care services that are not covered by CHIP. Some CHIP members may choose to receive these services even though they are not covered. In the event the member decides to receive non covered services provider's must execute a private pay agreement with the member for the non covered service(s). A sample of a very simple private pay is included here:

<u>Member Private Pay Agreement</u>	
Date: _____	
Member Name: _____	
Member ID Number: _____	
Description of Non-Covered Service to be received: _____ _____ _____ _____	
I have read and understand the description of the non-covered service described above. I agree that this service will not be billed to Seton Health Plan CHIP. I further agree that I assume financial responsibility for this service and agree to pay for this service as described below:	
Price of Service: \$ _____	
Payment Terms: _____ _____ _____	
Signature of Patient/Parent/Guardian: _____	Office Staff Signature: _____
Date: _____	Date: _____

SETON HEALTH PLAN - CHIP CLAIMS AND REIMBURSEMENT

SUBMITTING A EMERGENCY SERVICES CLAIM

If emergency care is needed, it should be provided immediately in accordance with the procedures described in the "Emergency Services" section of this manual. Services provided in an emergency situation will be reimbursed in accordance with the Hospital's or Provider's agreement with Seton Health Plan. Non-participating providers and hospitals who provide emergency care to CHIP members will be paid according to the Medicaid allowable fee schedule.

SUBMITTING A HEALTHCARE CLAIM

In order to process your medical claims quickly and accurately, we ask that you submit a clean claim on a standard "HCFA 1500 AMA or HCFA 1450 facility (UB04) claim form: (please note that claims received without this information below may be rejected and returned to the provider)

- All Information as Requested on "HCFA 1500" or UB04;
- Member Name and Health Plan Identification Number including the two (2) digit suffix found on the member's ID card(box 1a);
- Patient Name, address, city, state, zip code AND date of birth
- Authorization/Pre-certification number, *if applicable*;
- Referring Physician, *if applicable*;
- Attending Physician's Name;
- Valid CPT4 and/or HCPC Procedure Code;
- Valid ICD9 Diagnosis Code;
- Provider Tax ID Number;
- Complete provider mailing and billing address, along with provider phone number;
- Other Insurance Information, *if applicable*;
- Member's group number;
- Plan Name - Seton Health Plan CHIP;

All claims, paper and electronic, must be **submitted within 95 days from the date of service** using one of the methods outlined below. All requests for reconsideration or appeals must be received within 90 days of the EOB date.

Please submit paper claims (non-behavioral health) to:
SETON HEALTH PLAN -CHIP
PO Box 15507
Austin, Texas 78681-5507

You may submit claims to SHP **electronically via the Texas Health Information Network (THIN)**. When submitting claims, please use the following **THIN Payer Identification number SHPCH. Electronic claims must be submitted in ANSI 837 format.**

Seton Health Plan CHIP members will only be charged/billed for applicable co-payments, as indicated on the member's identification card and/or as verified with the Member Services department.

Seton Health Plan physicians and other providers may not seek additional payment from members beyond these co-payments, except for non-covered services. At no time should members be billed for covered services. **For services that are not covered under the plan, the member must be notified in advance that the service is not covered and that the member will be responsible for payment in full for that service.**

Payment will be made by SHP to the provider within 30 days receipt of the claim from the provider.

Providers reimbursed on a capitation basis by Seton Health Plan CHIP should reference their contract with SHP to find out what services are included in the capitation payment. If you have additional questions or need more information please contact Seton Health Plan provider relations at 512/324-3125.

Providers who have a specific claim question should contact member services. Member services can review both the claim note and the authorization note of the claim in question.

If you do not agree with the way a claim was processed you may appeal it. Please refer to the health plan's web site (setonhealthplan.com) for the reconsideration form. Your appeal will be reconsidered once this form is submitted. If the claim denial is upheld you may submit another appeal to the health plan. If that appeal is not successful you have a final appeal level that you may access. For more information contact provider relations at 512/324-3125 or shpproviderservices@seton.org.

CHIP Behavioral Health Claims should be mailed to:

**Tejas Behavioral Health Care
PO Box 3216
Austin, Texas 78764**

COORDINATION OF BENEFITS

Coordination of Benefits (COB) refers to the determination of the payment responsibilities between two group health care plans or other insurers

providing coverage for the same individual at the time an allowable expense is incurred. Such determination as to which plan pays first and in what amount, is calculated by rules contained in the respective benefit plan documents. These rules are designed to prevent overpayment for the same service by the respective plans. Seton Health Plan CHIP rules are as follows:

- Seton Health Plan CHIP will always be the payer of last resort. Even if the member is enrolled in the State of Texas Medicaid program, CHIP will be secondary.
- If SHP CHIP is secondary, Seton Health Plan's payment responsibility shall be limited to that amount which, when added to the coverage provided by the other benefit plan, would be equivalent to that benefit provided by SHP if it were the only plan.

SETON HEALTH PLAN - CHIP PRACTICE GUIDELINES

DESCRIPTION OF PRACTICE GUIDELINES

These are a few of the practice guidelines that represent Seton Health Plan's standards on certain medical illnesses and procedures. SHP follows the recommendations of both the American Academy of Pediatrics and American Academy of Family Practice standards of Care. You can find detailed information on these items and more at the following web sites:

<http://aappolicy.aappublications.org/>

<http://www.aafp.org/x132.xml>

Seton also utilizes information from the following practice guidelines as general care guidelines. If you require a copy of the guidelines please refer to the web site below or contact a provider relations representative at SHP and one will be mailed to you.

Asthma guidelines from National Institutes of Health

<http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm>

Obstetrical guidelines from American College of Obstetricians and Gynecologists

http://www.acog.org/from_home/login.cfm?urlReq=/publications/guidelinesForPerinatalCare/

AMBULATORY CARE

Preventative Health Care/Well Exams

It has been recognized that early detection of health problems combined with an appropriate treatment plan can significantly reduce the morbidity/mortality of a set population. By promoting preventative health care, it is hoped that our members' overall health will improve and health care costs will be reduced.

Well-Woman Exam

- Height, weight, and blood pressure every 1-3 years
- Cholesterol check every 1-5 years, baseline at first visit
- Perform routine pelvic examinations and Papanicolaou smears. These examinations should be carried out on some regular schedule. A typical schedule could be at the age of 18 or the onset of sexual activity and should be repeated at one to three intervals depending on risk. High-risk status would include those with early onset of sexual intercourse and those with multiple partners. If a previous Pap smear has been abnormal it may be indicated that it be repeated at more frequent intervals than annually. On the other hand if a previously abnormal Pap smear has been normal for three consecutive examinations, the frequency of testing can be according to the baseline schedule.
- Perform laboratory testing for sexually transmitted disease for those patients with symptoms or multiple sexual partners
- Counseling and/or treatment with estrogen for post menopausal/hx of osteoporosis patients.

Well-Man Exam

- Height, weight, and blood pressure every 1-3 years
- Teaching/reinforcement of TSE yearly
- Cholesterol check every 1-5 years, baseline at first visit

ASTHMA CHRONIC RECURRENT

Asthma is the fourth leading pulmonary problem in primary care practice. Complete documentation of the patient's case is important to the management of chronic asthma. Standard records should include: a detailed history of the first attack, subsequent attacks, and triggers for symptoms. Monitoring by chest x-rays and pulmonary function tests are essential to record status and progress of the disease. Pulmonary function tests can be quite extensive or concentrate on the Functional Vital Capacity (FVC), and can be performed in the physician's office when appropriate.

- Adequate historical documentation of episodes (i.e. wheezing, frequency and duration of symptoms).
- Patient and/or parental education to include environmental precautions/smoking cessation.
- Pharmacological use and intervention of prescription and/or over-the-counter medications documented.
- Documented results of peak flow rates, pulse oximetry, spirometry on PFTs when ordered.
- Education/review of home diary/home treatment plan, warning signs.
- Asthma medical management: aerosols, metered dose inhalers, documented dose/education/follow-up.

NORMAL PREGNANCIES

All patients should be first examined between the initial 6 to 8 weeks of pregnancy. Follow-up visits should occur at 4 week intervals within the first 32 weeks of pregnancy, at 2-week intervals during 32-36, and then weekly until delivery.

The quality issues that should be addressed include early diagnosis and appropriate prenatal care. The first exam should include a complete physical exam. Laboratory tests should include CBC, STS, culture for gonorrhea, blood typing and Rh factor, antibody screening rubella antibody titer, complete urinalysis and Pap test. Patients of African descent should be tested for sickle cell trait or disease. Genetic studies should be offered to those in a high-risk category. Patients with a history of heart or lung disorders should have a chest x—ray. At each exam, patient’s weight and BP should be noted, and the size and shape of the uterus examined to determine whether growth and advancement are normal for gestation age. The urine should be tested for albumin and glucose. Fetal heart tones should be recorded at each visit, starting with the 18th week. At 15 to 16 weeks, an alpha-fetoprotein (AFP) test should be offered. Screening for abnormal carbohydrate metabolism should be done early in the second trimester. At approximately 28 weeks, all women should have glucose challenge screening. Hematocrit should be measured at each trimester.

- Family history of genetic abnormalities.
- Prenatal profile, plus rubella and hepatitis B titers and urinalysis; all elements should be recorded.
- Patient education about pregnancy, diet, alcohol, tobacco, activity, sex, prenatal classes, and hygiene, or enrollment in prenatal class.
- Clinical data recorded at each prenatal visit, including BP, urine, weight, fetal viability, and fundal height; all elements should be recorded.
- Glucose challenge screening test during second or third trimester.
- Hematocrit or hemoglobin at beginning of third trimester.

- RH antibody titer after 28 weeks in RH negative mother.
- Alpha-fetoprotein obtained during first trimester.
- Postpartum follow-up within 8 weeks of delivery.
- Triple test.

WELL BABY CARE (Newborn to 1 Year)

The assessment for growth is a major pediatric concern. Growth patterns, which deviate from the norm, may indicate the presence of disease or deformation. Early identification of deviations can often be treated without any permanent effects to the child. Head circumference measurement is an important growth indicator during a child's first year, along with the other measures of weight and length (height). Physicians should measure head circumference routinely, as part of a well baby visit, in order to assess the health of the baby.

Quality issues include: documentation of periodic head circumference measurement, height and weight recorded at least twice the first year, and presence and completion of an immunization schedule.

- Birth history.
- Height and weight measurements recorded at every well baby visit during the first year.
- Head circumference measurement recorded at every well baby visit during the first year.
- Indications of growth and meeting developmental milestones at each well baby visit.
- Immunization schedule present and maintained (American Academy of Family Physicians or American Academy of Pediatrics schedules are acceptable), or administration by another physician or clinic is confirmed and recorded, of parental refusal documented on the chart; all immunizations to show site of administration, laboratory number, manufacturer, and initials of person administering.
- Record of PKU test or neonatal screen performed in the hospital or birthing center, or performed within two weeks of discharge; it is ideal for both PKU tests to be documented (one at the hospital and one in the office).
- Nutritional education.
- Parent education: counseling parent smoking, car seats, sleeping on back.

WELL CHILD CARE (15-24 MONTHS)

Regular pediatric review of children ages 15-24 months, the chart should include the completion of an immunization schedule as set forth by the American Academy of Pediatrics or American Academy of Physicians and an indication that growth and development has been measured at least twice.

The quality indicators to be utilized are the vaccination for MMR (measles, mumps, and rubella) and recording of height and weight. There should be some indication in the chart that the child either was given the MMR, that another physician gave the MMR, or that the parents refused the immunization. The MMR is chosen as a practical indicator with the assumption that if the MMR is complete, the other necessary immunizations were also given (i.e., DPT and TOPV.)

- Immunization schedule present and maintained (American Academy of Family Physicians or American Academy of Pediatrics schedules are acceptable), or administration by another physician or clinic is confirmed and recorded, or parental refusal documented on the chart. All immunizations document site of administration, laboratory number, manufacturer, and initials of person administering.
- Documentation of Mantoux or TB tine test.
- Indications of growth and meeting developmental milestones recorded at each well child visit.
- Parenting instruction, including parenting skills, documented.
- Parent education, including accident prevention, documented.
- Nutritional education.

SETON HEALTH PLAN - CHIP REFERRAL GUIDELINES

REFERRAL PROCESS

Seton Health Plan CHIP members must have a referral from his/her Primary Care Physician before attempting to see a network specialist (for a listing of SHP Chip specialists, visit our website www.seton.net/HealthInsurance/SetonHealthPlanProvOABC/index.asp). The PCP's office will contact Seton Health Plan Medical Management department by fax or phone to make a referral. The Medical Management Department information is as follows:

SETON HEALTH PLAN CHIP MEDICAL MANAGEMENT DEPARTMENT

FAX: (512) 420-2798

PHONE: (512) 420-2777 or (877) 451-5601

A copy of the referral form is in the "Forms and Updates" section of this manual.

How to Make A Referral

THE PRIMARY CARE PHYSICIAN (PCP) REFERS TO THE LIST OF PARTICIPATING SPECIALISTS AND CHOOSES AN APPROPRIATE SPECIALIST FOR THE PRELIMINARY DIAGNOSIS. THE RECOMMENDED CARE SHOULD BE MEDICALLY NECESSARY AND A COVERED BENEFIT. THE PCP CAN MAKE A REFERRAL BY CALLING THE MEDICAL MANAGEMENT DEPARTMENT AND PROVIDING THE FOLLOWING INFORMATION:

- The name of the PCP and name of person calling
- The patient name and Seton Health Plan ID #
- The patient's date of birth
- Primary diagnosis
- The specialist name
- Number of visits requested

The PCP may also complete and fax a referral form. Routine referrals are entered within 2 working days. Urgent requests are processed according to the immediacy of the services requested and not to exceed 24 hours.

Referral numbers will be faxed back to the requesting provider's office and the specialist's office within 48 hours. An authorization letter will be mailed to the member indicating the services approved, date span, and specialist's name, address and phone number to call for an appointment.

To confirm a referral has been entered the PCP, Specialist and members may call 420-2777 or (877) 451-5601 or on-line at Seton website at

<http://seton.net/HealthInsurance> and click on the Member or Provider link.

Referrals will typically be made for a maximum of 3 office visits and effective for 90 days (OB referrals will be for the term of the pregnancy).

Referrals (1) to non-participating specialists, (2) for more than three offices visits, or (3) for longer than 90 days must be authorized by Medical Management.

There will be **no** retroactive referrals.

Please note: A referral or authorization is not a guarantee that services will be covered or that payment will be made. All medical service rendered are subject to review, which includes but is not limited to, determination of eligibility in accordance with the terms of the members benefit plan, co-payments, reasonable and customary charges and policy maximums.

CONTINUITY OF CARE

Seton Health Plan (SHP) Continuity of Care policy is a plan that focuses on transferring the member from an out-of-network provider to an equally qualified in-network provider while accounting for such member's medical condition, their need for accessibility, and any quality of care issues.

Emergency Services outside of Seton Health Plan services area will be processed and paid accordingly.

There may be occasion when a member moves out of the Seton Health Plan CHIP service area. Once that member has established relationships with providers in their new location, SHP providers should make every effort to coordinate care with the providers in the member's new service area.

Pre-existing Conditions. CHIP does not contain pre-existing limitations. Therefore, pre-existing limitations on coverage are not imposed.

SETON HEALTH PLAN - CHIP PERFORMANCE REVIEW

GOAL:

The goal of Seton Health Plan's Performance Improvement (PI) Program is to continuously improve the level of care and services provided to the enrolled population. Methods to achieve this include, but are not limited to, establishing standards and performance goals for the delivery of care and services, measuring performance outcomes, and taking actions to improve outcomes. The PI Program is based on outcomes and process measures, process redesign, measures of member access and satisfaction while continuously focusing on the highest priority aspect of health care delivery.

SCOPE:

The scope of the PI Program encompasses both clinical care and services provided to internal and external customers. PI service indicators and performance goals are established for physician accessibility, physician availability, plan accessibility, member satisfaction surveys, complaint and grievance monitoring and analysis, provider satisfaction, and departmental performance monitors. PI clinical indicators and studies are selected based on SHP's demographic and epidemiological data and include measurement of:

- Services provided in institutional settings (hospitals, long-term care, home health agencies, pharmacies, rehabilitation, residential, mental health);
- Services provided in non-institutional settings (home health care, free-standing surgical centers, urgent care, ER, physical therapy);
- Services provided in individual provider's offices (primary care, mental health, OB/GYN), and high volume specialists;
- Preventive health guidelines and practice guidelines;
- Services reflecting acute and chronic care;
- Continuity and coordination of care; and
- Under- and over-utilization.

OBJECTIVES:

The Seton Health Plan will, using input from its operations:

- Design and maintain PI structure and process that supports continuous quality improvement.
- Establish clinical and service indicators that reflect demographic

and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and/or periodic monitoring and evaluation.

- Maintain an ongoing up-to-date credentialing and recredentialing system that complies with NCOA, TDI and other regulatory standards, including primary verification, the use of PI information in recredentialing, and provider office site visits.
- At least annually, measure availability and accessibility to care and service for plan members.
- Measure member satisfaction and identify and address areas of dissatisfaction.
- At least annually, monitor the impact of UM program, including measuring provider and member satisfaction.
- Continue to develop/adopt/adapt practice guidelines reflective of the population.
- Perform a site visit and medical records audit for PCP, OB/Gyn, and other high volume specialists every 2 years.
- Evaluate under- and over-utilization and continuity/coordination of care through medical record review, analysis of member complaints; provider utilization profiles, identification of low utilization levels, PMPM comparisons; referral/1000, and intervention with individual practitioners.
- Coordinate PI activities with all other activities including, but not limited to, the identification and reporting of risk situations, the identification and reporting of adverse occurrences from UM activities, and the identification and reporting of potential quality of care concerns through complaints and grievances collected through the member services department.

SETON HEALTH PLAN - CHIP UTILIZATION MANAGEMENT

Seton Health Plan's (SHP) Utilization Management Program oversees the delivery of health care services rendered to members throughout the Service Area. The program is designed to ensure that utilization issues are identified, documented, and reviewed, and that appropriate improvement plans are initiated to address utilization problems in a consistent and timely manner.

The program delegates, where appropriate, the authority and responsibility to monitor the health care services delivered to members, review medical expenses, identify issues which impact service and quality, resolve problems and recommend action plans on a local level to participating physicians with oversight and support provided by Seton Health Plan.

GOALS

The goals of the program are to:

- Facilitate appropriate allocation of resources through systematic monitoring and evaluation of the appropriateness, quality, and cost effectiveness of medical, surgical and mental health care services.
- Improve the quality of patient care by identifying and communicating potential quality issues through the quality improvement program (QIP) for resolution.
- Identify and take appropriate action where over-utilization and under-utilization are identified through prospective, concurrent and retrospective review, profiling of services and the medical review of claims.

SCOPE

The Seton Health Plan Medical Director is responsible for ensuring that the basic components of the utilization management program is established and operating effectively.

The utilization management program includes ongoing regular access to the Seton Health Plan Medical Director and a clear commitment of the plan Medical Director to contact his/her peers regarding utilization management activities. A plan physician (or Medical Director) will do all "denials" or "failure to pre-certify". All requests for additional information pertaining to questionable cases or potential denials will be managed under the direction of the plan Medical Director.

Systems in place to evaluate and monitor basic health services include, but are not limited to:

- Pre-admission review for all non-emergency hospitalization. Review of emergency admission following notification.
- Concurrent reviews of inpatient care.
- Authorization of referrals to participating specialists.

- Authorization of selected outpatient procedures, surgeries and services, durable medical equipment (DME) and non-participating specialists.
- Drug use evaluation which focuses on the evaluation of drug use patterns and the assessment of appropriate, cost-effective, quality drug therapy.
- Second surgical opinion, if appropriate.

A formal SHP two level appeals process meeting Texas Department of Insurance regulations is in place, which is followed for all appeals of UM decisions. The appeals process is presented in a later section of this manual.

OBJECTIVES

- Assure consistency in application of all UM functions in Service Area.
- Review and evaluate health care services for quality, medical necessity and appropriateness.
- Monitor and enforce compliance with all contractual and regulatory requirements.
- Identify actual and potential quality issues through the review process and refer to the appropriate quality improvement personnel.
- Aggregate utilization data to identify aberrant practice patterns, recommending changes as required.
- Provide guidelines for receiving, processing, and responding to member grievances relating to utilization management and review practices.
- Provide and enforce a conflict of interest policy.
- Coordinate UM and QIP activities to maintain continuous quality improvement.
- Evaluate the UM Program on an annual basis.

UTILIZATION MANAGEMENT FUNCTIONS

- **Pre-certification** involves prior authorization for utilization of plan services. Seton Health Plan uses Pre-certification to determine the medical necessity of a treatment or service before it is provided. Pre-certification is an integral component of managed care. It allows for benefit interpretation, evaluation of proposed treatment, of medical necessity, level of care assessment, the assignment of the initial length of stay, and appropriate placement prior to the delivery of services. Pre-certification also initiates the case management process.

Pre-certification of all non-emergency inpatient admissions, ambulatory or same day admissions is done using Interqual, Milliman & Robertson's Health Care Guidelines, Volume III, and Ambulatory Care Guidelines and Surgical Care Guidelines, Volume I, as necessary, to assure optimal utilization.

This process is intended to initiate a review process that will establish and support a strong team relationship between the Pre-certification Nurse and the Primary Care Physician (PCP), admitting physicians and attending

physicians and the Plan Medical Director. The Seton Health Plan has developed specific policies and procedures for the Pre-certification process that facilitate the delivery of optimal health care.

All requests are reviewed and authorized by the nurse review staff and/or the SHP Medical Director. In most cases Pre-certification authorizations are returned within two (2) business days. Cases requiring further information and/or medical director review may require up to three (3) working days from receipt of complete information. Pre-certification requests may be faxed or phoned to SHP and the authorization number will be faxed (or provided during phone call) to the requesting party.

- **Inpatient Services** involving all inpatient admissions and out-of-network facilities require prior authorization, except on an emergent basis. SHP must be notified within 48 hours of all emergency admissions.

Non-Participating Provider Pre-certifications are provided in emergency situations that occur outside the service area or in cases where medical necessity indicates the need of a specialty not represented on the SHP provider panel.

- **Mental Health Pre-certifications** and benefits are completely separate from the medical services. If the PCP identifies an immediate need for mental health services, he/she may contact Tejas Behavioral Health Services (**Tejas**) at 800-852-7691 or a par provider. Tejas is a network of social workers, counselors, psychiatrists and psychologists. A broad variety of services are available through these mental health practitioners. All mental health services need to be approved in advance by Tejas or a par provider.

The SHP Medical Director, except in cases of emergency care received outside of the service area, must authorize use of **any** non-participating providers. In cases of life or limb threatening emergencies, appropriate care should be provided in all instances. Once the member's condition is stabilized, the member may be transferred to a participating physician and/or facility for further care.

In the event that a member chooses a non-participating physician or facility and the event is not an emergency situation, the member will be financially responsible for all the costs, both professional and institutional.

Inpatient Hospital Concurrent Review and Discharge Planning is a process that ensures the length of stay in the hospital is appropriate for the member's medical condition and that quality care is being administered at all times, whether admitted for non-emergency or emergency treatment. If it appears that continued hospitalization may no longer be necessary

following discussion between the Medical Director and the attending physician, both the member and the facility will be notified in writing that benefits will not be paid if the member remains in the hospital.

Ambulatory Pre-certification will be assisted by the Case Coordinator who will work with the patient and the physician in arranging for the patient's discharge needs. The Case Coordinator will arrange for any home care services, skilled nursing care, or medical equipment that is required after leaving the hospital. This process helps assure that every patient is provided with appropriate care, both in the hospital and afterward.

Retrospective Review is the review of medical necessity, appropriateness, and quality of care, after the care has been rendered, and after the patient has been discharged from the health care setting. It is conducted on inpatients discharged prior to concurrent review, as part of the appeals and reconsideration process, and as specified by the plan. The Case Coordinator does retrospective review. The review includes adequate documentation of information justifying the medical necessity for admission, principal discharge plan diagnosis and medical/surgical procedure performed. The SHP Medical Director reviews any case prior to an adverse determination.

Medical Case Management (MCM) is initiated to ensure appropriate utilization and timely delivery of quality health care. The case manager develops, coordinates, and implements cost-effective care plans. He/she also serves as an advocate to coordinate and optimally utilize health care and community related services for the member. Selection criteria for MCM are as follows:

- 1) Diagnosis (es) that could result in catastrophic outcomes.
- 2) Catastrophic illnesses or medically complex conditions.
- 3) Organ transplants
- 4) Complex procedures with known high dollar claim liability.
- 5) Members who have exhibited non-compliance in managing their disease process.

The SHP's case managers identify catastrophic cases through the catastrophic case management operational guidelines, which include the Pre-certification process and various reports from internal information systems. The case manager focuses on the member's needs and discusses treatments, services, and goals with the attending physician and other health professionals. The member and family are involved as much as possible. The case is reviewed on an ongoing basis and the care plan is revised as necessary after consultation with the physician and other health care professionals. The case manager sees that the available options are explained and understood by everyone involved.

The SHP's case coordinator evaluates potential cases for MCM. The attending physician may also recommend the patient for medical case management by calling (877) 451-5628.

SETON HEALTH PLAN - CHIP CREDENTIALING & RECREDENTIALING

I. Purpose

Seton Health Plan (SHP) establishes criteria for the initial Credentialing & triennial Recredentialing of providers contracted to provide services to enrollees of SHP. SHP is responsible for ensuring that standards for participation are adhered to across the provider network.

II. Policy

SHP documents information regarding the professional experience and qualifications of providers contracted to provide services to enrollees. SHP Credentials MDs, DOs, DPMs, DDSs, (oral surgeon) DCs and other licensed independent practitioners who treat members outside the inpatient setting, as well as facilities. Physicians or providers who are members of a contracting group shall be credentialed individually. Practitioners have the right, upon request, to be notified of the status of their credentialing or recredentialing application.

SHP does not discriminate against providers who serve high-risk populations or who specialize in the treatment of costly conditions nor does the health plan discriminate against providers based on age, sex, race, religion and/or national origin.

SHP will maintain confidential, individual provider files in a secure location that only the Credentialing Department can access. Any employee working for SHP Credentialing Department and any practitioner/non-practitioner serving as a member of the Credentialing Committee and/or Quality Improvement Committee will sign a confidentiality statement.

In collecting and maintaining Credentialing files, SHP will comply with State and Federal regulatory and legislative requirements. SHP may delegate Credentialing and Recredentialing responsibilities to organizations that have demonstrated the ability to manage a current and on-going process for Credentialing/Recredentialing and comply with the SHP's Credentialing standards.

Any provider, who applies to contract with SHP and is denied, is given written notice with reasons for the denial.

III. Authority

The SHP Board of Directors (BOD) has authorized the Credentialing Committee under the direction of the Medical Director to perform the following functions: Credentialing, Recredentialing, Policy & procedure annual review, and Peer Review. The information submitted to the Credentialing Committee for consideration has undergone a review for completeness, accuracy and conflicting information. The Credentialing Committee will review the credentials of all practitioners being credentialed or recredentialed that do not meet the organization's established criteria. A quorum for the Credentialing Committee is defined as the Chairperson and one (1) member to be present for any action to be taken. The SHP BOD has authorized the SHP Quality Improvement Committee (QIC) to oversee the Credentialing Committee. The QIC is responsible for approving any decisions regarding denying, reducing, suspending or terminating clinical privileges based on the recommendations of the Credentialing Committee.

The Credentialing Committee membership will include:

- Primary Care Providers (PCP) – 1-3
- Specialty Care Providers (SCP) – 1-3
- SHP Medical Director (Chairman)
- SHP Support Staff (non-voting members)

The Credentialing Committee will meet monthly (this may include fax pack meetings). Only clean files are included in a fax pack meeting. A clean file is defined as a Credentialing or Recredentialing file that meets all requirements in the designated time frames with no history gaps or malpractice issues. When a fax pack meeting is utilized, each member is faxed a summary of information. Once the review is completed, the committee makes his/her recommendations. These recommendations are faxed to the Credentialing Department. If the majority of the Credentialing Committee responds affirmatively, approval is granted. A provider answering "yes" to any questions on the questionnaire or with any other special information to review (i.e. malpractice case, license limitations, etc.) will not be included in a fax pack meeting. Minutes will be recorded at each meeting per policy and procedure.

See Policy Number CR101 for further details on the Credentialing and Recredentialing Procedures for Physicians and facilities.

Reducing, Suspending and Terminating Provider Privileges

In order to ensure the delivery of quality health care to SHP's members, it is necessary to have a mechanism in place whereby a provider's privileges may be suspended or terminated in any instance where the quality of care may result in danger to the health of members.

For the process regarding Termination, Suspension, or Reduction of Privileges see SHP Policy CR 105. The provider is given the option of an appeal

hearing, included in Policy CR109, Appeals Process for Reduction, Suspension, or Termination of Practitioners.

Members receiving care from terminated providers must be notified at least 30 days before the effective date of the termination unless the termination reason is related to imminent harm.

Practitioners seeking reinstatement following a break in service of more than 30 calendar days from the provider network must undergo initial credentialing before being approved to rejoin the network.

SHP is responsible for reporting any adverse actions included in Policy CR106, Reporting of Providers to the Appropriate Agencies.

Provider Right To Appeal Credentialing Decision

Seton Health Plan will have a fair hearing and appeal process allowing adverse decisions affecting network participation to be reviewed. Providers who have completed the initial credentialing or recredentialing process unsuccessfully or have had their membership reduced, suspended or terminated, have the right to request an appeal. The Medical Quality Improvement Committee is responsible for the denying of credentialing/recredentialing privileges, reducing or suspending a provider's membership or termination of provider membership.

Delegation

Seton Health Plan is fully accountable for all delegated credentialing and recredentialing of providers. Therefore, all delegated credentialing must follow the established criteria by SHP. The responsibility for assuring the function is performed appropriately cannot be delegated. The use of a CVO and/or "sister" company is considered delegation.

Seton Health Plan does not discriminate against providers who serve high-risk populations or who specialize in the treatment of costly conditions nor does the health plan discriminate against providers based on age, sex, race, religion and/or national origin. Please refer to Policy CR 108 for further details.

SETON HEALTH PLAN – CHIP GOVERNANCE: REASONS AND PROCEDURES

In order to ensure the delivery of quality health care to Seton Health Plan members, it is necessary to have a mechanism in place, which governs a provider's privileges. A provider's privileges may be immediately suspended or restricted in any instance where the quality of care may result in imminent danger to the health of SHP members. Therefore, Seton Health Plan has created the following reasons for immediate suspension or termination from network membership:

- Medical License is suspended or revoked;
- DEA or DPS License is suspended or revoked;
- Any sanction activity reported to Medicare or Medicaid;
- Conviction of a felony charge;
- Loss of hospital and network privileges;
- Loss of malpractice insurance;
- Major qualities of care issues are detected.

Seton Health Plan's responsibilities and actions in the matter of terminating a contract are as follows:

- A. The Credentialing Department will notify the Medical Director or the Executive Director of any serious complaint or problem that warrants immediate actions.
- B. Suspension or termination will remain in effect unless and until such circumstance is reversed by recommendation of the Seton Health Plan and determination from the Quality Improvement Committee to determine otherwise.
- C. The Governing Board Chairperson will notify the provider of Seton Health Plan's decision to terminate or suspend the provider agreement. This notice, sent by return receipt mail, will inform the provider of the decision.

SETON HEALTH PLAN – CHIP MEMBER COMPLAINT & APPEAL PROCESS

WHAT SHOULD I DO IF I HAVE A COMPLAINT?

If you have a complaint, you should call Seton Health Plan Member Services right away at 1-877-451-5601. A Seton Health Plan Member Services Representative will help you file the complaint. The Member Services Representative will also help you go through all the steps of having your complaint heard. You can also send your complaint in writing to:

**Member Services-Seton Health Plan
P.O. Box 14545
Austin, TX 78761**

We will send you a letter within 5 days of receiving your complaint. We will then look into the issue. We will resolve the complaint within 30 days of receiving it, and notify you by mail. You may not agree with our decision. If not, you may file an appeal (see below).

WHAT IF I AM NOT HAPPY WITH THE RESOLUTION OF MY COMPLAINT?

If you do not feel the answer Seton Health Plan gave for your complaint is right, you can appeal the decision.

You should call Member Services and talk with a Member Services Representative, who will help you file the appeal. When you file an appeal, Seton Health Plan will review the case further.

You also have the right to file a complaint with the Texas Department of Insurance (TDI). You can file a complaint with TDI at any time. You do not have to wait until you get a decision from Seton Health Plan.

HOW WILL I BE NOTIFIED IF SERVICES ARE DENIED?

You will be notified by mail of any services that have been denied by SHP. Your provider will be notified of the denial as well.

WHAT CAN I DO IF SETON Health Plan CHIP DENIES OR LIMITS MY DOCTOR'S REQUEST FOR A COVERED SERVICE?

The member or the member's representative may appeal if you do not agree with SHP's decision regarding your health care.

WHAT ARE THE TIMEFRAMES FOR THE APPEAL PROCESS?

An Acknowledgment letter will be sent to you within 5 days of SHP receiving the appeal. SHP will resolve the appeal within 30 days and send you a resolution letter that explains the decision.

WHEN DO I HAVE THE RIGHT TO REQUEST AN APPEAL?

You can appeal a decision if you feel:

- SHP did not approve or give the member care that should be covered.
- SHP is discontinuing care the member still needs.

DOES MY REQUEST HAVE TO BE IN WRITING?

No, the member or the member's representative may file an oral or written request for an appeal.

CAN SOMEONE FROM SHP HELP ME FILE AN APPEAL?

You can call Member Services and talk with a Member Services Representative, who will help you file the appeal.

WHAT IS AN EXPEDITED APPEAL?

In some cases an expedited appeal may be obtained, if waiting for a standard appeal could seriously harm the member's health or ability to function.

HOW DO I REQUEST AN EXPEDITED APPEAL?

If you or the member wishes to request an expedited appeal, contact SHP and specifically state that you want an expedited appeal or that you believe the member's health could be seriously harmed by waiting for the standard appeal.

DOES MY REQUEST HAVE TO BE IN WRITING?

Yes, the request does have to be in writing. Someone from Seton Health Plan CHIP member services can help you write the appeal.

WHAT ARE THE TIMEFRAMES FOR AN EXPEDITED APPEAL?

Expedited appeals will be resolved within 1 business day.

WHAT HAPPENS IF THE MCO DENIES THE REQUEST FOR AN EXPEDITED APPEAL?

Seton Health Plan CHIP will evaluate the request and medical condition to determine if the appeal qualifies as an expedited appeal. If Seton Health Plan CHIP does not feel the appeal qualifies as expedited you may always contact your physician for assistance.

WHO CAN ASSIST ME IN FILING AN APPEAL?

You can call Member Services and talk with a Member Services Representative, who will help you file the appeal.

WHAT IS AN INDEPENDENT REVIEW ORGANIZATION (IRO)?

They are people outside of Seton Health Plan that help make medical necessity decisions. If requested during the appeal process they will review your case and make a decision.

HOW DO I REQUEST AN IRO REVIEW?

An IRO request form will be sent to you with every denial and appeal resolution letter. Complete the form and return it to SHP to request the IRO review. A SHP Member Service Representative can help you if you need assistance.

WHAT ARE THE TIMEFRAMES FOR THIS PROCESS?

SHP will resolve the appeal within 30 days and send you a resolution letter that explains the decision.

WHAT IF I STILL DO NOT AGREE AFTER AN APPEAL?

If you still disagree with their decision, you can appeal to the Texas Department of Insurance.

The address to file a complaint with TDI is:

**Texas Department of Insurance
333 Guadalupe Street
Austin, TX 78714-9104**

If you file or make a complaint, Seton Health Plan cannot and will not hold it against you. We will still be here to help you get quality care.

**SETON HEALTH PLAN - CHIP
PROVIDER COMPLAINT & APPEALS PROCESS**

Seton Health Plan (SHP) shall make every effort to resolve provider complaint and appeals using established and consistent procedures for reviewing and responding not later than 30 days from the date the complaint/appeal was received.

SHP has established consistent procedures for reviewing and responding to provider complaint and appeals. A provider complaint or appeal must be received by SHP in writing regardless of the reason for the requested review.

Dissatisfactions involving aspects of SHP operations including claims payment issues are considered provider complaints and will be handled in accordance with the Provider Complaint Policy. Provider benefit denial appeals are treated as member complaints and are handled according to the Member Complaint and Appeal Policy.

The claim appeal is received and forwarded to the customer service unit responsible for claim appeals. The appeal is logged and an acknowledgement letter is sent to the provider not later than the fifth business day after the date of receiving the complaint.

The letter acknowledges the complaint/appeal was received and explains to the provider that the appeal will be resolved within 30 days of receipt. They will be notified in writing of the decision.

SHP maintains a provider claim appeal log, which includes documentation of each appeal received and details of the action taken to resolve the appeal. Provider claim appeals are logged to identify trends or opportunities for improvement.

The claim appeal is then directed to the appropriate department for review and final determination. If the complaint/appeal requires medical necessity determination it will be forwarded to the Medical Management Department for the Medical Director to review. If the complaint/appeal does not require medical necessity review it will be resolved by Provider Services.

SHP shall issue a written response to the provider within 30 days that explains the health plan's decision, including any medical or contractual reasons, if the complaint was reviewed by another physician and his or her specialty, and contains the complete description of the process for appeal, including the deadlines for the appeals process and the deadlines for the final decision on the appeal.

Seton Health Plan (SHP) will not engage in retaliatory action, including refusal to renew or termination of a contract, against a provider because provider has, on behalf of an member, reasonably filed a complaint against SHP or appealed a decision of SHP.

If an Seton Health Plan (SHP) CHIP provider who has attempted to resolve a complaint through SHP's complaint process and is dis-satisfied with the resolution, may submit a complaint to the Texas Department of Insurance (TDI) alleging a violation of Chapter 20A. TDI will complete an investigation of a complaint against SHP to determine whether a violation has occurred not later than the 60th day after the date TDI receives the complaint and all information necessary to make a determination. TDI may extend the time necessary to complete an investigation if:

- (1) additional information is needed;
 - (2) an on-site review is necessary;
 - (3) SHP, the provider, or the complainant does not provide all documentation necessary to complete the investigation;
- or
- (4) other circumstances beyond the control of TDI occur.

The address for TDI is:

**Texas Department of Insurance
333 Guadalupe Street
Austin, TX 78714-9104**

SETON HEALTH PLAN - CHIP GLOSSARY OF TERMS

The following are some definitions that may be of assistance when reviewing your provider manual:

Authorization Number

The Authorization Number is utilized when a member needs a procedure that requires Pre-certification. The Medical Management department will assign an authorization numbers to those services that require Pre-certification and are medically necessary. Pre-certification procedures require an authorization number for reimbursement.

Co-payment

A fixed payment the member pays each time he or she visits a health plan physician, emergency room, hospital, or obtains prescriptions. Members are responsible for any applicable Co-payments, at the time clinical services are rendered by a physician or designee. Refer to the patient's ID card to determine the appropriate Copayment amount.

Deductible

A fixed dollar amount the patient must pay each year before the insurer will begin covering the cost of care. To obtain information on member-specific amounts, please contact the SHP Member Services. Deductibles can also be billed to the patient following receipt of the EOB from Seton Health Plan.

Fee for Service

The traditional method of paying for medical services. A provider charges a fee for each service provided, and payment is made for all or part of that fee. In some instances, a member may pay a Copayment for each visit.

Health Maintenance Organization (HMO)

An organization that provides health care in return for set monthly payments. Most HMOs provide care through a network of doctors, hospitals and other medical professionals that their members must use in order to be covered for that care.

Managed Care Organization

An umbrella term for HMOs and all health plans that provide health care in return for set monthly payments and coordinate care through a defined network of Primary Care Physicians and hospitals.

Medical Case Management (MCM)

Innovative approaches to managing care for chronic or catastrophic illnesses.

Network

The doctors, clinics, health centers, medical group practices, hospitals, and other providers that an HMO, PPO, or other managed care plan has selected and contracted with to care for its members.

Out of Network

A provider and/or facility not in the contracted network of approved doctors and hospitals. Members who receive care out-of-network (sometimes called out-of-area) without first obtaining a referral from the Seton CHIP may have to pay for all or most of that care themselves. Exceptions are usually made for extreme emergencies or urgent care needed when traveling away from home.

Pre-certification

A formal process by which certain medical services receives prior authorization by Seton Health Plan. It is not a guarantee of reimbursement, but does provide verification, based on information available to Seton Health Plan, that the proposed treatment represents a covered service to a SHP member eligible to receive such treatment or services.

Preventive Health Care

Care designed to prevent disease altogether, to detect and treat it early, or to manage its course most effectively. Examples of preventive care include immunizations and regular screenings like Pap smears or cholesterol checks.

Primary Care

Preventive Health Care and routine medical care that is typically provided by a provider trained in family care, internal medicine, or pediatrics.

Primary Care Physician (PCP)

A physician, usually an internist, pediatrician, or family care, devoted to the general medical care of patients. The PCP is expected to provide all care for that patient or request an authorization to a Specialist.

Referral

To ensure that services will be covered, the CHIP member must have a Referral from his/her Primary Care Physician before attempting to see a network Specialist. The PCP will contact SHP Medical Management Department by fax or phone to make a Referral.

Specialist (SCP)

A physician or other healthcare professional whose training and expertise are in a specific area of medicine, like cardiology or dermatology.

SETON HEALTH PLAN - CHIP REGULATORY EXPLANATIONS

This section is designed to facilitate understanding of the regulatory issues. The following represents important information regarding federal and state legislation affecting all of our network providers. The Seton Health Plan has created this section to provide detailed information regarding plan and governmental regulations regarding Health Maintenance Organizations.

If the Seton Health Plan chooses to amend or alter any program or any contract, network providers have thirty days to object to the proposed amendments. If a provider chooses to object, the provider has the right to terminate his contract with Seton Health Plan. The provider must give thirty (30) days notice to SHP of the termination decision.

Hold-Harmless Clause. In the event that the Seton Health Plan becomes insolvent or breaches the terms of the provider contract, the provider cannot attempt to collect reimbursement, for services rendered, from SHP members. The provider may only collect those charges, such as Copayments and co-insurance, which are assigned to the SHP member per his/her benefit plan.

Continuity of Treatment. The provider contract specifies that network physicians must provide or arrange for medical services for members throughout the length of their negotiated contracts. If the contract is terminated, the provider is required to maintain a relationship, either through direct provision of care or through arrangement with another physician, with the SHP member during the phase-out period of the agreement. If the provider chooses to transfer the member to another physician, the contract provider is required to provide a written notification of the transfer to the Seton Health Plan. The degree of reimbursement for services rendered after contract termination will be decided by SHP, in conjunction with the providers involved in the member's care.

SETON HEALTH PLAN will reimburse providers within thirty (30) days of receipt of a "clean claim". This payment, with the exception of member responsibilities (Co-payments, co-insurance, deductibles), will be accepted as the full compensation for the services rendered.

Special Circumstance. In the event that a provider renders services to a member of special circumstance, termination of that provider's contract does not release SHP's obligation to reimburse the provider for services rendered to that member. Seton Health Plan will reimburse those services at the contracted rate for up to ninety (90) days from the date of termination. Seton Health Plan will reimburse the provider for up to nine(9) months if the member, at the time of termination, has been diagnosed with a terminal disease. In addition to this, if the provider has a member beyond

her 24th week of pregnancy, coverage will extend through the delivery of the child, immediate postpartum care and the follow-up check-up within the first six weeks of delivery. The provider should identify special circumstances and request that the member be permitted to continue treatment under the provider's care.

Emergency care involves care that a prudent lay person, with an average knowledge of medicine and health status, would deem immediately necessary to avoid serious injury, impairment, jeopardy, dysfunction, or disfigurement to a patient (in the case of a pregnant woman, serious jeopardy to the health of the fetus). An emergency will be treated immediately by an emergency room and payment will be made to that facility for care rendered. However, the member needs to notify the Seton Health Plan of the treatment and/or admission as soon as possible (within 48 hours).

SETON HEALTH PLAN - CHIP WASTE, FRAUD & ABUSE

Waste, Fraud and Abuse Information

Each year the state of Texas loses millions of dollars due to waste, fraud, and abuse in the State of Texas Children's Health Insurance (CHIP) program. It is everyone's duty to prevent waste, fraud and abuse.

WHAT IS FRAUD AND ABUSE?

Fraud is a deception or misrepresentation made by a person. The person knows that it could mean they get a special benefit for themselves or someone else.

Abuse is when providers' actions are not good fiscal, business or medical practices. These actions result in unnecessary costs to CHIP. It also means they get paid for services that were not medically necessary. It also means they perform services that do not meet certain standards.

Members may also do things that result in unnecessary costs to Seton Health Plan (SHP) CHIP. That would also be **abuse**. An example would be getting the same drug from more than one pharmacy. Or they may get drugs they don't need. Also, loaning your SHP CHIP ID card to someone else. The most common kind of abuse by members is going to the Emergency Room when it is not necessary.

FRAUD INFORMATION

REPORTING PROVIDER OR RECIPIENT WASTE, ABUSE OR FRAUD

If you suspect a Seton Health Plan CHIP member (a person who receives benefits) or a Seton Health Plan CHIP provider (e.g., doctor, dentist, counselor, etc.) has committed waste, abuse or fraud, you have a responsibility and a right to report it.

Reporting Provider/Clients Waste, Abuse and Fraud

- You can report providers / clients directly to your health plan at:

Seton Health Plan CHIP

Attention: Philip Mahon

7715 Chevy Chase Drive, Building IV, Suite 225

Austin, Texas 78752

Toll Free Phone Number – **1-877-451-5601**

Or if you have access to the Internet go to HHSC OIG website at <http://www.hhs.state.tx.us> and select “Reporting Waste, Abuse and Fraud”. The site provides information on the types of waste, abuse and fraud to report. If you do not have Internet access and prefer to talk to a person, call the Office of Inspector General (OIG) Fraud Hotline at 1-800-436-6184, or you may send a written statement to the following OIG addresses:

To report providers, use this address:	To report clients, use this address:
Office of Inspector General	Office of Inspector General
Medicaid Provider Integrity	General Investigations/Mail Code
Mail Code 1361	1362
P.O. Box 85200	P.O. Box 85200
Austin, TX 78708-5200	Austin, TX 78708-5200

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

- When reporting a Seton Health Plan CHIP provider (e.g., doctor, dentist, counselor, etc.) provide the following:
 - Name, address, and phone number of provider;
 - Name and address of the facility (hospital, nursing home, home health agency, etc.);
 - Medicaid number of the provider and facility is helpful;
 - Type of provider (physician, physical therapist, pharmacist, etc.);
 - Names and phone numbers of other witnesses who can aide in the investigation
 - Dates of events; and
 - Summary of what happened.
- When reporting a client (a person who receives benefits) provide the

following:

- The person's name;
- The person's date of birth, social security number, or case number if available;
- The city where the person resides; and
- Specific details about the waste, abuse or fraud.

SETON HEALTH PLAN - CHIP IMMUNIZATION GUIDELINES

Seton Health Plan CHIP Follows the Vaccine Schedule Issued by the Centers for Disease Control and Prevention found at this web link:
<http://www.cdc.gov/nip/recs/child-schedule-color-print.pdf>

Vaccines for the Children's Health Insurance Plan (CHIP) will be obtained through and the Texas Department of Health (TDH) Texas Vaccines for Children Program (TVFC). All Primary Care Providers must be enrolled in the Texas Vaccines for Children Program in order to take advantage of this free vaccine. Otherwise, the CHIP Health Plans and/or the primary care providers will provide vaccines to CHIP children at their own expense.

If you are not enrolled and receiving vaccines from the TVFC, you may enroll today. The forms necessary for enrollment to the TVFC are the Provider Enrollment, Provider Profile, Provider Listing and the Patient Eligibility Screening record, all of which can be found at <http://www.dshs.state.tx.us/immunize/tvfc/default.shtm> Just simply go to this web address and click on Enrollment Application under Provider Recruitment. All the necessary forms will need to be completed and mailed to:

Texas Department of State Health Services
Immunization Branch
1100 W. 49th St.
Austin, TX 78756

It does take several weeks for the forms to be processed so please submit them immediately. After you have submitted the completed enrollment forms, TDH regional staff or local health department/district staff will contact you to schedule training in your office. Training requires about one (1) hour of your time.

SETON HEALTH PLAN - CHIP SCOPE OF BENEFITS

The following pages have a list of all of the benefits your child has in CHIP. It includes the medical benefits. It also includes the behavioral health benefits.

You can get the following services by calling:

Tejas Behavioral Health and Substance Abuse Services **1-800-852-7691**

Block Vision **1-800-879-6901**

Delta Dental **1-866-561-5892**

WHAT IS MEDICALLY NECESSARY?

Covered CHIP services must meet the CHIP definition of "Medically Necessary." "Medically necessary" health care services mean:

- (1) 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 a Member's health conditions;
 - c. consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
 - d. consistent with the diagnoses of the conditions;
 - e. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
 - f. are not experimental or investigative; and
 - g. are not primarily for the convenience of the Member or Provider; and

- (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. in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

- c. furnished in the most appropriate and least restrictive setting in which services can be safely provided;
- d. the most appropriate level or supply of service that can safely be provided;
- e. could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered;
- f. not experimental or investigative; and
- g. not primarily for the convenience of the Member or Provider.

HOW LONG DO CHIP BENEFITS LAST?

There is no lifetime maximum on benefits; however, during the 12-month period, enrollment period limitations do apply to certain services, as specified in the following chart. Co-pays apply until a family reaches its specific cost-sharing maximum.

Covered Benefit	Description
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> Hospital-provided Physician or Provider services Semi-private room and board (or private if medically necessary as certified by attending) General nursing care Special duty nursing when medically necessary ICU and services Patient meals and special diets Operating, recovery and other treatment rooms Anesthesia and administration (facility technical component) Surgical dressings, trays, casts, splints Drugs, medications and biologicals Blood or blood products that are not provided free-of-charge to the patient and their administration X-rays, imaging and other radiological tests (facility technical component) Laboratory and pathology services (facility technical component) Machine diagnostic tests (EEGs, EKGs, etc.) Oxygen services and inhalation therapy Radiation and chemotherapy Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. Hospital, physician and related medical services, such as anesthesia, associated with dental care
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> Semi-private room and board Regular nursing services Rehabilitation services Medical supplies and use of appliances and equipment furnished by the facility

Covered Benefit	Description
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	<p>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:</p> <ul style="list-style-type: none"> X-ray, imaging, and radiological tests (technical component) Laboratory and pathology services (technical component) Machine diagnostic tests Ambulatory surgical facility services Drugs, medications and biologicals Casts, splints, dressings Preventive health services Physical, occupational and speech therapy Renal dialysis Respiratory services Radiation and chemotherapy Blood or blood products that are not provided free-of-charge to the patient and the administration of these products Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.

Covered Benefit	Description
<p>Physician/Physician Extender Professional Services</p>	<p>Services include, but are not limited to, the following:</p> <p>American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations)</p> <p>Physician office visits, in-patient and out-patient services</p> <p>Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation</p> <p>Medications, biologicals and materials administered in Physician's office</p> <p>Allergy testing, serum and injections</p> <p>Professional component (in/outpatient) of surgical services, including:</p> <p>Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care</p> <p>Administration of anesthesia by Physician (other than surgeon) or CRNA</p> <p>Second surgical opinions</p> <p>Same-day surgery performed in a Hospital without an over-night stay</p> <p>Invasive diagnostic procedures such as endoscopic examinations</p> <p>Hospital-based Physician services (including Physician-performed technical and interpretive components)</p> <p>In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.</p> <p>Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.</p>

Covered Benefit	Description
<p>Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies</p>	<p>\$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:</p> <p>Orthotic braces and orthotics</p> <p>Prosthetic devices such as artificial eyes, limbs, and braces</p> <p style="padding-left: 40px;">Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease</p> <p>Other artificial aids including surgical implants</p> <p>Hearing aids</p> <p style="padding-left: 40px;">Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit.</p> <p style="padding-left: 40px;">Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A)</p>
<p>Home and Community Health Services</p>	<p>Services that are provided in the home and community, including, but not limited to:</p> <p>Home infusion</p> <p>Respiratory therapy</p> <p>Visits for private duty nursing (R.N., L.V.N.)</p> <p style="padding-left: 40px;">Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).</p> <p style="padding-left: 40px;">Home health aide when included as part of a plan of care during a period that skilled visits have been approved.</p> <p>Speech, physical and occupational therapies.</p> <p style="padding-left: 40px;">Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker</p> <p style="padding-left: 40px;">Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services</p> <p style="padding-left: 40px;">Services are not intended to replace 24-hour inpatient or skilled nursing facility services</p>

Covered Benefit	Description
<p>Inpatient Mental Health Services</p>	<p>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:</p> <p>Neuropsychological and psychological testing.</p> <p>Inpatient mental health services are limited to:</p> <p>45 days 12-month inpatient limit</p> <p>Includes inpatient psychiatric services, up to 12-month period limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities. Court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination</p> <p>25 days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or sub-acute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem cost</p> <p>20 of the inpatient days must be held in reserve for inpatient use only</p> <p>Does not require PCP referral</p>

Covered Benefit	Description
<p>Outpatient Mental Health Services</p>	<p>Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:</p> <p>Medication management visits do not count against the outpatient visit limit.</p> <p>The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility</p> <p>Up to 60 days 12-month period limit for rehabilitative day treatment</p> <p>60 outpatient visits 12-month period limit</p> <p>60 rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost</p> <p>60 outpatient visits can be converted to skills training (psycho educational skills development) or rehabilitative day treatment on the basis of financial equivalence against the outpatient visit cost</p> <p>Includes outpatient psychiatric services, up to 12-month period limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities. Court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination</p> <p>Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards those limits</p> <p>A Qualified Mental Health Professional (QMHP), as defined by and credentialed through Texas Department of State Health Services (DSHS) standards (TAC Title 25, Part II, Chapter 412), is a Local Mental Health Authorities provider. A QMHP must be working under the authority of an DSHS entity and be supervised by a licensed mental health professional or physician. QMHPs are acceptable providers as long as the services would be within the scope of the services that are typically provided by QMHPs. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services</p> <p>Does not require PCP referral</p>

Covered Benefit	Description
Inpatient Substance Abuse Treatment Services	<p>Services include, but are not limited to:</p> <p>Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs</p> <p>Does not require PCP referral</p> <p>Medically necessary detoxification/stabilization services limited to 14 days per 12-month period.</p> <p>24-hour residential rehabilitation programs, or the equivalent, up to 60 days per 12-month period</p> <p>30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost</p> <p>30 days must be held in reserve for inpatient use only.</p>
Outpatient Substance Abuse Treatment Services	<p>Services include, but are not limited to, the following:</p> <p>Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.</p> <p>Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day</p> <p>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</p> <p>Outpatient treatment services up to a maximum of:</p> <p>Intensive outpatient program (up to 12 weeks per 12-month period)</p> <p>Outpatient services (up to six-months per 12-month period)</p> <p>Does not require PCP referral</p>
Rehabilitation Services	<p>Services include, but are not limited to, the following:</p> <p>Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following:</p> <p>Physical, occupational and speech therapy</p> <p>Developmental assessment</p>

Covered Benefit	Description
Hospice Care Services	<p>Services include, but are not limited to:</p> <p>Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death</p> <p>Treatment for unrelated conditions is unaffected</p> <p>Up to a maximum of 120 days with a 6 month life expectancy</p> <p>Patients electing hospice services waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime</p> <p>Services apply to the hospice diagnosis</p>
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	<p>HMO cannot require authorization as a condition for payment for emergency conditions or labor and delivery.</p> <p>Covered services include, but are not limited to, the following:</p> <p>Emergency services based on prudent lay person definition of emergency health condition</p> <p>Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers</p> <p>Medical screening examination</p> <p>Stabilization services</p> <p>Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services</p> <p>Emergency ground, air and water transportation</p> <p>Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.</p>
Transplants	<p>Services include, but are not limited to, the following:</p> <p>Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.</p>
Vision Benefit	<p>The health plan may reasonably limit the cost of the frames/lenses.</p> <p>Services include:</p> <p>One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization</p> <p>One pair of non-prosthetic eyewear per 12-month period</p>

Covered Benefit	Description
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation
Tobacco Cessation Program	Covered up to \$100 for a 12- month period limit for a plan-approved program Health Plan defines plan-approved program. May be subject to formulary requirements.

WHAT IS NOT A CHIP COVERED SERVICE?

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care

- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan

CHIP DME/SUPPLIES

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

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

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Formula		X	<p>Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product</p> <p><u>Does not include formula:</u> For members who could be sustained on an age-appropriate diet. Traditionally used for infant feeding In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are <i>not</i> medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.</p>
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catheterization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

CO-PAYMENTS FOR CERTAIN MEDICAL SERVICES

The following table lists the CHIP co-payment schedule according to family income. Co-payments for medical services or prescription drugs are paid to the health care provider at the time of service. No co-payments are paid for preventive care such as well-child or well-baby visits or immunizations. Talk to your doctor about prescribing Generic drugs instead of Brand-name drugs. Often the generic drugs are just as good as brand-name drugs.

HOW MUCH ARE CHIP CO-PAYMENTS?

A CHIP enrollee's health plan ID card lists the co-payments that apply to his/her family situation. A member should always present your ID card when he/she receives office visit or emergency room services or has a prescription filled.

CHIP COST-SHARING CAPS

Each member guide given to CHIP enrollee includes a tear-out form that

helps to track your CHIP expenses. To ensure that a member does not exceed your cost-sharing limit, they are asked to keep track of their CHIP-related expenses on this form. The Children's Health Insurance Program welcome letter tells them exactly what their cost-sharing cap is, based on the family's income. If a member has misplaced this letter, please advise him/her to call Children's Health Insurance Program at 1-800-647-6558 and they will tell the CHIP enrollee what the annual limit is.

When a member reaches the annual cap, he/she is requested to send the form to Children's Health Insurance Program and we will issue a new member ID card within several days. This new card will indicate that no co-payments are due when your child receives services.

Federal Poverty Levels	Office Visits	Cost per emergency room visit	Inpatient Hospitalization	Prescriptions Generic Drugs	Prescriptions Brand Drugs	Annual reporting caps
Native Americans	\$0	\$0	\$0	\$0	\$0	\$0
At or Below 100%	\$3	\$3	\$10	\$0	\$3	Self declared cap of 1.25% of gross family income per eligibility period
101%-150%	\$5	\$5	\$25	\$0	\$5	Self declared cap of 1.25% of gross family income per eligibility period
151%-185%	\$7	\$50	\$50	\$5	\$20	Self declared cap of 2.5% of gross family income per eligibility period
186%-200%	\$10	\$50	\$100	\$5	\$20	Self declared cap of 2.5% of gross family income per eligibility period

SETON HEALTH PLAN - FORMS

PRIOR AUTHORIZATION GRID

REFERRAL FORM

Seton Health Plan CHIP

Phone Number (512) 420-2777 or 1-877-451-2798
Fax Number (512) 420-2798 or toll free (866) 272-2542

Referral Type:

- Routine (Process in 48 hours)
- Urgent (Process in 24 hours)

Referral/Pre-Certification Form

Request Date: _____ Submitted by: _____ Phone/ext: _____ Fax: _____

PATIENT INFO:

Patient Name: *(last)* _____ *(first)* _____ (MI) _____

Patient's ID Number: _____ DOB _____

Address: _____ City _____ State _____ Zip _____

Primary Care Physician (PCP): _____

Requesting MD *(if different than PCP)* _____

Requested Specialist/Service: _____ Requested number of visits: _____

Diagnosis/ICD-9 Codes: _____ LMP: _____ EDC: _____

Reason for Referral- Please include pertinent Medical Records including patient history, previous treatment and responses *(be specific)*:

FOR SURGICAL REQUESTS:

NAME OF FACILITY: _____ DOS: _____

CPT CODES: _____

Work related: YES _____ NO _____ MVA Subrogation? YES _____ NO _____ Date of injury: _____

TO BE COMPLETED BY SETON HEALTH PLAN MEDICAL SERVICES

Authorization Number: _____ Number of Visits Approved: _____

Authorization Date: _____ Expiration Date: _____

Comments/Questions:

This authorization is not a guarantee that services will be covered or payment will be made. All medical services rendered are subject to review, which includes but is not limited to, determination of eligibility in accordance with the terms of the member's benefit plan, any deductibles, co-payments, reasonable and customary charges and policy maximums.

NOTICE OF CONFIDENTIALITY: THE INFORMATION CONTAINED IN THIS FACSIMILE (FAX) IS PRIVILEGED AND CONFIDENTIAL. IT IS INTENDED FOR THE INDIVIDUAL ENTITY INDICATED ON THIS REFERRAL FORM. YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION, COPYING, OR OTHER USE OF THIS INFORMATION BY ANYONE OTHER THAN THE RECIPIENT IS UNAUTHORIZED AND STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS FAX IN ERROR, PLEASE NOTIFY THE MEDVIEW UM DEPARTMENT.

Seton Health Plan - Utilization Management Program List -Effective 08/01/07 (updated 7/12/07) This program list does not guarantee payment. Please contact health plan to verify member eligibility and covered benefits All out-of plan or non-contracted services require plan approval		
Services	Seton CHIP	CPT codes & notes
Acupuncture	NB	
Ambulance	D-ER P-EL	Ambulance/EMS svc covered if pt. transported to hospital
Behavioral Health, Inpatient	P	Reference member ID card for phone number
Behavioral Health, Inpatient Substance Abuse	P	Reference member ID card for phone number
Behavioral Health, Outpatient - Office Visits for BH or Substance Abuse	D	Reference member ID card for phone number
Behavioral Health, Outpatient - Intensive Outpatient Program	P	
Behavioral Health - Psychological Testing	P	CPT Code: 96101, 96102
Biofeedback	NB	
Chemotherapy	P	
Chiropractic	P	
Cognitive Training/Retraining	NB	
Cosmetic Surgery	P/NB	Certain procedures are covered, prior auth required in all cases
Cyberknife	P	
Dental Trauma	P	
Diabetic Classes (Seton Network Facilities Only)	D	
Dialysis	P	
Disc Arthroplasty	NB	
DME (quantity limits apply)	*D<\$500 P>\$500	See quantity limit grid.
Rental Items requiring authorizations regardless of dollar amount		
Apnea Monitor	P	E0618-E0619
Bedside Commode	P	E0163-E0166; E0168
Bili lights (phototherapy)	P	E0202
BIPAP	P	E0470-E0472
Blood glucose monitor with voice synthesizer	P	E2100
Breast Pump	P**	E0602-E0604
CPAP	P	E0601
CPM; Dynamic splinting; Passive motion device	P	E1800-E1840/ E0935
Enteral Therapy, supplies and formula	P	B4034-B4036/B4150-B4156
Feeding pump (Enteral Therapy)	P	B9000-B9999
Gastric suction pump	P	E2000
Hospital Beds and Accessories	P	E0250-E0270/E0277-E0297/K0549-K0550
Humidifier, with positive airway pressure device	P	E0561-E0562

Services	Seton CHIP	CPT codes & notes
Humidifiers/compressors for use with O2/IPPB	P	E0550- E0565
Jaw motion rehab system (CPM)	P	E1700
Oxygen and Related Respiratory Equipment	P	E0424-E0500/E1353-E1390/E1405-E1406
Patient Lifts	P	E0621-E0636
Powered air flotation bed/mattress (low air loss)	P	E0193
Powered/Nonpowered overlay for mattress	P	E0371-E0372
Pressure-relief pads, alternating; air; water mattress	P	E0180-E0187/E0194-E0199
Pulse Oximeter	P	5024X
Safety enclosure frame/canapy for use with hosp bed	P	E0316
Suction Machine	P	E0600
TENS; Neuromuscular and bone growth stimulators	P	E0720-E0765
Wheelchairs	P	E1050-E1298/K0001-K0014
Wound V.A.C. (Negative pressure wound therapy)	P	E2402
Emergency Services	D	
Experimental /Investigational	NB	
Genetic Counseling	P	
Genetic Testing	P	Includes the following tests: BRCA1&2 (ovarian and breast cancer); MLH1&2 (hereditary nonpolyposis colorectal cancer-HNPCC); APC (familial adenomatous polyposis-FAP); Codes: S3818, S3819, S3819, S3820, S3822, S3823, S3828, S3829, S3830, S3831, S3833, S3834, NOT COVERED - APOE epsilon 4-(susceptibility to Alzheimer's) S3852
Hearing Aids	P	
Health Education - (Asthma Education Class)	P	
Home Health Care/ Home Infusion	P	
Hospice	P	
Infertility Eval/Test/Treat	NB	
Injectible Drugs Not Covered thru Pharmacy Benefit	P	Includes following drugs administered in physician office or outpt setting: Botox, Depo-Provera, IGG, Lupron Depot, Remicaid, Supartz, Synvisc, Synagis, Tysabri, Xolair
Inpatient		
Scheduled (Elective)	P	
Rehab Facility	P	
Trauma/ER Admit	P/N	
Lab Services	D	
Laser Assisted Uvulopalatoplasty	P	
Neuropsychological Testing	P	
Nursing Home Care	NB	

Services	Seton CHIP	CPT codes & notes
Nutritional Counseling - (Seton Network Facilities Only)	**D	
Optometric Exam	NB	
Orthotics (limited coverage)	**P	>Contact Mbr Srv regarding benefits; > Refer to L Code grid for auth requirements
Oral Surgery/ TMJ/ Orthognathic	P	
Outpatient Surgery ***		Includes CPT codes: 10040-69999
Scheduled	P	
Trauma/ER Admit	P/N	
Outpatient Therapeutic Studies		
Amniocentesis	D	Includes CPT code: 59000
Arthrogram	D	Includes CPT code: 73615, 73085, 73525, 73580, 73542, 73040, 70328-70332, 73115
Doppler Study - Arterial	D	Includes CPT codes: 93922-93924, 93886-93888
Doppler Study - Venous	D	Includes CPT codes: 93965-93971
Cardiac Catherization	P	Includes CPT codes: 93501-93556
Cardiac EP Study	P	Includes CPT codes: 93600-93662
Colonoscopy	P	Includes CPT codes: 45355-45387
Echocardiogram	D	Includes CPT codes: 93320-93350
EEG	D	Includes CPT codes: 95816, 95819
EGD	P	Includes CPT codes: 43200-43259
EKG	D	Includes CPT codes: 93000, 93010, 93014
Holter Monitor	D	Includes CPT codes: 93224-93237, 93271-93272
Hysterosalpinogram (HSG)	P	Includes CPT code: 74740
Sigmoidoscopy	D	Includes CPT codes: 45330-45345
Sterotactic Breast Biopsy	P	Includes CPT code: 76095
Stress Test - Cardiac	D	Includes CPT codes: 93015-93024
Visual Field Testing	D	Includes CPT codes: 92081-92083
Pain Management	P	Includes CPT codes: 62274-62275, 62278-62279, 62281-62282, 62289, 62298, 62350, 62360-62362, 62310-62319, 64400-64530
Prosthetics	P	
Radiology/Imaging		
Angiography/Venography	D	
Barium Enema	D	Includes CPT codes: 74270-74280
Bone Density Study	D	Includes CPT codes: 76071, 76076, 76070, 76075, 76977
Ca Scoring (Heart Saver CT)	NB	
CT Scan	P	
CT Chest & Cardiac Angiography	P	Not a benefit if provided at a non-Seton facility
IVP (Intravenous Pyelogram)	D	Includes CPT codes: 7440-74415
Mammography	D	Includes CPT codes: 76090-76092
Nuclear Medicine (NM)		Includes CPT codes: 78000-79999
1) Adenosine Stress Test	D	CPT codes: 78460-78465
2) Bone Scan	D	CPT codes: 78300-78320
3) Perfusion Studies	D	CPT codes: 78460-78465 78478-78480
4) Persantine Stress Test	D	CPT codes: 78460-78465
5) Thallium Stress Test	D	CPT codes: 78460-78465

Services	Seton CHIP	CPT codes & notes
6) Thyroid Uptake Scan	D	CPT codes: 78000-78003
7) Other NM not listed	D	Includes CPT codes: 78000-79999
MRA	P	
MRI	P	
MRI - w/anesthesia	P	
MRI - Breast	P	
MRI - Open	P	
PET Scan	P	
Upper GI	D	CPT codes: 74246-74249
Imaging Services Not Listed	D	
Radiation Therapy	P	
Referral to Specialist	P	
Referral to Specialty Clinic (Brackenridge/CHOA Clinics)	P	
Rehab Services		
Cardiac Rehab	P	
Pulmonary Rehab	P	
PT, OT, ST	P	
Wound Care	D	
Sleep Study	P	
Skilled Nursing Facility	P	
Transplants	P	
Non Emergent Transportation/ Air Ambulance	P	
Varicose Vein Treatment	P	
Weigh to Health Dietitian Outpatient Visits	NB	
Weigh to Health Physician Directed Program	NB	99201-99215
Notes:	* Contact Customer Service regarding annual benefit limit	
	** Subject to plan limitations	
	*** Outpatient surgery/procedure performed in facility - not to include office procedure	
	**** Refer to Community Women's Wellness Center 232-4707	
Abbreviations	A - MAP Dental Trauma contact (512) 708-3666;	
	D - Direct access to in-plan contracted providers	
	N - Notify the Health Plan of admission within 24 hours	
	P - Plan approval required by phone/fax with medical information	
	NB - Not a benefit	
	ER - Emergency	
	EL - Elective	
General Instructions & Reminders	< SHP Precertification/Referral telephone # (512) 324-3135; Fax # (512) 324-1936	
	< SETON CHIP Precertification/Referral telephone # - 1-877-451-5628; Local (512) 420-2777	

Services	Seton CHIP	CPT codes & notes
	Fax # - (512) 420-2798	
	< For SHP eligibility, benefits, provider network and claims status call - Local number (512) 421-5667 or	
	toll free # 1-866-272-2507;	
	< For CHIP eligibility, benefits, provider network and claims status call 1-877-451-5601	
	< Behavioral Health Services: Refer to the telephone # listed on the member's ID card	
	< To facilitate review, please provide all pertinent clinical information related to the referral at the time of	
	the request	
	SHP Provider Relations Number is 512/324-3125	
Revised 7/12/07		

NOTES