

## Section 4: Covered Benefits

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### *STAR Covered Services*

Driscoll Children's Health Plan is required to provide specific medically necessary services to its STAR Members. The following list provides an overview of benefits. Please refer to the current Texas Medicaid Provider Procedure Manual and the bi-monthly Texas Medicaid Bulletin for a more inclusive listing of limitations and exclusions. These services include, but may not be limited to:

- Adult Well Check-up
- Ambulance Services
- Audiology services including hearing aids for adults (hearing aids for children are provided through the PACT program)
- Ambulatory Surgical Center Services (ASC)+
- Behavioral Health Services including: +
  - Inpatient and outpatient mental health services for children (under age 21)
  - Outpatient chemical dependency services for children (under age 21)
  - Detoxification services
  - Psychiatry services
  - Counseling services for adults (21 years of age and over)
- Birthing Center Services
- Chiropractic Care +
- Dialysis +
- Durable Medical Equipment+
- Emergency Care
- Family Planning Services
- Home Health Services+
- Hospital – All In-patient Services+
- Hospital – All Out-patient Services+
- Laboratory Services
- Medical Check-ups and Comprehensive Care Program (CCP) Services for children (under age 21) through the Texas Health Steps Program
- Optometry, glasses, and contact lenses, if medically necessary
- Prescription Drugs (through the Vendor Drug Program)
- Primary Care Physician (PCP) Services
- Podiatry Services +
- Professional Services – Physicians and Practitioners +
- Respiratory Care Services+

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**DCHP Provider Services 1-877-DCH-DOCS (324-3627)**

**Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)**

**Case Management: 1-877-222-2759 (FAX 1-866-741-5650)**

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**Member Services FAX: 361-904-0187**

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### ***STAR Covered Services - continued***

- Radiology, imaging and X-rays
- Therapies – Physical, Occupational and Speech +
- Transplantation of organs and tissues +
- Vision

+ May require prior authorization for services at the number shown on this page.

#### *Medicaid/STAR Program Limitations and Exclusions*

Refer to the Texas Medicaid Provider Procedures Manual and the bi-monthly Texas Medicaid Bulletin for the most current information regarding Program limitations and exclusions. The following is the list as of 2006, of limitations and exclusions:

- Autopsies
- Biofeedback therapy
- Bladder stimulators
- Breast implants
- Cardiac rehabilitation programs
- Care and treatment related to any condition for which benefits are provided or available under Workers' Compensation laws
- Cellular therapy
- Chemolase injection (chymodiactin, chymopapain)
- Chemonucleolysis intervertebral disc
- Cosmetic procedures
- Custodial care
- Dentures or endosteal implants for adults
- Dermabrasion
- Direct graduate medical education for teaching hospitals
- Dressing/supplies billed in the physician's office
- Ergonovine provocation test
- Excise tax
- Fabric wrapping of abdominal aneurysms
- Fetal fibronectin
- Gastric stapling/bypass
- Hair analysis
- Heart-lung monitoring during surgery
- Histamine therapy – intravenous
- Hyperthermia
- Hysteroscopy for infertility
- Immunotherapy for malignant diseases
- Inborn errors of metabolism

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- Infertility
- Inpatient hospital services to a client in an institution for TB, mental disease, or a nursing section of public institutions for the mentally retarded
- Inpatient hospital tests that are not specifically ordered by a physician who is responsible for the diagnosis or treatment of the client's condition
- Intestinal bypass surgery and gastric stapling for the treatment of morbid obesity
- Intra-gastric balloon for obesity
- Intravenous embolization – cerebral, maxillary, and renal
- Joint sclerotherapy
- Keratoprosthesis/refractive keratoplasty
- Laetrile
- Mammoplasty for gynecomastia
- Mental health counseling and testing services by a Psychologist for clients 21 years of age and older
- Mental health counseling services by a LCSW, LPC, or LMFT for clients 21 years and older
- More than \$200,000 per client per benefit year (Nov 1 through Oct 31) for any medical and remedial care services provided to a hospital inpatient by the hospital, except in case of approved organ transplant, and for THSteps Comprehensive Care Program (THSteps-CCP).
- Obsolete diagnostic tests
- Oral medications, except when billed by hospital (inpatient or ER)
- Orthoptics (except THSteps-CCP)
- Orthotics (except THSteps-CCP)
- Outpatient and non-emergency inpatient services provided by military hospitals
- Outpatient Behavioral Health services performed by a psychiatric nurse, mental health worker, social worker, or psychological associate regardless of physician or licensed psychologist supervision
- Oxygen (except THSteps-CCP and home health)
- Payment for eyeglass materials or supplies regardless of cost if they do not meet Medicaid program specifications
- Penile prosthesis
- Podiatry, optometric, and hearing aid services in long term care facilities, unless ordered by the attending physician
- Private room facilities, except when a critical or contagious illness exists that results in disturbance to other patients and is documented as such when it is documented that no other rooms are available for an emergency admission, or when the hospital only has private rooms
- Procedures and services considered experimental or investigational
- Prosthetic and orthotic devices
- Prosthetic eye or facial quarter

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- Psychiatric services:
  - Outpatient BH services exceeding 30 visits per calendar year for which no prior authorization has been given
  - Reimbursement is not available for inpatient psychiatric hospital services, including physician fees, delivered to clients between 22 and 64 years of age
  - Outpatient BH services in freestanding psychiatric hospitals for Medicaid (except THSteps-CCP)
  - Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services
- Quest test (infertility)
- Recreational therapy
- Review of old x-ray films
- Routine circumcision for clients age one year and older
- Separate fees for completing or filing a Medicaid claim form. The cost of claims filing is to be incorporated in the provider's usual and customary charges to all clients
- Services and supplies to any resident or inmate in a public institution
- Services or supplies for which benefits are available under any other contract, policy, or insurance, or which would have been available in the absence of the Medicaid program
- Services or supplies for which claims were not received within the filing deadline
- Services or supplies not reasonable and necessary for diagnosis or treatment
- Services or supplies not specifically provided by the Texas Medicaid Program
- Services or supplies provided in connection with a routine physician exam, except in connection with family planning services, THSteps, or the no authorized by DCHP
- Services or supplies in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member, or when prior authorized for specific purposes by DCHP
- Services or supplies provided outside of the United States
- Services or supplies provided to a client after a finding has been made under utilization review procedures that these services or supplies are not medically necessary
- Services or supplies provided to a Medicaid client before the effective date of his or her designation as a client or after the effective date of his or her denial of eligibility
- Services payable by any health, accident, other insurance coverage, or any private or other governmental benefit system, or any legally liable third party
- Services provided by an interpreter
- Services provided by ineligible, suspended, or excluded providers
- Services provided by the client's immediate relative or household member
- Services provided by VA facilities or U.S. public health service hospitals
- Sex change operations
- Silicone injections

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- Social and educational counseling except for family planning and genetics education and counseling services
- Sterilization reversal
- Sterilizations (including vasectomies) unless the client has given informed consent 30 days before surgery, is mentally competent, and is 21 years of age or older at the time of consent
- Take-home and self-administered drugs except as provided under the vendor drug or family planning pharmacy services
- Tattooing
- Telephone calls with clients or pharmacies (except as allowed for case management)
- Thermogram
- Treatment for obesity
- Treatment of flatfoot conditions and the prescription of supportive devices (including special shoes), the treatment of subluxations of the foot and routine foot care more than once every six months, including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygienic care.
- Vision care services for clients 21 years of age and older
- Whole blood or packed red cells when available at no cost to the client

*Spell of Illness Limitation Removed*

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

*Adult Well Check*

An annual adult physical exam is an additional benefit for STAR Members 21 years and older. The annual adult well exam may be received in addition to the member's annual GYN visit (family planning visit) for females. The member does not need a referral from the PCP for the annual GYN visit.

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***CHIP Covered Services***

<b>CHIP Type of Benefit</b>	<b>Description of CHIP Benefit</b>	<b>CHIP Limitations</b>	<b>Co-Pay for CHIP</b>
<b>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</b>	<p>Medically necessary services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Hospital-provided physician or provider services</li> <li>▪ Semi-private room and board (or private if medically necessary as certified by attending)</li> <li>▪ General nursing care</li> <li>▪ ICU and services</li> <li>▪ Patient meals and special diets</li> <li>▪ Operating, recovery and other treatment rooms</li> <li>▪ Anesthesia and administration (facility technical component)</li> <li>▪ Surgical dressings, trays, casts, splints</li> <li>▪ Surgically implanted devices;</li> <li>▪ Drugs, medications and biologicals</li> <li>▪ blood or blood products not provided free-of-charge to the patient and their administration</li> <li>▪ X-rays, imaging and other radiological tests (facility technical component)</li> <li>▪ Laboratory and pathology services (facility technical component)</li> <li>▪ Machine diagnostic tests (EEGs, EKGs, etc)</li> <li>▪ Oxygen services and inhalation therapy</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization for non-emergency care and following stabilization of an emergency condition</li> <li>▪ Requires authorization for in-network or out-of-network facility and physicians services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of inpatient co-pay applies</li> </ul>

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CHIP Type of Benefit	Description of CHIP Benefit	CHIP Limitations	Co-Pay for CHIP
	<ul style="list-style-type: none"> <li>▪ Radiation and chemotherapy</li> <li>▪ Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care</li> <li>▪ In-network or out-of-network facility for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section</li> <li>▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care</li> </ul>		
<b>Skilled Nursing Facilities (Includes Rehabilitation Hospitals)</b>	Medically necessary services include, but are not limited to, the following: <ul style="list-style-type: none"> <li>▪ Semi-private room and board</li> <li>▪ Regular nursing services</li> <li>▪ Rehabilitation services</li> <li>▪ Medical supplies and use of appliances and equipment furnished by the facility</li> </ul>	<ul style="list-style-type: none"> <li>• Requires authorization and physician prescription</li> <li>▪ 60 days per 12-month period limit</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>

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<b>Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center</b>	Medically necessary services include, but are not limited to, the following services provided in a hospital clinic, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: <ul style="list-style-type: none"> <li>▪ X-ray, imaging, and radiological tests (technical component)</li> <li>▪ Laboratory and pathology services (technical component)</li> <li>▪ Machine diagnostic tests</li> <li>▪ Ambulatory surgical facility services</li> <li>▪ Drugs, medications and biologicals</li> <li>▪ Casts, splints, dressings</li> <li>▪ Preventive health services</li> <li>▪ Physical, occupational and speech therapy</li> <li>▪ Renal dialysis</li> <li>▪ Respiratory Services</li> <li>▪ Radiation and chemotherapy</li> <li>▪ Blood or blood products not provided free-of-charge to the patient and the administration of these products</li> <li>▪ Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.</li> </ul>	<ul style="list-style-type: none"> <li>▪ May require prior authorization and physician prescription</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of co-pay applies to prescription drug services</li> <li>▪ Co-pays do not apply to preventive services</li> </ul>
<b>Physician / Physician Extender Professional Services</b>	Medically necessary services include, but are not limited to, the following: <ul style="list-style-type: none"> <li>▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to</li> </ul>	<ul style="list-style-type: none"> <li>▪ May require authorization for specialty services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of co-pay applies to office visits</li> <li>▪ Co-pays do not apply to preventive</li> </ul>

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	<p>vision and hearing screening and immunizations)</p> <ul style="list-style-type: none"> <li>▪ Physician office visits, inpatient and outpatient services</li> <li>▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation</li> <li>▪ Medications, biologicals and materials administered in physician's office</li> <li>▪ Allergy testing, serum and injections</li> <li>▪ Professional component (in/outpatient) of surgical services, including:               <ul style="list-style-type: none"> <li>• Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care</li> <li>• Administration of anesthesia by physician (other than surgeon) or CRNA</li> <li>• Second surgical opinions</li> <li>• Same-day surgery performed in a hospital without an over-night stay</li> <li>• Invasive diagnostic procedures such as endoscopic examination</li> </ul> </li> <li>▪ Hospital-based physician services (including physician-performed technical and interpretative components)</li> <li>▪ In-network and out-of-network physician services</li> </ul>		<p>visits or to prenatal visits after the first visit</p>

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	<p>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> <ul style="list-style-type: none"> <li>▪ Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.</li> </ul>		
<p><b>Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies</b></p>	<p>Covered services include DME (equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury or disability, and is appropriate for use in the home), 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, but not limited to:</p> <ul style="list-style-type: none"> <li>▪ Orthotic braces and orthotics</li> <li>▪ Prosthetic devices such as artificial eyes, limbs and braces</li> <li>▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease</li> <li>▪ Hearing aids</li> <li>▪ Other artificial aids</li> <li>▪ Diagnosis-specific disposable medical</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization and physician prescription</li> <li>▪ \$20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>

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	supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements		
<b>Home and Community Health Services</b>	<p>Medically necessary services are provided in the home and community and include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ Home infusion</li> <li>▪ Respiratory therapy</li> <li>▪ Visits for private duty nursing (R.N., L.V.N.)</li> <li>▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.).</li> <li>▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved</li> <li>▪ Speech, physical and occupational therapies.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization and physician prescription</li> <li>▪ Services are not intended to replace the child's caretaker or to provide relief for the caretaker</li> <li>▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services</li> <li>▪ Services are not intended to replace 24-hour inpatient or skilled nursing facility services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>
<b>Inpatient Mental Health Services</b>	<p>Medically necessary services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ Neuropsychological and psychological testing.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization for non-emergency services</li> <li>▪ Does not require PCP referral.</li> <li>▪ Inpatient mental health services are limited to:</li> <li>▪ 45 days 12-month period inpatient limit</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of inpatient co-pay applies</li> </ul>

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		<ul style="list-style-type: none"> <li data-bbox="850 306 1122 1234">▪ 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.</li> <li data-bbox="850 1245 1122 1770">▪ 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</li> </ul>	

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		<p>health services on the basis of financial equivalence against the inpatient per diem cost</p> <ul style="list-style-type: none"> <li>▪ 20 of the inpatient days must be held in reserve for inpatient use only</li> </ul>	
<p><b>Outpatient Mental Health Services</b></p>	<ul style="list-style-type: none"> <li>▪ Medically necessary services include, but are not limited to, mental health services, including for serious mental illness, provided on an outpatient basis.</li> <li>▪ Medication management visits do not count against the outpatient visit limit.</li> <li>▪ Neuropsychological and psychological testing.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization.</li> <li>▪ Does not require PCP referral.</li> <li>▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.</li> <li>▪ Up to 60 days 12-month period limit for rehabilitative day treatment.</li> <li>▪ 60 outpatient visits 12-month period limit</li> <li>▪ 60 rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of co-pay applies to office visits.</li> </ul>

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		<ul style="list-style-type: none"> <li data-bbox="846 264 1128 659">▪ 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.</li> <li data-bbox="846 701 1128 1633">▪ 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.</li> <li data-bbox="846 1675 1128 1766">▪ Inpatient days converted to sub-acute outpatient</li> </ul>	

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		<p>services are in addition to the outpatient limits and do not count towards those limits.</p> <ul style="list-style-type: none"> <li>▪ A Qualified Mental Health Professional (QMHP), as defined by and credentialed through the Texas Department of State Health Services (DSHS) standards (TAC Title 25, Part II, Chapter 412), is a Local Mental Health Authorities provider. A QMHP must be working under the authority of a DSHS entity and be supervised by a licensed mental health professional or physician. QMHPs are acceptable providers as long as the services would be within the scope of the services that are typically provided by QMHPs. Those services include individual and group skills training (which can be components of interventions such as day treatment</li> </ul>	

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CHIP Type of Benefit	Description of CHIP Benefit	CHIP Limitations	Co-Pay for CHIP
		and in-home services), patient and family education, and crisis services.	
<b>Inpatient Substance Abuse Treatment Services</b>	<ul style="list-style-type: none"> <li>▪ Medically necessary services include, but are not limited to, inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization for non-emergency services</li> <li>▪ Does not require PCP referral.</li> <li>▪ Medically necessary detoxification/stabilization services, limited to <u>14 days per 12-month period</u>.</li> <li>▪ 24-hour residential rehabilitation programs, or the equivalent, up to <u>60 days per 12-month period</u>.</li> <li>▪ 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost.</li> <li>▪ 30 days must be held in reserve for inpatient use only.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of inpatient co-pay applies</li> </ul>

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**DCHIP Provider Services 1-877-DCH-DOCS (324-3627)**

**Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)**

**Case Management: 1-877-222-2759 (FAX 1-866-741-5650)**

**CHIP Member Services: 1-877-451-5598    STAR Member Services: 1-877-220-6376**

**Member Services FAX: 361-904-0187**

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CHIP Type of Benefit	Description of CHIP Benefit	CHIP Limitations	Co-Pay for CHIP
<b>Outpatient Substance Abuse Treatment Services</b>	<ul style="list-style-type: none"> <li>▪ Medically necessary outpatient substance abuse treatment services include, but are not limited to, prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders.</li> <li>▪ 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.</li> <li>▪ 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.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization.</li> <li>▪ Does not require PCP referral.</li> <li>▪ Outpatient treatment services up to a maximum of:               <ul style="list-style-type: none"> <li>▪ Intensive outpatient program (up to 12 weeks per 12-month period).</li> <li>▪ Outpatient services (up to six-months per 12-month period)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of co-pay applies to office visits.</li> </ul>
<b>Rehabilitation Services</b>	<ul style="list-style-type: none"> <li>▪ Medically necessary habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to, the following:               <ul style="list-style-type: none"> <li>▪ Physical, occupational and speech therapy</li> <li>▪ Developmental assessment</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires prior authorization and physician prescription</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>

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CHIP Type of Benefit	Description of CHIP Benefit	CHIP Limitations	Co-Pay for CHIP
<b>Hospice Care Services</b>	<p>Medically necessary hospice services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ 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</li> <li>▪ Treatment for unrelated conditions is unaffected</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires authorization and physician prescription</li> <li>▪ Services apply to the hospice diagnosis</li> <li>▪ Up to a maximum of 120 days with a 6 month life expectancy</li> <li>▪ Patients electing hospice services waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>
<b>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</b>	<p>Health plan cannot require authorization as a condition for payment for emergency conditions or labor and delivery.</p> <p>Medically necessary covered services include:</p> <ul style="list-style-type: none"> <li>▪ Emergency services based on prudent lay person definition of emergency health condition</li> <li>▪ 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</li> <li>▪ Medical screening examination</li> <li>▪ Stabilization services</li> <li>▪ Access to DSHS designated Level I and Level II trauma centers or hospitals meeting equivalent levels of care for</li> </ul>	<ul style="list-style-type: none"> <li>▪ May require authorization for post-stabilization services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable co-pays apply to emergency room visits (facility only)</li> </ul>

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<b>CHIP Type of Benefit</b>	<b>Description of CHIP Benefit</b>	<b>CHIP Limitations</b>	<b>Co-Pay for CHIP</b>
	<p>emergency services</p> <ul style="list-style-type: none"> <li>▪ Emergency ground, air or water transportation</li> </ul>		
<b>Transplants</b>	<p>Medically necessary services include:</p> <ul style="list-style-type: none"> <li>▪ 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</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires authorization</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>
<b>Vision Benefit</b>	<p>Medically necessary services include:</p> <ul style="list-style-type: none"> <li>▪ One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization</li> <li>▪ One pair of non-prosthetic eyewear per 12-month period</li> </ul>	<p>The health plan may reasonably limit the cost of the frames/lenses.</p> <ul style="list-style-type: none"> <li>▪ Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable level of co-pay applies to office visits billed for refractive exam</li> </ul>
<b>Chiropractic Services</b>	<p>Medically necessary services do not require physician prescription and are limited to spinal subluxation</p>	<ul style="list-style-type: none"> <li>• Requires authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit)</li> <li>• Requires authorization for additional visits.</li> </ul>	<ul style="list-style-type: none"> <li>• Applicable level of co-pay applies to chiropractic office visits</li> </ul>
<b>Tobacco Cessation Programs</b>	<ul style="list-style-type: none"> <li>▪ Covered up to \$100 for a 12-month period limit for a plan- approved program</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires authorization</li> <li>▪ Health Plan defines plan-approved</li> </ul>	<ul style="list-style-type: none"> <li>▪ Co-pays do not apply</li> </ul>

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CHIP Type of Benefit	Description of CHIP Benefit	CHIP Limitations	Co-Pay for CHIP
		program. ▪ May be subject to formulary requirements.	

**EXCLUSIONS for CHIP benefits**

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles 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

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- 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.
- 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

**DME/SUPPLIES – for CHIP Programs**

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

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SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
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.
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.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that

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SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			<p>normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include:</p> <ul style="list-style-type: none"> <li>• 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</li> </ul> <p>Does not include formula:</p> <ul style="list-style-type: none"> <li>• For members who could be sustained on an age-appropriate diet.</li> <li>• Traditionally used for infant feeding</li> <li>• 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)</li> <li>• 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.</li> </ul> <p>Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are <i>not</i> medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.</p>
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets,	X		Eligible for coverage for individual with an

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SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Urinary			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 parenteral nutrition has been authorized by the Health Plan.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.

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SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
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.

### *DCHP Value Added Benefits*

In addition to the benefits for STAR and CHIP, DCHP provides certain value added benefits for members. The DCHP value added services are:

Value added Benefit	STAR Program	CHIP Program
Enhanced Obesity and Nutrition Services for Children	BENEFIT: Available to STAR members <b>age 20</b> and under.  PROGRAM: See program description below this table.	BENEFIT: Available to CHIP members <b>age 18</b> and under.  PROGRAM: See program description below this table.
Value-added Vision Services	BENEFIT: \$100 per 24 month period for corrective eyewear.  LIMITATION: covered when there exists combined power in any meridian greater than +/- 0.38 diopters in at least one eye, necessary prism of at least 0.50 diopters in at least one eye, anisometropia greater than +/- 0.38 diopters or cylinder power greater than +/- 0.38 diopters.	BENEFIT: \$100 per 12 month period for corrective eyewear, plus repairs costing \$2 or less.  LIMITATION: covered when there exists combined power in any meridian greater than +/- 0.38 diopters in at least one eye, necessary prism of at least 0.50 diopters in at least one eye, anisometropia greater than +/- 0.38 diopters or cylinder power greater than +/- 0.38 diopters.
Temporary Cell Phone	BENEFIT: for members who meet medical criteria, including but not necessarily limited to, pregnancy, unstable diabetes and uncontrolled asthma. Contact DCHP Case Management for eligibility determination.	BENEFIT: for members who meet medical criteria, including but not necessarily limited to, pregnancy, unstable diabetes and uncontrolled asthma. Contact DCHP Case Management for eligibility determination.
Home Visits for New Mothers	BENEFIT: Up to 6 in home visits	BENEFIT: Up to 6 in home visits

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	<p>in the first 6 months after birth of newborn.</p> <p>PROGRAM: Assessment of mother and infant which may include but is not limited to:</p> <ul style="list-style-type: none"> <li>• Evaluate physical and emotional health status of mother and assess for complications (bleeding, fever, breast soreness/discharge, bladder &amp; bowel symptoms, depression)</li> <li>• Evaluate health status of infant and assess for complications (intake/output, jaundice, safety)</li> <li>• Assessment of infant feeding; identification and correction of feeding problems</li> <li>• Evaluate for parenting, attachment and family transition issues</li> <li>• Provide assistance with access to other services, i.e. WIC, Family Planning, etc.</li> </ul>	<p>in the first 6 months after birth of newborn.</p> <p>PROGRAM: Assessment of mother and infant which may include but is not limited to:</p> <ul style="list-style-type: none"> <li>• Evaluate physical and emotional health status of mother and assess for complications (bleeding, fever, breast soreness/discharge, bladder &amp; bowel symptoms, depression)</li> <li>• Evaluate health status of infant and assess for complications (intake/output, jaundice, safety)</li> <li>• Assessment of infant feeding; identification and correction of feeding problems</li> <li>• Evaluate for parenting, attachment and family transition issues</li> <li>• Provide assistance with access to other services, i.e. WIC, Family Planning, etc.</li> </ul>
Transportation	<p>NOT APPLICABLE. This benefit is provided through HHSC (not part of DCHP covered services) by calling <b>1-877-633-8747</b>.</p>	<p>BENEFIT: Transportation to medical appointment.</p> <p>PROGRAM: Members contact DCHP Case Management to access services.</p>

**Program Description Of Enhanced Obesity & Nutrition Benefit:**

This DCHP program works with families and their physicians to prevent and treat obesity. DCHP uses the S.A.F.E. (**S**kip or **S**top high calorie drinks, **A**lter your snack habits, **F**orget fast food, and **E**xercise daily) program developed by Dr. Stephen Ponder, a Pediatric Endocrinologist. This program has been endorsed by the Texas Pediatric Society and the Texas Medical Association. The program has two components. The first is prevention: 1) plotting Body Mass Index (BMI) during check-ups, 2) recognition that patient is at-risk for obesity or is overweight, 3) anticipatory guidance by the physician, and 4) nutrition and exercise counseling. The second is treatment. The program offers enrollment in the applicable Driscoll Children’s Hospital obesity program: 1) Weigh-To-Go (6-wk program, 9-14 yr olds), 2) Weigh-of-Life-Kids! (3- wk program for parents of 4-8 yr olds), 3) Weigh-To-Go-Next-Step (follow-up from Weigh-To-Go) or, 4) Individual monthly counseling sessions for 14-20 yr olds that are above the 90<sup>th</sup> percentile for BMI. Programs are family-oriented and offer multi-disciplinary services to

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educate children and families about nutrition, life style, and exercise to improve self-esteem. Full kitchen and gym facilities are available. Families are taught the nutritional content of foods, how to read food labels, making healthy choices when buying food, and cooking healthy. Includes individual counseling with a Registered Dietician.

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## ***Prescription Drugs***

The Prescription Drug Benefit for STAR and CHIP recipients is not covered by DCHP. The Vendor Drug Program (VDP) administers this benefit. The VDP makes payment for prescriptions of covered outpatient drugs only to pharmacy providers contracted to provide VDP services. The VDP maintains an open formulary that includes drugs prescribed for medical treatment of illness or injuries.

DCHP does not reimburse claims for the following:

- Over the counter drugs
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care
- Nutritional products
- Medical supplies or equipment (Exception: Medical Supplies not covered by the VDP will be covered by DCHP –e.g. Diabetic supplies, peak flow meters, spacers, etc.)
- Products unsuitable for use outside of physician offices or health care facilities.

The VDP operates a Vendor Drug Help Desk to assist contracted pharmacy providers with information pertaining to the online status of paid and rejected claims, eligibility, and general information regarding STAR and CHIP policies and procedures. The hotline is open weekdays from 8:30 a.m. to 5:15 p.m. (Central Standard Time) for providers only, at **1-800-435-4165**.

Providers may contact DCHP Provider Services with questions about potential health plan coverage and reimbursement of nutritional products, medical supplies and equipment.

### **No Limit on Prescriptions for STAR Adult Members**

DCHP STAR adult members may receive more than the 3-prescription limit that is established for adults in the traditional (non-Managed Care) Medicaid program.

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## ***Medical Supplies***

### ***Medical Supplies Exception:***

DCHP is contracted with a Pharmacy Benefits Manager (PBM) to administer the distribution of certain medical supplies. The following medical supply items can be obtained by DCHP STAR and CHIP members through any participating pharmacy.

### **SPECIAL EQUIPMENT AND SUPPLIES**

Alcohol, swabs (diabetic)-88870
Alcohol, swabs-88870
Ana Kit Epinephrine-93071
Batteries – initial-88885
Batteries – replacement-88885
Diabetic Supplies-88875
Dressing Supplies/Decubitus-88875
Dressing Supplies/Peripheral IV Therapy-88875
Electrodes-88885
Enteral Nutrition Supplies-88885
Eye Patches-88885
Formula (with prior authorization)-93450
Insulin Pump (External) Supplies-88875
IV Therapy Supplies-88895
Lancet Device-88865
Lancets-88864
Nebulizer Mask and Tubing (Replacement)
Needles and Syringes/Other-88889
Novopen-88889
Ostomy Supplies-88830
Parenteral Nutrition/Supplies-88875
Peak Flow Meters
Saline, Normal-7970
Spacer
Spacer with Mask

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**DCHP Provider Services 1-877-DCH-DOCS (324-3627)**

**Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)**

**Case Management: 1-877-222-2759 (FAX 1-866-741-5650)**

**CHIP Member Services: 1-877-451-5598    STAR Member Services: 1-877-220-6376**

**Member Services FAX: 361-904-0187**

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## ***Dental Services***

Delta Dental administers the dental benefit for STAR and CHIP recipients. To obtain information about dental benefits for STAR and CHIP members, please call:

**Provider Questions: 1-866-561-5891**

**Member Questions: 1-866-561-5892**

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## ***Non-Urgent Medical Transportation Services***

### **STAR PROGRAM:**

The Texas Department of Health Medical Transportation Program (MTP) is designed to serve STAR patients that have no other means of transportation for medical and dental appointments. MTP will utilize the most cost-effective method of transportation that does not endanger a patient's health, to include an ambulance or wheelchair van.

To request medical transportation services, a member should contact MTP at: **1-877-633-8747**. To arrange for transportation, call at least 48 hours in advance of the office visit, Monday through Friday, 8:00 a.m. to 5:00 p.m.

### **CHIP PROGRAM:**

Non-Urgent medical transportation services to CHIP members are provided by DCHP as a value-added benefit. This program is outlined in the value-added benefit section above. To access services, CHIP members can call DCHP Case Management Monday through Friday, 8:00 a.m. to 5:00 p.m.

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## ***Non-Covered Services – Advance Beneficiary Notice and Private Pay Form***

Providers are not allowed to bill non-covered services to STAR or CHIP members or their families unless a signed Advance Beneficiary Notice (ABN) and Private Pay Form (see Appendix A) was obtained prior to furnishing the services to the DCHP member AND the member or responsible party was informed that the service would not be covered by DCHP.

The ABN must be maintained in the provider's records and must be made available to DCHP or the state or other governmental agency of competent jurisdiction upon request.

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DCHP has an ABN and Private Pay Form shown in Appendix A, but providers are not required to use this specific form and may use their own form or other payers' form so long as the form contains the same material information.

The Advance Beneficiary Notice and Private Pay Form should be maintained in provider's medical record and copies may, from time to time, be requested by DCHP or HHSC.

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### ***Co-pay Levels for CHIP Children***

The co-pay amounts applicable to each individual member will appear on the member's DCHP ID card. For applicable services, provider should collect or bill co-pay amounts in accordance with member's ID card. For information regarding co-pay levels shown in the table on the next page.

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COVERED SERVICES	COST SHARING FOR CHIP MEMBERS				
	Maximum Member Out of Pocket Payments **				
	Native Americans	At or below 100% Federal Poverty Level	101-150% Federal Poverty Level	151-185% Federal Poverty Level	186-200% Federal Poverty Level
Maximum Family Cost Sharing	\$0	1.25% annual cap	1.25% annual cap	2.5% annual cap	2.5% annual cap
	CO-PAY LEVELS				
Office Visit	\$0	\$3	\$5	\$7	\$10
Well-Child Care & Immunizations	-0-	-0-	-0-	-0-	-0-
Emergency Room Visit	\$0	\$3	\$5	\$50	\$50
Physical, Occupational and Speech Therapy*	-0-	-0-	-0-	-0-	-0-
Inpatient Hospital Care*	\$0	\$10	\$25	\$50	\$100
Outpatient Surgery*	\$0	\$0	\$0	\$0	\$0
Outpatient Visits* (such as X-rays, lab tests, casts, renal dialysis)	\$0	\$0	\$0	\$0	\$0
Outpatient Mental Health Visit – limited benefit * (same as Office Visit above)	\$0	\$3	\$5	\$7	\$10
Prescriptions (co-pay amount per prescription or 34-day supply)	\$0 for generic	\$0 for generic	\$0 for generic	\$5 for generic	\$5 for generic
	\$0 for brand-name	\$3 for brand-name	\$5 for brand-name	\$20 for brand-name	\$20 for brand-name
Home Health Care*	-0-	-0-	-0-	-0-	-0-
	Plus costs for related prescriptions.				
Durable Medical Equipment (DME), Prosthetic Devices & Disposable Medical Supplies*	-0-	-0-	-0-	-0-	-0-
	Plus costs for related prescriptions. \$10,000 limit per enrollment period				
Case Management for Children with Special Health Care Needs	-0-	-0-	-0-	-0-	-0-
Transplants*	-0-	-0-	-0-	-0-	-0-

\*May require authorization or physician prescription - For complete details of benefit coverage call Driscoll Children's Health Plan Member Services at 1-877-451-5598.

\*\* HHSC will approve when a member meets his/her maximum out-of-pocket level and notify DCHP. HHSC will notify DCHP, and then DCHP will give the member new ID card reflecting the new levels of copays applicable.

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