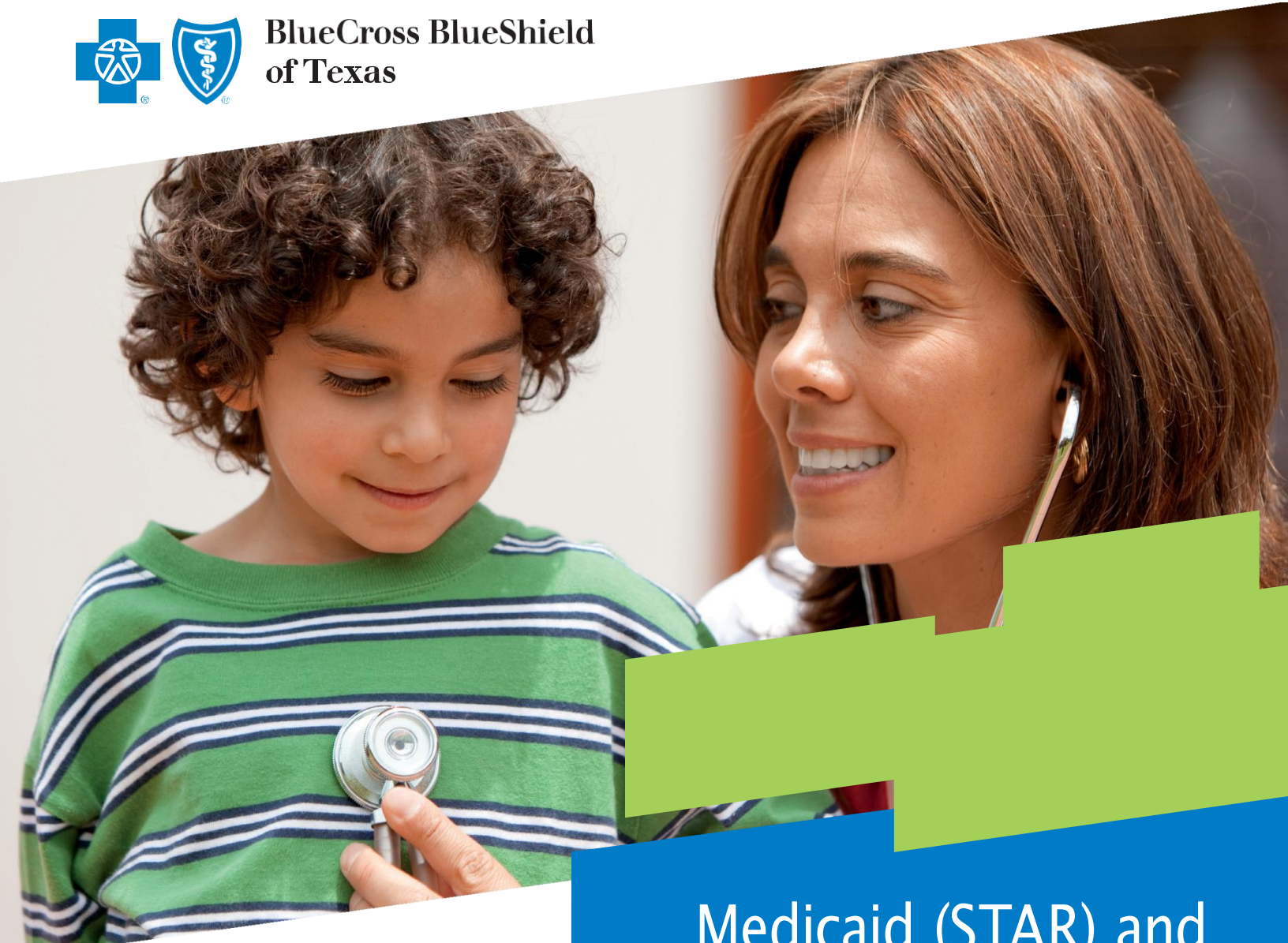




BlueCross BlueShield
of Texas



Medicaid (STAR) and CHIP Provider Manual

For Physicians, other Professional Providers,
Facilities and Ancillary Providers



Provider Customer Service: 1-877-560-8055

bcbstx.com/provider/Medicaid/index.html

Travis Service
Area Effective
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Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Welcome!

Welcome to the Blue Cross and Blue Shield of Texas Provider Manual. This manual is for Blue Cross and Blue Shield of Texas (BCBSTX) contracted physicians, other professional providers, facilities and ancillary providers who serve our members enrolled in the Texas Medicaid (STAR) and Children's Health Insurance Program (CHIP). Please note that pharmacy providers have a separate manual. For information on how to access the Pharmacy Manual, please see the Pharmacy Providers on page 224 of this section.

BCBSTX is contracted by the Texas Health and Human Services Commission (HHSC) to serve STAR and CHIP members who reside in the Travis Service Area. This includes the counties of Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson.

The manual will use the following terms and abbreviations:

BCBSTX	=	Blue Cross and Blue Shield of Texas
STAR	=	State of Texas Access Reform (Medicaid)
CHIP	=	Children's Health Insurance Program
HHSC	=	Texas Health and Human Services Commission
Providers	=	Physicians, other professional providers, facilities and ancillary providers

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Chapter 1

Introduction

WELCOME

Welcome to the Blue Cross and Blue Shield of Texas Provider Manual. This manual is for Blue Cross and Blue Shield of Texas (BCBSTX) contracted physicians, other professional providers, facilities and ancillary providers who serve our members enrolled in the Texas Medicaid (STAR) and Children’s Health Insurance Program (CHIP). Please note that pharmacy providers have a separate manual. For information on how to access the Pharmacy Manual, please see the **Pharmacy Providers** on page 224 of this section.

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IMPORTANT INFORMATION

Our Website - www.bcbstx.com

The BCBSTX STAR and CHIP website is <http://bcbstx.com/provider/Mmedicaid/index.html>.

Throughout this manual, we will refer to our website as a source of information, resources, forms and other tools that can assist our providers.

Fast Access to Key Information

Important contact information, phone and fax numbers, website and other helpful resources are listed in **Chapter 2 – Important Contact Information**.

This Manual Contains Proprietary Information

By accepting this manual, BCBSTX providers agree to:

- Not disclose the information contained in this manual,
- Protect and hold the information in the manual as confidential, and
- Use this manual solely for the purposes of referencing information regarding the provision of medical services rendered to STAR and CHIP Members

Important Considerations

There are instances throughout this manual where information is provided as a sample or example. This information is for illustrative purposes only and is not intended to be used or relied upon.

Procedures Performed by Blue Cross and Blue Shield of Texas and its Material Subcontractors

Medical procedures arranged by BCBSTX and its material subcontractors are referred to in this manual. It is the sole responsibility of BCBSTX to ensure that delegated functions are performed in accordance with federal and state standards. Further, BCBSTX requires all material subcontractors to have policies and procedures that meet our contractual obligations to HHSC.

Please note: Services should be provided without regard to the member's race, religion, sex, color, national origin, age, or physical or behavioral health status.

Chapter 1

Websites

The BCBSTX website and this manual may contain links and references to Internet sites owned and maintained by third-party entities. Neither BCBSTX nor its related affiliated companies operate or control, in any respect, any information, products or services of third-party entities. Such information, products, services and related materials are provided 'as is' without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. BCBSTX disclaims all warranties, express or implied, including, but not limited to, implied warranties of merchantability and fitness. BCBSTX does not warrant or make any representations regarding the use or results of the use of third party materials in terms of their correctness, accuracy, timeliness, reliability or otherwise.

Member Handbook

The Member Handbook governs the member's benefits, conditions, limitations and exclusions. In the event of any conflict between the terms outlined in this manual and the Member Handbook, the terms of the Member Handbook shall govern. The STAR and CHIP Member Handbooks, and the CHIP Evidence of Coverage (EOC) are available on line at bcbstx.com/Medicaid.

Participating Provider Agreement

The contents of this manual, including any future revisions, are part of the BCBSTX **Participating Provider Agreement**. Should any language contained in this manual conflict with language contained in the **Participating Provider Agreement**, the **Participating Provider Agreement** will prevail.

Updates to this Manual

BCBSTX intends to publish an updated manual annually. If new procedures and processes take effect after this manual has been published, BCBSTX will communicate updates via its website, fax, e-mail or special mailings. Updates will be posted on the BCBSTX website at http://www.bcbstx.com/provider/Medicaid/education_reference.html and are considered addendums to this manual. This manual does not contain legal, tax or medical advice. Please consult your own advisors for such advice.

If you have questions about the content of this manual, please contact one of the following:

Provider Customer Service: **877-560-8055**

Local Network Management Office: **855-212-1615**

Email: TexasMedicaidNetworkDepartment@bcbstx.com.

OBJECTIVES OF THE PROGRAMS

State of Texas Access Reform (STAR)

BCBSTX STAR provides delivery of primary and acute care services to members, ages 0-64, who are not served by, or eligible for, other state-assisted health insurance programs. BCBSTX's program emphasizes early intervention and promotes improved access to quality care with a special focus on prenatal care and Texas Health Steps Checkups for Children.

The goals of the BCBSTX STAR program are to:

- Improve access to care for members,
- Improve quality and continuity of care for members,
- Decrease inappropriate use of the health care delivery system, such as using emergency rooms for non-emergency care, and
- Promote provider and member satisfaction.

Children's Health Insurance Program (CHIP)

BCBSTX CHIP is the children's health insurance option. Similar to the national Children's Health Insurance Program, CHIP's principal objective is to provide affordable primary and preventive health care to low-income, uninsured children between the ages of 0 through 18 who are not eligible for STAR due to family income above the Federal Poverty Level (FPL).

CHIP Perinate Program

The CHIP Perinate Program provides non-Medicaid eligible women with delivery and pre-natal and post-natal benefits. This program allows pregnant women who are ineligible for Medicaid because of income or immigration status to receive prenatal care. It also provides CHIP benefits to the child upon delivery for the duration of the coverage period.

Chapter 1

NETWORK LIMITATIONS/ACCESS TO CARE

BCBSTX Medical Management works collaboratively with Network Management on a case-by-case basis to identify and help ensure that members are able to access appropriate medical services within the participating provider network. Network Management will determine if medical services can be provided in-network. If Network Management determines that services can only be provided by a non-participating provider, they will approve services for coverage under BCBSTX. Network Management will attempt to contract with the provider. If the provider is unwilling, the provider will be asked to agree to a Single Case Agreement. If the provider accepts standard fees, the provider will be authorized to provide the care on an out-of-network basis. If the provider requires fee negotiation, the provider will be asked to sign a Single Case Agreement and then will be provided with an authorization number.

Primary Care Providers (PCPs)

PCPs and other professional providers are responsible for establishing a ‘medical home’ for their BCBSTX members. PCPs are responsible for providing timely preventive services, giving diagnosis and treatment, and educating members on how to appropriately use available health services.

PCPs must comply with all state and federal laws and abide by the terms of their contracts. Primary care is limited to the member’s benefit coverage.

PCPs can offer behavioral health services when:

- Clinically appropriate and within the scope of their practice
- The member’s current condition is not so severe, confounding or complex as to warrant a referral to a behavioral health provider
- The member is willing to be treated by the PCP
- The services rendered are within the scope of the benefit plan

Specialty Care Providers

Specialty care providers are responsible for supplementing PCP services. PCPs identify and refer members to BCBSTX’S contracted network specialist physicians or other professional providers for conditions that are beyond the PCP’s scope of practice and medically necessary. BCBSTX must not pay any claims submitted by a provider based on an order or referral that excludes the National Provider Identifier (NPI) for the ordering or referring provider. Also, BCBSTX must not pay any claim submitted by a provider excluded or suspended from the Medicare, Medicaid, CHIP, or CHIP Perinate programs for fraud, abuse, or waste. Specialists diagnose and treat conditions specific to their area of expertise. Specialist care is limited to the member’s benefit coverage.

Specialists must give regular reports to the member’s assigned PCP after the initial consultation and follow-up evaluations, and must include the diagnosis, recommendations and treatment plan. Members with Special Health Care Needs (SHCN) such as disabling conditions and chronic illnesses, pregnant women, or children with special health care needs may request that their specialist also be their PCP. The request for a specialist to be a PCP must be sent to Medical Management for review and approval to ensure that the specialist is willing and able to meet the requirements. Medical management will approve the specialist as a PCP.

CHIP Perinate Providers

CHIP Perinate providers are responsible for providing OB/GYN services to CHIP Perinate members/mothers for the duration of the pregnancy and postpartum period, as well as medically necessary services for the unborn child. In addition, they are responsible for providing all other services covered under the CHIP Perinate Program for the CHIP Perinate newborn member. Providers participating in the CHIP network are also available to CHIP Perinate members.

Pharmacy Providers

Pharmacy providers are responsible for providing prescription drug services to all covered members in accordance with the standard practices of their communities. Prescriptions may be filled at retail and specialty via an arrangement with Prime Therapeutics, the pharmacy benefits manager. Phone numbers for Prime are in Chapter 2. An operations manual for pharmacy providers is available on the Provider Resources page of our website at <http://bcbstx.com/provider/Medicaid/index.html> under **Pharmacy Network Provider Supplement**.

For more information about PCP, Specialist, other Providers and Pharmacy Provider roles and responsibilities, please see **Chapter 13, Provider Roles and Responsibilities**.

Role of Main Dental Home

Dental plan members, i.e. STAR members under age 21 and CHIP members under age 19, may select a dental managed care plan and choose their Main Dental Homes. Dental plans will assign each member to a Main Dental Home if the member does not choose one within a designated time frame. Whether chosen or assigned, each member (child) who is age six months or older must have a designated Main Dental Home.

A Main Dental Home serves as the member's main dentist for all aspects of oral health care. The Main Dental Home has an ongoing relationship with that member, to provide comprehensive, continuously accessible, coordinated, and family-centered care. The Main Dental Home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists can serve as Main Dental Homes. The two dental plans that serve eligible members are Dentaquest and MCNA. See Chapter 2 for their contact information. Adults are not eligible for dental benefits with the exception of the BCBSTX Value-Added Service (VAS) for Pregnant Adult Women. See Chapter 3 for STAR VAS and Chapter 4 for CHIP VAS.



Chapter 2

Important Contact Information

IMPORTANT CONTACT INFORMATION

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
BCBSTX	Provider Relations and Network Management	855-212-1615	Monday – Friday 8 a.m. – 5 p.m. Central Time
Behavioral Health Services	STARandCHIP: Magellan Healthcare “Magellan”	TTY: 800-327-7390 800-735-2988 www.magellanprovider.com	24 hours a day/ seven day a week
Case Management and Referrals	Case Management	STARandCHIP: 877-560-8055 Fax: 855-417-1289	Monday – Friday 8 a.m. – 8 p.m. Central Time
Claims Payment Issues	Web portal	www.availity.com	24 hours a day/ seven day a week
	Provider Customer Service	STARandCHIP: 877-560-8055 TTY: 711	Monday – Friday 8 a.m. – 8 p.m. Central Time
	Claims Address	Blue Cross and Blue Shield of Texas P.O. Box 51422 Amarillo, TX 79159-1422	
Claims Electronic Processing	Electronic Data Interchange (EDI)	Payer ID 66001 www.availity.com	24 hours a day/ seven day a week

Chapter 2

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
Complaints and Appeals	Member Customer Service	<p>Members: 888-657-6061 TTY 711</p> <p>Providers: 877-560-8055 TTY 711</p> <p>Email: GPDTXMedicaidAG@bcbsnm.com</p> <p>Mail: PO Box 27838 Albuquerque, NM 87125-7838</p>	Monday – Friday 8 a.m. – 8 p.m. Central Time
Dental Services	DentaQuest Provider Services	<p>STARandCHIP: 800-896-2374 www.dentaquest.com</p>	<p>Monday – Friday: 8 a.m. – 7 p.m.</p> <p>Saturday: 8 a.m. – Noon</p> <p>Central Time</p>
	MCNA Dental Provider Services	<p>STARandCHIP: 800-494-6262 www.mcna.net</p>	Monday – Friday 8 a.m. – 4 p.m. Central Time (excludes holidays)

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
Drugs or Prescriptions – Prime Therapeutics BIN 011552 PCN TXCAID Group# WFTA	Prime Therapeutics	Prime Therapeutics Customer Service: STAR: 855-457-0405 CHIP: 855-457-0403 Prime Mail Customer Service: STAR: 855-457-0406 CHIP: 855-457-0404	24 hours a day/ seven days a week
	Prior Authorization	Prime Therapeutics Customer Service: STAR: 855-457-0405 CHIP: 855-457-0403 Prime Mail Customer Service: STAR: 855-457-0406 CHIP: 855-457-0404	Monday – Friday 6 a.m. – 9 p.m. Central Time
	e-Prescribing	Available through Prime Therapeutics for providers to check eligibility, review medication history and review formulary information.	24 hours a day/ seven days a week
	Other resources	www.txvendordrug.com	
Early Childhood Intervention	Early Childhood Intervention	800-628-5115 TTY: 866-581-9328 www.dars.state.tx.us/ecis	Monday – Friday 8 a.m. – 5 p.m. Central Time
Eligibility Member Eligibility and Verifying PCP (STAR and CHIP)	Web Portals	www.availity.com www.tmhp.com	24 hours a day/ seven days a week
	Customer Service	Members: 888-657-6061 TTY: 711 Providers: 877-560-8055	Monday – Friday 8 a.m. – 8 p.m. Central Time
	Automated Inquiry System (AIS)	800-925-9126	24 hours a day/ seven days a week

Chapter 2

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
Fraud and Abuse	Customer Service	Members: 888-657-6061 TTY: 711 Providers: 877-560-8055	Monday – Friday 8 a.m. – 8 p.m. Central Time
General Assistance <ul style="list-style-type: none"> • Eligibility for Medicaid • State resources for food, housing, child care and after school programs • Senior services • Help after a disaster • Tax help 	2-1-1 Information Service and Search South Central Texas (Bastrop, Blanco, Burnet, Caldwell, Fayette, Hays, Lee, Llano, Travis, and Williamson counties)	Call 2-1-1 From within the service area, call 512-973-9203 Outside the service area call toll-free 877-541-7905 www.211.org	24 hours a day/ seven day a week
Hospital or Facility Admission Notification	Utilization Management Department	Voice: 877-560-8055 Fax: 855-879-7180	Monday – Friday 8 a.m. – 8 p.m. Central Time
Interpreter Services	Customer Service	Members: 888-657-6061 TTY: 711 Providers: 877-560-8055	Monday – Friday 8 a.m. – 8 p.m. Central Time
Legal Aid	Texas Rio Grande Legal Aid, Inc. 4920 N. I-35 Austin, TX 78751 (Bastrop, Blanco, Burnet, Caldwell, Hays, Llano, Mason, Travis and Williamson counties)	512-374-2700 800-369-9270 Fax: 512-447-3940 www.trla.org/office/austin	Monday – Thursday 8 a.m. – 7:30 p.m. Friday 8 a.m. – 5:30 p.m. Central Time

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
Member Services	Customer Service	Members: 888-657-6061 TTY: 711	Monday – Friday 8 a.m. – 8 p.m. Central Time
Member Outreach or Member Advocate	Member Outreach	TTY: 877-375-9097 711 Fax: 512-349-4867	Monday – Friday 8 a.m. – 5 p.m. Central Time
Member Information Changes (contact, address, telephone and other changes)	Health and Human Services Commission	Call: 2-1-1 877-541-7905 TTY: 877-833-4211 www.211texas.org/211	24 hours a day/ seven days a week
Medical Management		Fax: 877-560-8055 855-879-7180	Monday – Friday 8 a.m. – 8 p.m. Central Time
24 Hour Nurse Advice Line Questions and After-hours Inquiries	24 Hour Nurse Advice Line	844-971-8906	24 hours a day/ seven day a week
Over-the-Counter Products (Limited)	Prime Therapeutics	STAR Help Desk: 855-457-0405 CHIP Help Desk: 855-457-0403 BIN: 011552 PCN: TXCAID	Monday – Saturday 6 a.m. – 9 p.m. Central Time

Chapter 2

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
Pharmacy	Prime Therapeutics	Provider Customer Service STAR 866-294-1562 CHIP 866-323-2088 BIN: 011552 PCN: TXCAID	24 hours a day 7 days a week
		Prior Authorization Voice: STAR: 866-533-7008 CHIP: 866-472-2095 FAX (both programs) 800-357-9577 BIN (Plan ID): 003858	Monday – Saturday 6 a.m. – 9 p.m. Central Time
Prior Authorization and Referrals – Medical	Utilization Management Department	Fax: 877-560-8055 855-879-7180	Monday – Friday 8 a.m. – 8 p.m. Central Time
Provider Services	Customer Service	877-560-8055	Monday – Friday 8 a.m. – 8 p.m. Central Time
State Aid Information and referral for state resources for food, housing, child care, after-school programs, senior services, help after a disaster and tax help	2-1-1 Information Service and Search South Central Texas (Bastrop, Blanco, Burnet, Caldwell, Fayette, Hays, Lee, Llano, Travis, and Williamson counties)	Call 2-1-1 From within the service area: 512-973-9203 Outside the service area: Toll-free 877-541-7905 www.211.org or click 2-1-1 website	24 hours a day/ seven days a week
Texas Health Steps (STAR)	Texas Department of State Health Services (CSHS)	877-847-8377	Monday – Friday 8 a.m. – 6 p.m. Central Time

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
TTY - Members with Hearing Loss	Customer Service	TTY: 888-657-6061 711	Monday – Friday 7 a.m. – 6 p.m. Central Time
	Texas Relay Service	Texas Relay 800-735-2989 711	24 hours a day/ seven day a week
Transportation Services - STAR *See page 38 for STAR Non-emergency Transportation Value Added Service; See page 47 for CHIP Non-emergency Transportation Value Added Service	HHSC Medical Transportation Program	877-633-8747	Monday – Friday 8 a.m. – 5 p.m. Central Time
Vision Services	Davis Vision	Member Services: 888-588-4825 TTY: 800-523-2847 Provider Services: 800-77DAVIS (800-773-2847) TTY: 800-523-2847 Website: www.davisvision.com	Monday - Friday 7 a.m. - 10 p.m. Central Time Saturday 8 a.m. - 3 p.m. Central Time Sunday 11 a.m. - 3 p.m. Central Time



Chapter 3

STAR Member Benefits

STAR COVERED SERVICES

The services listed below are subject to modification based on federal and state laws and regulations and HHSC policy updates. This is not an exhaustive list of benefits. Services requiring authorization are posted on the provider website or you can call Provider Customer Service at **877-560-8055**.

Covered Benefit	Description
Ambulance Services	<p>Covered when the member has an emergency medical condition. An emergency medical condition is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance abuse) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in one of the following:</p> <ul style="list-style-type: none"> • Placing the member's health (or with pregnant member, health of the member or the unborn child) in serious jeopardy • Serious impairment to bodily functions • Serious dysfunction of any bodily organ or part <p>Logistical problems may also define an emergency:</p> <ul style="list-style-type: none"> • Facility-to-facility transport may be considered an emergency if emergency treatment is not available at the first facility and the member requires emergency care <p>Air ambulance transport services may be covered only if one of the following conditions exists:</p> <ul style="list-style-type: none"> • The medical condition requires immediate and rapid ambulance transportation that could not have been provided by standard automotive ground ambulance • The point of member pick up is inaccessible by standard automotive ground vehicle • Great distances or other obstacles are involved in transporting the client to the nearest appropriate facility <p>Please note: Prior authorization is required for non-emergency ambulance transport services.</p>
Audiology Services	<p>Audiology services, including hearing aids, for adults and children.</p>

Chapter 3

Covered Benefit	Description
<p>Behavioral Health Services</p> <p>Inpatient Behavioral Health Services</p>	<ul style="list-style-type: none"> • Inpatient behavioral health services for adults or children; acute care hospitals for psychiatric conditions. • Inpatient behavioral health services for children under age 21 to free-standing psychiatric facility. • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • Admissions for chronic diagnoses such as mental retardation, organic brain syndrome or chemical dependency/abuse are not a covered benefit for acute care hospitals without an accompanying medical condition. • Targeted Case Management and Mental Health Rehabilitation • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
<p>Behavioral Health Services</p> <p>Outpatient Behavioral Health Services</p>	<ul style="list-style-type: none"> • Medically necessary services for the treatment of mental, emotional or chemical dependency disorders. • Outpatient behavioral health. • Medication management. • Neuropsychological and psychological testing.
<p>Behavioral Health Services</p> <p>Inpatient Substance Abuse Treatment Services</p>	<ul style="list-style-type: none"> • Detoxification (inpatient and residential) is limited to 21 days per year. • Residential Treatment: Rehabilitation is limited to 35 days per episode. Two episodes of care per rolling six-month period and four episodes per rolling year. Specialized female (including pregnant women and women with children) up to 90 days per episode. Members ages 20 and under are eligible for additional days.

Covered Benefit	Description
<p>Behavioral Health Services</p> <p>Outpatient Substance Abuse Treatment Services</p>	<ul style="list-style-type: none"> • SUD treatment services are age appropriate medical and psychotherapeutic services designed to treat a member’s substance disorder and restore function. • Group counseling is limited to 135 hours per member, per calendar year. • Individual counseling is limited to 26 hours per member per calendar year. • Additional counseling services may be considered for ages 20 and under based upon medical necessity. • Assessment for substance abuse disorder may be covered once per episode of care when provided using a standardized screening and assessment tool. • Medication Assisted Therapy (MAT) In Person: Limited to once per day and prior authorization is required. • Medication Assisted Therapy (MAT) Take Home: Limited to once per day up to 30 doses and prior authorization is required. • Ambulatory (Outpatient) Detoxification Services may be covered for a medically appropriate duration of care based on treatment needs for up to 21 days. Clients ages 20 and under may receive additional days of treatment with prior authorization. • Inpatients residing in a DSHS facility are not eligible for outpatient services. • Does not require a PCP referral.
<p>Chiropractic Services</p>	<p>Limited to an acute condition or an acute exacerbation of chronic condition for a maximum of 12 visits in a consecutive 12-month period, and a maximum of one visit per day.</p> <p>If the condition persists more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute.</p>
<p>Dental Services, Primary and Preventive</p>	<p>Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth and removal of cysts. For more information about primary and preventive STAR dental benefits, please contact:</p> <p>DentaQuest Provider Services</p> <p>STAR and CHIP: 800-896-2374, Monday–Friday 8 a.m.–7 p.m., Saturday 8 a.m.–Noon Central Time</p> <p>www.dentaquest.com</p> <p>MCNA Dental Provider Services</p> <p>STAR and CHIP: 800-494-6262, Monday–Friday 8 a.m.–4 p.m., Central Time (excludes holidays)</p> <p>www.mcna.net</p>

Chapter 3

Covered Benefit	Description
Dialysis	Inpatient and outpatient services require prior authorization.
Direct Birthing Services	<ul style="list-style-type: none"> • Provided by a physician or advanced practice nurse in a licensed birthing center. • Provided by a licensed birthing center.
Division for the Blind Services	<p>The Division for the Blind Services (DBS) of the Texas Department of Assistive and Rehabilitative Services (DARS) assists blind or visually impaired individuals and their families.</p> <p>DBS staff work in partnership with Texans who are blind or visually impaired to get high-quality jobs, live independently, or help a child receive the training needed to be successful in school and beyond.</p> <p>For more information, call the Division for the Blind Services at 800-628-5115.</p>
Durable Medical Equipment and Supplies	<ul style="list-style-type: none"> • Most DME needs prior authorization • Covered when medically necessary • Given for use in home when medically necessary <p>Not covered if:</p> <ul style="list-style-type: none"> • Used for exercise • The equipment is experimental or used for research • More than one piece of equipment serves the same use <p>Advance practice registered nurses (APRNs) and physician assistants (PAs) are prohibited from prescribing any durable medical equipment (including limited home health supplies) and outpatient schedule 11 controlled substance for Medicaid clients. This includes any product dispensed through the pharmacy.</p>

Covered Benefit	Description
<p>Early Childhood Intervention Case Management and Service Coordination</p> <p>Early Childhood Intervention: 800-628-5115; TTY: 866-581-9328</p> <p>See also ‘Texas Health Steps Case Management for Children and Pregnant Women’ later in this chapter.</p>	<p>Early Childhood Intervention (ECI) is a statewide program for families with children, age 0 to 3 years, with disabilities or developmental delays. ECI supports families to help children reach their developmental potential.</p> <p>All health care providers are required to identify and refer children up to 35 months of age suspected of having a developmental disability or delay, or of being at risk of delay, to ECI for screening and assessment as soon as possible but no longer than seven days after identification.</p> <p>Families and professionals work together to develop an Individual Family Service Plan (IFSP) for appropriate services based on the unique needs of the child. The IFSP describes the member’s disability or delay, services required, and the individual accountable for service delivery. It becomes a permanent part of the member’s medical record. The local ECI program implements and coordinates ongoing case management.</p> <p>Appropriate services are provided in collaboration with an interdisciplinary team, including the PCP, member, family, ECI case manager, plan staff and any other team professional.</p> <p>BCBSTX may not limit services recommended in the IFSP. Educational materials are approved by the Texas Interagency Council on Early Childhood Intervention.</p> <p>Services by non-network providers are permitted when no in-network provider is available.</p> <p>Call 800-628-5115 or visit the ECI website at www.dars.state.tx.us/ecis to learn more.</p>
<p>Emergency Services</p>	<p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Emergency services based on prudent lay person’s definition of emergency health condition • Hospital emergency room, ancillary services and physician services 24 hours a day/ seven day a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level I and Level II Trauma Centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth and removal of cysts

Chapter 3

Covered Benefit	Description
Family Planning Services	<p>Services, supplies or medications provided to Members of childbearing age in order to temporarily or permanently prevent or delay pregnancy. The following are not considered family planning services:</p> <ul style="list-style-type: none"> • Therapeutic abortion services • Routine infertility studies or procedures to promote fertility • Hysterectomy for sterilization purposes only • Transportation*, parking or child care <p>For the latest information on Family Planning Services, go to: www.dshs.state.tx.us/famplan/services.shtm</p>
Home Health Care Services	<p>Requires prior authorization. Medically necessary services include:</p> <ul style="list-style-type: none"> • Home health aide services • Physical therapy visits • Occupational visits • Speech therapy visits • Durable Medical Equipment (DME) • Medical supplies
Hospice Services Provided by the Department of Aging and Disability Services (DADS)	<p>Medicaid Hospice provides palliative care to all Medicaid-eligible members (no age restriction) who sign statements electing hospice services and are certified by physicians to have six months or fewer to live if their terminal illness runs its normal course. The following are part of hospice services:</p> <ul style="list-style-type: none"> • Hospice care includes medical and support services designed to keep members comfortable and without pain during the last weeks and months before death. • When members elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness. • Medicare and Medicaid members must elect both the Medicare and Medicaid Hospice programs. Individuals who elect hospice care are issued Medicaid Identification with 'HOSPICE' printed on it. Members may cancel their election at any time. • All members are disenrolled from BCBSTX upon enrollment into a hospice program. <p>To learn more, call Department of Aging and Disability Services (DADS) at 800-458-9858.</p>

* BCBSTX will assist members with transportation through the Value-Added Services transportation benefit to go to family planning providers if the state program for transportation does not.

Covered Benefit	Description
Hospital Services	Includes inpatient and outpatient.
Laboratory and Radiology	Laboratory (including pregnancy tests) and radiology services that are rendered during pregnancy must be billed separately from prenatal care visits.
Mastectomy, Breast Reconstruction, and Related Follow-up Procedures	<p>Inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate. Physician and professional services provided in an office, inpatient, or outpatient setting for:</p> <ul style="list-style-type: none"> • All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed • Surgery and reconstruction on the other breast to produce symmetrical appearance • Treatment of physical complications from the mastectomy and treatment of lymphedemas • Prophylactic mastectomy to prevent the development of breast cancer • External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
Medical Checkups and Comprehensive Care Program (CCP) See Texas Health Steps later in this chapter.	Services for children under age 21 through the Texas Health Steps program.
Podiatry	<p>Covered services include:</p> <ul style="list-style-type: none"> • Medical problems of the feet • Medical or surgical treatment of disease, injury or defects of the feet <p>The following are not covered:</p> <ul style="list-style-type: none"> • Routine foot care • Treating the feet when the bones are not in line and surgery is not required • Cutting or removing corns, warts or calluses • Experimental procedures • Acupuncture
Prenatal Care	<p>Limited to a combined total of 20 outpatient prenatal care visits and one postpartum care visit per pregnancy.</p> <ul style="list-style-type: none"> • Normal pregnancies usually require 11 visits per pregnancy. • High-risk pregnancies usually require 20 visits per pregnancy.

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Covered Benefit	Description
Prescription Drugs (Outpatient Only)	<p>STAR members' pharmacy benefits are administered by Prime Therapeutics LLC for BCBSTX. These benefits, based on medical necessity, cover outpatient prescription drugs obtained through any in-network pharmacy. Members may obtain medication from any network pharmacy.</p> <p>The formulary is a comprehensive list of drugs compiled and governed by Vendor Drug Program (VDP) available to STAR members. The goal of the formulary is to ensure that members receive therapeutically appropriate and cost-effective drug therapy.</p> <p>The formulary is updated by VDP regularly. Providers should always refer to the website for accurate formulary and other additional information.</p> <p>To view the formulary, go to the BCBSTX website or go to the VDP website at www.txvendordrug.com.</p> <p>Prime Therapeutics offers e-prescribing through Sure Scripts, which allows providers to:</p> <ul style="list-style-type: none"> • Submit prescriptions electronically • Verify client eligibility • Review medication history • Review formulary and PDL information <p>The formulary is also available for mobile devices on www.epocrates.com.</p>
Prescription Drugs (Outpatient Only) (continued)	<p>Additional outpatient prescription drug information:</p> <ul style="list-style-type: none"> • No copay is required for prescriptions. • Prior authorization is required for certain drugs. • We do not reimburse claims for diet aids, cosmetic or hair-growth drugs, erectile dysfunction drugs, or infertility drugs. • We limit over-the-counter drugs to those on the Medicaid formulary. • We have limited home health supplies available under the pharmacy benefit. All other medical supplies and equipment are available under the medical benefit. • We do not reimburse claims for nutritional products (enteral or parenteral) under the pharmacy benefit. Medical prior authorization is required. • We offer free prescription delivery from those Texas VDP approved delivery pharmacies in our pharmacy provider service area network. • We will coordinate or provide rides to the pharmacy if no other transportation is available.

Covered Benefit	Description
<p>Prescription Drugs (Outpatient Only) (continued)</p>	<p>Quantity Supply</p> <p>All medications will be limited to a one-month supply with a maximum 34-day supply at all retail pharmacies. If a medical condition warrants a greater quantity supply than the defined one-month supply of medication, prior authorization is available.</p> <p>Some over-the-counter supplies are available from pharmacies that are designated to provide Comprehensive Care Program (CCP) items for STAR children.</p> <p>Limited Home Health Supplies</p> <p>Limited home health supplies such as needles, syringes, test strips, monitors and aerosol holding chambers are covered under the pharmacy benefit. Claims for these supplies should be submitted as a pharmacy claim to Prime Therapeutics:</p> <p>STAR: 855-457-0405</p> <p>CHIP: 855-457-0403</p> <p>For more information about Limited Home Health Supplies, please refer to the Durable Medical Equipment section later in this chapter.</p> <p>340B Billing Requirements</p> <p>Pharmacies billing claims for drugs purchased under the 340B Drug Discount Program should identify these claims using National Council for Prescription Drug Program values as applicable.</p> <p>For more information on 340B Billing Requirements, please see Chapter 6: Claims and Billing.</p>
<p>Prescription Drugs - Specialty Medications</p>	<p>Specialty medications are high-cost injectable drugs that generally require close supervision and monitoring of the patient’s drug therapy. These drugs often require special handling such as temperature-controlled packaging and overnight delivery and are often unavailable at retail pharmacy stores.</p> <p>Self-injectable medications will be covered under the pharmacy benefit program. Self-injectable medications will be limited up to a 34-day supply per fill. Office-based injectables are covered under the member’s medical benefit. For questions about specialty drugs contact Prime:</p> <p>STAR: 855-457-0405</p> <p>CHIP: 855-457-0403</p>

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Covered Benefit	Description
<p>Prescription Drugs</p> <p>Emergency Prescription Supply</p>	<p>A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List (PDL) or because they are subject to clinical edits.</p> <p>The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member’s medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.</p> <p>The PDL is available online at www.txvendordrug.com/pdl/.</p> <p>A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.</p> <p>To be reimbursed for a 72-hour emergency prescription supply, pharmacies may enter an ‘8’ in field 461-EU (Prior Authorization Type Code) and code 801 in field 462-EV (Prior Auth Number Submitted), to override a 75/PA required rejection and submit a claim for a 72-hour emergency supply.</p> <p>Providers may call the Prime Help Desk for more information about the 72-hour emergency prescription supply policy:</p> <p>STAR: 855-457-0405</p> <p>CHIP: 855-457-0403</p>
<p>Prior Authorization</p>	<p>Prior authorization (PA) is required for all non-preferred and non-formulary medications that appear on the Texas Medicaid Formulary. PA is not available for drugs that are not covered or not included in this benefit. PA may be obtained by phone or by fax.</p> <p>STAR: 855-457-0405 Fax: 877-560-8055</p> <p>CHIP: 855-457-0403 Fax: 855-879-7180</p>

Covered Benefit	Description
<p>Public Health Services</p> <p>Essential Public Health Services and Resources</p>	<p>BCBSTX must provide the following Covered Services or refer to Public Health Entities:</p> <ul style="list-style-type: none"> • Testing for Sexually Transmitted Diseases (STDs) • Confidential HIV testing • Immunizations • Tuberculosis (TB) care • Family Planning services • Texas Health Steps medical checkups • Prenatal services • Texas Vaccines for Children (TVFC) Program <p>Please Note: These services may be provided without referral and members may self-refer.</p> <p>BCBSTX may contract with public health entities as well as physicians or other professional providers in private practice to supply these services.</p> <p>BCBSTX must coordinate with public health entities in each service area to provide essential public health care services. In addition to the requirements listed above or otherwise required under state law or this contract, the HMO must meet the following requirements:</p> <ul style="list-style-type: none"> • Report to public health entities regarding communicable diseases and/or diseases that are preventable by immunization as defined by state law • Notify the local public health entity, as defined by state law, of communicable disease outbreaks involving members • Educate members and providers regarding Women, Infants and Children (WIC) services available to members • Coordinate with local public health entities that have a child lead program, or with DSHS regional staff when the local public health entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure
<p>Radiology, Imaging and X-rays</p>	<p>Some services require prior authorization. Radiology services include:</p> <ul style="list-style-type: none"> • X-rays and noninvasive diagnostic testing • Mammograms for women 40 years of age and older • CTs and MRIs if medically necessary

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Covered Benefit	Description
<p>School Health and Related Services (SHARS)</p>	<p>School Health and Related Services (SHARS) is a Medicaid financing program and is a joint program of the Texas Education Agency and the Texas Health and Human Services Commission (HHSC). Primary care providers should educate eligible members about SHARS.</p> <p>SHARS allows local school districts/shared services arrangements (SSAs) to obtain Medicaid reimbursement for certain health-related services provided to students in special education. School districts/SSAs receive federal Medicaid money for SHARS services provided to students who meet all three of the following requirements:</p> <ol style="list-style-type: none"> 1. Be Medicaid eligible, 2. Meet eligibility requirements for Special Education described in the Individuals with Disabilities Education Act (IDEA), and 3. Have Individual Educational Plans (IEPs) that prescribe the needed services. <p>Services include:</p> <ul style="list-style-type: none"> • Assessment • Audiology • Counseling • School health services • Medical services • Occupational therapy • Physical therapy • Psychological services • Speech therapy • Special transportation <p>To learn more about SHARS, visit www.tmhp.com. BCBSTX is not responsible to pay for SHARS. SHARS claims are submitted to HHSC.</p>

<p>Texas Health Steps</p> <p>Texas Health Steps is also known as Early Periodic Screening and Diagnostic Tool (EPSDT)</p> <p>Case Management for Children and Pregnant Women</p>	<p>To be eligible for Children and Pregnant Women (CPW) case management services, a member must:</p> <ul style="list-style-type: none"> • Be eligible for Medicaid • Be a pregnant member with a high-risk condition, or a child (birth through 20 years of age) with a health condition or health risk • Be in need of services to prevent illnesses or medical conditions to maintain function or slow further deterioration • Agree to receive case management services. <p>Pregnant women with high-risk conditions are defined as having one or more medical and/or personal/psychosocial conditions.</p> <p>Children with certain high-risk health conditions are defined as being at risk of having a medical condition, illness, injury or disability that results in a limitation of function, activities or social roles as compared to healthy same-age peers in the general areas of physical, cognitive, emotional or social growth and development.</p> <p>To refer members to CPW services, contact the Texas Health Steps program at 877-847-8377 or visit the CPW provider list at: www.dshs.state.tx.us/caseman/providerRegion.shtm.</p> <p>A referral for CPW services can be received from any source. A Case Management provider will contact the family to offer a choice of providers and to obtain information necessary to request prior authorization for case management services.</p>
<p>Therapies</p>	<ul style="list-style-type: none"> • Physical • Occupational • Speech

Chapter 3

Covered Benefit	Description
<p>Transplants</p> <p>Transplantation of Organs and Tissues</p>	<p>Requires prior authorization. The following are considered medically needed transplants:</p> <ul style="list-style-type: none"> • Heart • Lungs • Combined heart and lung • Liver • Kidney • Cornea • Stem cell <p>The first transplant is covered, but only one future re-transplant because of rejection is allowed.</p>
<p>Transportation</p> <p>Medical Transportation Services Available through the Texas Health and Human Services Commission</p>	<p>The MTM is a free service for non-emergency medical transportation. Medicaid offers this service when Medicaid members have no other way to get to:</p> <ul style="list-style-type: none"> • A doctor's appointment • An appointment with another health care provider • A dental appointment • A pharmacy <p>For more information about the MTM program, call Customer Service: 888-657-6061; TTY: 711</p>
<p>Transportation Value-Added Service</p>	<p>Members who are having difficulty obtaining non-emergency transportation from the MTM can arrange for transportation from us by calling: Customer Service at 888-657-6061 or TTY (for hearing and speech impaired) 711.</p>

Covered Benefit	Description
<p>Tuberculosis Services Provided by DSHS-approved Providers (Directly observed therapy and contact investigation.)</p>	<p>Plan providers screen, diagnose and treat tuberculosis (TB). All confirmed or suspected cases are reported immediately (within 24 hours) to the Local Tuberculosis Control Health Authority (LTCHA). All Health and Human Services Commission (HHSC) reporting procedures are to be followed.</p> <p>A contact investigation and Directly Observed Therapy (DOT) referral is initiated. Upon request, LTCHA, HHSC and Department of Health Services (DHS) are given access to the medical records of members with suspected or confirmed TB. Any member who is noncompliant, drug-resistant or presents a public threat must be reported to the LTCHA.</p> <p>Additionally, network physicians and care coordinators will work closely with the Texas Department of State Health Services (DSHS) South Texas Hospital and Texas Center for Infectious Disease for voluntary and court-ordered admissions of members with drug resistant TB.</p> <p>Following treatment from a local TB program or inpatient hospital treatment, network physician and care coordinators will participate with post-discharge planning and safe re-entry into the community.</p>
<p>Vision</p>	<p>Annual routine eye health examination inclusive of refraction and dilation (when professionally indicated) at no cost. Prescription eyewear (if applicable) as follows:</p> <ul style="list-style-type: none"> • Spectacle lenses every year (clear plastic single vision, bifocal or trifocal lenses [any Rx] at no cost) • A large assortment of frames are available every year (see benefit guide for more information) at no cost • Enhanced eye wear for children offer as a Value-Added Service. • To arrange for a routine eye examination and fulfillment of glasses, contact Davis Vision: <p>Member Services: 888-588-4825; TTY: 800-523-2847</p> <p>Provider Services: 800-77DAVIS (800-773-2847); TTY: 800-523-2847</p> <p>Website: www.davisvision.com</p>

COORDINATION WITH STATE SERVICES

The State of Texas has chosen to provide certain member services under individual contracts with vendors and providers. While BCBSTX is not financially responsible for these services, BCBSTX will work closely with those providers and vendors to assure that members receive all medically appropriate and necessary services.

PCPs coordinate health services for their members, no matter where the services originate. The PCP is responsible for arranging and coordinating appropriate referrals to other providers and specialists and for managing, monitoring, and documenting the services of other providers.

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In addition to HMO coverage, STAR members are eligible for the services described below. BCBSTX and our network providers are expected to refer to and coordinate with these programs. These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM).

- Texas Health Steps Environmental Lead Investigation (ELI)
- Early Childhood Intervention (ECI) case management/service coordination (therapies are paid for by BCBSTX)
- Early Childhood Intervention specialized skills training
- Case Management for Children and Pregnant Women (CPW)
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services Blind Children’s Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Health and Human Services Commission’s Medical Transportation Program (MTP)
- Department of Aging and Disability Services (DADS) Hospice Services
- Personal Care Services for person’s birth through age 20
- Essential public health services and disaster relief services
- Women, Infants and Children (WIC), IMMTRAC immunization Registry, Texas Vaccines for Children (TVC), Texas Women’s Health Program, Childhood Lead Poisoning Testing Program

VALUE-ADDED SERVICES – STAR

Non-emergency Transportation Services

BCBSTX will offer a non-emergency transportation service to access covered services and health education classes when other transportation is not readily available or it is not feasible for a member to use the HHSC Medical Transportation Program. This benefit will assist members in keeping medical appointments and help improve health outcomes.

STAR members will be eligible for assistance only when state-provided transportation is unavailable or to assist the member to coordinate with the state provided transportation services.

The following member information must be provided to the intake operator at the time of the call:

- Medicaid ID number
- Name, address, and telephone number
- Name, address, and telephone number of the health care provider
- Purpose of the trip
- Affirmation that no other means of transportation are available
- Special needs, wheelchair lift, or attendant need

Limitations: BCBSTX transportation is available for STAR members when MTP is not available. NEMT requires 1-3 days minimum advanced scheduling and prior authorization.

Free Infant Car Safety Seat Program

The BCBSTX Free Infant Car Safety Seat Program encourages expectant members to receive early and ongoing prenatal care and promote infant safety. Pregnant members will be eligible for a free car seat by completing the following activities:

- Visit the doctor in the first trimester or within the first month of enrollment.
- Complete an appropriate number of prenatal visits based on their length of pregnancy at the time of enrollment. The number of prenatal visits is defined using the HEDIS definition of appropriate number of prenatal visits based on length of enrollment in the plan until time of delivery.
- Enroll in Special Beginnings[®] program.
- All expectant STAR members are eligible.

Limitations: Members must be pregnant and must complete the above listed activities in order to receive a free infant care safety seat.

Enhanced Eyewear for Children

BCBSTX offers an enhanced eyewear benefit, which exceeds state requirements and provides our child and adolescent members with an upgrade on stylish frames. All enrolled children ages 0 to 18 years of age are eligible to receive this enhanced eyewear benefit. Children are eligible for one enhanced pair per year for a maximum value of \$175.

Limitations: Available for STAR children ages 18 and under. Benefit is limited to one pair of stylish frames every year after completion of an eye exam. The maximum value of the frames will not exceed \$175.

24 Hour Nurse Advice Line

Help is available to members through a 24-hour, seven-day-a-week, toll-free Nurse Advice Line. Nurses are available to provide general health management information. Nurses deliver relevant information on health issues and community health services. Teens can call and confidentially speak to a nurse about adolescent health issues. The Nurse Advice Line also features an audiotape library with more than 300 health-related topics. The Nurse Advice Line uses interpreter services to accommodate the needs of members who are non-English speaking.

To contact the 24-Hour Nurse Advice Line call **844-971-8906** (TTY): **711**

Limitations: There are no limitations for this benefit. Members may access the Nurse Advice Line at any time.

Sports and Camp Physicals

BCBSTX will cover Sports and Camp Physicals performed by primary care providers once a year to encourage children's participation in sports and physical fitness programs. The goal of this program is to prevent childhood obesity by encouraging participation in physical activities. This benefit is available for all CHIP members aged 18 and under.

Limitations: Sports and Camp Physicals will be a covered benefit as provided by STAR providers. Sports and Camp Physicals are limited to STAR kids ages 18 and under.

Chapter 3

Pregnancy, Delivery and Newborn Care Classes

BCBSTX offers a comprehensive series of Pregnancy, Delivery and Newborn Care classes to encourage expectant members to receive early and ongoing prenatal care to promote healthy births. Pregnant members will be eligible for three delivery classes (one per trimester), or they can attend our one day overview class.

First trimester topics:	Second trimester topics:	Third trimester topics:
<ul style="list-style-type: none">• Stages and phases of labor• When to go and what to bring to the hospital• Lamaze coaching• Techniques of breathing and relaxation	<ul style="list-style-type: none">• Pain relief options• Variations in labor• Early recovery expectations• Cesarean section experience• Include a brief labor rehearsal	<ul style="list-style-type: none">• Newborn behaviors and appearance• Newborn genital care• Diapering, dressing and umbilical cord care• Newborn health and safety basics• Breast feeding basics

Classes will be offered at various locations in the community. All members are eligible for these classes no matter where they plan to deliver.

BCBSTX members who need transportation to classes are encouraged to utilize the BCBSTX transportation Value Added Service as described earlier in this chapter. Spanish-speaking classes are available. Members may request to attend a class taught in Spanish when registering for the class.

Limitations: STAR members must be pregnant. Classes will be offered at various community based locations, based on space availability.

Breast Feeding Coaching

BCBSTX will offer breast feeding coaching to interested expectant members. This coaching will provide practical information to prepare moms for breastfeeding.

Coaching topics will include:

- Benefits of breastfeeding to mother and baby
- How milk is made
- Infant feeding cues
- Mother and baby positioning
- Tips for success
- How to tell if infant is getting enough milk
- Problem prevention (sore nipples, engorgement)
- Options for feeding during separation from infant

Breast feeding coaching can be requested by calling Customer Service or Member Outreach.

Member Outreach will coordinate services by contacting the home health agency to schedule a breast feeding coaching visit by the In-home Wellness Nurse.

Limitations: All enrolled pregnant or newly delivered STAR women who are interested in breast feeding their newly delivered infant are eligible. The member must have delivered while on the Plan.

In-home Wellness Visits for Newborns and their Moms

BCBSTX will provide discharged newborns and their mom a home visit upon request from the member or from their PCP or OB/GYN. All members who have delivered on the Plan are eligible for the In-home Wellness visit. These services are also beneficial to all members with a high-risk pregnancy and/or who have been followed by Case Management.

Home visits will be conducted by a registered nurse within five days of discharge in an effort to reduce morbidity associated with common conditions that present in the postnatal period, but they can be requested at any time. The goal is to improve overall quality of care for newborns and their moms and reduce hospital based services.

If the home visiting nurse identifies issues that require referral of mom or baby to their OB/GYN or the newborn's PCP, the member will be referred to BCBSTX Case Management to ensure follow-up on any identified issues.

Limitations: STAR members must have delivered a live baby while on the Plan.

STAR Members can ask for a breast pump by calling their OB/GYN and asking them to order a pump through a durable medical equipment vendor or you can call an in-network durable medical equipment vendor directly to request a pump. The vendor will call the doctor for an order. Call Customer Service to get names of durable medical equipment vendors. If you need help getting a breast pump, call Member Outreach at **1-877-375-9097**.

BCBSTX Offers Farmers Market Vouchers for Pregnant Moms

BCBSTX is making it easier for pregnant members to maintain a healthy diet consisting of at least five servings of fruits and vegetables each day. Pregnant members will receive 10 vouchers, worth \$2 each toward the purchase of fresh produce from one of four selected farmers' markets in Travis County. Expecting members can request vouchers by contacting the BCBSTX Member Advocate. Members are eligible for 10 vouchers up to 2 times per pregnancy. That adds up to \$40 in fruit and vegetable purchases.

Limitations: Vouchers are redeemable for fresh fruits and vegetables at the market locations listed below:

- SFC East Market, 51st Street and 183 (YMCA)
- SFC Downtown, 4th and Guadalupe
- SFC Triangle, 46th and Lamar
- SFC Sunset Valley, 3200 Jones Road (Tony Burger Center)

No cash is provided if the member does not use the full value of the voucher. Members must provide their own transportation to the market. Pregnant moms can get 10 vouchers, up to two times per pregnancy. Upon request and validation of membership, the vouchers will be mailed within five days of the request. Members may request vouchers on four separate occasions with a minimum of two weeks between requests.

Chapter 3

Dental Services for Adult Pregnant Women

BCBSTX offers the following dental services to pregnant STAR members over age 21:

- Oral Exam
- Sealants
- Fillings
- Extractions
- Cleanings
- X-rays
- Scaling and planning

Members must see a participating dental provider within the Liberty Dental Network and may only receive benefits up to a maximum of \$250 annually.

Limitations: BCBSTX will provide dental care for pregnant women not covered by the STAR dental program. Adult pregnant women over age 21 enrolled in STAR. Members must see a participating dental provider in the network; benefits per scheduled treatment up to a maximum of \$500.

Safety Booster Seats for Kids

BCBSTX offers free children's safety booster seats for children ages 2 to 12 who have outgrown their baby car seat, and weigh between 30 to 100 pounds. To get the booster seat, the child must have a Well Child checkup or Texas Health Steps checkup within 90 days of signing up with BCBSTX, or a yearly Well Child checkup or Texas Health Steps checkup.

Limitations: Booster seat is for children 2-12 who have outgrown their infant car seat and meet the height and weight requirements for the booster seat. The booster seat is for kids 30 to 100 pounds and a maximum height of 57 inches. Parents or guardians are responsible for ensuring that their child meets the height/weight criteria that must be met to safely use the booster seat.

Safety Helmet for Kids

BCBSTX offers free safety helmets to help children stay safe while riding bikes, skate boards or doing other outdoor activities. Members ages 3 to 18 can receive a free safety helmet every two years. To get the safety helmet, the child must have a Well Child checkup or Texas Health Steps checkup within 90 days of signing up with BCBSTX, or a yearly Well Child checkup or Texas Health Steps checkup.

Limitations: Members are limited to one new safety helmet every other year. Members will be required to complete the appropriate paperwork and submit it to demonstrate that they met the criteria to receive a helmet.

Multi-lingual Glucometers

STAR members with diabetes who need help monitoring their blood sugar can receive a multi-lingual glucometer that speaks their tests results in English, Spanish, French and Arabic.

Limitations: the multi-lingual glucometer speaks English, Spanish, Arabic and French. Refills of testing strips may be obtained through Longhorn Health Solutions or other DME providers and is a covered benefit program under STAR. BCBSTX Medicaid diabetic members who are willing to enroll in the BCBSTX Condition Care program must request the multi-lingual glucometer and have a linguistic need.

Free Diaper Bag with New Baby Items

BCBSTX will provide pregnant or newly delivered members who have attended our pregnancy classes with a free diaper bag that includes new baby items.

Limitations: Members must be on the Plan to be eligible. Members also need to have attended one BCBSTX approved prenatal education class to be eligible to request the gift. Moms must attend the pregnancy class graduation ceremony to get their diaper bag of items.

Hands-free Breast Pump Bra

BCBSTX will provide mothers who deliver on our Plan and who are breastfeeding a hands-free breast feeding bra. The bra will be provided during the In-home Wellness Visit.

Limitations: Members must be on the Plan to be eligible. Members must have also delivered their new baby on the Plan and be willing to meet with the In-home Wellness Nurse to have the bra delivered.

Breast Feeding Support Kit Gift

Pregnant members who are breast feeding will be eligible for a breast-feeding support kit gift. This gift will be delivered by the In-home Wellness Nurse. The kit includes disposable breast milk bags, soothing breast pads, breast soothing cream, a breast milk storage tracking refrigerator magnet, nipple protectors and a case. These items are provided to members who can benefit from use after working with the In-home Wellness Nurse.

Limitations: Members must have delivered while on our Plan and notify BCBSTX upon delivery. Members have up to 30 days post-delivery to contact the Plan to request the support kit. Members who breast feed must be willing to have an In-home Wellness Visit to receive the breast-feeding support kit, which will be delivered during the visit. Breast nipple protectors are handed out to members by the In-home Wellness Nurse as needed.

Prenatal Doctor Visit Incentive

Pregnant members who complete their first prenatal visit within the first trimester or 42 days of enrolling in the Plan will be eligible to request a \$25 gift card. Providers will be asked to sign the form to verify an eligible visit has occurred.

Limitations: Pregnant members must have completed a prenatal visit within the first trimester of their pregnancy or within 42 days of enrolling in the Plan. Members have to complete the documentation and send it in to request the gift card. Members must be active on the Plan to receive the gift card.

Postpartum Visit Incentive

Newly delivered members are eligible to request a \$50 gift card by completing their postpartum visit between 21 and 56 days post-delivery.

Limitations: Newly delivered members who delivered their baby on our plan must have completed a post-partum visit between 21 and 56 days post-delivery. Members have to complete the documentation and send it in to request the gift card. Members must be active on the Plan to receive the gift card. Providers will be asked to sign the form to verify a timely postpartum visit has occurred.

Chapter 3

Timely Well Child Checkups Incentive

Child members within a defined age range are eligible to request a \$50 gift card when they complete the required well child checks:

- 15 Months old: six checkups by age 15 months of age
- 3-6 Years old: one checkup by the end of the calendar year
- 12-20 Years old: one checkup by the end of the calendar year

Limitations: Parents or guardians of child members must ensure their child member completes a well child check to qualify. Members or a parent or guardian of under-aged members have to complete the documentation and send it in to request the gift card. Members must be active on the Plan to receive the gift card. Providers will be asked to sign the form to verify a timely postpartum visit has occurred.

ADDITIONAL BENEFITS

Care Van Program

BCBSTX works with the Caring for Children Foundation of Texas, Inc. to make the Care Van Program available to members enrolled in the STAR program. The Care Van Program has delivered hundreds of thousands of immunizations to date.

The Care Van Program conducts 50 outreach immunization clinics in the Travis Service Area each year, helping to ensure that members receive needed immunizations. All enrolled STAR Members are eligible to receive immunizations at Care Van clinics.

To view a listing of Care Van Immunization Events go to the Care Van website at www.carevan.org/care_van_program.htm

To schedule the Care Van for your clinic or health-related event call **800-258-5437** and select Option 1 or send an e-mail to info@carevan.org.

Text4baby

BCBSTX offers this free mobile information program to all pregnant CHIP members. The program gives pregnant women and new moms tips to help care for their health and give their babies the best start in life they can have. Members who sign up for this service get free SMS text messages each week, timed to their due date or the baby's first birthday. Members can sign up for the service by texting **BABY to 511411 (or BEBE for Spanish messages)**. Members can use this service from the time they find out they are pregnant through the baby's first birthday. To sign up for this service, go to the link below and follow the directions. text4baby.org. Data fees/charges may apply.

PRIOR AUTHORIZATION GUIDELINES

Services Requiring Prior Authorization

The services listed below require prior authorization (PA). This list will be updated as needed. Providers are responsible for verifying eligibility and authorization for non-emergency services prior to rendering services to a BCBSTX Member. For benefits to be paid, the member must be eligible on the date of service and the service must be a covered benefit. Except in an emergency, failure to obtain prior authorization for the designated services below may result in a denial for reimbursement.

iExchange, our Web based prior authorization tool, provides you with real-time responses for direct submission of inpatient admissions and select outpatient medical services, and enables you to send prior authorization submissions after hours and on weekends. For additional information about iExchange, including how to register, visit the Provider Tools page on our Provider website at www.bcbstx.com/provider/tools/iexchange_index.html.

BCBSTX offers a variety of forms to obtain authorization prior to rendering services. You will find this toolkit on the Provider Resources webpage under **Prior Authorization Requirements** at <http://www.bcbstx.com/provider/Medicaid/forms.html>. Here are some tips for getting the fastest response to your authorization request:

- Access forms online as needed, rather than pre-printing and storing them. We revise forms periodically and outdated forms can delay your request.
- Fully complete forms before printing and faxing. Unanswered questions typically result in delays.

Services requiring prior authorization include, but are not limited to, the following:

- Inpatient hospital care
- Outpatient surgical services delivered in an ambulatory surgical center or outpatient hospital setting
- Outpatient observation status (in a hospital setting)
- Selected durable medical equipment (DME)
- Formula
- Home health care
- Sensory integration therapy
- All infusion therapies
- Physical, Occupational and Speech therapy (not evaluations)
- Radiology Services - PET/SPECT scans, CTAs and MRIs
- Cosmetic procedures
- Experimental and investigational therapies
- Cardiac and pulmonary rehabilitation
- Transplants
- Hospice
- Skilled Nursing Facilities (SNFs)
- Out-of-network specialist referrals
- Out-of-network services, except family planning, emergency services, chiropractic services and dialysis

For instructions regarding Prior Authorization, see **Services Requiring Prior Authorization** in **Chapter 10: Utilization Management**.

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FORMULARY AND PRIOR AUTHORIZATION (PA)

Select medications on the formulary may require prior authorization. Medication utilization must meet FDA approved indications as well as BCBSTX STAR guidelines. If a medication requires prior authorization, a PA form must be completed by the prescriber for submission to BCBSTX.

To obtain a PA form and a list of drugs that require prior authorization, go to bcbstx.com/provider/Medicaid/rx_prior_auth.html or call Prime Therapeutics' Prior Authorization department at **855-457-0407**.

Fax: Please fax your PA forms to **877-243-6930**. To expedite request and review time, an online PA may be submitted via covermymeds.com.

MEDICAID (STAR) PROGRAM LIMITATIONS AND EXCLUSIONS

Refer to the Texas Medicaid Provider Procedures Manual for the most current information regarding limitations and exclusions. The following services, supplies, procedures, and expenses are NOT benefits of BCBSTX. This list is not all-inclusive:

- Autopsies
- Biofeedback therapy
- Care and treatment related to any condition for which benefits are provided or available under Workers' Compensation laws
- Cellulartherapy
- Chemolase injection (chymodiactin, chymopapain)
- Custodial care
- Dentures or endosteal implants for adults
- Ergonovine provocation test
- Excisetax
- Fabric wrapping of abdominal aneurysms
- Hair analysis
- Heart–lung monitoring during surgery
- Certain health care acquired conditions (HCAC)
- Histamine therapy–intravenous
- Hyperthermia
- Hysteroscopy for infertility

- Immunizations or vaccines unless they are otherwise covered by Texas Medicaid (These limitations do not apply to services provided through the Texas Health Steps Program) **Note:** Flu shots are covered.
- Immunotherapy for malignant diseases
- Infertility
- Inpatient hospital services to a client in an institution for tuberculosis, behavioral disease, or a nursing section of public institutions for the mentally retarded
- Inpatient hospital tests that are not specifically ordered by a physician/doctor who is responsible for the diagnosis or treatment of the client's condition
- Intra-gastric balloon for obesity
- Joint sclerotherapy
- Keratoprosthesis/refractive keratoplasty
- Laetrile
- Mammoplasty for gynecomastia
- More than \$200,000 per member per benefit year (November 1 through October 31) for any medical and remedial care services provided to a hospital inpatient by the hospital. If the \$200,000 amount is exceeded because of an admission for an approved organ transplant, the allowed amount for that claim is excluded from the computation. This limitation does not apply to members eligible for the Comprehensive Care Program (CCP). Unlike fee-for-service Medicaid, there is no spell-of-illness limitation for STAR members in managed care and the \$200,000 annual limit on inpatient services does not apply to STAR members.
- Obsolete diagnostic tests
- Oral medications, except when billed by a hospital and given in the emergency room or the inpatient setting (hospital take-home drugs or medications given to the client are not a benefit)
- Orthotics (except Comprehensive Care Program [CCP])
- Outpatient and non-emergency inpatient services provided by military hospitals
- Outpatient behavioral health services performed by a Licensed Chemical Dependency Counselor (LCDC), psychiatric nurse, behavioral/health worker, non-LCSW social worker, or psychological associate (excluding a masters-level licensed psychological associate [LPA]) regardless of physician or licensed psychologist supervision
- Oxygen (except Comprehensive Care Program [CCP] and home health)
- Parenting skills
- Payment for eyeglass materials or supplies regardless of cost if they do not meet Texas Medicaid specifications
- Payment to physicians for supplies is not an allowable charge. All supplies, including anesthetizing agents such as xylocaine, inhalants, surgical trays, or dressings, are included in the surgical payment
- Podiatry, optometric, and hearing aid services in long term care facilities, unless ordered by the attending physician

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- Private room facilities except when a critical or contagious illness that results in disturbance to other patients and is documented as such exists. **Exceptions:**
 - When it is documented that no other rooms are available for an emergency admission
 - When the hospital only has private rooms
- Procedures and services considered experimental or investigational
- Prosthetic and orthotic devices (except Comprehensive Care Program [CCP])
- Prosthetic eye or facial quarter
- Quest test (infertility)
- Recreational therapy
- Review of old X-ray films
- Routine cardiovascular and pulmonary function monitoring during the course of a surgical procedure under anesthesia
- Separate fees for completing or filing a Medicaid claim form. The cost of claims filing is to be incorporated in the Provider's usual and customary charges to all members.
- Services and supplies to any resident or inmate in a public institution
- Services or supplies for which benefits are available under any other contract, policy, or insurance, or which would have been available in the absence of Texas Medicaid
- Services or supplies for which claims were not received within the filing deadline
- Services or supplies not reasonable and necessary for diagnosis or treatment
- Services or supplies not specifically provided by Texas Medicaid
- Services or supplies provided in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member, or when prior authorized for specific purposes by TMHP (including removal of keloid scars)
- Services or supplies provided outside of the U.S., except for deductible and coinsurance portions of Medicare benefits as provided for in this manual

- Services or supplies provided to a member after a finding has been made under utilization review procedures that these services or supplies are not medically necessary
- Services or supplies provided to a Texas Medicaid member before the effective date of his or her designation as a member, or after the effective date of his or her denial of eligibility
- Services payable by any health, accident, other insurance coverage, or any private or other governmental benefit system, or any legally liable third party
- Services provided by an interpreter (except sign language interpreting services requested by a physician)
- Services provided by ineligible, suspended, or excluded providers
- Services provided by the member's immediate relative or household member
- Services provided by Veterans Administration facilities or U.S. Public Health Service Hospitals
- Sex change operations
- Silicone injections
- Social and educational counseling except for certain health and disability related and counseling services
- Sterilization reversal
- Sterilizations (including vasectomies) unless the member 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 (commercial or decorative only)
- Telephone calls with members or pharmacies (except as allowed for case management)
- Thermogram
- Treatment of flatfoot conditions for solely cosmetic purposes

Unlike fee-for-service Medicaid, there is no spell-of-illness limitation for STAR members in managed care and the \$200,000 annual limit on inpatient services does not apply to STAR members.

Chapter 3

Durable Medical Equipment and Other Products Normally Found in a Pharmacy

BCBSTX reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment. Limited home health supplies such as needles, syringes, monitors, test strips, and aerosol holding chambers are available under the pharmacy benefit. The benefit also includes glucose monitors with special features to address certain medical exceptions. For more information on the limited home health supplies available under this benefit, please refer to the Vendor Drug Program (VDP) website at www.txvendordrug.com/formulary/limited-hhs.shtml.

Please note that standard home glucose monitors (procedure code E0607) are not a BCBSTX STAR benefit, however the related test strips are. In addition, glucose monitors that have been purchased are anticipated to last a minimum of three years and may be considered for replacement when three years have passed or the equipment is no longer repairable.

A multi-lingual talking meter is available to STAR members as a Value-Added Service. Contact Member Outreach to request a multi-lingual talking meter:

Member Outreach: **877-375-9097**

Member Outreach fax: **512-349-4867**

Providers are required to submit all claims for limited home health supplies through the Pharmacy Payment System. **These claims (STAR only) will now be processed as a pharmacy benefit, not a medical benefit. All CHIP DME should continue to be filed as a medical benefit.**

For children (birth through age 20), BCBSTX also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through 20), a pharmacy must first be enrolled as a DME provider. Pharmacies in the BCBSTX/Prime network that wish to provide DME services, and are enrolled on the TMHP website as DME providers, may complete a DME Provider Contract with BCBSTX to provide these services. Please contact your Provider Representative at **855-212-1615** to receive DME Provider Contract information.

Once a pharmacy is contracted as a DME provider, claims may be submitted with the billing NPI and rendering NPI (as appropriate) on the CMS 1500 claim form. Call **877-560-8055** for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20). Claims for limited home health supplies may be submitted to Prime Therapeutics.



Chapter 4

CHIP Member Benefits

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CHIP COVERED SERVICES

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Behavioral Health Services - Inpatient	<p>Behavioral health services, including services for serious behavioral 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> <ul style="list-style-type: none"> • Neuropsychological and psychological testing • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • Does not require PCP referral 	<p>Not a covered benefit.</p>
Behavioral Health Services - Outpatient	<p>Behavioral health services, including services for serious behavioral/mental illness, provided on an outpatient basis, including, but not limited to:</p> <ul style="list-style-type: none"> • Visits offered in a variety of community based settings (including school and home-based) or in a state-operated facility • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. 	<p>Not a covered benefit.</p>

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Behavioral Health Services - Outpatient (continued)	<p>A Qualified Behavioral Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be Providers working through a DSHS-contracted Local Behavioral/Mental Health Authority or a separate DSHS-contracted entity.</p> <p>QMHP-CSs shall be supervised by a licensed behavioral health professional or physician and provide services in accordance with DSHS standards.</p> <p>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>	
Case Management and Care Coordination Services	<p>These services include outreach education, case management, care coordination and community referral.</p>	<p>Not a covered benefit.</p>
Chiropractic Services	<p>Services do not require physician prescription and are limited to spinal subluxation.</p>	<p>Not a covered benefit.</p>
Delivery and Post-Partum Care	<p>Covered Services include:</p> <ul style="list-style-type: none"> • Child’s benefit begins at birth and ends on last day of 12-month continuous eligibility period. 	<ul style="list-style-type: none"> • Birth-related services only for pregnant member, and coverage ends on last day of month in which they give birth. <p>Exception: Member receives two (2) post-partum visits even if it is beyond last day of birth month.</p>

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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
<p>Durable Medical Equipment</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> <ul style="list-style-type: none"> • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements <p>Advance Practice Registered Nurses (APRNs) and Physician Assistants (PAs) are prohibited from prescribing any durable medical equipment (including limited home health supplies) and outpatient schedule 11 controlled substance for Medicaid clients. This includes any product dispensed through the pharmacy.</p>	<p>Not a covered benefit.</p>

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
<p>Emergency Services, including Emergency Hospitals, Physicians and Ambulance Services</p>	<p>Authorization is not required as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day/ seven day a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level I and Level II Trauma Centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin. 	<p>BCBSTX cannot require authorization as a condition for payment for emergency conditions related to labor with delivery.</p> <ul style="list-style-type: none"> • Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth • Emergency services based on prudent layperson definition of emergency health condition • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child • Stabilization services related to the labor with delivery of the covered unborn child <p>Emergency ground, air and water transportation for labor and threatened labor is a covered benefit.</p> <p>Emergency ground, air and water transportation for an emergency associated with:</p> <ol style="list-style-type: none"> a. Miscarriage or b. A non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. <p>Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are</p>

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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Home and Community Health Services	<p>Services that are provided in the home and community, including, but not limited to:</p> <ul style="list-style-type: none"> • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies • Services are not intended to replace the child's caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services 	<p>Not a covered benefit.</p>
Hospice Care Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness • Up to a maximum of 120 days with a 6-month life expectancy • Patients electing hospice services may cancel this election at anytime • Services apply to the hospice diagnosis 	<p>Not a covered benefit.</p>

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Hospital Services – Inpatient Inpatient General Acute and Inpatient Rehabilitation Hospital Service	Services include, but are not limited to: <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 	For CHIP Perinates in families with incomes at or below 186% of the Federal Poverty Level, the facility charges are not a covered benefit, however, professional services charges associated with labor with delivery are a covered benefit. Hospitals bill TMHP under the Emergency Medicaid Program. For CHIP Perinates in families with income above 186% to 201% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or non-viable pregnancy. Services include: <ul style="list-style-type: none"> • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component)
Hospital Services – Inpatient Inpatient General Acute and Inpatient Rehabilitation Hospital Services (continued)	Services include, but are not limited to: <ul style="list-style-type: none"> • 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 and so on) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to Department of State Health Services • (DSHS)-designated Level III perinatal centers or hospitals meeting equivalent levels of care 	Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to (a) miscarriage or (b) non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> • Dilation and curettage (D&C) procedures • Appropriate provider-administered medications • Ultrasounds • Histological examination of tissue samples

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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
<p>Hospital Services – Inpatient</p> <p>Inpatient General Acute and Inpatient Rehabilitation Hospital Services (continued)</p>	<p>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.</p> <p>Hospital, physician and related medical services, such as anesthesia, associated with dental care.</p> <p>Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero)</p> <p>Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:</p> <ul style="list-style-type: none"> • Dilation and curettage (D&C) procedures • Appropriate provider-administered medications • Ultrasounds • Histological examination of tissue samples • Surgical implants • Other artificial aids including surgical implants 	

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
<p>Hospital Services – Inpatient</p> <p>Inpatient General Acute and Inpatient Rehabilitation</p> <p>Hospital Services (continued)</p>	<p>Inpatient services for a mastectomy and breast reconstruction include:</p> <ul style="list-style-type: none"> • All stages of reconstruction on the affected breast • External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed • Surgery and reconstruction on the other breast to produce symmetrical appearance; and • Treatment of physical complications from the mastectomy and treatment of lymphedemas <p>Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit.</p> <p>Pre-surgical or post-surgical orthodontic services for anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:</p> <ul style="list-style-type: none"> • Cleft lip and/or palate • Severe traumatic skeletal and/or congenital craniofacial deviations • Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment 	

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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
<p>Hospital Services - Outpatient</p> <p>Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center), and Ambulatory Health Care Center</p> <p>(continued)</p>	<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 	<p>Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:</p> <ul style="list-style-type: none"> • X-ray, imaging and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs • Outpatient services associated with (a) a miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) • Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: <ul style="list-style-type: none"> • Dilation and curettage (D&C) procedures • Appropriate provider-administered medications • Ultrasounds • Histological examination of tissue samples

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
<p>Hospital Services - Outpatient</p> <p>Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center), and Ambulatory Health Care Center</p> <p>(continued)</p>	<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"> • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products <p>Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero)</p> <p>Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:</p> <ul style="list-style-type: none"> • Dilation and curettage (D&C) procedures; • Appropriate provider-administered medications; • Ultrasounds, and • Histological examination of tissue samples. • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility • Surgical implants • Other artificial aids including surgical implants 	<p>Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Laboratory and radiological services that directly relate to antepartum care and/or the delivery of the covered CHIP Perinate until birth. 2. Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or non-viable pregnancy. 3. Amniocentesis, cordocentesis, fetal intrauterine transfusion (FIUT) and ultrasonic guidance for cordocentesis, FIUT are covered benefits with an appropriate diagnosis. 4. Laboratory tests are limited to: non-stress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.

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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
<p>Hospital Services - Outpatient</p> <p>Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center), and Ambulatory Health Care Center</p> <p>(continued)</p>	<p>Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:</p> <ul style="list-style-type: none"> • All stages of reconstruction on the affected breast • External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed • Surgery and reconstruction on the other breast to produce symmetrical appearance • Treatment of physical complications from the mastectomy and treatment of lymphedemas <p>Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit.</p> <p>Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:</p> <ul style="list-style-type: none"> • Cleft lip and/or palate • Severe traumatic skeletal and/or congenital craniofacial deviations • Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment 	<p>5. Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.</p>

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Physician/ Physician Extender Professional Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screenings and immunizations), and screening for behavioral health problems and behavioral health disorders • Physician office visits, inpatient and outpatient services • Laboratory, X-rays, imaging and pathology services, including technical component and/or professional interpretation • Medications, biologicals and materials administered in physician's office • Allergy testing, serum and injections 	<p>Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Medically necessary physician services for prenatal and postpartum care and/or the delivery of the covered unborn child until birth • Physician office visits, inpatient and outpatient services • Laboratory, X-rays, imaging and pathology services including technical component and/or professional interpretation • Medically necessary medications, biologicals and materials administered in physician's office
Physician/ Physician Extender Professional Services (continued)	<p>Services include, but are not limited to (continued):</p> <ul style="list-style-type: none"> • Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> – Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care – Administration of anesthesia by physician (other than surgeon) or Certified Registered Nurse Anesthetist (CRNA) – Second surgical opinions – Same-day surgery performed in a hospital without an overnight stay – Invasive diagnostic procedures such as endoscopic examinations – Hospital-based physician services, including physician-performed technical and interpretive components 	<p>Services include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Professional component (in/outpatient) of surgical services, including: <ul style="list-style-type: none"> – Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. – Administration of anesthesia by a physician (other than surgeon) or CRNA – Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.

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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Physician/ Physician Extender Professional Services (continued)	<p>Physician and professional services for a mastectomy and breast reconstruction include:</p> <ul style="list-style-type: none"> • All stages of reconstruction on the affected breast; • External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed • Surgery and reconstruction on the other breast to produce symmetrical appearance; and • Treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). 	<p>Professional component of inpatient/outpatient surgical services (continued):</p> <ul style="list-style-type: none"> • Surgical services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) • Hospital-based physician services (including Physician performed technical and interpretive components). • Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation. • Professional component of amniocentesis, cordocentesis, Fetal Intrauterine Transfusion (FIUT) and ultrasonic guidance for amniocentesis, cordocentesis, and FIUT.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Physician/ Physician Extender Professional Services (continued)	<p>Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to:</p> <ul style="list-style-type: none"> • Dilation and curettage (D&C) procedures • Appropriate provider-administered medications • Ultrasounds • Histological examination of tissue samples • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: <ul style="list-style-type: none"> – Cleft lip and/or palate – Severe traumatic skeletal and/or congenital craniofacial deviations – Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment. 	<p>Professional component associated with</p> <ol style="list-style-type: none"> a. A miscarriage or b. A nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). <p>Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to:</p> <ul style="list-style-type: none"> • Dilation and curettage (D&C) procedures; • Appropriate provider-administered medications; • Ultrasounds, and • Histological examination of tissue samples.

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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
<p>Prenatal Care and Pre-Pregnancy Family Services and Supplies</p>	<p>Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services.</p> <p>Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.</p>	<p>Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include:</p> <ul style="list-style-type: none"> • One visit every four weeks for the first 28 weeks of pregnancy; • One visit every two to three weeks from 28 to 36 weeks of pregnancy; and • One visit per week from 36 weeks to delivery. <p>More frequent visits are allowed as medically necessary. Benefits are limited to 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy.</p> <p>More frequent visits may be necessary for high-risk pregnancies.</p> <p>High-risk prenatal visits are not limited to 20 visits per pregnancy.</p> <p>Documentation supporting medical necessity must be maintained in the physician’s files and is subject to retrospective review.</p>

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Prenatal Care and Pre-Pregnancy Family Services and Supplies (continued)		Visits after the initial visit must include: <ul style="list-style-type: none"> • Interim history (problems, marital status, fetal status); • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities), and • Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative • Women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client)

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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)															
<p>Prescription Drug Benefits</p>	<p>CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug. Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals • Drugs and biologicals provided in an inpatient setting <table border="1" data-bbox="305 766 932 1234"> <thead> <tr> <th data-bbox="310 772 630 867">Federal Poverty Level (FPL)</th> <th data-bbox="634 772 786 867">Generic</th> <th data-bbox="790 772 927 867">Brand</th> </tr> </thead> <tbody> <tr> <td data-bbox="310 873 630 930">At or below 100%</td> <td data-bbox="634 873 786 930">\$0</td> <td data-bbox="790 873 927 930">\$3</td> </tr> <tr> <td data-bbox="310 936 630 1031">Up to and including 151% of FPL</td> <td data-bbox="634 936 786 1031">\$0</td> <td data-bbox="790 936 927 1031">\$5</td> </tr> <tr> <td data-bbox="310 1037 630 1131">Above 151% through 186%</td> <td data-bbox="634 1037 786 1131">\$10</td> <td data-bbox="790 1037 927 1131">\$35</td> </tr> <tr> <td data-bbox="310 1138 630 1232">Above 186% through 201%</td> <td data-bbox="634 1138 786 1232">\$10</td> <td data-bbox="790 1138 927 1232">\$35</td> </tr> </tbody> </table> <p>Prime Therapeutics offers e-prescribing administered through Prime Therapeutics, which allows providers to:</p> <ul style="list-style-type: none"> • Submit prescriptions electronically, • Verify client eligibility, • Review medication history, and • Review formulary information. <p>For additional information visit the website www.txvendordrug.com.</p> <p>The formulary is also available for mobile devices on www.epocrates.com.</p>	Federal Poverty Level (FPL)	Generic	Brand	At or below 100%	\$0	\$3	Up to and including 151% of FPL	\$0	\$5	Above 151% through 186%	\$10	\$35	Above 186% through 201%	\$10	\$35	<p>Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals • Drugs and biologicals provided in an inpatient setting <p>CHIP Perinate has no copayments for this benefit.</p> <p>BCBSTX offers e-prescribing abilities through Prime Therapeutics for providers to:</p> <ul style="list-style-type: none"> • Submit prescriptions electronically, • Verify client eligibility, • Review medication history, and • Review formulary information. <p>For additional information visit the website www.txvendordrug.com.</p> <p>The formulary is also available for mobile devices on www.epocrates.com.</p>
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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Prescription Drug Benefits – Continued	<p>Limited Home Health Supplies</p> <p>Limited home health supplies such as needles, syringes, test strips, monitors and aerosol holding chambers are covered under the pharmacy benefit. Claims for these supplies should be submitted as a pharmacy claim to Prime Therapeutics:</p> <p>CHIP: 855-457-0403</p>	<p>Limited Home Health Supplies</p> <p>Limited home health supplies such as needles, syringes, test strips, monitors and aerosol holding chambers are covered under the pharmacy benefit. Claims for these supplies should be submitted as a pharmacy claim to Prime Therapeutics:</p> <p>CHIP: 855-457-0403</p>

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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
<p>Prescription Drugs (Outpatient Only)</p>	<p>Prime Therapeutics LLC administers the BCBSTX pharmacy benefit for CHIP Members. These benefits cover outpatient prescription drugs obtained through any in-network pharmacy based on medical necessity. Members may obtain medication from any network pharmacy.</p> <p>The formulary is used to administer pharmacy benefits for BCBSTX CHIP members. The goal of the formulary is to ensure that members receive therapeutically appropriate and cost-effective drug therapy. Since the formulary promotes rational, scientific care based on consideration of published clinical studies, Food and Drug Administration (FDA) data, community standards, and cost-benefit evaluations, the formulary serves as a primary reference in the selection of medications for CHIP members. The formulary is reviewed and, as necessary, updated once per quarter. Providers should always refer to the website for accurate formulary lists.</p> <p>Please refer to the formulary for a list of covered drugs. To view the formulary and for additional information, go to www.txvendordrug.com. The formulary is also available for mobile devices on www.epocrates.com.</p> <p>BCBSTX offers e-prescribing abilities through Prime Therapeutics for Providers to:</p> <ul style="list-style-type: none"> • Verify client eligibility, • Review medication history, and • Review formulary and PDL information. • Above 100% through 151% FPL: Generic \$0; Brand \$5 • Above 151% through 186% FPL: Generic \$10, Brand \$35 • Above 186% through 201% FPL: Generic \$10; Brand \$35 • Prior authorization is required for certain drugs • Over the counter medications are not covered in the CHIP prescription benefit • We do not cover diet aids, cosmetic or hair-growth drugs, erectile dysfunction drugs, or drugs for infertility • We do not reimburse claims for nutritional products (enteral or parenteral), medical supplies or equipment under the pharmacy benefit • We offer free prescription delivery from those Texas VDP approved delivery pharmacies in our Pharmacy Provider Service Area network. <p>Quantity Supply: All medications will be limited to a one-month supply with a maximum 34-day supply at all retail pharmacies. If a medical condition warrants a greater quantity supply than the defined one-month supply of medication, then prior authorization (PA) is available.</p>	

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Prior Authorization	<p>Prior authorization (PA) is required for all non-formulary medications that appear on the Texas Medicaid Formulary. PA is not available for drugs that are not covered or not included in this benefit. PA may be obtained by phone or by fax.</p> <p>Prime Therapeutics BIN 011552 PCN; TXCAID TX CHIP Pharmacy Help Desk: 855-457-0403 TX STAR Pharmacy Help Desk: 855-457-0405</p>	
Specialty Medications	<p>Specialty medications are high-cost injectable drugs that generally require close supervision and monitoring of the patient's drug therapy. These drugs often require special handling such as temperature-controlled packaging and overnight delivery and are often unavailable at retail pharmacy stores.</p> <p>Self-injectable medications will be covered under the pharmacy benefit program, limited up to a 34-day supply per fill.</p> <p>Office-based injectables are covered under the medical benefit.</p>	

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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Emergency Prescription Supply	<p>A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), such as those that are subject to clinical edits.</p> <p>The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing Provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.</p> <p>A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply. The 72-hour emergency supply is not applicable if the three-prescription limit has been reached.</p>	
Rehabilitation Services	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services including, but not limited to physical, occupational and speech therapy. • Developmental assessment. 	<p>Not a covered benefit.</p>
Skilled Nursing Facilities (SNFs) (includes rehabilitation hospitals)	<p>Services include, but are not limited to:</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 	<p>Not a covered benefit.</p>

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Substance Abuse - Inpatient Substance Abuse Treatment Services	<p>Services include, but are not limited to:</p> <p>Inpatient and residential substance abuse treatment services including detoxification, crisis stabilization, and 24-hour residential rehabilitation programs.</p> <p>Does not require PCP referral.</p> <p>Services provided by:</p> <p>Magellan: 800-327-7390</p> <p>TTY: 800-735-2988</p> <p>www.magellanprovider.com</p>	<p>Not a covered benefit.</p>
Substance Abuse - Outpatient Substance Abuse Treatment Services (continued)	<p>Services include, but are not limited to:</p> <ul style="list-style-type: none"> • Prevention and intervention services provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for 4 to 12 weeks, but less than 24 hours per day. • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skill training • Does not require PCP referral 	<p>Not a covered benefit.</p>
Tobacco Cessation Program	<p>Covered up to \$100 for a 12-month limit for a plan-approved program. May be subject to formulary requirements.</p>	<p>Not a covered benefit.</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>	<p>Not a covered benefit.</p>

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Covered Benefit	CHIP Members and CHIP Perinate Newborn Members Description	CHIP Perinate Members (Unborn Child)
Transportation: Value-Added Service	Members can arrange for transportation from us by calling Customer Service: 888-657-6061 TTY 711	Members can arrange for transportation from us by calling Customer Service: 888-657-6061 TTY 711
Vision Benefit (through Davis Vision)	Annual routine eye health examination inclusive of refraction and dilation (when professionally indicated) at no cost. Prescription eyewear (if applicable) as follows: <ul style="list-style-type: none"> • Spectacle lenses every year (clear plastic single vision, bifocal or trifocal lenses, any prescription, at no cost) • A large assortment of frames are available every year (see benefit guide for more information) at no cost • Free one year breakage warrantee on Davis Vision supplied material • Medically necessary contacts paid in full with prior approval 	Not a covered benefit.

Covered services must meet the CHIP definition of medically necessary covered services. There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations apply to certain services, as specified in the benefit matrix, above. There is no spell-of-illness limitation for CHIP and C
HIP Perinate Newborn Members.

VALUE-ADDED SERVICES – CHIP AND CHIP PERINATE

Non-Emergency Transportation Services

BCBSTX will offer non-emergency transportation services to access covered services and health education classes when other transportation is not readily available or feasible for a member to use. This benefit will assist members in keeping medical appointments and help improve health outcomes.

The following member information must be provided to the intake operator at the time of the call:

- CHIP ID number
- Name, address, and telephone number
- Name, address, and telephone number of the health care provider
- Purpose of the trip
- Affirmation that no other means of transportation are available
- Special needs, wheelchair lift, or attendant need

Services and benefits available include:

- Transportation to and from appointment
- Lodging assistance
- Meal assistance

All lodging and meals expenses will require prior approval. They will only be approved for prior approved medical appointments that are over 75 miles from the member's home. There is a daily limit of \$120 per night for lodging and \$50 per day for meals with a total maximum amount of \$1000 within a 12-month period. These expenses will be reimbursed once the member turns in receipts for their approved travel costs.

Limitations: BCBSTX transportation is available for CHIP and CHIP Perinate members for approved rides in the service area when the distance is less than 75 miles. Prior authorization is required. If the distance is over 75 miles, lodging and food allowances are included for CHIP members and one parent, guardian or authorized caregiver only. This does not apply to CHIP Perinate members. All lodging and meal expenses for CHIP members will require three days prior approval. Approval for BCBSTX transportation overnight lodging and transport may be approved in less than three days on a case by case basis. They will only be approved for prior approved medical appointments greater than 75 miles from the member's home. There is a daily limit of \$120 per night for lodging and \$50 per day for meals with a total maximum amount of \$1,000 per 12-month period.

24 Hour Nurse Advice Line

Help is available to CHIP and CHIP Perinate members through the 24-hour, seven-day-a-week, toll-free Nurse Advice Line. Nurses deliver relevant information on health issues and community health services. Teens can call and speak confidentially to a nurse about adolescent health issues. The 24-Hour Nurse Advice Line also features an audiotape library with more than 300 health-related topics. The Nurse Advice Line uses interpreter services to accommodate the needs of members who are non-English speaking.

To contact the Nurse Advice Line call: **844-971-8906**; TTY: **800-368-4424**

Limitations: There are no limitations for this benefit. Members may access the Nurse Advice Line at any time.

Enhanced Eyewear for Children

Through Davis Vision, BCBSTX offers an enhanced eyewear benefit that exceeds state requirements and provides our child and adolescent members with an upgrade on stylish frames. All enrolled CHIP children ages 0-18 years of age are eligible to receive the enhanced eyewear benefit. Children are eligible for one enhanced pair per year for a maximum value of \$175.

Limitations: Benefit will be limited to one pair of stylish frames every year after completion of an eye exam. The maximum value of the frames will not exceed \$175. Enhanced frames are restricted to CHIP members and do not apply to CHIP Perinate members.

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Free Infant Car Safety Seat Program

The BCBSTX Free Infant Car Safety Seat Program encourages expectant CHIP members to receive early and ongoing prenatal care and promote infant safety. Pregnant members will be eligible for a free car seat by completing the following activities:

- Visiting their doctor in first trimester or within the first month of enrollment
- Completing an appropriate number of prenatal visits based on length of pregnancy at the time of enrollment. The number of prenatal visits is defined using the Healthcare Effectiveness Data and Information Sets (HEDIS) definition of appropriate number of prenatal visits based on length of enrollment in BCBSTX until time of delivery.
- Enrolling in the Special Beginnings® program

All expectant CHIP members are eligible for this benefit. For more information about Special Beginnings or the free infant car safety seat, call the Customer Service at **877-560-8055**.

Limitations: Members must be pregnant and must complete the above listed activities to receive a free infant care safety seat.

Sports and Camp Physicals

BCBSTX will cover Sports and Camp Physicals performed by primary care providers once a year to encourage children's participation in sports and physical fitness programs. The goal of this program is to prevent childhood obesity by encouraging participation in physical activities. This benefit is available for all CHIP members aged 18 and under.

Limitations: Sports and Camp physicals will be available as provided by CHIP providers. Sports and Camp Physicals are limited to CHIP kids ages 18 and under, and do not apply to CHIP Perinate.

Pregnancy/Delivery and Newborn Care Classes

BCBSTX offers a comprehensive series of pregnancy, delivery and newborn care classes to encourage expectant members to receive early and ongoing prenatal care to promote healthy births. Pregnant members will be eligible for three classes, one per trimester, or they may attend our one-day overview class.

First trimester topics:	Second trimester topics:	Third trimester topics:
Stages and phases of labor	Pain relief options	Newborn behaviors and appearance
When to go and what to bring to the hospital	Variations in labor	Newborn genital care
Lamaze coaching	Early recovery expectations	Diapering, dressing and umbilical cord care
Techniques of breathing and relaxation	Cesarean section experience	Newborn health and safety basics
	Include a brief labor rehearsal	Breast feeding basics

Classes will be offered at various community-based locations. All members are eligible for these classes no matter where they plan to deliver.

BCBSTX members who need transportation to classes are encouraged to utilize the BCBSTX transportation Value Added Service as described above. Spanish-speaking classes are available. Members may request to attend a class taught in Spanish when registering for the class.

Limitations: CHIP and CHIP Perinate members must be pregnant. Classes will be offered at various community-based locations, based on available space.

Breast Feeding Coaching

BCBSTX will offer breast feeding coaching to interested expectant CHIP members to provide practical information that prepares moms for breastfeeding.

Coaching topics will include:

- Benefits of breast feeding to mother and baby
- How milk is made
- Infant feeding cues
- Mother and baby positioning
- Tips for success
- How to tell if infant is getting enough milk
- Problem prevention (sore nipples, engorgement)
- Options for feeding during separation from infant

Breast feeding coaching can be requested by calling Customer Service or a Customer Advocate. The Customer Advocates coordinate service by contacting the home health agency to schedule a breast feeding coaching visit by the In-home Wellness Nurse.

Limitations: All newly enrolled pregnant or newly enrolled CHIP/CHIP Perinate women who are interested in breast feeding their newly delivered infant are eligible. The member must have delivered while on the Plan.

Free Breast Pumps for Completing Breast Feeding Coaching

BCBSTX offers free breast pumps to new moms who have completed breast feeding coaching. These services are related to a delivery while on BCBSTX plan. The free breast pump is provided to all moms who complete the breast-feeding coaching by the In-home Wellness Nurse. The pump will be given to the mom at the time of the coaching.

Limitations: New moms are encouraged to have completed breast feeding coaching to receive the breast pump. Breast pumps will be hand delivered to all members who request an In-home Wellness Visit, at no charge to the member.

In-Home Wellness Visits for Newborns and Moms

BCBSTX will provide discharged newborns and moms an In-home Wellness Visit upon request from the member or from their PCP or OB/GYN. All members who have delivered on the Plan are eligible for the In-home Wellness Visit. These services are also beneficial to all members with a high-risk pregnancy and/or who have been followed by Case Management.

Home visits will be conducted by a registered nurse within five days of discharge in an effort to reduce morbidity associated with common conditions that present in the postnatal period, but they can be requested at any time. The goal is to improve overall quality of care for newborns and their moms and reduce hospital-based services.

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If the home visiting nurse identifies issues that require referral of mom or baby to their OB/GYN or the newborn's PCP, the member will be referred to BCBSTX Case Management to ensure follow-up on any identified issues.

Limitations: CHIP and CHIP Perinate members must have delivered a live baby while on the Plan.

BCBSTX Offers Farmers Market Vouchers for Pregnant Moms

BCBSTX is making it easier for pregnant members to maintain a healthy diet consisting of at least five servings of fruits and vegetables each day. Pregnant members will receive 10 vouchers, worth \$2 each; toward the purchase of fresh produce from one of four selected Farmers Markets in Travis County. Expecting members can request vouchers by contacting the BCBSTX Customer Advocate. Members are eligible for 10 vouchers up to two times per pregnancy. That adds up to \$40 in fruit and vegetable purchases.

Limitations: Vouchers are redeemable for fresh fruits and vegetables at the market locations listed below:

- SFC East Market, 51st Street and 183 (YMCA)
- SFC Downtown, 4th and Guadalupe
- SFC Triangle, 46th and Lamar
- SFC Sunset Valley, 3200 Jones Road (Tony Burger Center)

No cash is provided if the member does not use the full value of the voucher. Member must provide their own transportation to the market. Vouchers are for pregnant moms for 10 vouchers, up to two times per pregnancy. Vouchers will be mailed to the member within five days of request and validation of membership. Members may request vouchers on four separate occasions with a minimum of two weeks between requests.

Dental Services for Adult Pregnant Women

BCBSTX will offer the following dental services to CHIP Perinate members over 19 years of age:

- Oral Exam
- Sealants
- X-rays
- Scaling and planning
- Cleanings
- Extractions
- Fillings

Members must see a participating dental provider within the Liberty Dental Network and may only receive benefits up to a maximum of \$250 annually.

Limitations: BCBSTX will provide dental care for pregnant women not covered by the CHIP dental program. Adult pregnant women defined as CHIP Perinate women over age 19. Members must see a participating dental provider in the network; benefits for treatment services per scheduled treatment up to a maximum of \$500. Dental services are limited to CHIP Perinate women over 19 years of age. They do not apply to CHIP members.

Safety Booster Seats for Kids

BCBSTX offers free children's safety booster seats for children between the ages of 2 to 12 who have outgrown their baby car seat, and weigh between 30 and 100 pounds. To get the booster seat, the child must have a Well Child checkup or Texas Health Steps checkup within 90 days of signing up with BCBSTX, or a yearly Well Child checkup or Texas Health Steps checkup.

Limitations: Booster seats are for children ages 2 - 12 who have outgrown their infant car seat and meet the height and weight requirements for the booster seat. The booster seat is for children 30 to 100 pounds and a maximum height of 57". Parents or guardians are responsible for ensuring that their child meets the height/weight criteria to safely use the booster seat.

Safety Helmets for Kids

BCBSTX offers free safety helmets to help children stay safe while riding bikes, skate boards or doing other outdoor activities. Members ages 3 to 18 can receive a free safety helmet every two years. To get the safety helmet, the child must have a Well Child checkup or Texas Health Steps checkup within 90 days of signing up with BCBSTX, or a yearly Well Child checkup or Texas Health Steps checkup.

Limitations: Members are limited to one new safety helmet every other year. Members will be required to complete and submit the appropriate paperwork to demonstrate that they meet the criteria to receive a helmet.

Free Diaper Bag with New Baby Items

BCBSTX will provide pregnant or newly delivered members who have attended our pregnancy classes with a free diaper bag that includes new baby items.

Limitations: Members must be on the Plan to be eligible. Members also need to have attended one BCBSTX approved prenatal education class to be eligible to request the gift.

Hands Free Breast Pump Bra

BCBSTX will provide for mothers who are breastfeeding, and delivered on our plan a hands-free breast feeding bra. The bra will be provided during the In-home Wellness Visit.

Limitations: Members must be on the Plan to be eligible. Members must have also delivered their new baby on the Plan and be willing to meet with the In-home Wellness Nurse to have the bra delivered.

Breast Feeding Support Kit Gift

Pregnant CHIP members who are breastfeeding will be eligible for a breast-feeding support kit gift. This gift will be delivered by the In-home Wellness Nurse. The kit includes breast milk disposable bags, soothing breast pads, breast soothing cream, a breast milk storage tracking refrigerator magnet, nipple protectors and a case. These items are provided to members who can benefit from use after working with the In-home Wellness Nurse.

Limitations: Members must have delivered while on our Plan and notify BCBSTX upon delivery. Members have up to 30 days post-delivery to contact the Plan and request the support kit. Breast feeding members must be willing to have an In-home Wellness Visit to receive the breast-feeding support kit, which will be delivered during the visit. Breast nipple protectors are handed out to members by the In-home Wellness Nurse as needed.

Free Breast Pump for CHIP Perinate

CHIP Perinate members are eligible for a free breast pump as part of their Value-Added Services.

Chapter 4

Timely Well Child Checkups Incentive

Child members within the age ranges below are eligible to request a \$50 gift card when they complete the required well child checks:

- 15 Months old: six checkups by 15 months of age
- 3-6 Years old: one checkup by the end of the calendar year
- 12-20 Years old: one checkup by the end of the calendar year

Limitations: Parents or guardians of child members must ensure their enrolled children complete well child checks in the specified time frames. Members or a parent or guardian of under-aged members have to complete the documentation and send it in to request the gift card. Members must be active on the Plan to receive the gift card.

ADDITIONAL BENEFITS

Care Van Program

BCBSTX provides greater outreach to children enrolled in the CHIP program by expanding Care Van Program operations for Care Van immunization clinics. All enrolled CHIP members are eligible to receive immunizations at Care Van clinics. The Care Van Program conducts 50 outreach immunization clinics in the Travis service area each year.

Text4baby

BCBSTX offers this free mobile information program to all pregnant CHIP members. The program gives pregnant women and new moms' tips to help care for their health and give their babies the best start in life they can have. Members who sign up for this service get free SMS text messages each week, timed to their due date or the baby's first birthday. Members can sign up for the service by texting **BABY to 511411 (or BEBE for Spanish messages)**. Members can use this service from the time they find out they are pregnant through the baby's first birthday. To sign up for this service, go to the link below and follow the directions. text4baby.org. Data fees/charges may apply.

PRIMARY CARE PROVIDER REQUIREMENTS FOR BEHAVIORAL HEALTH

The PCP must have behavioral health screening and evaluation processes available for detection, treatment or referral of members. PCPs are responsible for documenting in medical records any referrals and any known self-referrals for behavioral health services.

PCPs are also encouraged to:

- Maintain contact with behavioral health provider.
- Document behavioral health assessments and treatments – medical record documentation and referral information using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) multi-axial classifications.
- Inform the provider of any condition the member may have that could affect the behavioral health service.
- Communicate and coordinate services essential to ensuring quality and continuity of care. The PCP should assist with behavioral health referrals and provide Magellan with supporting documentation.
- Initiate a member referral for behavioral health services by contacting Magellan by phone at **800-327-7390** (TTY: **800-735-2988**).
- Obtain consent for disclosure of information.

Behavioral health providers are encouraged to contact a member's PCP to discuss the patient's general health. They must also contact members who have missed appointments within 24 hours to reschedule appointments per HHSC-mandated provisions. Training for PCPs is available on the BCBSTX website.

BEHAVIORAL HEALTH SERVICES

Member Access to Behavioral Health Services

Behavioral health services are provided for the treatment of behavioral/mental health disorders, emotional disorders, and chemical dependency disorders. Behavioral health services do not require a PCP referral. Members may self-refer to any Medicaid-enrolled behavioral health provider for treatment.

A PCP may, in the course of treatment, refer a patient to a behavioral health provider for assessment or for treatment of an emotional, mental or chemical dependency disorder. A PCP may also provide behavioral health services within the scope of his practice.

Assessment Instruments for Behavioral Health Available for Use by Primary Care Providers

In addition to the screening tools provided in the Texas Medicaid Provider Procedures manual, additional tools are available by contacting Magellan Customer Service department at **800-327-7390** or visiting www.MagellanAssist.com and access the PCP Toolkit.

Chapter 4

Targeted Case Management and Rehabilitation

Covered services are provided to members with Severe and Persistent Behavioral/Mental Health Illness (SPMI) and Serious Emotional Disturbance (SED), when medically necessary, targeted case management and rehabilitation is a covered benefit under BCBSTX. Magellan contracts with local mental health authorities (LMHAs) to provide these services.

Coordination Between Behavioral Health and Physical Health Services

BCBSTX requires that all physicians and professional providers have screening and evaluation procedures for the detection, treatment of, or referral for, any known or suspected behavioral health problems and disorders. Physicians and professional providers may provide any clinically appropriate behavioral health services within the scope of their practice.

BCBSTX requires that all behavioral health service providers refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or the member's legal guardian's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so.

BCBSTX also requires that behavioral health providers send initial and regular summary reports of a member's behavioral health status to the primary care provider (PCP) or professional provider, with the member's or the member's legal guardian's consent.

Court-ordered Commitments

Court-ordered commitment means a commitment of a member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

Follow-up After Hospitalization for Behavioral Health Services

BCBSTX requires that all members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Providers must contact members who have missed appointments within 24 hours to reschedule appointments.

Focus Studies and Utilization Management Reporting Requirements

Consistent with National Committee for Quality Assurance (NCQA) standards, Magellan analyzes relevant utilization data against established thresholds for each health plan to detect potential under- and over-utilization on at least a semi-annual basis.

If findings from these monitors fall outside the specified target ranges or threshold and indicate potential under- or over-utilization that may adversely affect members, further drill-down analyses will occur based upon the recommendation of the Magellan Utilization Management Committee (UMC). The drill-down analyses may include data from specific provider and practice sites, including but not limited to:

- Case management services as needed for members receiving behavioral health services
- Retrospective reviews of services provided without authorization
- Investigation and resolution of member and provider complaints and appeals within established time frames
- Coordination with the local mental health authorities
- Focus studies
- Claims payment for covered behavioral health services

Magellan’s Claims Address

Magellan Health Services

Attn: Claims

P.O. Box 2154

Maryland Heights, MO 63043

Magellan established a comprehensive Quality Improvement program to help ensure that high quality behavioral health treatment and services are provided to CHIP members, including focused activities to monitor and evaluate access across the behavioral health continuum of care.

To help ensure continuity and coordination of care, Magellan takes specific actions to help CHIP members follow up with a behavioral health outpatient provider in a timely manner after discharge from an inpatient treatment facility.

Procedures for Follow-up on Missed Appointments

Behavioral health providers are encouraged to contact a member’s PCP to discuss the patient’s general health and must contact members who have missed appointments within 24 hours to reschedule appointments, per HHSC-mandated provisions.

Cost Sharing

CHIP members are responsible for the copayments listed on their ID card until they meet their cost sharing limit. Once the cost sharing limit is met, members should contact Maximus, the Administrative Services Contractor to obtain a new ID card. CHIP Perinate, CHIP Perinate Newborn members, and CHIP members who are Native Americans or Alaskan Natives do not have cost sharing. Additionally, for CHIP members there is no cost-sharing on benefits for well-baby and well-child services, preventive services or pregnancy-related assistance.

Chapter 4

CHIP Cost Sharing	Effective January 1, 2014***
Enrollment Fees (for 12-month enrollment period)	
At or below 151% of FPL*	\$0
Above 151% up to and including 186% of FPL	\$35
Above 186% up to and including 201% of FPL	\$50
Copayments (per visit)	
At or below 100% of FPL	
	Charge
Office Visit	\$3
Non-emergency ER	\$3
Generic Drug	\$0
Brand Drug	\$3
Cost-sharing Cap	5% of family's income**
Facility Copayment, Inpatient	\$15
Above 100% up to and including 151% of FPL	
	Charge
Office Visit	\$5
Non-emergency ER	\$5
Generic Drug	\$0
Brand Drug	\$5
Cost-sharing Cap	5% of family's income**
Facility Copayment, Inpatient (per admission)	\$35
Above 151% up to and including 186% of FPL	
	Charge
Office Visit	\$20
Non-emergency ER	\$75
Generic Drug	\$10
Brand Drug	\$35
Cost-sharing Cap	5% of family's income**
Facility Copayment, Inpatient (per admission)	\$75
Above 186% up to and including 201% of FPL	
	Charge
Office Visit	\$25
Non-emergency ER	\$75
Generic Drug	\$10
Brand Drug	\$35
Cost-sharing Cap	5% of family's income**
Facility Copayment, Inpatient (per admission)	\$125

* The Federal Poverty Level (FPL) refers to income guidelines established annually by the federal government.

** Per 12-month term of coverage. ***Subject to annual change by Texas Health and Human Services.

EXCLUSIONS FROM COVERED SERVICES - CHIP

- Certain Health Care Acquired Conditions (HCAC)
- 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 BCBSTX
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by BCBSTX 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 BCBSTX
- 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

Chapter 4

EXCLUSIONS FROM COVERED SERVICES – CHIP PERINATE

For CHIP Perinate members in families with incomes at or below 186% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. 'Initial Perinatal Newborn admission' means the hospitalization associated with the birth.

- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth
- Inpatient behavioral/mental health services
- Outpatient behavioral/mental health services
- Durable medical equipment or other medically related remedial devices
- Disposable medical supplies
- Home and community-based health care services
- Nursing care services
- Dental services
- Inpatient substance abuse treatment services and residential substance abuse treatment services
- Outpatient substance abuse treatment services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Hospice care
- Skilled nursing facility and rehabilitation hospital services
- Emergency services other than those directly related to the labor with delivery of the covered unborn child
- Transplant services
- Tobacco Cessation programs
- Chiropractic services
- Medical transportation not directly related to labor or threatened labor, miscarriage or non-viable pregnancy, and/or delivery of the covered unborn child
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or post-partum care
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico,
- U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)
- Mechanical organ replacement devices including, but not limited to artificial heart

- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
 - Prostate and mammography screening
 - Elective surgery to correct vision
 - Gastric procedures for weight loss
 - Cosmetic surgery/services solely for cosmetic purposes
 - Out-of-network services not authorized by the health plan except for emergency care related to the labor with delivery of the covered unborn child
 - Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
 - Acupuncture services, naturopathy and hypnotherapy
 - Immunizations solely for foreign travel
 - Routine foot care such as hygienic care
 - Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
 - Corrective orthopedic shoes
 - Convenience items
 - Orthotics primarily used for athletic or recreational purposes
 - Custodial care: This is care that assists with the activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services
- Convenience items
- Donor non-medical expenses
- Charges incurred as a donor of an organ



Chapter 5

Member Eligibility

ELIGIBILITY VERIFICATION

The Texas Health and Human Services Commission (HHSC) determine eligibility and Maximus, the enrollment broker, facilitates enrollment into health plans for STAR and CHIP members. Following notification from the HHSC or contracted eligibility agents, BCBSTX electronically updates member eligibility each day.

Confirm Member Identity

To prevent fraud and abuse, providers should confirm the identity of the person presenting the ID card. Providers must verify the member's eligibility before services are provided. Claims submitted for services rendered to non-eligible members will not be eligible for payment.

STAR – HOW TO VERIFY MEMBER ELIGIBILITY

At each member visit, before rendering services, providers must ask to see the member’s BCBSTX and state identification (ID) cards to verify health plan eligibility.

State of Texas Access Reform (STAR) members should provide their state eligibility card, the Texas Benefits Medicaid Card, the card is part of an online system providers can use to verify a member’s Medicaid eligibility and access their Medicaid health history. This ID system also offers a secure provider portal, www.yourtexasbenefitscard.com, where providers can get up-to-date member’s eligibility information.

Each person approved for Medicaid benefits gets a ‘Your Texas Benefits Medicaid Card’. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient’s eligibility for the date of service prior to services being rendered. There are several ways to do this:

- **Availity website:** Log on to the Availity website, an online tool for providers, by going online to www.availity.com. Registration is required to use this site.
- Call BCBSTX Provider Services at **877-560-8055**.
- Swipe the patient’s Your Texas Benefits Medicaid Card through a standard magnetic card reader, if your office uses that technology
- Use TexMedConnect on the TMHP website at www.tmhp.com
- Call the Your Texas Benefits provider helpline at **1-855-827-3747**
- Call Provider Services at the patient’s medical or dental plan

Important: Do not send patients who forgot or lost their State-issued Medicaid cards to an HHSC benefits office for a paper form. They can request a new card by calling **1-855-827-3748**. Medicaid members can also go online to order new cards or print temporary cards.

STAR SAMPLE STATE-ISSUED AND BCBSTX MEMBER ID CARDS


Following enrollment in the Medicaid managed care STAR program, each STAR Member receives two member identification (ID) cards that he or she must present at each visit to a provider: One card is from the State of Texas, and the other is from BCBSTX.

The State-issued ID card is called Your Texas Benefits Medicaid Card and contains:

- Member name and Medicaid ID number (i.e., patient control number – PCN)
- Managed care program name, if applicable
- Date the card was issued
- Billing information for pharmacies
- Health plan names and contact information
- Pharmacy and physician information for those in the Medicaid Limited program
- Toll-free number for general inquiries

Chapter 5

Sample Your Texas Benefits Medicaid Card



Your Texas Benefits
Health and Human Services Commission

Member name:

Member ID:

Issuer ID: Date card sent:

Note to Provider:
Ask this member for the card from their Medicaid medical plan. Providers should use that card for billing assistance. No medical plan card? Pharmacists can use the non-managed care billing information on the back of this card.

Need help? ¿Necesita ayuda? 1-800-252-8263

Members: Keep this card with you. This is your medical ID card. Show this card to your doctor when you get services. To learn more, go to www.YourTexasBenefits.com or call 1-800-252-8263.

Miembros: Lleve esta tarjeta con usted. Muestre esta tarjeta a su doctor al recibir servicios. Para más información, vaya a www.YourTexasBenefits.com o llame al 1-800-252-8263.

THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES.

Providers: To verify eligibility, call 1-855-827-3747. Non-pharmacy providers can also verify eligibility at www.YourTexasBenefitsCard.com. Non-managed care pharmacy claims assistance: 1-800-435-4165.


Non-managed care Rx billing: RxBIN: 610084 / RxPCN: DRTXPROD / RxGRP: MEDICAID

TX-CA-1213


Sample BCBSTX Medicaid (STAR) ID Card

BCBSTX's Member ID card contains the following information:


- Member name, ID number, group number, patient control number (PCN)
- Name of assigned primary care provider (PCP), effective date and phone number
- Phone number for Customer Service, the 24-Hour Nurse Advice Line, behavioral health benefits, pharmacy benefits and behavioral health services
- Instructions for obtaining care in an emergency



BlueCross BlueShield of Texas
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association



TEXAS STAR
Your Health Plan • Your Choice



TEXAS
Health and Human Services

Member Name:
SHANE TEST

Alpha Prefix: **XYZ**

Subscriber ID: **987654321**

Medicaid ID Number:
123456789

PCP Effective Date: **01/01/2017**

Rx Group No.: **TXS1**

Rx BIN: **001122**

Rx PCN: **TXCAID**

PBM: **PRIME**

PCP: GEORGE CURIOUS
877-800-5555

bcbstx.com/Medicaid

Customer Care/Atención al Cliente (Medical/Prescription Drug/Vision):
24 hours/7 days a week **1-888-657-6061**
TTY: **711**

24-Hour Nurse Line/línea de ayuda de enfermería disponible las 24 horas:
TTY: **1-844-971-8906**
711

Prescription Drug/Medicamentos Recetados:
TTY: **1-888-657-6061**
711

Behavioral Health Services Hotline/Behavioral Health Línea Directa de Servicios:
24 hours/7 days a week **1-800-327-7390**
TTY: **1-800-735-2988**

For emergency care received outside of Texas: Hospital and physicians should file claims to the local BCBS Plan. Card Issued <DT>

Show this BCBS card to your health care provider each time you get covered services. Some services may need preapproval. **Directions for what to do in an emergency:** In case of emergency call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible. This card is for member ID only and does not prove eligibility.

Muestre la tarjeta BCBS a su proveedor de atención médica cada vez que reciba servicios cubiertos. Puede que algunos servicios necesiten aprobación previa. Instrucciones en caso de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible. Esta tarjeta es solo para identificación de los miembros y no es comprobante de elegibilidad.

Claims: PO Box 51422
Amarillo, TX 79159-1422

CHIP MEMBER ELIGIBILITY

A CHIP Perinate (unborn child) who lives in a family with an income at or below 186% of the Federal Poverty Level (FPL) will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker. A CHIP Perinate mother in a family with an income at or below 186% of the FPL may be eligible to have the cost of the birth covered through Emergency Medicaid. Clients under 186% of the FPL will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to HHSC's enrollment broker.

A CHIP Perinate will continue to receive coverage through the CHIP Program as a CHIP Perinate Newborn if born to a family with an income above 186% to 201% FPL and the birth is reported to HHSC’s enrollment broker. A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in the CHIP Perinatal health plan.

Determination of eligibility is made by HHSC or Maximus, the Administrative Service Contractor.

CHIP – HOW TO VERIFY MEMBER ELIGIBILITY

Providers can verify CHIP member eligibility in one of the following ways:

- Availity website: Log on to the Availity website, an online tool for providers, at www.availity.com. Registration is required to use this site.
- Call BCBSTX Provider Services at **877-560-8055**.

CHIP SAMPLE MEMBER ID CARDS

Following enrollment in our CHIP program, each member receives a member identification card that must be presented to providers at each visit. Members in CHIP do not have a Medicaid identification card from the state. BCBSTX’s member ID card contains the following information:

- Member name, ID number, group number, patient control number (PCN)
- Name of assigned primary care provider (PCP), effective date and phone number
- Copayments (CHIP Perinate, Native American and Alaskan Native members do not have copayments/cost sharing)
- Phone number for Customer Service, the 24-Hour Nurse Advice Line, behavioral health services, pharmacy benefits and behavioral health services
- Instructions for obtaining care in an emergency

Sample BCBSTX ID Card – CHIP





Mail claims for all services to:

Blue Cross and Blue Shield of Texas

Attn: Claims

PO Box 51422

Amarillo, TX 79159-1422

 BlueCross BlueShield of Texas <small>A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association</small>		 	
Member Name: DAMIAN J TEST3 Alpha Prefix: ABC Subscriber ID: 987654321 CHIP ID No: 123456789		PCP: MARY LAMB 877-800-5555	
PCP Effective Date: 03/01/2017 Rx Group No.: TXJ1 Rx BIN: 010101 Rx PCN: TXCAID PBM: PRIME		Office Visit/ Visitas al consultorio: \$20 Non-Emergency ER/ No emergencias en la ER: \$75 Hospital per admit/ por hospital admiten: \$75 Emergency Room/ Emergencia en la ER: \$0 Pharmacy (Brand/ Farmacia (marca): \$35 Pharmacy (Generic)/ Farmacia (genérico): \$10	
 Customer (Medical) P 24 hours/7 TTY: 24-Hour Nurse Line/línea de ayuda de enfermería disponible las 24 horas: TTY: Prescription Drug/ Medicamentos Recetados: TTY: Behavioral Health Services Hotline/ Behavioral Health Línea Directa Servicios: 24 hours/7 days a week TTY:		1-844-971-8906 711 1-888-657-6061 711 1-800-327-7390 1-800-735-2988	
<p>Show this BCBS card to your health care provider each time you get covered services. Some services may need preapproval. Directions for what to do in an emergency: In case of emergency call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible. This card is for member ID only and does not prove eligibility.</p> <p>Muestre la tarjeta BCBS a su proveedor de atención médica cada vez que reciba servicios cubiertos. Puede que algunos servicios necesiten aprobación previa. Instrucciones en caso de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible. Esta tarjeta es solo para identificación de los miembros y no es comprobante de elegibilidad.</p> <p>Claims: PO Box 51422 Amarillo, TX 79159-1422</p>		<p>For emergency care received outside of Texas: Hospital and physicians should file claims to the local BCBS Plan.</p> <p>Card Issued <DT></p>	

Chapter 5

Sample ID Card - CHIP Perinate ID OVER 198% Federal Poverty Level (FPL)


For hospital, facility and professional services billing, mail claims to:

Blue Cross and Blue Shield of Texas

Attn: Claims

PO Box 51422

Amarillo, TX 79159-1422



Blue Cross Blue Shield of Texas

Show this BCBS card to your health care provider each time you get covered services. Some services may need preapproval. **Directions for what to do in an emergency:** In case of emergency call 911 or go to the closest emergency room. This card is for member ID only and does not prove eligibility.

Muestre la tarjeta BCBS a su proveedor de atención médica cada vez que reciba servicios cubiertos. Puede que algunos servicios necesiten aprobación previa. Instrucciones en caso de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible. Esta tarjeta es solo para identificación de los miembros y no es comprobante de elegibilidad.

For emergency care received outside of Texas: Hospital and physicians should file claims to the local BCBS plan.

bcbstx.com/Medicaid

Customer Care/Atención al Cliente (Medical/Prescription Drug/Vision): 24 hours/7 days a week **1-888-657-6061 711**
 TTY: **1-888-657-6061 711**
 24-Hour Nurse Line/línea de ayuda de enfermería disponible las 24 horas: **1-844-971-8906 711**
 TTY: **1-844-971-8906 711**
 Prescription Drug/Medicamentos Recetados: **1-888-657-6061 711**
 TTY: **1-888-657-6061 711**
 Behavioral Health Services Hotline/Behavioral Health Línea Directa de Servicios: 24 hours/7 days a week **1-800-327-7390**
 TTY: **1-800-735-2988**
 For Hospital Facility and Professional Services Billing: BCBSTX P.O. Box 51422 Amarillo, TX 79159-1422

Card Issued <DT>



Blue Cross Blue Shield of Texas
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.




Member Name: **TY O TEST7**
 Alpha Prefix: **ZYX**
 Subscriber ID: **987654321**
 CHIP ID No: **123456789**

PCP: **N/A**
 N/A

Effective Date: **01/01/2017**
 Rx Group No.: **ABC3**
 Rx BIN: **001122**
 Rx PCN: **TXCAID**
 PBM: **PRIME**

For emergency care received outside of Texas: Hospital and physicians should file claims to the local BCBS plan. Para servicios médicos de emergencia recibidos fuera del Estado de Texas: Hospitales y médicos deben presentar la documentación ante el plan de BCBSTX.


Sample ID Card – CHIP Perinate ID under 198% Federal Poverty Level (FPL)

For hospital and facility billing, mail claims to:

Texas Medicaid & Health Care Partnership (TMHP)

P.O. Box 200555

Austin, TX 78720-0555



Blue Cross Blue Shield of Texas

Show this BCBS card to your health care provider each time you get covered services. Some services may need preapproval. **Directions for what to do in an emergency:** In case of emergency call 911 or go to the closest emergency room. This card is for member ID only and does not prove eligibility.


Muestre la tarjeta BCBS a su proveedor de atención médica cada vez que reciba servicios cubiertos. Puede que algunos servicios necesiten aprobación previa. Instrucciones en caso de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible. Esta tarjeta es solo para identificación de los miembros y no es comprobante de elegibilidad.

For emergency care received outside of Texas: Hospital and physicians should file claims to the local BCBS plan.



bcbstx.com/Medicaid

Customer Care/Atención al Cliente (Medical/Prescription Drug/Vision): 24 hours/7 days a week **1-888-657-6061 711**
 TTY: **1-888-657-6061 711**
 24-Hour Nurse Line/línea de ayuda de enfermería disponible las 24 horas: **1-844-971-8906 711**
 TTY: **1-844-971-8906 711**
 Prescription Drug/Medicamentos Recetados: **1-888-657-6061 711**
 TTY: **1-888-657-6061 711**
 Behavioral Health Services Hotline/Behavioral Health Línea Directa de Servicios: 24 hours/7 days a week **1-800-327-7390**
 TTY: **1-800-735-2988**
 Hospital Facility Billing: Professional/Other Services Billing: TMHP BCBSTX P.O. Box 200555 Austin, TX 78720-0555 Amarillo, TX 79159-1422

Card Issued <DT>



Blue Cross Blue Shield of Texas
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Member Name: **TY O TEST7**
 Alpha Prefix: **ZYX**
 Subscriber ID: **987654321**
 CHIP ID No: **123456789**

PCP: **N/A**
 N/A

Effective Date: **01/01/2017**
 Rx Group No.: **ABC3**
 Rx BIN: **001122**
 Rx PCN: **TXCAID**
 PBM: **PRIME**

For emergency care received outside of Texas: Hospital and physicians should file claims to the local BCBS plan. Para servicios médicos de emergencia recibidos fuera del Estado de Texas: Hospitales y médicos deben presentar la documentación ante el plan de BCBSTX.

For professional and other services billing, mail claims to:

Blue Cross and Blue Shield of Texas

Attn: Claims

PO Box 51422

Amarillo, TX 79159-1422

Sample ID Card – CHIP Perinate Newborn





There is no copayment or cost sharing for covered services for CHIP Perinate or CHIP Perinate Newborns. Mail claims for all services to:

Blue Cross and Blue Shield of Texas

Attn: Claims

PO Box 51422

Amarillo, TX 79159-1422

 <p>Blue Cross BlueShield of Texas</p> <p>Show this BCBS card to your health care provider each time you get covered services. Some services may need preapproval. Directions for what to do in an emergency: In case of emergency call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible. This card is for member ID only and does not prove eligibility.</p> <p>Muestre la tarjeta BCBS a su proveedor de atención médica cada vez que reciba servicios cubiertos. Puede que algunos servicios necesiten aprobación previa. Instrucciones en caso de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible. Esta tarjeta es solo para identificación de los miembros y no es comprobante de elegibilidad.</p> <p>Claims: PO Box 51422 Amarillo, TX 79159-1422</p>	<p>bcbstx.com/Medicaid</p> <p>Customer Care/Atención al Cliente (Medical/Prescription Drug/Vision): 24 hours/7 days a week 1-888-657-6061 711</p> <p>TTY: 711</p> <p>24-Hour Nurse Line/línea de ayuda de enfermería disponible las 24 horas: 1-844-971-8906 711</p> <p>TTY: 711</p> <p>Prescription Drug/Medicamentos Recetados: 1-888-657-6061 711</p> <p>TTY: 711</p> <p>Behavioral Health Services Hotline/Behavioral Health Línea Directa de Servicios: 24 hours/7 days a week 1-800-327-7390 1-800-735-2988</p> <p>TTY: 711</p> <p>For emergency care received outside of Texas: Hospital and physicians should file claims to the local BCBS Plan.</p> <p>Card Issued <DT></p>	 <p>BlueCross BlueShield of Texas A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association</p> <p>Member Name: TREVON C TEST6</p> <p>Alpha Prefix: ABC</p> <p>Subscriber ID: 987654321</p> <p>CHIP ID No: 123456789</p> <p>PCP Effective Date: 02/01/2017</p> <p>Rx Group No.: ABCI</p> <p>Rx BIN: 001122</p> <p>Rx PCN: TXCAID</p> <p>PBM: PRIME</p>	  <p>CHIP Perinate NB</p> <p>PCP: ALVIN MUNK 512-555-1122</p> <p>For CHIP Perinate newborns no co-payment or cost-sharing for covered services</p> <p>Servicios incluidos en la cobertura CHIP Perinate para recién nacidos no requieren copagos ni gastos</p>
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Pharmacy Electronic Member Eligibility (STAR and CHIP)

Pharmacists and other pharmacy staff may call or use a secure online network to confirm eligibility. Each member has a sturdy, plastic Your Texas Benefits Medicaid Card issued by HHSC. Pharmacists and other pharmacy staff will use one of the existing vendor drug eligibility verification tools to obtain out-patient pharmacy eligibility and prescription benefits data for any client.

BCBSTX Provider Services at **877-560-8055** can also assist with determining member eligibility or pharmacies. You can call the Prime Pharmacy Customer Service Help Desk at the numbers on Page 17.



Chapter 6

CLAIMS AND BILLING

INTRODUCTION AND GENERAL CLAIMS GUIDELINES

We need your help to achieve BCBSTX's goal of accurate and efficient claims payment. Share the following guidelines with your staff and, if applicable, with your billing service agent and electronic data processing service agent. It is important that everyone involved understands the guidelines for preparing and submitting claims for services rendered to BCBSTX members.

THE IMPORTANCE OF A CLEAN CLAIM

This section will help you understand how to submit a claim to BCBSTX correctly the first time, which will help avoid delays in processing.

Claims submitted correctly the first time are called 'clean'. That means that all required fields have been completed in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. It also means that the correct form was used for the type of service provided.

We return claims submitted with incomplete or invalid information, and request the claim be corrected and resubmitted. If using a clearinghouse for Electronic Data Interchange (EDI), the clearinghouse/gateway also rejects claims that are incomplete or invalid. You are responsible for working with your EDI vendor to help ensure that claims that 'error out' from the EDI gateway are corrected and resubmitted.

McKesson ClaimsXten™

For Blue Cross and Blue Shield of Texas Medicaid-State of Texas Access Reform (STAR) and Children's Health Insurance Program (CHIP) programs, BCBSTX uses claims editing software from McKesson called ClaimsXten. ClaimsXten incorporates the McKesson editing rules that determine whether a claim should be paid, rejected or requires manual processing.

These editing rules assess Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes on the CMS-1500 form. A claim auditing action then determines how the procedure codes and code combinations will be adjudicated. The auditing action recognizes historical claims related to current submissions and may result in adjustments to previously processed claims. You can find descriptions of specific reimbursement policies in this manual.

ClaimsXten may be updated periodically. BCBSTX will give providers advance notice per your provider agreement. For the latest information and current ClaimsXten rules, you can log into our website at <http://bcbstx.com/provider/Medicaid/index.html> and scroll down to **Claims**.

Claim Forms

Generally, there are two types of forms used for submitting claims for reimbursement. They are:

1. The CMS-1500 for professional services (refer to the CMS-1500 Claim Form section)
2. The CMS-1450 (UB-04) for institutional services (refer to the CMS-1450 (UB-04) Claim Form section)

These forms are available in both electronic and hard copy/paper format.

Information on how to complete each of these forms is available later in this Manual. Click on the appropriate form name in the **Claim Forms and Filing Limits** table below to link to a sample image of that form followed by general instructions on how to complete its more important fields.

Chapter 6

Claim Filing Limits

All claims must be submitted within the contracted filing limit to be considered for payment. We will deny claims that are received past the filing limit. See the **Submitting a Claim** section for standard claim filing and processing timeframes.

Submit claims as soon as possible following delivery of service to avoid delays in processing.

BCBSTX is not responsible for a claim never received. Prolonged periods before resubmission may cause you to miss the filing limit. Determine filing limits as follows:

- If BCBSTX is the primary payer, you have a specific length of time between the last date of service on the claim and the BCBSTX receipt date.
- If BCBSTX is secondary payer, you have a specific length of time between the other payer's Remittance Advice (RA) date and the BCBSTX receipt date.

CLAIM FORMS AND FILING LIMITS

Form	Type of Service to be Billed	Time Limit to File (Refer to the Provider contract to confirm correct filing limits for claims.)
CMS-1500 Claim Form	Physician and other professional services:	Within 95 days of date of service
	Ancillary services including: Physical, occupational and speech therapy, audiologists, ambulance, ambulatory surgical center, dialysis, durable medical equipment (DME), diagnostic imaging centers, hearing aid dispensers, home infusion, hospice, laboratories, prosthetics and orthotics, and free standing SNFs. Some ancillary providers may use a CMS-1450 (UB-04) if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.	Within 95 days of date of service
CMS-1450 (UB-04) Claim Form	Hospitals, institutions, home health services and ancillary providers	Within 95 days of date of service (If the member is an inpatient for longer than 30 days, interim billing is required as described in the hospital agreement.)

OTHER FILING LIMITS

Action	Description	Time Frame
Third Party Liability (TPL) or Coordination of Benefits (COB)	If the claim has TPL or COB or requires submission to a third party before submitting to BCBSTX, the filing limit starts from the date on the notice from the third party.	From date of notice from third party: <ul style="list-style-type: none"> • 95 Days for CMS-1500 claims • 95 Days for CMS-1450 (UB-04) claims
Checking Claim Status	Claim status may be checked anytime by logging on to the Availity website at www.availity.com	30 business days after BCBSTX's receipt of claim, contact Customer Service at: 877-560-8055; TTY: 711
Provider Dispute	To request a claim appeal, send your request in writing to: Blue Cross and Blue Shield of Texas Attn: Complaints and Appeals PO Box 27838 Albuquerque, NM 87125-7838 You may also use our Provider Appeal Request Form .	120 calendar days from the receipt of BCBSTX Remittance Advice (RA) or notice of action.

Chapter 6

MEDICAID COVERED SERVICES

If you need additional information or have questions regarding your capitation report, please contact BCBSTX Customer Service at **877-560-8055**. Providers should also refer to the Texas Medicaid Provider Procedures Manual for information on Medicaid-covered services.

- Ambulance services
- Audiology services, including hearing aids for adults
- Behavioral health services, including:
 - Inpatient and outpatient behavioral/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 older)
 - Targeted Case Management and Mental Rehabilitation
- Birthing center services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Medical Checkups and Comprehensive Care Program (CCP) services for children (under 21) through the Texas Health Steps Program
- Optometry, glasses and contact lenses, if medically necessary
- Podiatry
- Prenatal care
- Primary care services
- Radiology, imaging and X-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues

PROVIDERS NOT CONTRACTED WITH BCBSTX

BCBSTX accepts the following claims from non-contracted providers within the indicated time frames:

Type of Service	In-State or Within 50 Miles of State Border	Out-of-State
Emergency Services	95 days from the date of service or discharge date	365 days
Texas Medicaid Enrolled	95 days with prior authorization if services are not available in Texas	365 days with prior authorization if services are not available in Texas
Newly Enrolled in Texas Medicaid	Within 95 days of the date the new provider identifier is issued, and within 365 days of the date of service	365 days with prior authorization if services are not available in Texas
Non-Texas Medicaid Enrolled	Denied unless prior authorized for services not available in Texas	Denied unless prior authorized for services not available in Texas

PAPER CLAIMS AND CORRESPONDENCE MAILING ADDRESS

Blue Cross and Blue Shield of Texas

Attn: Claims

PO Box 51422

Amarillo, TX 79159-1422

If feasible, providers will be notified in writing of any changes in the claims submission address at least 30 days prior to the effective date of coverage. If we are unable to provide 30 days' notice, a 30-day extension will be added to the claim's filing deadline to help ensure claims are routed to the correct processing center.

Questions about Claims

If you have questions about claims status or how to file a claim, including how to complete claims forms, please contact the Customer Service at **877-560-8055**.

Chapter 6

SUBMITTING A CLAIM

Methods for Submitting Claims

There are two methods for submitting a claim:

1. Electronic Data Interchange (EDI) (preferred)
2. Paper or hard copy

Electronic Claims

Completion of electronic claims can speed claim processing and prevent delays.

Submit claims electronically through a plan-approved electronic billing system software vendor and/or clearinghouse.

If you use EDI, you must include the following provider information:

- Provider name
- Rendering Provider NPI (National Provider Identifier)
- Group NPI (National Provider Identifier)
- The Federal Provider Tax Identification (ID) number
- BCBSTX's Payer Identification (ID) number 66001 (Verify this number with your clearinghouse, as it may be different for this payer within their processes.)

BCBSTX cannot be responsible for claims never received. You must work with your vendors to help ensure files are successfully submitted to BCBSTX. Failure of a third party to submit a claim to BCBSTX may risk your claim being denied for untimely filing if those claims are not successfully submitted during the filing limit.

After submitting electronic claims, do the following:

- Monitor claim status on the provider portal or through the BCBSTX Customer Service Interactive Voice Response (IVR) at **877-560-8055**. Please note that the IVR accepts either your billing National Provider Identifier (NPI) or your Federal Tax Identification Number (TIN) for provider identification. Should the system not accept you're billing NPI or Federal TIN, the system will route your call to a Customer Service representative who will help you with your query. For purposes of assisting you, we may ask you for your TIN.
- Watch for (and confirm) plan Batch Status Reports from your vendor/clearinghouse to help ensure your claims have been accepted by BCBSTX.
- Correct any errors and resubmit the claim (electronically) immediately to prevent denials due to untimely filing.

A front-end edit process may occur with your contracted vendor and/or clearinghouse. If claims do not meet the required HIPAA compliance standards, the claim may be 'rejected' by your EDI vendor or clearinghouse. An error report will be sent to you and your claim will never reach BCBSTX's EDI gateway. You will need to review these reports and file again.

For EDI claims submissions that require attachments, please contact your clearinghouse for guidelines.

- Learn more about EDI and how to get connected.
- Get technical assistance and support.

Paper Claims

Paper claims are scanned for clean and clear recording of data. To get the best results, paper claims must be legible and submitted in the proper format. Follow these paper claim submission requirements to speed processing and prevent delays:

- Use the correct form and be sure the form meets Centers for Medicare and Medicaid Services (CMS) standards
- Use black or blue ink; do not use red ink, as the scanner may not be able to read it
- Do not stamp or write over boxes on the claim form
- Send the original claim form to BCBSTX, and retain the copy for your records
- Do not staple original claims together; BCBSTX will consider the second claim as an attachment and not an original claim to be processed separately
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned with corresponding information. If using a dot matrix printer, do not use 'draft mode' since the characters generally do not have enough distinction and clarity for the optical character reader to accurately read the contents.

When submitting paper claims, the following provider information must be included:

- Provider Name
- National Provider Identifier (NPI)
- Rendering Provider Group or Billing Provider
- Medicare number (if applicable)
- The Federal Provider Tax Identification (ID) number

Attachments to Paper Claims

Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim.

Paper Claim Submission Mailing Addresses

Mail paper claims for BCBSTX to:

Blue Cross and Blue Shield of Texas

Attn: Claims

PO Box 51422

Amarillo, TX 79159-1422

Chapter 6

BEHAVIORAL HEALTH CLAIMS

Claims for STAR and CHIP behavioral health services can be submitted to:

Magellan

Attn: Claims

P.O. Box 2154

Maryland Heights, MO 63043

CLINICAL SUBMISSIONS CATEGORIES

Following is a list of claims categories that may require routine submission of clinical information before or after payment of a claim:

- Claims involving precertification/prior authorization/predetermination (or some other form of utilization review) including but not limited to:
 - Claims pending for lack of precertification or prior authorization
 - Claims involving medical necessity or experimental/investigative determinations
 - Claims involving drugs administered in a physician's office requiring prior authorization
 - Claims requiring certain modifiers
 - Claims involving unlisted codes
 - Claims for which we cannot determine from the face of the claim whether it involves a covered service; thus, the benefit determination cannot be made without reviewing medical records (including but not limited to emergency service-prudent layperson reviews and specific benefit exclusions). A prudent layperson is someone who possesses an average knowledge of health and medicine.
 - Claims that we have reason to believe involve inappropriate (including fraudulent) billing
 - Claims that are the subject of an audit (internal or external), including high-dollar claims
 - Claims for individuals involved in case management or disease management
 - Claims that have been appealed (or that are otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated)

Other situations in which clinical information might routinely be requested:

- Accreditation activities
- Quality improvement/assurance activities
- Credentialing
- Coordination of benefits
- Recovery/subrogation

Examples provided in each category are for illustrative purposes only and are not meant to represent a complete list within the category.

NATIONAL PROVIDER IDENTIFIER

The National Provider Identifier (NPI) is a 10-digit number. NPIs are issued only to providers of medical and health services and supplies. NPI is one provision of the Administrative Simplification portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). NPI is intended to improve the efficiency of the health care system and reduce fraud and abuse.

There are several advantages to using your NPI for claims and billing. NPI offers providers the opportunity to bill with only one number. Some of the advantages for plan providers using NPI include the following:

- The billing process is simplified, as it is no longer necessary to maintain and use legacy identifiers for each of the plans.
- Administering changes for addresses and locations is easy.
- Providers will only have one number for electronically transacting business with any health plan with which they are affiliated.

Providers may apply for an NPI individually online at the National Plan and Provider Enumeration System (NPPES) website at www.nppes.cms.hhs.gov or by obtaining a paper application by calling the NPPES number at **800-465-3203**.

Unattested NPIs

BCBSTX will deny claims with an unattested NPI, even if you provide legacy information. Attestation is the process of registering and reporting your NPI with your state Medicaid agency. Providers serving Texas Medicaid (STAR) patients are required to register and attest their NPI with the State of Texas Medicaid & Healthcare Partnership (TMHP). You can attest (register and report) your NPI with Texas Medicaid and Healthcare Partnership (TMHP) at www.tmhp.com. Attesting makes processing and paying your claims more efficient and accurate. During attestation, you may also be assigned a benefit code to identify specific state programs as part of NPI-related data. You can verify your NPI assignment at the National Plan and Provider Enumeration System (NPPES) website at www.nppes.cms.hhs.gov.

The Centers for Medicare and Medicaid Services (CMS) has developed regulations for a batch enumeration called Electronic File Interchange, or EFI. The EFI process will be available to large provider groups such as hospitals and provider practice groups. More information on EFI can be found at www.nppes.cms.hhs.gov.

Although a provider may not be currently billing to Medicaid or other publicly funded programs, a participating provider must still apply for an NPI with CMS. According to the NPI Final Rule, BCBSTX requires the NPI on paper claims for our participating providers.

Online Resources for NPI Information

The following websites offer additional NPI information:

Centers for Medicare and Medicaid Services: www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvidentStand/index.html

National Plan and Provider Enumeration System (NPPES): www.nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

Workgroup for Electronic Data Interchange: www.wedi.org

National Uniform Claims Committee: www.nucc.org

Chapter 6

BENEFIT CODES

Submit claims with the appropriate benefit code for services, as required. For electronic claims, add the benefit code in SBR Loop 2000B, SBR03. For paper claims, add the benefit code in Box 11 on the CMS-1500 Claim Form. If you submit a claim without the benefit code when it is required, the claim will be returned for resubmission.

If a benefit code is not applicable, leave the field blank. [Include only required codes (with *)]

Benefit Code	Service
CCP*	Comprehensive Care Program (CCP) – Box 11
CSN	Children with Special Health Care Needs (CSHCN) Services Program Provider
DE1	Texas Health Steps Dental
DM2	Texas Medicaid Home Health DME
DM3	CSHCN Services Program Home Health DME
EC1	Early Childhood Intervention (ECI) Providers
EP1*	Texas Health Steps – Box 11c
HA1	Hearing Aid
IM1	Immunization
MA1	Maternity
MH2	Behavioral/Mental Health Case Management
TB1	Tuberculosis (TB) Clinic
WC1	Women, Infants, and Children (WIC) Program

*Required codes for submission to BCBSTX for submitting claims; all other codes are required by HHSC when claims are sent to the state for reimbursement.

FAMILY PLANNING CLAIMS SUBMISSION

BCBSTX reimburses the following family planning procedure codes:

99201	99202	99203	99204	99205
99211	99212	99213	99214	99215

BCBSTX reimburses the following Family Planning Diagnosis codes:

Z33011	Z30013	Z30014	Z30018	Z3002	Z3009
Z302	Z3040	Z3041	Z3042	Z30430	Z30431
Z30432	Z30433	Z3049	Z308	Z309	Z9851
Z9852					

Family Planning follow-up visits may be billed with or without modifier FP.

BILLING REQUIREMENTS FOR CHIP PERINATE POSTPARTUM VISITS

CHIP Perinate mothers are entitled to a maximum of two postpartum visits. CHIP Perinate mother's eligibility terminates at the end of the month the baby was born. Providers, who call to check benefits after the month of the baby's birth, will be advised the CHIP Perinate mother is not eligible. CHIP Perinate mothers may receive their postpartum visits after their eligibility ends (at the end of the month of the baby's birth). In order to be reimbursed for the postpartum visits, providers must bill using the following CPT delivery codes that include postpartum care. The reimbursement amount for the below procedure codes includes both postpartum care visits. **These changes only apply to CHIP Perinate postpartum visits.**

If the provider bills any other code and the date of service is after the CHIP Perinate mother's eligibility has terminated, the provider will not receive payment for the postpartum care.

If the claim was submitted with the incorrect code, the original delivery claim with the correct code may be re-submitted within the 120-day appeal deadline.

CPT Delivery Code	Description
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum
59515	Cesarean delivery only; including postpartum care
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

Exceptions to this billing process must be approved by BCBSTX Provider Relations

Chapter 6

BILLING REQUIREMENTS FOR CLINICIAN ADMINISTERED DRUGS

A national drug code (NDC) and Healthcare Common Procedure Coding System (HCPCS) procedure code must be submitted on all medical claims for clinician-administered drugs. If a submitted claim is missing the NDC information or the NDC is not valid for the corresponding HCPCS code, BCBSTX will deny or reject the entire claim for failing to comply with the Clean Claim Standards. This requirement applies to the STAR program only.

Entity Type 1 and Entity Type 2 Providers

An individual health care provider should apply for an Entity Type 1 NPI. This includes, but is not limited to, physicians, dentists and chiropractors.

Organizations such as hospitals should apply for an Entity Type 2 NPI. The definition of an organization includes, but is not limited to, medical groups, group practices, Federally Qualified Health Centers and Rural Health Centers.

Note: Submit Texas Health Steps medical groups with Type 1 and 2 – Organization NPI as the billing NPI; do not include rendering NPI information on Texas Health Steps groups claims. BCBSTX requires benefit code **EP1** (Texas Health Steps) when filing a Texas Health Steps claim. Leave 24J blank.

Only use billing NPI Box 33A on Texas Health Steps claims for both Type 1 and Type 2 entities.

On paper claims, include this benefit code on the CMS-1500 Claim Form in box 11. Texas Health Steps claims submitted without the benefit code will be returned.

For solo or Type 1 providers, use Individual NPI in box 33A when submitting Texas Health Steps claims and include the EP1 benefit code to avoid claims returned for resubmission. Leave 24J blank.

BILLING REQUIREMENTS FOR 340B DRUG DISCOUNT PROGRAM

The 340 Drug Discount Program requires drug manufacturers to provide covered out-patient drugs to certain eligible health care entities at or below statutorily defined discount prices.

Pharmacies billing claims using pharmaceutical stock purchased under Section 340B pricing should identify these claims using National Council for Prescription Drug Program (NCPDP) values as applicable. Currently, NCPDP standard allows pharmacies to identify these claims as 340B by:

- Submitting Submission Clarification Code value 20 in field 420-DK.

CHIP PROVIDER RESPONSIBILITY

CHIP providers are responsible for collecting any applicable copayments or deductibles **at the time of service**, in accordance with CHIP's cost-sharing limitations.

The copayment is listed on the member's ID card.

Families that meet the enrollment period cost-sharing limit requirement must report it to Maximus, the Texas Health and Human Service Commission (HHSC) Administrative Services Contractor. Upon notification from Maximus that the cost-sharing limit has been reached, BCBSTX will issue the CHIP member a new member ID card within five days, showing that the member's cost-sharing limit has been met. No copayments may be collected from these CHIP members for the balance of their term of coverage.

EXCEPTIONS TO CHIP PROVIDER RESPONSIBILITY

1) Immunizations, Well-Child, Well-Baby

No copayments apply, at any income level, to well-child or well-baby visits or immunizations, except for costs associated with unauthorized non-emergency services provided by out-of-network providers and for non-covered services.

2) Native Americans and Alaskan Natives

Federal law prohibits charging copayments, deductibles or out-of-pocket costs to CHIP and CHIP Perinate members who are Native Americans or Alaskan Natives. When a member is identified as a Native American or Alaskan Native, the member will be issued a member ID card showing the member has no cost-sharing obligations.

3) CHIP Perinate

No copayments apply, at any income level.

Chapter 6

COORDINATION OF BENEFITS

When applicable, BCBSTX coordinates benefits with any other carrier or program that the member may have for coverage, including Medicare. Indicate 'Other Coverage' information on the appropriate claim form.

If there is a need to coordinate benefits, include at least one of the following items from the other carrier or program when submitting a COB claim:

- Third-party Remittance Advice (RA)
- Third-party letter explaining the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other carrier or program first. Please make sure that the information you submit explains any coding listed on the other carrier's RA or letter. We cannot process your claim without this specific information.

BCBSTX must receive COB claims within 95 days from the date on the other carrier's or program's RA or letter of denial of coverage.

When submitting COB claims, specify the other coverage in:

- Boxes 9a-d of the CMS-1500 claim form
- Boxes 58-62 of the CMS-1450 (UB-04) claim form

Third-party Recovery

You may not interfere with or place any liens upon the state's right or BCBSTX's right, acting as the state's agent, to recovery from third-party billing.

CLAIMS PROCESSING

A brief description of claims processing methods follows. All paper submitted claims are assigned a unique Document Control Number (DCN). The DCN identifies and tracks claims as they move through the claims processing system. This number contains the Julian date, which indicates the date the claim was received. It monitors timely submission of a claim.

Document Control Numbers are composed of 11 digits:

- Two-digit plan year
- Two-digit BCBSTX reel identification
- Three-digit Julian date
- Four-digit sequential number

Claims entering the system are processed on a line-by-line basis except for inpatient claims. Inpatient claims are processed on a whole-claim basis. Each claim is subjected to a comprehensive series of checkpoints called edits. These edits verify and validate all claim information to determine if the claim should be paid, denied or pended for manual review.

You are responsible for all claims submitted with your provider number, regardless of who completed the claim. If you use a billing service you must help ensure that your claims are submitted properly.

Note: Entities submitting claims for services rendered by a health care provider are subject to Texas HHSC suspension if they submit claims for a Provider who is suspended from HHSC.

Claim Returned for Correction/Additional Information

If the claim is not clean, it will be denied and a remit will be sent explaining the denial.

Claim Filing with Wrong Plan

If you file a claim with the wrong insurance carrier and provide documentation verifying the initial timely claims filing within 95 days of the date of the other carrier's denial letter or RA form, BCBSTX processes your claim without denying it for failure to file within filing time limits.

CLAIMS PAYMENT

Upon receiving claims, BCBSTX analyzes them for medically necessary and covered services. BCBSTX generates a Remittance Advice (RA), either paper or electronic, summarizing services rendered and payer action taken, and sends the appropriate payment amount to the provider.

BCBSTX shall adjudicate (finalize as paid or denied) a clean claim within 30 days from the date the claim is received. BCBSTX will pay providers interest at a rate of 18 percent per annum, calculated daily on clean claims that are not adjudicated within 30 days.

BCBSTX shall adjudicate (finalize as paid or denied) a clean electronic pharmacy claim within 18 days point of sale process, and paper pharmacy claim submitted no later than 21 days. BCBSTX will pay pharmacy providers interest at a rate of 18 percent per annum, calculated daily on clean claims for pharmacy claims that are not adjudicated within 18 days.

Unless otherwise noted below, physicians and other professional providers will receive payment and Remittance Advices (RAs) in a paper format.

Electronic Fund Transfer

BCBSTX allows the electronic fund transfer (EFT) option for claims payment transactions. This allows claims payments to be deposited directly into a previously selected bank account.

Electronic Remittance Advices

Providers contracted with BCBSTX can choose to receive Electronic Remittance Advices (ERAs). ERAs are received through a mailbox set up between a provider or clearinghouse and BCBSTX. Use the mailbox to send and receive ERA files, which are in an ASC X 12N 835 file format. There is no charge for the service, but enrollment is required.

Electronic data transfers and claims are HIPAA-compliant and meet federal requirements for EDI transactions, code sets, member confidentiality, and privacy. To enroll for Electronic Remittance Advices, go to

www.bcbstx.com/provider/claims/era.html.

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CLAIMS OVERPAYMENT RECOVERY PROCEDURE

When a claims overpayment is discovered, BCBSTX will notify the provider. If a provider is notified by BCBSTX of an overpayment, or discovers that they have received an overpayment, the provider should return the overpayment to BCBSTX by mailing a check and a copy of the overpayment notification to:

Blue Cross and Blue Shield of Texas

Attn: Overpayment Recovery

PO Box 51422

Amarillo, TX 79159-1422

Note: the address above cannot accept overnight packages. If you are sending an overnight package, please contact Customer Service at **877-560-8055**.

If you believe that the overpayment was created in error, you should contact BCBSTX in writing. For a claims re-evaluation, send your correspondence to the address indicated on the overpayment notification.

CLAIM STATUS INQUIRY AND FOLLOW-UP

Checking Claim Status

You should receive a response from BCBSTX within 30 days of receipt of a clean claim. If the claim contains all required information, BCBSTX enters the claim into BCBSTX's claims system for processing and sends you a Remittance Advice (RA).

Claim Status Online

You can confirm BCBSTX's receipt of your claim through the Availity online tool at www.availity.com. Using Availity, you can also view claims status and payment information.

Telephonic Claim Status

You can also confirm that BCBSTX received your claim by calling Customer Service at **877-560-8055**. Hours are Monday - Friday, 8 a.m. to 8 p.m. (Central Standard Time), except certain holidays.

Claim Follow-up/Resubmission

You can initiate follow-up action to determine claim status if there has been no response from BCBSTX to a submitted claim after 30 days from the date the clean claim was submitted.

To follow up on a claim, you should:

- Check www.availability.com for disposition of the claim. Please note that the IVR accepts either your billing National Provider Identifier (NPI) or your federal Tax Identification Number (TIN) for provider identification. Should the system not accept your billing NPI or Federal TIN, the system will route your call to a Customer Service representative who will help you with your query. For purposes of assisting you, we may ask you for your TIN.
- Contact Customer Service at **877-560-8055**
- Provide a copy of the original claim submission and all supporting documentation (such as records and reports) that you deem pertinent or that has been requested by BCBSTX to:

Blue Cross and Blue Shield of Texas

Attn: Complaints and Appeals

PO Box 27838

Albuquerque, NM 87125-7838

Reviewing Batch Status Reports (EDI Claims Only)

If you submitted your claim electronically, you should receive and confirm the contents of BCBSTX Batch Status Reports from your electronic vendor/clearinghouse and correct any errors. Errors must be promptly corrected and resubmitted (electronically) to prevent denials due to untimely filing.

Questions about Claim Status and Follow-up

BCBSTX's Customer Service is available to answer any questions and provide further instructions regarding claim follow-up. A Customer Service representative can:

- Research the status of claims.
- Advise you of necessary follow-up action, if any.

CLAIM PAYMENT APPEAL PROCEDURE

Claim Payment Appeals is the process by which a provider may challenge the disposition of a claim that has already been adjudicated. Provider appeals include, but are not limited to:

- Payer allowance
- Medical policy or medical necessity
- Incorrect payment/coding rules applied

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Provider appeals are not considered:

- Corrected claim
- General inquiry/question
- Claim denials needing additional information
- Requests for claim payment appeals must be submitted in writing to BCBSTX within 120 days of a claim disposition. Include all pertinent information.

Blue Cross Blue Shield of Texas

Attn: Complaint and Appeal Department

PO Box 27838

Albuquerque, NM 87125-7838

Fax: **855-235-1055**

Email: GPDTXMedicaidAG@bcbsnm.com

Providers may also submit provider appeals through the Availity online tool at www.availity.com.

Claim payment appeal requests are resolved within 30 days of receipt of written request. After the review is complete, a resolution letter with the details of our decision will be sent to the provider.

If a provider is not satisfied with the outcome of the review conducted through the Provider Appeal Process, additional steps can be taken:

1. Mediation (handled per the BCBSTX physician agreement)
2. Arbitration (handled per the BCBSTX physician agreement)

If the above processes have been exhausted for a STAR claim, the provider may file a complaint with:

Health and Human Services Commission

Managed Care Operations—H320

P.O. Box 85200

Austin, TX 78708-520

If the above processes have been exhausted for a CHIP claim, the provider has the right to file an appeal with the Texas Department of Insurance (TDI). Provider Complaints or Appeals to TDI should be sent to:

Texas Department of Insurance

P.O. Box 149091

Austin, Texas 78714-9091

Phone: **512-463-6500** or **800-252-3439**

Email: ConsumerProtection@tdi.state.tx.us

Online form: www.tdi.texas.gov/consumer/cportal.html

COMMON REASONS FOR REJECTED AND RETURNED CLAIMS

Many of the claims returned for further information are returned for common billing errors.

Problem	Explanation	Resolution
Member's ID Number is Incomplete	BCBSTX provides ID cards to the member in addition to the state ID card. The member's plan ID number is called the member number and is the same as their medical ID.	Use the Member's ID number from the BCBSTX ID card. Inclusion of the alpha prefix at the beginning of the member's nine-digit BCBSTX ID number is encouraged for electronic claims, but not required. We will not reject the claim.
Duplicate Claim Submission	Overlapping service dates for the same service create a question about duplication. Claim was submitted to BCBSTX twice without additional information for consideration.	List each date of service, line by line on the claim form. Avoid spanning dates, except for inpatient billing. Make sure you read your RAs, CDNs and mail back forms for important claim determination information before resubmitting a claim. Additional information may be needed.
Authorization Number Missing/ Does Not Match Services	The authorization number is missing, or the approved services do not match the services described in the claim.	Confirm that the Authorization Number is provided on the claim form (CMS-1500 Box 24 and CMS-1450 (UB-04) Box 63) and that the approved services match the provided services.
Missing Codes for Required Service Categories	Current Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) manuals must be used because changes are made to the codes quarterly or annually. Manuals may be purchased at any technical bookstore, or through the American Medical Association or the Practice Management Information Corporation.	Make sure all services are coded with the correct codes (see lists provided). Check the code books or ask someone in your office who is familiar with coding.

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Problem	Explanation	Resolution
Unlisted Code for Service	Some procedures or services do not have a code associated with them, so an unlisted procedure code is used.	BCBSTX needs a description of the procedure and medical records when appropriate in order to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer's invoice. For clinician administered drugs/injections, the National Drug Code (NDC) number is required.
By Report Code for Service	Some procedures or services require additional information.	BCBSTX needs a description of the procedure and medical records when appropriate to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer's invoice. For drugs/injections, the NDC number is required.
Unreasonable Numbers Submitted	Unreasonable numbers, such as '9999' may appear in the Service Units fields.	Make sure to check your claim for accuracy before submitting it.
Submitting Batches of Claims	Stapling claims together can make subsequent claims appear to be attachments, rather than individual claims.	Make sure each individual claim is clearly identified and not stapled to another claim.
Nursing Care	Nursing charges are included in the hospital and outpatient care charges. Nursing charges that are billed separately are considered unbundled charges and are not payable. In addition, BCBSTX will not pay claims using different room rates for the same type of room to adjust for nursing care.	Do not submit bills for nursing charges.
Hospital Medicare ID Missing	The Medicare ID number is required to process hospital claims at their appropriate contracted rates.	On the CMS-1450 (UB-04) form, hospitals must enter their Medicare ID number in Box 51.



Chapter 7

BILLING PROFESSIONAL AND ANCILLARY CLAIMS

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PROFESSIONAL BILLING REQUIREMENTS BY SERVICE CATEGORY

After Hours

BCBSTX considers normal business hours for PCPs as Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Time. Services provided outside of normal business hours should bill CPT code 99050 in addition to the codes reflecting the services rendered to receive additional reimbursement.

Behavioral Health

For STAR and CHIP members, behavioral health services are provided and administered by Magellan. All billing should go to Magellan:

Magellan

Attention: Claims

P.O. Box 2154

Maryland Heights, MO 63043

To access Magellan's Provider Manual, go to www.magellanprovider.com.

Emergency Services

Authorizations are not required for medically necessary emergency services. Emergency services are defined in your BCBSTX provider contract, by state and local law, and in the member handbook.

Related professional services offered by physicians during an emergency room visit are reimbursed according to your BCBSTX provider contract.

For professional emergency services billing, indicate the injury date in Box 14 on the CMS-1500 claim form if applicable.

All members should be referred to the primary care provider (PCP) of record for follow-up care. Unless clinically required, follow-up care should never occur in the emergency department of a hospital.

Emergency Service Claims

An emergency is defined as any condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a layperson possessing an average knowledge of health and medicine could reasonably expect that in the absence of immediate medical care could result in:

- Placing the patient's health or, with respect to a pregnant member, the health of the member or the unborn child in serious jeopardy
- Causing serious impairment to bodily functions
- Causing serious dysfunction to any bodily organ or part

Covered services include: hospital-based emergency department services (room and ancillary) needed to evaluate or stabilize an emergency medical condition and/or emergency behavioral health condition, as well as services by emergency professional/physicians.

Hospitals and physicians rendering services in the emergency department will be reimbursed for emergency services at 100% of the applicable rate when services are billed with 99284 and 99285. Hospital and physician reimbursement will be reduced by 40% for services billed with 99281, 99282 and 99283.

This includes a medical screening to evaluate care levels and stabilization services needed to admit or release a patient. Physicians must use Medicaid allowable codes to identify emergency services.

Durable Medical Equipment

See the **Ancillary Billing Requirements by Service Category** section in **Chapter Eight** for DME billing requirements.

Hospital Readmissions Policy

After a member is discharged from a hospital confinement, BCBSTX does not reimburse for a readmission if the readmission occurs within 30 days. This is per HHSC policy for readmissions.

Initial Health Assessments and Texas Health Steps Visits in the First 90 Days

The PCP functions as the medical home or patient advocate and is responsible for member access to health care. BCBSTX strongly recommends that an initial health assessment (IHA), consisting of a complete history and physical, be conducted within 90 days from the adult member's date of enrollment with us. Children under 21 are required to be seen for a Texas Health Steps visit if they are newly enrolled with BCBSTX within 90 days of enrollment, even if not due for a visit. The claim should be billed as an exception to periodicity with Modifier 32. Preventive services are to be rendered according to Adult and Pediatric Preventive Healthcare Guidelines.

Billing Codes for Initial Health Assessments

When billing for preventive services, use these International Classification of Diseases, (ICD-10) diagnosis codes:

- Z00121 for children (newborn to 18 years of age)
- Z00129 for adults (19 years and older)

For details on correct billing procedures, refer to the Submitting a Claim section. You may also reference the Physician's Current Procedural Terminology manual published by the American Medical Association (AMA).

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Texas Health Steps

Newly enrolled members in STAR must be seen within 90 days of joining the plan for a Texas Health Steps visit. BCBSTX provides providers with a list of their assigned member with their enrollment date. Providers should reach out to these members to schedule an appointment for a Texas Health Steps checkup. A checkup for an existing member from birth through 35 months of age is timely if received within 60 days beyond the periodic due date based on the member's birth date. A Texas Health Steps medical checkup for an existing member, age three years and older is due annually beginning on the child's birthday and is considered timely if it occurs no later than 364 calendar days after the child's birthday.

Requirements for all Texas Health Steps claims:

- Use benefit code EP1 in field 11 of the CMS 1500 claim form
- Use Z00121 and Z00129 field 21 of the CMS 1500 claim form
- No rendering NPI required for Texas Health Steps or preventive visits
- No requirement to bill other insurance coverage for Texas Health Steps claims

Texas Health Steps Visits and Acute Care Services Performed on the Same Day

When a Texas Health Steps visit is billed for the same date of service as an acute care visit, both services may be reimbursed when billed by the same provider or provider group.

- Providers must bill an acute care visit on a separate claim without the benefit code EP1
- Providers must use modifier 25 to describe the circumstances in which an acute care visit was provided at the same time as a Texas Health Steps visit

CHIP Preventive Visits and Acute Care Services Performed on the Same Day

When a CHIP Preventive checkup is billed for the same date of service as an acute care visit, both services may be reimbursed when billed by the same provider or provider group.

- Providers must bill an acute care visit on a separate claim without benefit code EP1
- Providers must use modifier 25 to describe circumstances in which an acute care visit was provided at the same time as a Chip Preventive visit
- Use Z00121 and Z00129 for the CHIP Preventive visit
- A copay will apply to the acute care services

PREVENTIVE MEDICINE SERVICES, NEW PATIENT

Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunizations, laboratory/diagnostic procedures for a new patient.

Code	Description
99381	Infant (age under 1 year)
99382	Early childhood (ages 1 through 4 years)
99383	Late childhood (ages 5 through 11 years)
99384	Adolescent (ages 12 through 17 years)
99385	18–39 years
99386	40–64 years
99387	65 years and over

PREVENTIVE MEDICINE SERVICES, ESTABLISHED PATIENT

Periodic comprehensive preventive medicine re-evaluation and management of an individual, including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunizations, laboratory/diagnostic procedures for an **established patient**.

Code	Description
99391	Infant (age under 1 year)
99392	Early childhood (ages 1 through 4 years)
99393	Late childhood (ages 5 through 11 years)
99394	Adolescent (ages 12 through 17 years)
99395	18–39 years
99396	40–64 years
99397	65 years and over

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ADULT PREVENTIVE CARE PROCEDURE CODES

Code	Description
76091	Mammogram (specialty center)
82270	Fecal Occult Blood Test (lab procedure code only)
82465	Total Serum Cholesterol (lab procedure code only)
84153	PSA (lab procedure code only)
86580	Tuberculosis (TB) Screening (PPD)
88150	Pap Smear (lab procedure code only)
90658	Flu Shot
90718	Td-Diphtheria–Tetanus Toxoid–0.5 ml
90732	Pneumovax

MATERNITY SERVICES

BCBSTX requires itemization of maternity services when submitting claims for reimbursement. Please use the appropriate CPT or HCPCS codes and ICD diagnosis codes when billing. This includes the applicable evaluation and management code, along with coding for all other procedures performed.

Medicaid (STAR) delivery charges should be billed with the appropriate CPT codes. Delivery charges should be billed with appropriate CPT codes.

Code	Description
59409	Vaginal delivery only
59612	
59514	Cesarean section only
59620	
59430	Postpartum outpatient visit

CHIP/CHIP Perinate delivery charges should be billed with the appropriate CPT codes. Delivery charges should be billed with appropriate CPT codes.

Code	Description
59410	Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care
59515	Cesarean section only (including postpartum care)
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps) (including postpartum care)
59622	Cesarean section only, following attempted vaginal delivery after previous cesarean delivery (including postpartum care)

Claims for Obstetric Deliveries to Require a Modifier

Claims submitted for obstetric deliveries with procedure codes 59409, 59410, 59514, 59515, 59612, 59614, 59620, or 59622 will require one of the following modifiers:

Modifier	Description
U1	Medically necessary delivery prior to 39 weeks of gestation*
U2	Delivery at 39 weeks of gestation or later
U3	Non-medically necessary delivery prior to 39 weeks of gestation

* Medicaid STAR claims must include a medically necessary diagnosis from the list of **Medically Necessary Obstetric Diagnosis Codes** located at <http://www.bcbstx.com/provider/Medicaid/claims.html>, Related Resources.

Note: Claims for deliveries that are submitted without one of the required modifiers will be denied.

BCBSTX restricts any cesarean section, labor induction, or any delivery following labor induction to one of the following additional criteria:

- Gestational age of the fetus should be determined to be at least 39 weeks or fetal lung maturity must be established before delivery.
- When the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery.

Cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to 39 weeks of gestation and are not considered medically necessary will be denied.

Records will be subject to retrospective review. Payments made for non-medically indicated Cesarean section, labor induction, or any delivery following labor induction that fail to meet these criteria (as determined by review of medical documentation), will be subject to recoupment. Recoupment may apply to all services related to the delivery, including additional physician fees and the hospital fees.

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- BCBSTX reimburses only one delivery or cesarean section procedure per member in a seven-month period. Reimbursement includes multiple births.
- Delivering physicians who perform regional anesthesia or nerve block may not receive additional reimbursement because these charges are included in the reimbursement for the delivery.
- BCBSTX reimburses anesthesia services and delivery at full allowance when provided by the delivering obstetrician.
- BCBSTX will reimburse antepartum care, deliveries, including cesarean sections performed by physicians, and postpartum care. (Codes 59410, 59515, 59614 and 59622 are deliveries that include the postpartum visit.)
- When billing BCBSTX, you must itemize each service individually and submit claims as the services are rendered. The filing deadline will be applied to each individual date of service submitted to BCBSTX.
- Laboratory (including pregnancy test) and radiology services provided during pregnancy must be billed separately and be received by BCBSTX within 95 days from the date of service.
- Use modifier TH, obstetrical treatment or service, prenatal or postpartum, with all antepartum procedure codes.

Initial prenatal visits are payable with the following CPT codes along with modifier TH:

99201 = Office/Outpatient Visit, New – Minor

99202 = Office/Outpatient Visit, New – Low to Moderate Severity

99203 = Office/Outpatient Visit, New – Moderate Severity

99204 = Office/Outpatient Visit, New – Moderate Complexity; Moderate to High Severity

99205 = Office/Outpatient Visit, New – High Complexity, Moderate to High Severity

An 'initial prenatal visit' is defined as the first pregnancy-related office visit.

Providers must bill the most appropriate new or established patient prenatal or postpartum visit procedure code. New patient codes may be used when the client has not received any professional services from the same physician or a physician of the same specialty who belongs to the same group, within the past three years.

Postpartum care visits are payable with the following CPT codes along with modifier TH:

99211 = Office/Outpatient Visit, Established – Minor

99212 = Office/Outpatient Visit, Established – Low to Moderate Severity

99213 = Office/Outpatient Visit, Established – Moderate Severity

99214 = Office/Outpatient Visit, Established – Moderate Complexity, Moderate to High Severity

99215 = Office/Outpatient Visit, Established – High Complexity, Moderate to High Severity

- Postpartum care provided after discharge must be billed with CPT code 59430 and modifier TH. **This applies to STAR members only.** Please see **Chapter 6: CHIP Perinate Postpartum Billing Requirements** for detailed information on billing CHIP Perinate postpartum care.
- Use of the appropriate evaluation and management, antepartum or postpartum, CPT codes is necessary for appropriate reimbursement. You should indicate the estimated date of confinement (EDC) in Box 24D of the CMS-1500 claim form.

- If a member is admitted to the hospital during the course of her pregnancy, the diagnosis necessitating the admission should be the primary diagnosis on the claim.
- If high risk, the high-risk diagnosis must be documented on the claim form. The nature of the high-risk care visit must be identified in the diagnosis field in Box 21 of the CMS-1500 claim form, or the appropriate field.
- Use the CMS-1500 claim form with itemized E&M codes.

GLOBAL CODES

Global codes **cannot** be used for billing BCBSTX. If BCBSTX receives a claim with global coding, it will be denied. The provider has 120 days from the date of the first denial to appeal the claim.

NEWBORNS

After a BCBSTX member gives birth, please bill using the mother's Medicaid ID number until the state assigns a permanent Medicaid ID number to the newborn. You also need to provide the name, date of birth and other pertinent information about the newborn by submitting the **Newborn Notification Enrollment Report** found on our website at <http://bcbstx.com/provider/Medicaid/index.html>.

Hospitals may bill claims for newborn delivery and other newborn services separately from the claims for services they provide for the mother. In **all** claims filings, however, use the mother's Medicaid ID number when the newborn's permanent Medicaid ID number is not available.

Providers may bill using the mother's Medicaid ID number up to 90 days after the baby is born or until the newborn is assigned a Medicaid ID number, whichever comes first.

If a newborn needs medication from the retail pharmacy before the newborn's permanent ID has been received from the state, the pharmacy can contact BCBSTX Customer Service from 8 a.m. to 8 p.m. by calling **888-657-6061** and requesting assistance with verifying member eligibility. BCBSTX Customer Service will provide the pharmacy with the newborn's plan identification number. If the newborn requires a prescription after hours (8 p.m. to 8 a.m. and all day weekend or holidays) and before the state has issued the newborn's permanent ID, the pharmacy can contact the customer service number above and prompt for the after-hours triage team. The triage team will provide the pharmacy with a temporary plan ID for the newborn if able to verify eligibility.

Submit newborn claims using the state-issued Medicaid ID number of the newborn. Do **not** use the temporary ID numbers (those ending with NB followed by one or more digits); BCBSTX rejects claims that have temporary ID numbers.

To prevent any lapse in plan coverage for newborns, please ask your patients to take these important steps as soon as their babies are born:

- Immediately contact the Texas Health and Human Services Commission (HHSC) or their social worker to request the required paperwork.
- Fill out and return the required paperwork to the state to enroll their newborn in STAR or CHIP.

BCBSTX **requires** that you notify us of all deliveries within three days of delivery. Use the **Newborn Enrollment Notification Report** found on the BCBSTX website at <http://bcbstx.com/provider/Medicaid/index.html>.

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Also, notify BCBSTX when you receive a newborn's permanent Medicaid ID number. Use the **Newborn Enrollment Notification Report** found on the <http://bcbstx.com/provider/Medicaid/index.html>.

Prior authorization is waived on circumcisions until child is one years old.

Circumcision charges should be billed with appropriate CPT codes.

Code	Description
54150	Circumcision, Using Clamp or Other Device – Newborn
54152	Circumcision, Using Clamp or Other Device – Except Newborn
54160	Circumcision, Surgical Excision Other Than Clamp, Device or Dorsal Split – Newborn
54161	Circumcision, Surgical Excision Other Than Clamp, Device or Dorsal Split – Except Newborn

SELF-REFERABLE SERVICES

STAR members may access the following services at any time without pre-authorization or referral by their PCP:

- Diagnosis and treatment of sexually transmitted diseases (STDs)
- Testing for the human immunodeficiency virus (HIV)
- Family planning services: Services to prevent or delay pregnancy from any Medicaid family planning provider, in-network or out-of-network
- Annual well member exam (ICD Diagnosis Z0000, Z0001, Z01411, Z01419) (in-network only)
- Prenatal services (in-network only): Obstetric care unless the member is in the third trimester
- Early Childhood Intervention (ECI): Only initial evaluation does not require prior authorization.
- Vision services provided by Davis Vision

SPORTS AND CAMP PHYSICALS

There are some important considerations for Sports and Camp Physicals invoice submission:

1. The primary care provider (PCP) should verify the eligibility of assigned members and verify that the member has not already received a Sports and Camp Physical within one year of the last physical.
2. The provider will conduct a physical that meets the minimum requirements defined by a Sports or Camp Physical.
3. The provider will submit a Sports and Camp Physical invoice form within 95 days of the date of service.
4. The invoice will be sent to the following address:

Blue Cross Blue Shield Texas
Attn: Sports/Camp Physicals
P.O. BOX 201166
Austin, Texas 78720-9919

5. Providers will receive \$25 for Sports and Camp Physicals that meet the criteria in number 1, above.
6. Providers are not eligible for any additional payment for services provided during a Sports or Camp Physical.

FAMILY PLANNING SERVICES

The following is a list of **diagnosis** codes specific to family planning services.

Diagnosis	Code Description
Z30011	Encounter for initial prescription of contraceptive pills
Z30013	Encounter for initial prescription of injectable contraceptive
Z30014	Encounter for initial prescription of intrauterine contraceptive device
Z30018	Encounter for initial prescription of other contraceptives
Z3002	Counseling and instruction in natural family planning to avoid pregnancy
Z3009	Encounter for other general counseling and advice on contraception
Z302	Encounter for sterilization
Z3040	"Encounter for surveillance of contraceptives..... unspecified"
Z3041	Encounter for surveillance of contraceptive pills
Z3042	Encounter for surveillance of injectable contraceptive
Z30430	Encounter for insertion of intrauterine contraceptive device
Z30431	Encounter for routine checking of intrauterine contraceptive device
Z30432	Encounter for removal of intrauterine contraceptive device
Z30433	Encounter for removal and reinsertion of intrauterine contraceptive device
Z3049	Encounter for surveillance of other contraceptives
Z308	Encounter for other contraceptive management
Z309	Encounter for contraceptive management, unspecified d
Z9851	Tubal ligation status
Z9852	Vasectomy status

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The following is a list of **procedure** codes associated with family planning. They are payable without authorization requirements because they are self-referable.

HCPCS/CPT	Description
00840	Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy
00851	Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy, tubal ligation/transaction
00921	Anesthesia for intraperitoneal procedures in lower abdomen, including urinary tract, vasectomy, unilateral or bilateral
11975	Norplant implant
11976	Norplant removal
11977	Removal with reinsertion, implantable contraceptive capsules
55250	Vasectomy
57170	Diaphragm fitting
58300	IUD insertion
58301	IUD removal only
58600	Ligation or transection of fallopian tubes, abdominal or vaginal approach, unilateral or bilateral
58615	Occlusion of fallopian tubes by device (for example, band, clip, Falope ring), vaginal or suprapubic approach
81025	Pregnancy test
84703	Chorionic gonadotropin assay
89320	Semen analysis; complete (volume, count, motility, and differential)

OTHER SERVICES

The following is a list of procedure codes that include other sensitive services.

HCPCS/CPT	Description
46608	Anoscopy; with removal of foreign body
57415	Removal of impacted vaginal foreign body (separate procedure) under anesthesia
59840	Dilation and curettage – used to induce a first trimester abortion, for termination of a pregnancy in the first 12 – 14 weeks of gestation
59841	Dilation and curettage – used to induce a second trimester abortion, for termination of a pregnancy after 12 – 14 weeks of gestation
99170	Anogenital examination with colposcopic magnification in childhood for suspected trauma

The following is a list of procedure codes that include other sensitive services for minors over the age of 12 and through age 18 (plus 364 days).

HCPCS/CPT	Description
80100	Drug screen, qualitative; multiple drug classes chromatographic method, each procedure
80101	Drug screen, qualitative; single drug class method (for example, immunoassay, enzyme assay), each drug class
80102	Drug confirmation, each procedure
80103	Tissue preparation for drug analysis
80154	Benzodiazepines
80173	Haloperidol
80184	Phenobarbital
82055	Alcohol (ethanol); any specimen except breath
82075	Alcohol (ethanol); breath
82101	Alkaloids, urine, quantitative
82120	Amines, vaginal fluid, qualitative
82145	Amphetamine or methamphetamine
82205	Barbiturates, not elsewhere specified
82520	Cocaine or metabolite

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HCPCS/CPT	Description
82646	Dihydrocodeinone
82649	Dihydromorphinone
82654	Diethadione
82742	Flurazepam
83840	Methadone
83992	Phencyclidine

BILLING STERILIZATION CLAIMS

Use the CMS-1500 claim form and follow appropriate coding guidelines. Attach a copy of the completed Sterilization Consent Form for either gender receiving the sterilization. The form is available in either English or Spanish on the TMHP website at www.tmhp.com/Pages/Medicaid/medicaid_forms.aspx under the **Legal** heading.

TEXAS VACCINES FOR CHILDREN – STAR AND CHIP

Plan Providers who administer vaccines to children 0-18 years of age may enroll in the Texas Vaccines for Children (TVFC) program. Providers who administer vaccines to children 0-18 years of age must be enrolled in Texas Health Steps, formerly known as the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program. To enroll in Texas Health Steps and the Texas Vaccines for Children (TVFC) program, Providers should visit the Texas Medicaid and Healthcare Partnership website at: www.tmhp.com/Pages/Medicaid/Medicaid_home.aspx. Providers that are not enrolled in the TVFC program will only be reimbursed for the administration fee and not for the vaccine.

Reimbursement for TVFC

BCBSTX will only reimburse the administration fee for any vaccine available through the TVFC program. The only time a provider will be reimbursed for use of private vaccine stock is when the TVFC posts a message on its website that no stock is currently available. In that case, the Medicaid claim should include modifier U1, which indicates private stock.

Billing for Immunizations Provided by the Vaccines for Children Program

When billing immunizations provided to you by the Texas Vaccines for Children (TVFC) program, you must use the appropriate CPT code on one line of Box 24D of the CMS-1500 form. On another line of Box 24D, use the appropriate administration procedure code (90471 through 90474). In Box 23 of CMS-1500, insert the PCP name.

Billing for Immunizations NOT Covered by the TVFC Program

When billing immunizations not covered by the TVFC program, use the appropriate CPT code on one line of Box 24D and the appropriate administration procedure code on another line of Box 24D. The SL modifier is not required.

Contact the Texas Vaccines for Children program at **800-252-9152**.

Immunizations and Vaccines

Immunizations covered under the Texas Vaccines for Children program

CPT Code	Description
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.)
90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633	Hepatitis A vaccine, pediatric/adolescent dosage – 2-dose schedule, for intramuscular use
90634	Hepatitis A vaccine, pediatric/adolescent dosage – 3-dose schedule, for intramuscular use
90636	Hepatitis A and Hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90645	Haemophilus influenza b vaccine (Hib), HbOC conjugate (4-dose schedule), for intramuscular use
90646	Haemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
90647	Haemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3-dose schedule), for intramuscular use
90648	Haemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use
90649	Human Papilloma Virus (HPV) vaccine (Gardasil)*

*The HPV vaccine will be considered for reimbursement to providers for patients ages 9 to 18 when the vaccine is not available through the Texas Vaccines for Children (TVFC) program. Providers should submit claims with the U1 modifier.

When billed without a modifier, the procedure code is informational only, allowing providers to be paid the administration fee. In addition, the HPV vaccine will be payable to providers who administer the HPV vaccine for patients ages 19 to 20.

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Providers enrolled in TVFC must use TVFC as the source of the HPV vaccine for eligible patients when TVFC has HPV available for shipment.

CPT Code	Description
90655	Influenza virus vaccine, split virus, preservative free, for children 6–35 months of age, for intramuscular use
90657	Influenza virus vaccine, split virus, for children 6–35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90669	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), for use in individuals younger than 7 years, for intramuscular use
90701	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use
90702	Diphtheria and tetanus toxoids (DT) adsorbed, for use in individuals younger than 7 years, for intramuscular use
90703	Tetanus toxoid absorbed, for intramuscular use
90705	Measles virus vaccine, live, for subcutaneous use
90706	Rubella virus vaccine, live, for subcutaneous use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90710	Measles, mumps, rubella and varicella vaccine (MMRV)
90712	Poliovirus vaccine, any types (OPV), live, for oral use
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
90714	Tetanus and diphtheria toxoids (Td) absorbed, preservative free, for use in individuals 7 years or older, for intramuscular use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine, live, for subcutaneous use
90718	Tetanus and diphtheria toxoids (Td) adsorbed, for use in individuals 7 years or older, for intramuscular use
90720	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Haemophilus influenza b vaccine (DTP-Hib), for intramuscular use

CPT Code	Description
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Haemophilus influenza b vaccine (DtaP-Hib), for intramuscular use
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immuno-suppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any groups), for subcutaneous use
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetraivalent), for intramuscular use
90743	Hepatitis B vaccine, adolescent (2-dose schedule), for intramuscular use
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3-dose schedule), for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90748	Hepatitis B and Haemophilus influenza b vaccine (HepB-Hib), for intramuscular use

Modifier	Description
SK	Members of high-risk population

Immunization Administration Procedures Covered Under the TVFC Program

CPT Code	Description	Immunization Administration
90465	First injection, single or combination vaccine/toxoid, per day.	Immunization administration in patients younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family.
90466	Each additional injection, single or combination vaccine/toxoid, per day. (List separately in addition to code for primary procedure.)	
90467	First administration, single or combination vaccine/toxoid, per day.	Immunization administration in patients younger than 8 years of age (includes intranasal or oral routes of administration) when the physician counsels the patient/family.
90468	Each additional administration, single or combination vaccine/toxoid, per day. (List separately in addition to code for primary procedure.)	

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CPT Code	Description	Immunization Administration
90471	One vaccine, single or combination vaccine/toxoid.	Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections).
90472	Each additional vaccine, single or combination vaccine/toxoid. (List separately in addition to code for primary procedure.)	
90473	One vaccine, single or combination vaccine/toxoid.	Immunization administration (includes intranasal or oral route).
90474	Each additional vaccine, single or combination vaccine/toxoid (list separately in addition to code for primary procedure.)	

BILLING MEMBERS FOR SERVICES NOT MEDICALLY NECESSARY OR NOT COVERED

You may bill a BCBSTX member for a service that is not medically necessary or not a covered benefit if all of the following conditions are met:

1. The patient requests a specific service or item that in your or BCBSTX's opinion may not be reasonable and medically necessary.
2. You must obtain and keep a written acknowledgement statement (see the sample **Member Acknowledgement Statement** form at our website <http://bcbstx.com/provider/Medicaid/index.html>.) Verifying that you notified the BCBSTX member of financial responsibility for services rendered.
3. This acknowledgement must be signed and dated by the member. If the services the member requested are determined not to be medically necessary by BCBSTX, then the signed acknowledgement statement must indicate that the member has been notified of the responsibility to pay these services.

Private Pay Agreement

You may bill a member without a signed Acknowledgement Statement form if:

1. The service received is not a benefit of the Medicaid program. You must inform the member that the service in question is not a benefit under BCBSTX and notify the Member of financial responsibility.
2. You accept the member as a private-pay patient. You must advise members that they are accepted as private-pay patients at the time of service and will be responsible for paying for all services received. In this situation, BCBSTX strongly encourages that notification be in writing with the member's signature and date so there is no question of whether the member has been properly notified of the private-pay status (refer to the sample **Member Acknowledgement Statement** on our website).

You are prohibited from balance billing or collecting any amount from a Medicaid (STAR) member for health care services provided pursuant to your contract with BCBSTX. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a covered service. For CHIP members, you are prohibited from billing other than for co-payments.

ADDITIONAL BILLING RESOURCES

The following references provide detailed instructions on uniform billing requirements:

- CPT (current year), American Medical Association. To order, call **800-621-8335**.
- Healthcare Common Procedure Coding System (HCPCS), National Level II (current year). To order, call **800-621-8335**.
- ICD (current edition), Volumes 1, 2, 3 (current year) Practice Management Information Corporation. To order, call **800-621-8335**.

CMS-1500 CLAIM FORM

Who should use a CMS-1500 claim form?

All professional providers and vendors should bill BCBSTX using the most current version of the CMS-1500 form.

Completing a CMS-1500 Claim Form

Complete all the fields for reimbursement. See the recommended fields for CMS-1500 section for complete instructions.

CODING — PROFESSIONAL

To be sure that claims are processed in an orderly and consistent manner, we use standardized codes. The Healthcare Common Procedure Coding System (HCPCS) provides codes for billing for a variety of services. These codes are sometimes called national codes. HCPCS consists of two principal subsystems, referred to as Level I and Level II.

- Level I consists of Current Procedural Terminology (CPT) codes maintained by the American Medical Association (AMA). CPT codes are represented by five numeric digits.
- Level II consists of other codes that identify products, supplies and services not included in the CPT codes, such as ambulance and durable medical equipment (DME). These are sometimes called the alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits.
- In some cases, two digit/character modifier codes should accompany the Level or Level II coding.

To help ensure accurate handling and prompt payment of claims, use the following national guidelines when coding claims:

- Current Procedural Terminology (CPT) codes: Refer to the current edition of the physicians' CPT manual, published by the American Medical Association; to order, call **800-621-8335**.
- Healthcare Common Procedure Coding System (HCPCS): Refer to the current edition of HCPCS published by the Centers for Medicare and Medicaid Services (CMS); to order, call **800-621-8335**.

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See the Texas Medicaid Provider Procedures Manual for billing tips:
www.tmhp.com/Pages/Medicaid/Medicaid_home.aspx.

Modifier Codes: Use modifier codes when appropriate with the corresponding, HCPCS or CPT codes; for paper claims, all modifiers should be billed immediately following the procedure code in Box 24D of the CMS-1500.

On-Call Services

Insert On-Call for PCP in Box 23 of the CMS-1500 claim form when the rendering physician is not the PCP, but is covering for or has received permission from the PCP to provide services that day.

Member ID Number

Use the member's STAR or CHIP ID **number from the BCBSTX ID card** which is their Medicaid number.

Rendering Physician National Provider Identifier

Indicate the rendering physician's National Provider Identifier (NPI) number in Box 24J of the CMS-1500 form. Missing or invalid numbers may result in nonpayment.

Mid-level practitioners must submit claims with their name and NPI number in Box 19 of the CMS-1500 and the supervising physician's NPI number in Box 24J of the CMS-1500 form. The following are defined as mid-level:

- Physician Assistants
- Nurse Practitioners
- Certified Nurse Midwives

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) may put their billing/group NPI number in Box 24J and 33. Refer to the recommended fields for CMS-1500 section for field descriptions or visit the Centers for Medicare and Medicaid Services website at www.cms.hhs.gov

SAMPLE SECTIONS FOR THE CMS-1500 CLAIM FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA												PICA							
1. MEDICARE <input type="checkbox"/> (Medicare#) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medic#) <input type="checkbox"/> TRICARE <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#) <input type="checkbox"/>				1a. INSURED'S I.D. NUMBER (For Program in Item 1)															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD				SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)											
CITY				STATE				CITY				STATE							
ZIP CODE				TELEPHONE (Include Area Code)				ZIP CODE				TELEPHONE (Include Area Code)							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER											
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>				a. INSURED'S DATE OF BIRTH MM DD YY				SEX M <input type="checkbox"/> F <input type="checkbox"/>							
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)											
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				c. INSURANCE PLAN NAME OR PROGRAM NAME											
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.											
SIGNED _____ DATE _____								SIGNED _____											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD				15. OTHER DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				17b. NPI				20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.																			
A. _____ B. _____ C. _____ D. _____																			
E. _____ F. _____ G. _____ H. _____																			
I. _____ J. _____ K. _____ L. _____																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSET Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1		R		R		R		R		R		R		NR		NR		C	
2														NPI					
3														NPI					
4														NPI					
5														NPI					
6														NPI					
25. FEDERAL TAX I.D. NUMBER				SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gr... see back) YES <input type="checkbox"/> NO <input type="checkbox"/>							
R								B				C							
28. TOTAL CHARGE \$				29. AMOUNT PAID \$				30. Rsvd for NUCC Use											
R				C				NR											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)								32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()							
SIGNED _____ DATE _____								a. C NPI				b. NR							
								a. R NPI				b. NR							

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Chapter 7

Recommended Fields for CMS-1500

The following guidelines will assist in completing the CMS-1500 form. The letter 'M' indicates a mandatory field. For additional information please refer to the TMHP website at www.tmhp.com.

Field #	Title	Explanation
Field 1	Medicare/Medicaid /TRICARE CHAMPUS/ CHAMPVA/Group Health Plan/FECA Blk Lung/Other ID	If the claim is for Medicaid, put an 'X' in the Medicaid box. If the member has both Medicaid and Medicare, put an X in both boxes. Attach a copy of the form submitted to Medicare to the claim.
Field 1a (M)	Insured's ID Number	Use the member's STAR or CHIP ID number from the BCBSTX ID card with the billing prefix at the beginning of the ID number for a total of 10 characters. Electronic claims with nine digit BCBSTX ID#s will be accepted but it is recommended that you use 10.
Field 2 (M)	Patient's Name	Enter the last name first, then the first name, then middle initial (if known). Do not use nicknames or full middle names.
Field 3 (M)	Patient's Birth Date /Patient's Sex	Write date of birth as MM/DD/YYYY (Month/Day/Year). For example, write September 1, 1963, as 09/01/1963. Check the appropriate box for the patient's sex.
Field 4 (M)	Insured's Name	'Same' is acceptable if the insured is the patient.
Field 5 (M)	Patient's Address/Telephone	Enter complete address and phone number. Include any unit or apartment number. Abbreviations for road, street, avenue, boulevard, place or other common ending to the street name are acceptable.
Field 6	Patient Relationship to Insured	The relationship to the member or subscriber.
Field 7	Insured's Address	'Same' is acceptable if the insured is the patient.
Field 8	Patient Status	Check single, married or other for marital status. If applicable, check employed, full-time student or part-time student.

Field #	Title	Explanation
Field 9 (M)	Other Insured's Name	If there is other insurance coverage in addition to the member's plan coverage, enter the name of the insured.
Field 9a (M)	Other Insured's Policy or Group Number	Name of the insurance with the group and policy number.
Field 9b (M)	Other Insured's Date of Birth	Date of birth format: MM/DD/YYYY.
Field 9c (M)	Employer's or School Name	Name of other insured's employer or school.
Field 9d (M)	Insurance Plan Name or Program Name	Name of plan carrier.
Field 10 (M)	Patient's Condition Related To	Include any description of injury or accident, and whether it occurred at work or not.
Field 10a (M)	Related to Employment?	Y or N. If insurance is related to Workers Compensation, enter Y.
Field 10b (M)	Related to Auto Accident/Place?	Y or N. Enter the state in which the accident occurred.
Field 10c (M)	Related to Other Accident?	Y or N.
Field 10d (M)	Reserved for local use	If applicable, use for Member copayment.
Field 11 (M)	Insured's Policy Group or FECA Number	Insured's group number. Complete information about insured, even if same as patient.
Field 11a (M)	Insured's Date of Birth/Sex	Date of birth format: MM/DD/YYYY. Sex: M or F.
Field 11b (M)	Employer's Name or School Name	Name of organization from which the insured obtained the policy.
Field 11c (M)	Insurance Plan Name or Program Name/ Texas Health Steps Benefit Code	Plan carrier/EP1 benefit code for paper claims.
Field 11d (M)	Is There Another Health Benefit Plan?	Y or N. If yes, items 9A-9D must be completed.
Field 12	Patient's or Authorized Person's Signature	Signature and date ('Signature on file' to indicate that the appropriate signature was obtained by the provider is acceptable for this field).

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Field #	Title	Explanation
Field 13	Insured's or Authorized Person's Signature	Signature ('Signature on file' is acceptable for this field).
Field 14 (M)	Date of Current Services	<p>Circle injury, illness or pregnancy (if applicable) and enter the date.</p> <p>A qualifier is mandatory if a date is entered. Enter the applicable qualifier to identify which date is being reported.</p> <p>431 – Onset of current symptoms or illness</p> <p>484 – Last menstrual period</p> <p>Enter the qualifier to the right of the vertical, dotted lines</p>
Field 15	First Date	<p>Date of first consultation for the patient's condition. Date format: MM/DD/YYYY.</p> <p>A qualifier is mandatory if a date is entered. Enter the applicable qualifier to identify which date is being reported.</p> <p>454 – Initial Treatment</p> <p>304 – Latest Visit or Consultation</p> <p>453 – Acute Manifestation of a Chronic Condition</p> <p>439 – Accident</p> <p>455 – Last X-ray</p> <p>471 – Prescription</p> <p>090 – Report Start (Assumed Care Date)</p> <p>090 – Report End (Relinquished Care Date)</p> <p>444 – First Visit or Consultation</p> <p>Enter the qualifier between the left-hand set of vertical, dotted lines. The 'Other Date' identifies additional date information about the patient's condition or treatment.</p>

Field #	Title	Explanation
Field 16	Dates Patient Unable to Work in Current Occupation (From–To)	Date format: MM/DD/YYYY.
Field 17 (M)	Name of Referring Physician or Other Source	Name of physician, clinic or facility referring the patient to the provider.
Field 17a (M)	blank	Enter any other ID number, such as a nine-digit Provider Identify or Universal Provider Identification Number (UPIN).
Field 17b (M)	NPI	Enter the NPI of the physician listed in item 17 as soon as it is available.
Field 18	Hospitalization Dates Related to Current Services (From – To)	Date format: MM/DD/YYYY.
Field 19 (M)	Reserved for Local Use	for multiple transfers, indicate that the claim is part of a multiple transfer and provide the other client's complete name and Medicaid number. Provide information about the accident including the date of occurrence, how it happened, whether it was self-inflicted or employment-related.
Field 20	Outside Lab? (Yes or No); \$ Charge	Information if lab services were sent to an outside lab.
Field 21 (M)	Diagnosis or Nature of Illness or Injury	Enter the appropriate diagnosis code or nomenclature. Check the manual or with a coding expert if you aren't sure.
Field 22	Medicaid Resubmission	Under 'Original Ref. No.' enter the 12-digit transaction control number (TCN) associated with any claim being resubmitted that is older than 1 year (365 days). If additional space is needed, use Box 19.
Field 23 (M)	Prior Authorization Number	Authorization information must be entered in this field, which can be a prior authorization, reference number or on-call physician for PCP.

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Field #	Title	Explanation
Field 24A (M)	Date(s) of Service	If dates of service cross over from one year to another, submit two separate claims (example: one claim for services in 2007, one claim for services in 2008). Itemize each date of service on the claim; avoid spanning dates.
Field 24B (M)	Place of Service	This is a two-digit code. Use current coding as indicated in the CPT manual.
Field 24C	EMG	Enter the appropriate condition indicator for Texas Health Steps medical checkups, if applicable.
Field 24D (M)	Procedure, Services or Supplies	Enter the appropriate CPT codes or nomenclature. Indicate appropriate modifier when applicable. Do not use 'not otherwise classified' (NOC) codes unless there is no specific CPT code available. If you use an NOC code, include a narrative description.
Field 24E (M)	Diagnosis Pointer	Use the most specific ICD code available.
Field 24F (M)	Dollar Charges	Charge for each single line item.
Field 24G	Days or Units	The quantity of services for each itemized line. For anesthesia, the actual time of the service rendered, in minutes.
Field 24H	EPSDT Family Plan	Indicate if the services were the result of a Texas Health Steps checkup or a family planning referral.
Field 24I (M)	ID Qualifier	Enter your ID Qualifier.
Field 24J (M)	Rendering Provider NPI. #	Enter your NPI, if available. A NPI is required for electronic claims, and we strongly encourage you to use your NPI number for paper claims.
Field 25	Federal Tax ID Number	This is a nine-digit number listed on your W-9.
Field 26	Patient's Account Number	This is for the provider's use in identifying patients and allows use of up to nine numbers or letters (no other characters are allowed).
Field 27 (M)	Accept Assignment?	All providers of Medicaid services must check YES.

Field #	Title	Explanation
Field 28 (M)	Total Charge	Total charge for each single line item.
Field 29 (M)	Amount Paid	Enter any payment that has been received for this claim.
Field 30	Balance Due	Must equal the amount in box 28 less the amount in box 29.
Field #	Title	Explanation
Field 31 (M)	Signature of Physician or Supplier Including Degrees or Credentials	Actual signature or typed/printed designation is acceptable.
Field 32 (M)	Service Facility Location Information	Include any suite or office number. Abbreviations for road, street, avenue, boulevard, place or other common ending to the street name are acceptable.
Field 32A (M)	blank	Enter the NPI of the service facility as soon as it is available.
Field 32B (M)	blank	Prior to May 23, 2007, enter the ID qualifier 1C followed by a space and the PIN of the service facility. As of May 23, 2007, leave blank.
Field 33 (M)	Billing Provider Info & PH #	Provider name, NPI, street, city, state, ZIP code and telephone number.
Field 33A (M)	blank	Enter the NPI number.
Field 33B (M)	blank	Enter the NPI number of the billing provider.



Chapter 8

BILLING INSTITUTIONAL CLAIMS

HOSPITAL AND INSTITUTIONAL BILLING REQUIREMENTS BY SERVICE CATEGORY

This section provides special billing requirements for each of the services listed below. The member's benefits may not cover some of these services so it is important to confirm coverage. Also, consult your BCBSTX provider agreement to find out more about billing for any of these services.

Maternity

The billing requirements for maternity care apply to all live and still birth deliveries, and include payment for all associated services, including, but not limited to:

- Room and board for mother (including all nursing care)
- Nursery for baby (including all nursing care)
- Delivery room/surgery suites
- Equipment, laboratory, radiology, pharmaceuticals, and other services incidental to admission.

The maternity care rate covers the entire admission, except for admissions that are approved for extension beyond what is contractually indicated on the continuous inpatient days. In such cases, the inpatient acute care requirements apply for each approved and medically necessary service day for the entire admission, unless otherwise indicated.

Therapeutic abortions, treatment for ectopic and molar pregnancies and similar conditions are excluded from payment under this rate.

Reimbursement for abortions is based on the physician's certification that the abortion was performed to save the mother's life, to terminate pregnancy resulting from rape, or to terminate pregnancy resulting from incest. At this time, the **Abortion Certification Statement Form** and claim must be filed on paper. The signature of the physician must be original script (not stamped or typed). Failure to submit the **Abortion Certification Statement Form**, or if the form is not completed correctly, will result in denial of your claim. The **Abortion Certification Statement Form** is located on the TMHP website at www.tmhp.com/TMHP_File_Library/TWHP/WHP%20Certification.pdf.

Inpatient Acute Care

The billing requirements for inpatient acute care apply to each approved and medically necessary service day in a licensed bed (not covered under another category in this section) and include, but are not limited to:

- Room and board (including all nursing care)
- Emergency room (if connected with admission), urgent care (if connected with admission)
- Surgery and recovery suites
- Equipment, supplies, laboratory, radiology, pharmaceuticals and other services incidental to the admission

Special billing instructions and requirements:

- Utilization Management approval is required for all admissions (except standard vaginal delivery and cesarean sections).

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Inpatient Sub-Acute Care

Sub-acute care includes levels of inpatient care less intensive than those required in an inpatient acute care setting.

The billing requirements for inpatient sub-acute care include each approved and medically necessary service day in a duly licensed and accredited facility at the appropriate level of care. Each inpatient sub-acute care admission is considered a separate admission from any preceding or subsequent acute care admission, and should be billed separately.

Covered services rendered during an admission include, but are not limited to:

- Room and board (including all nursing care)
- Equipment use, supplies, laboratory, radiology, pharmaceuticals and other services incidental to the admission.

All admissions and levels of care require prior approval. In addition, a treatment plan must accompany all sub-acute care admissions including:

- Functional, reasonable, objective and measurable goals within a predictable time frame for each skilled discipline.
- A discharge plan and options that are individually customized and identified from the admission date and that are carried forward from the admission date.
- Weekly summaries for each discipline; biweekly team conference reports are required.

Emergency Room Visits

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric emergency.

The billing requirements for an emergency room visit apply to all emergency cases treated in the hospital emergency room, for patients who do not remain overnight, and cover all diagnostic and therapeutic services provided, including, but not limited to:

- Facility use (including all nursing care)
- Equipment, laboratory, radiology, supplies, pharmaceuticals and other services incidental to the emergency room visit.

Reimbursement for emergency room services relates to the emergency diagnosis and can be based on urgent care rates, depending on the diagnosis.

Please Note: If the emergency room visit results in an admission, then all services provided in the emergency room must be billed in conformity with the guidelines and requirements for inpatient acute care. Consult your contract regarding the 24-hour rule.

Special billing instructions and requirements for ER visits:

- Emergency room visits should be billed with CPT codes 99284, 99285.
- Services billed with CPT codes 99281, 99282, 99283 will be reduced by 40 percent as non-emergent services.
- ICD principal diagnosis codes are required for all services provided in an emergency room setting.
- Bill each service date as a separate line item.
- Revenue codes 0450 to 0452, and 0459 are required, as are CPT codes 99284 and 99285.

Refer all members to the primary care provider of record for follow-up care. Unless clinically required, follow-up care should never occur in the hospital's emergency department.

Urgent Care Visits

Urgent care refers to non-scheduled, non-emergency hospital services required to prevent serious deterioration of a patient's health status as a result of an unforeseen illness or injury.

The billing requirements for urgent care visits apply to all urgent care cases treated and discharged from the hospital, outpatient department/emergency room, and include all diagnostic and therapeutic services provided, including, but not limited to:

- Facility use (including all nursing care)
- Equipment, laboratory, radiology, supplies, pharmaceuticals and other services incidental to the visit.

Urgent care visits do not apply to those cases that are admitted and treated for inpatient care following urgent care treatment.

Special billing instructions and requirements:

- Current ICD principle diagnosis codes are required for all services provided in an urgent care setting or designated facility.
- Bill each service date as a separate line item.
- Revenue codes required are 045X, 0516, 0526, 0700 or 072X, as well as CPT codes 99281-83.

Outpatient Laboratory, Radiology and Diagnostic Services

The billing requirements for outpatient laboratory, radiology, and diagnostic services (not included elsewhere) refer to services that include, but are not limited to:

- Clinical laboratory
- Pathology
- Radiology and other diagnostic tests

These billing requirements include services rendered in relation to an outpatient visit for laboratory, radiology or other diagnostic services, including, but not limited to:

- Facility use
- Nursing care (including incremental nursing)
- Equipment
- Professional services (if applicable)
- Specified supplies and all other services incidental to the outpatient visit

Outpatient radiation therapy is excluded from this service category and should be billed under the requirements of the other services category.

Outpatient Surgical Services

The billing requirements for outpatient surgical services apply to each outpatient hospital visit for outpatient surgery services, including, but not limited to:

- Facility use (including nursing care)
- Equipment, supplies, pharmaceuticals, blood, laboratory, radiology, imaging services, implantable prostheses and all other services incidental to the outpatient surgery visit

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Please Note: Even though a service is classified by the hospital as an outpatient service, if the member is receiving that service in the hospital as of 12 a.m., the hospital should bill at the inpatient diagnostic related grouping (DRG) rate.

For surgery services that are not defined in the surgery grouping, medical records might be requested by BCBSTX for review and determination of surgery grouping.

Special billing instructions and requirements:

- Include CPT/HCPCS codes for each surgical procedure in form locators 44 (HCPCS/RATES). Revenue codes 036X, 0480, 0481, 0490, 070X, 071X, 075X, 076X, 079X and 0975 are required with the appropriate CPT/HCPCS code.
- HIPAA mandates that outpatient surgery should be billed with CPT/HCPCS code.
- Service dates must accompany each procedure (both principal and other). Billing instructions and requirements for outpatient services:
 - CPT/HCPCS codes are required for each service.

80049 – 85097	93000 – 93018	94690
89050 – 89399	93040 – 93237	94760 – 94762
91100	93720 – 93799	95851–95857
	93980 – 93990	

- Bill each service for each date as a separate line item.
- Use the following required revenue codes with the appropriate CPT/HCPCS code:

0300 – 0302	0340 – 0341	061X
0305 – 0309	0349	0636
031X	035X	073X
032X	040X	074X
0330	0482	092X
0339	0483	0971–0972

When the Respiratory Therapy department performs ECG, EEG or EKGs, follow the billing requirements as outlined in this service category; do not apply the outpatient therapy billing requirements. The type of bill field entry must be 13X.

Outpatient Therapies

Outpatient therapy services include physical, occupational, speech and respiratory therapies. An outpatient therapy visit means a single service date. Outpatient therapy visits include, but are not limited to:

- Facility use (including all nursing care)
- Therapist/professional services
- Supplies, equipment, pharmaceuticals and other services incidental to the outpatient therapy visit

Special billing instructions and requirements:

- Bill each service date as a separate line item.
- Required revenue codes are:
 - Respiratory therapy – 041X
 - Physical therapy – 042X
 - Occupational therapy – 043X
 - Speech therapy – 044X
 - Or the applicable CPT/HCPCS codes

Outpatient Infusion Therapy Visit and Pharmaceuticals

The outpatient infusion therapy visit billing requirements apply to each outpatient hospital visit for infusion therapy services, including, but not limited to:

- Facility use (including all nursing care)
- Equipment, professional services, laboratory, radiology, supplies (for example, syringes, tubing, line insertion kits and so on)
- Intravenous solutions (excluding pharmaceuticals), kinetic dosing and other services incidental to the outpatient infusion therapy visit

An outpatient infusion therapy visit means a single service date.

The outpatient infusion therapy pharmaceuticals billing requirements apply to the drugs (for example, chemotherapy, hydration and antibiotics) used during each outpatient visit for infusion therapy services, except for blood and blood products, which are considered other services.

Special billing instructions and requirements:

- Revenue codes 026X, 028X, 0331, 0335 or 0940 are required for each outpatient infusion therapy visit.
- When billing therapeutic aphaeresis claims, use revenue code 0940 or 0949 with 36511- 36513, 36515-36516 or 36522 CPT/HCPCS codes; list pharmaceuticals as a separate line item.
- All applicable HCPCS codes are required for all pharmaceuticals when:
 - Billed with revenue codes 0250 to 0252, 0256 to 0259, or 063X; you must include the units with pharmaceutical CPT/HCPCS codes.
 - Billed with revenue codes 026X, 028X, 0331, 0335 or 0940.
 - List each drug for each visit as a separate line item and include a service date.

Chapter 8

REPORTING PROVIDER PREVENTABLE CONDITIONS WITH PRESENT ON ADMISSION CLAIMS

Hospitals in the BCBSTX network are required to report Provider-Preventable Conditions (PPCs) using Present on Admission (POA) claims. The following is a list of those PPCs for which BCBSTX may not pay claims:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
 - Fractures
 - Dislocations
 - Intracranial Injuries
 - Crushing Injuries
 - Burns
 - Electric Shock
- Manifestations of Poor Glycemic Control
 - Diabetic Ketoacidosis
 - Nonketotic Hyperosmolar Coma
 - Hypoglycemic Coma
 - Secondary Diabetes with Ketoacidosis
 - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection Following:
 - Coronary Artery Bypass Graft (CABG)—Mediastinitis
 - Bariatric Surgery
- Laparoscopic Gastric Bypass
- Gastroenterectomy
- Laparoscopic Gastric Restrictive Surgery
- Orthopedic Procedures
 - Spine
 - Neck
 - Shoulder
 - Elbow
- Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE) following total knee replacement or hip replacement. Not included for Medicaid for pediatric and obstetric populations.
- Surgery on the wrong patient
- Wrong surgery on a patient
- Wrong site surgery

Table of POA Codes

This table includes the Indicator Codes to be used on the hospital claim. Using the codes correctly ensures that you are reimbursed appropriately.

Indicator	Description	Reimbursable
Y	The condition was present on admission.	Yes
N	The condition was not present on admission.	No
W	The provider determined that it was not possible to document if the condition was present on admission.	Yes
U	The documentation was insufficient to determine if the condition was present on admission.	No
Blank	Exempt from POA reporting.	Exempt from POA reporting.

Note: If a diagnosis is exempt from POA reporting, providers should leave the POA indicator field blank on the claim. For a list of diagnoses that are exempt from POA reporting, refer to the **Texas Medicaid Provider Procedures Manual** located at www.tmhp.com.

Indicator Code Usage and Examples

Indicator code usage is different for electronic and paper claims:

For electronic claims, the POA indicator codes follow the diagnosis code in the appropriate 837i 2300 HI segment. They must be within 2300 HI01-09 through HI12-09 in accordance with the number of diagnosis codes billed.

Examples of diagnosis codes with PPC data:

- HI*BK: 5770:.....:Y~
- HI*BJ:78906~
- HI*BF: 3051:.....:Y*BF:4019:.....:Y*BF:3384:.....:Y*BF:77210:.....:Y*BF:V5869~

For paper claims, the POA Code is the eighth digit of Field Locator (FL) 67, Principal Diagnosis and Secondary Diagnosis fields, FL 67 A-Q. If the diagnosis is exempt from POA reporting, leave this field blank.

CMS- 1450 (UB-04) CLAIM FORM

Who Should Use the CMS-1450 (UB-04) Claim Form?

All Medicare-approved facilities should bill BCBSTX using the most current version of the CMS-1450 (UB-04) claim form. For help with the claim form, refer to the **Sample Section from the CMS-1450 (UB-04)**.

Completing a CMS-1450 (UB-04) Claim Form

Complete all fields for reimbursement. Refer to the **Recommended Fields for CMS-1450 (UB-04)**.

Chapter 8

Coding

Standardized code sets are used to ensure that claims are processed in an orderly and consistent manner. The Healthcare Common Procedure Coding System (HCPCS), sometimes called National Codes, provides codes for billing a variety of services. HCPCS consists of two principal subsystems, referred to as Level I and Level II:

- Level I consists of Current Procedural Terminology (CPT) codes maintained by the American Medical Association (AMA). CPT codes are represented by five numeric digits.
- Level II consists of other codes that identify products, supplies and services not included in the CPT codes, such as ambulance and durable medical equipment (DME). These are sometimes called the alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits.
- In some cases, two digit/character modifier codes should accompany the Level I or Level II coding.

CMS-1450 (UB-04) Revenue Codes

CMS-1450 (UB-04) revenue codes are required for all institutional claims.

Inpatient Coding — Institutional

For institutional inpatient coding, use the guidelines in the following code manuals:

- Current ICD applicable and procedure codes must be in Boxes 74–74e of the CMS-1450 (UB-04) form when the claim indicates a procedure was performed.
- Modifier Codes: Use modifier codes when appropriate; refer to the current edition of the physicians' Current Procedural Terminology manual published by the American Medical Association (AMA).
- Please refer to your contract for diagnostic related grouping (DRG) information.

Outpatient Coding — Institutional

For institutional outpatient coding, use the guidelines in the following code manuals:

- Healthcare Common Procedure Coding System (HCPCS): Refer to the current edition of HCPCS published by the Centers for Medicare and Medicaid Services (CMS).
- Current Procedural Terminology (CPT) Codes: Refer to the current edition of the physicians' CPT manual, published by the American Medical Association.
- BCBSTX requires that when outpatient services are billed, they must have itemized CPT/HCPCS codes; use of revenue codes only on outpatient claims will result in a delay or denial of the claim for lack of information.
- When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 (UB-04) claim.

Member ID Number

Use the member's Medicaid (STAR) or CHIP ID number from BCBSTX's ID card on all claims submitted. See **Recommended Fields for CMS-1450 (UB-04)** for field descriptions for the CMS-1450 (UB-04) claim form.

Visit the Centers for Medicare and Medicaid Services website at www.cms.hhs.gov for more information

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SAMPLE SECTION - CMS-1450 (UB-04) FORM WITH INSTRUCTIONS

Recommended Fields for CMS-1450 (UB-04)

The following guidelines will assist in completing the CMS-1450 (UB-04) form. 'M' indicates a mandatory field. For additional information please refer to the Texas Medicaid Healthcare Partnership (TMHP) website at www.tmhp.com.

Field	Box Title	Description
Field 1 (M)	blank	Facility name, address, phone and fax number.
Field 2	Provider's Tax ID	Facility pay to- name and address
Field 3a	PATCNTL #	Member account number
Field 3b	MED. REC#	Optional record number.
Field 4 (M)	TYPE OF BILL	Enter the appropriate three-digit code.
Field 5 (M)	FED. TAXNO.	Enter the provider's Federal Tax Identification Number.
Field 6 (M)	STATEMENT COVERS PERIOD	'FROM' and 'THROUGH' date(s) covered by the claim being submitted.
Field 7	blank	Leave blank.
Field 8a-b (M)	PATIENT NAME	Member's name as it appears on the ID card.
Field 9a-e (M)	PATIENT ADDRESS	Complete address (number, street, city, state, ZIP code, telephone number).
Field 10 (M)	BIRTHDATE	Enter the member's date of birth in MM/DD/YYYY format. For example, September 16, 1963 would be entered as 09/16/1963.
Field 11 (M)	SEX	Enter the member's gender.
Field 12 (M)	ADMISSION DATE	Member's admission date to the facility in MM/DD/YYYY format.
Field 13 (M)	ADMISSION HR	Enter the member's admission hour to the facility in military time (00 to 23) format.

Field	Box Title	Description
Field 14 (M)	ADMISSION TYPE	Type of admission. A qualifier is mandatory if a date is entered. Enter the applicable qualifier to identify which date is being reported. 431 – Onset of Current Symptoms or illness 484 – Last Menstrual Period Enter the qualifier to the right of the vertical, dotted lines
Field 15 (M)	ADMISSION SRC	Source of admission. A qualifier is mandatory if a date is entered. Enter the applicable qualifier to identify which date is being reported. 454 – Initial Treatment 304 – Latest Visit or Consultation 453 – Acute Manifestation of a Chronic Condition 439 – Accident 455 – Last X-ray 471 – Prescription 090 – Report Start (Assumed Care Date) 090 – Report End (Relinquished Care Date) 444 – First Visit or Consultation Enter the qualifier between the left-hand set of vertical, dotted lines. The 'Other Date' identifies additional date information about the patient's condition or treatment.
Field 16 (M)	DHR	Member's discharge hour from the facility in MM/DD/YYYY format.
Field 17 (M)	STAT	Member status.
Field 18–28	CONDITION CODES	Enter condition code (81) X0 – X9, if applicable.
Field 29	ACDT STATE	Accident state. Leave blank.
Field 30	blank	Leave blank.

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Field	Box Title	Description
Field 31–34 (M)	OCCURRENCE CODE OCCURRENCE DATE	Enter the occurrence codes (42).
Field 35–36	OCCURRENCE SPAN (CODE, FROM, & THROUGH)	Enter the dates in MM/DD/YYYY format.
Field 37	blank	Leave blank.
Field 38	blank	Enter the responsible party name and address, if applicable.
Field 39–41	VALUE CODES (CODE & AMOUNT)	Enter the appropriate value code (or codes), with the appropriate amount(s).
Field 42 (M)	REV. CD.	Revenue code. Revenue codes are required for all institutional claims.
Field 43 (M)	DESCRIPTION	Description of services rendered.
Field 44 (M)	HCPCS/RATE/HIPPS CODE	Enter the accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient services.
Field 45 (M)	SERV. DATE	Date of services rendered.
Field 46 (M)	SERV. UNITS	Number/units of occurrence for each line or service being billed.
Field 47 (M)	TOTAL CHARGES	Total charge for each line of service being billed.
Field 48	NON-COVERED CHARGES	Enter any non-covered charges.
Field 49	blank	Leave blank.
Field 50 (M)	PAYER NAME	Payer identification. Enter any third-party payers.
Field 51 (M)	HEALTH PLAN ID	Enter the TPI number.
Field 52	REL. INFO	Release of Information certification indicator.
Field 53	ASG BEN.	Assignment of Benefits certification indicator.
Field 54	PRIOR PAYMENTS	Prior payments.
Field 55	EST. AMOUNT DUE	Estimated amount due.
Field 56	NPI	Enter the NPI number.
Field 57 (M)	OTHER PRIV ID	In the OTHER field, enter the NPI number. Enter the other provider ID in the PRIV ID field, if applicable.
Field 58 (M)	INSURED'S NAME	Enter the member's name.

Field	Box Title	Description
Field 59	P.REL	Patient's relation to insured. Leave blank if member is the insured.
Field 60 (M)	INSURED'S UNIQUE ID	Insured's ID number – Certificate number on the member's ID card.
Field 61	GROUP NAME	Insured group name. Enter the name of any other health plan.
Field 62 (M)	INSURANCE GROUP NO.	Insurance group number. Enter the policy number of any other health plan.
Field 63	TREATMENT AUTHORIZATION CODES	Authorization number or authorization information must be entered in this field.
Field	Box Title	Description
Field 64	DOCUMENT CONTROL NUMBER	The control number assigned to the original bill.
Field 65	EMPLOYER NAME	Name of organization from which the insured obtained the other policy.
Field 66 (M)	DX	Enter the diagnosis and procedure code qualifier (ICD version indicator).
Field 67 (M)	blank	Principal diagnosis code. Enter the ICD diagnostic code.
Field 67a–q (M)	blank	Other diagnostic codes. Enter the ICD diagnostic codes, if applicable.
Field 68	blank	Leave blank.
Field 69	ADMITDX	Admitting diagnosis code. Enter the ICD diagnostic code, if applicable.
Field 70a–c (C)	PATIENT REASON DX	Enter the member's reason for this visit, if applicable.
Field 71	PPS CODE	Prospective payment system (PPS) code. Leave blank.
Field 72	ECI	External cause of injury code. Enter the ICD diagnostic code, if applicable.
Field 73	blank	Enter the benefit code, if applicable.
Field 74 (M)	PRINCIPAL PROCEDURE (CODE/DATE)	ICD principal procedure code and dates, if applicable.

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Field	Box Title	Description
Field 74a–e (M)	OTHER PROCEDURE (CODE/ DATE)	Other procedure codes.
Field 75	blank	Leave blank.
Field 76 (M)	ATTENDING	Enter the NPI number in the NPI field.
Field 77 (M)	OPERATING	Enter the NPI number in the NPI field.
Field 78–79 (M)	OTHER	Enter the NPI number in the NPI field.
Field 80	REMARKS	Use this field to explain special situations.
Field 81a–c	CC	Enter additional or external codes, if applicable.

SERVICES THAT MUST BE BILLED TO THE HEALTH AND HUMAN SERVICES COMMISSION (HHSC) STATE SERVICES

- Community Resource Coordination Groups (CRCGs)
- Early Childhood Intervention (ECI) Program - Case Management (Therapies are billed to the plan)
- Local school districts (SHARS)
- Health and Human Services Commission’s Medical Transportation Program (MTP);
- Texas Department of Assistive and Rehabilitative Services (DARS) Blind Children’s Vocational Discovery and Development Program;
- Texas Department of State Health (DSHS) services, including community behavioral health programs, Title V Maternal and Child Health, Children with Special Health Care Needs (CSHCN) Programs;
- Other state and local agencies and programs such as food stamps, the Women, Infants, and Children’s (WIC) Program and Case Management for Children and Pregnant Women (CPW)
- Civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy, which also work on behalf of the MSHCN population

Providers of these services must submit claims for these services to the HHSC claims administrator for reimbursement.

ANCILLARY BILLING REQUIREMENTS BY SERVICE CATEGORY

This section provides special billing requirements applicable to each service listed below. The member's benefits may not cover some of the services listed. Please be sure to confirm benefit coverage. Also, consult your BCBSTX Provider Agreement for specifics regarding billing for any of these or other services.

Most ancillary claims submitted are for:

- Laboratory and diagnostic imaging on a CMS-1500 form.
- Durable medical equipment on a CMS-1500 form. Other types of devices are also described.

Laboratory and Diagnostic Imaging

When filling out the CMS-1500 form for laboratory and diagnostic imaging, refer to the following guidelines:

- **Billing requirements per contract:** BCBSTX's billing requirements apply to all member claims, except some services administered through Texas HHSC and other state contract programs.
- **System edits:** Edits are in place for both electronic and paper claims. Claims not submitted in accordance with requirements cannot be readily processed, and most likely will be returned.
- **Valid coding:** For claims submitted to BCBSTX, valid HCPCS, CPT or revenue codes are required for all line items billed, whether sent on paper or electronically. Refer to the specific service category for special coding requirements.
- **Split year claims:** Services that begin before or in December and extend beyond December 31, should be billed as a split claim at calendar year end. Two CMS-1500s must be used and must be submitted together.
- **Contract change during course of treatment:** A provider's reimbursement may be affected by a contract change during a course of treatment. You are required to split the dates of service in order to be reimbursed at the new rate.
- **Itemization:** Services itemization is required when the 'from' and 'through' service dates are the same.
- **Medical records:** Medical records for certain procedures might be requested for determination of medical necessity.
- **Modifiers:** Use modifiers in accordance with your specific billing instructions.
- **Unlisted procedures:** There may be services or procedures performed by physicians that are not found in CPT; therefore, specific code numbers for reporting unlisted procedures have been designated. When an unlisted procedure code is used, BCBSTX needs a description of the service to calculate the appropriate reimbursement, and medical records may be requested.
- **CPT code 99070:** This code, for (supplies and materials provided over and above those usually included with the office visit or other services, is not accepted by BCBSTX. Health care professionals are to use HCPCS Level III codes, which give a detailed description of the service provided. BCBSTX will pay for surgical trays only for specific surgical procedures. Surgical trays billed with all other services will be considered incidental and will not be payable separately.

Chapter 8

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment (DME) is covered when prescribed to preserve bodily functions or prevent disability.

Durable Medical Equipment Prior Authorization

All custom-made DME requires prior authorization. Some other DME services may also require prior authorization. Prior to dispensing, please contact our Utilization Management (UM) department. Services that require prior authorization will be denied if approval is not obtained from the UM department.

The presence of a Healthcare Common Procedure Coding System (HCPCS) code does not necessarily mean that the benefit is covered or that payment will be made for a particular service. Some DME codes may be by report and therefore require additional information for prior authorization, as well as for processing at point of claim.

Durable Medical Equipment Billing

Durable Medical Equipment (DME) providers should bill with the appropriate modifier to identify rentals versus purchases (new or used). Claims submitted without the appropriate modifier will be reimbursed at rental price.

Modifier	Designation
NU	New
UE	Used
RR	Rental

Follow these general guidelines for DME billing:

- Use HCPCS codes for DME or supplies
- Use miscellaneous codes (such as E1399) when an HCPCS code does not exist for that particular item of equipment. An unlisted code like E1399 cannot be used to describe expensive or difficult-to-order items when codes for those items exist.
- Unlisted codes will not be accepted if valid HCPCS codes exist for the DME and supplies
- Attach the manufacturer's invoice to the claim if using a miscellaneous or unlisted code (such as E1399). The invoice must be from the manufacturer, not the office making a purchase.
- Catalog pages are not acceptable as a manufacturer's invoice

Durable Medical Equipment Rental

Durable Medical Equipment (DME) rentals require medical documentation from the prescribing doctor. Most DME is dispensed on a rental basis only, such as oxygen tanks or concentrators. Rented items remain the property of the DME provider until the purchase price is reached.

DME providers should use normal equipment collection guidelines. BCBSTX is not responsible for equipment not returned by members.

Charges for rentals exceeding the reasonable charge for a purchase are not accepted, and rental extensions may be obtained only on approved items.

Durable Medical Equipment Purchase

Durable Medical Equipment (DME) may be reimbursed on a rent-to-purchase basis over a period of 10 months, unless specified otherwise at the time of review by our UM department.

Wheelchairs/Wheeled Mobility Aids

Medicaid guidelines are followed when calculating payments for by report (customized) wheelchair claims.

Claims documentation must include:

- Item description
- Manufacturer name
- Model number
- Catalog number
- Completion of the Reserved for Local Use field (Box 19) on the CMS-1500 claim form with the total MSRP of the wheelchair, including all wheelchair accessories, modifications, or replacement parts, and the name of the employed Rehabilitation and Assistive Technology of America (RESNA) certified technician.
- You must mark each catalog page or invoice line so it can be matched to the appropriate claim line.
- For wheeled mobility aids, in addition to the above, the invoice must be an amount published by the manufacturer before August 1, 2003. If the item was not available before then, you must list the date of availability in the Reserved for Local Use field (Box 19) of the CMS-1500 claim form. The catalog page that initially published the item must be attached to the claim.

Wheelchair claims from manufacturers billing as providers must include:

- The MSRP from a catalog page dated before August 1, 2003. If the item was not available before August 1, 2003, the manufacturer's invoice must accompany the claim.
- The initial date of availability must be documented in the Reserved for Local Use field (Box 19) of the CMS-1500 claim form.

Modifiers

For a listing of DME modifier codes, please access Appendix 1 of the HCPCS 2006 publication available from the American Medical Association (AMA), or log on to their website, www.ama-assn.org for online access.

OTHER SERVICE TYPES

Ambulance

Ambulance providers, including municipalities, should use a CMS-1500 form to bill for ambulance services.

Use appropriate two-digit origin and destination codes that describe the 'to' and 'from' locations.

More information about BCBSTX's requirements for ambulance services can be found in the Texas Medicaid Provider Procedures Manual, available on this website www.tmhp.com.

Chapter 8

Ambulatory Surgical Centers

Most outpatient surgery delivered in an ambulatory surgical center needs pre-authorization.

Form CMS-1500: Free-standing ambulatory surgical centers bill on a CMS-1500 form. Check your BCBSTX Provider Agreement for more information.

Dialysis

All dialysis care must be pre-authorized (except where Medicare is primary payer). Contact BCBSTX's UM department for authorization prior to delivery of service.

Dialysis centers and other entities which perform dialysis should use the CMS-1450 (UB-04) form to bill for dialysis services.

More information about BCBSTX requirements for dialysis services can be found in the Texas Medicaid Provider Procedures Manual, available on this website www.tmhp.com.

Home Health Care

All home health care must be pre-authorized. Contact Utilization Management for authorization prior to delivery of the service.

When billing for a home health visit use a CMS-1450 (UB-04) form.

When billing for supplies and equipment used for a home health visit, please refer to the DME section for billing. For injections and home infusion therapy, the following Home Infusion Therapy section offers billing guidelines.

Home Infusion Therapy

Home Infusion Therapy is billed using a CMS-1500 form.

- Submit all claims within the contracted filing limit of 95 days from date of service.
- Authorization is required from Utilization Management for all infusion therapy and should be obtained before the services are rendered.
- Use the appropriate HCPCS injection codes to bill for all injections listed. The codes are available on the TMHP website at www.tmhp.com.
- Use HCPCS code J3490 along with the National Drug Code (NDC) for billing injections only if an appropriate injection code is not found.
- You must use the appropriate codes to bill for medical supplies and accessories shown in the medical supplies lists of the Provider Manual found on the TMHP website at www.tmhp.com.
- By Report HCPCS codes, including HCPCS code A9999, for supplies and accessories are reimbursed at the lesser of:
 - The amount billed, or
 - The manufacturer's purchase invoice amount, plus a 24 percent markup.

Hospice

All hospice care must be pre-authorized. Contact Utilization Management for authorization prior to hospice admission.

Bill hospice services on the CMS-1450 (UB-04) form.

- For BCBSTX members, the Hospice Care section of the TMHP Manual provides detailed billing instructions. Click the following link www.tmhp.com.

Occupational Therapy

All occupational therapy must be pre-authorized. Evaluations do not require pre-authorization. Contact Utilization Management for authorization prior to delivery of services. The occupational therapy setting determines the correct billing form:

- Form CMS-1500: When providing services in an office, clinic, or outpatient setting.
- Form UB-04: for occupational therapists affiliated with home health agencies and providing services in a patient's home.

Physical Therapy

All physical therapy must be pre-authorized. Evaluations do not require pre-authorization. Contact Utilization Management for authorization prior to delivery of services.

The physical therapy setting determines the correct billing form:

- Form CMS-1500: When providing services in an office, clinic setting, or outpatient setting.
- Form CMS-1450 (UB-04): When providing services in a rehabilitation center.
- Form UB-04: for physical therapists affiliated with home health agencies and providing services in a patient's home.

Physical therapy is coded using HCPCS codes. When completing claims do not enter the decimal points in the ICD codes or the dollar amounts. Do not include hyphens when entering modifiers.

Skilled Nursing Facilities

All Skilled Nursing Facility (SNF) care must be pre-authorized. Contact Utilization Management for authorization prior to SNF admission.

Form CMS-1450 (UB-04): SNF care is billed using a CMS-1450 (UB-04) form. Use codes 0550, 0551, 0552, 0559, 90300-903XX.

Speech Therapy

All speech therapy must be pre-authorized. Evaluations do not require pre-authorization. Contact Utilization Management for authorization prior to delivery of services.

The speech therapy setting determines the correct billing form:

- Form CMS-1500: When providing services in an office, clinic, or outpatient setting.
- Form UB-04: for speech therapists affiliated with home health agencies and providing services in a patient's home.

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ADDITIONAL BILLING RESOURCES

The following references provide detailed instructions on uniform billing requirements:

- Current Procedural Terminology (CPT) 2006, American Medical Association.
- Healthcare Common Procedure Coding System (HCPCS), National Level II (current year).
- ICD (current edition), Volumes 1, 2, 3 (current year). Practice Management Information Corporation.

CODE TABLES

The codes listed below are examples of some of the codes that, in the past, have been frequently utilized by providers in our Medicaid programs. Use professional judgment to determine the most appropriate code for the service rendered.

CPT codes are routinely updated for both additions and deletions. This list represents our best efforts to accurately reflect currently approved CPT codes as of the date of publication of this manual. The most current version of the CPT manual should be used for full descriptions of the codes.

Please note: Global Billing is not accepted. All charges must be itemized.

CPT CODES FOR EVALUATION AND MANAGEMENT

Office or Other Outpatient Services, New Patient

Code	Description
99201	Office or other outpatient visit for the evaluation and management of a new patient, the presenting problems are self-limited or minor.
99202	Office or other outpatient visit for the evaluation and management of a new patient, the presenting problems are of low to moderate severity.
99203	Office or other outpatient visit for the evaluation and management of a new patient, the presenting problems are of moderate severity.
99204	Office or other outpatient visit for the evaluation and management of a new patient, the presenting problems are of moderate complexity, moderate to high severity.
99205	Office or other outpatient visit for the evaluation and management of a new patient, the presenting problems are of high complexity; moderate to high severity.

Office or Other Outpatient Services, Established Patient

Code	Description
99211	Office or other outpatient visit for the evaluation and management of an established patient, the presenting problems are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, the presenting problems are self-limited or minor.
99213	Office or other outpatient visit for the evaluation and management of an established patient, the presenting problems are of low to moderate severity.
99214	Office or other outpatient visit for the evaluation and management of an established patient, the presenting problems are of moderate complexity, moderate to high severity.
99215	Office or other outpatient visit for the evaluation and management of an established patient, the presenting problems are of high complexity, moderate to high severity.

Office or Other Outpatient Consultations, New or Established Patient

Code	Description
99241	Office consultation for a new or established patient, the presenting problems are self-limited or minor.
99242	Office consultation for a new or established patient, the presenting problems are of low to moderate severity.
99243	Office consultation for a new or established patient, the presenting problems are of moderate severity.
99244	Office consultation for a new or established patient, the presenting problems are of moderate complexity, moderate to high severity.
99245	Office consultation for a new or established patient, the presenting problems are of high complexity, moderate to high severity.

Chapter 8

Other Services

The following is a list of procedure codes that include other services.

HCPCS/CPT	Description
46608	Anoscopy; with removal of foreign body.
57415	Removal of impacted vaginal foreign body (separate procedure) under anesthesia.
59840	Dilation and curettage — used to induce a first trimester abortion, for termination of a pregnancy in the first 12-14 weeks of gestation.
59841	Dilation and curettage — used to induce a second trimester abortion, for termination of a pregnancy after 12-14 weeks of gestation.
99170	Anogenital examination with colposcopic magnification in childhood for suspected trauma.

Medicaid Modifier Codes for Billing Medicaid Services

This table provides modifier codes for billing Medicaid services.

Modifier	Description
SK	Members of high-risk population
TC	Technical component



Chapter 9

BEHAVIORAL HEALTH

BEHAVIORAL HEALTH – PROGRAM OVERVIEW

Behavioral health services are covered services for the treatment of mental, emotional or chemical dependency disorders.

We provide coverage of medically necessary behavioral health services as indicated below:

- Texas Health Steps behavioral health services for Medicaid members birth through age 20 that are necessary to correct or ameliorate a mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a mental illness or condition must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole.
- For Medicaid members over age 20 and CHIP members, behavioral health-related health care services may include consideration of other relevant factors, such as:
 - Are 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
 - Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care
 - Are furnished in the most appropriate and least restrictive setting in which services can be safely provided
 - Are the most appropriate level or supply of service that can safely be provided
 - Could not be omitted without adversely affecting the member’s mental and/or physical health or the quality of care rendered
 - Are not experimental or investigative
 - Are not primarily for the convenience of the member or provider

We do not cover behavioral health services that are experimental or investigative. Covered services are not intended primarily for the convenience of the member or the provider. For more information about behavioral health services call **800-327-7390/TTY: 800-735-2988**.

PRIMARY CARE PROVIDER RESPONSIBILITIES FOR BEHAVIORAL HEALTH

The PCP must have behavioral health screening and evaluation processes in place that are appropriate for detection, treatment or referral of members. PCPs are responsible for documenting in medical records any referrals and any known self-referrals for behavioral health services.

PCPs also are encouraged to:

- Maintain contact with behavioral health providers
- Document behavioral health assessments and treatments – medical record documentation and referral information using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) multi-axial classifications
- Inform the provider of any condition the member may have that could affect the behavioral health service
- Communicate and coordinate care essential to ensuring quality and continuity of care. The PCP should assist with behavioral health referrals and provide Magellan with supporting documentation
- Initiate member referrals for behavioral health services by contacting Magellan
- Obtain consent for disclosure of information

- Behavioral health providers are encouraged to contact a member's PCP to discuss the patient's general health and must contact members who have missed appointments within 24 hours to reschedule appointments as per HHSC-mandated provisions.

Behavioral Health Services - Member Access to Behavioral Health Services

Behavioral health services are provided for the treatment of behavioral health disorders, emotional disorders, and chemical dependency disorders. Behavioral health services do not require a PCP referral. Members may self-refer to a Magellan provider.

A PCP may, in the course of treatment, refer a member to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. PCP's may also provide behavioral health services within the scope of their practice.

Behavioral Health Assessment Instruments for Primary Care Providers

In addition to the screening tools provided in the Texas Medicaid Provider Procedures Manual at <http://www.bcbstx.com/provider/Mmedicaid/behavioral.html>, more tools are available by contacting Magellan Customer Service department at **800-327-7390**.

Local Mental Health Authority (LMHA)

Covered services are provided to members with severe and persistent behavioral health/mental illness (SPMI) and serious emotional disturbance (SED), when medically necessary, whether or not the member is also receiving targeted case management or rehabilitation services through the LMHA. The LMHAs in our service area are contracted providers with our behavioral health provider.

A Case Management assessment that explores the physical, psychological and social needs of the member is included, whether or not the member receives targeted behavioral health case management. Based on this assessment, Case Management collaborates with the member to identify goals that will be the basis for the treatment plan.

Rehabilitation services may be provided to individuals who satisfy the criteria of the behavioral health priority population and who are determined to need them. These services may be provided to a person who has a single severe behavioral/mental disorder (excluding mental retardation, pervasive developmental disorder, or substance abuse) or a combination of severe behavioral/mental disorders.

Self-Referral to Any Network Behavioral Health Provider

Members may self-refer to any in-network behavioral health provider without a PCP referral. The provider is responsible for obtaining pre-authorization from Magellan at **800-327-7390** (TTY: **800-735-2988**).

Coordination between Behavioral Health and Physical Health Services

BCBSTX requires that all physicians and other professional providers have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Physicians and other professional providers may provide any clinically appropriate behavioral health services within the scope of their practice.

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BCBSTX requires that all behavioral health service providers refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's or the member's legal guardian's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so.

BCBSTX also requires that behavioral health providers send initial and quarterly summary reports of a member's behavioral health status to the PCP or other professional provider, with the member's or the member's legal guardian's consent.

Court-Ordered Commitments

Court-ordered commitment means commitment of a member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

Follow-up after Hospitalization for Behavioral Health Services

BCBSTX requires that all members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Providers must contact members who have missed appointments within 24 hours to reschedule appointments.

Focus Studies and Utilization Management Reporting Requirements

Consistent with National Committee for Quality Assurance (NCQA) standards, Magellan analyzes relevant utilization data against established thresholds for each health plan to detect potential under- and over-utilization on at least a semi-annual basis.

If findings from these monitors fall outside the specified target ranges or threshold and indicate potential under- or over-utilization that may adversely affect members, further drill-down analyses will occur based upon the recommendation of the Magellan Utilization Management Committee (UMC). The drill-down analyses may include the following data from specific provider and practice sites:

- Case management services as needed for members receiving behavioral health services
- Retrospective reviews of services provided without authorization
- Investigation and resolution of member and provider complaints and appeals within established time frames
- Coordination with the local behavioral health authorities
- Focus studies
- Claims payment for covered behavioral health services

Magellan's Claims Address

Magellan

Attn: Claims

P.O. Box 2154

Maryland Heights, MO 63043

Magellan has established a comprehensive Quality Improvement Program to help ensure that high quality behavioral health treatment and services are provided to STAR members, including focused activities to monitor and evaluate access across the behavioral health continuum of care.

Procedures for Follow-up on Missed Appointments

Behavioral health providers are encouraged to contact a member’s PCP to discuss the patient’s general health and must contact members who have missed appointments within 24 hours to reschedule appointments as per HHSC-mandated provisions.

COVERED BEHAVIORAL HEALTH SERVICES

Medicaid-covered behavioral health services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service (FFS) Medicaid coverage. The services may be subject to BCBSTX non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008, including:

- Inpatient mental health services
- Outpatient mental health services
- Psychiatry services
- Counseling services for adults (age 21 and older)
- Outpatient substance use disorder treatment services, including:
 - Assessment
 - Detoxification services
 - Counseling treatment
 - Medication-assisted therapy
- Residential substance use disorder treatment services, including detoxification services
- Substance use disorder treatment, including room and board
- Mental Health Rehabilitative Services
- Targeted Case Management

CHIP Covered Behavioral Health Services (These services are not covered for CHIP Perinate)

- Inpatient mental health
- Outpatient mental health
 - Assessment
 - Counseling
 - Detoxification services
 - Crisis stabilization
 - Psychological and neuropsychological testing
 - Rehabilitative 24-hour and day treatment
- Inpatient substance abuse
- Outpatient substance abuse
 - Assessment
 - Detoxification services
 - Psychiatry
 - Psychological and neuropsychological Testing
 - Crisis stabilization

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Attention Deficit Hyperactivity Disorder (ADHD)

Treatment of children diagnosed with ADHD, including follow-up care for children who are prescribed ADHD medication, is covered as outpatient mental health services. Reimbursement for these services will be determined according to the Provider Agreement. Covered benefits are as outlined in the TMPPM.

Mental Health Rehabilitative Services and Targeted Case Management

Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM) must be available to eligible STAR Members with Severe and Persistent Mental Illness (SPMI) or Severe Emotional Disturbance (SED).

SPMI is a condition of an adult 18 years of age or older. It is a diagnosable mental, behavioral, or emotional disorder that meets the criteria of DSM-IV-TR and that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

SED is a condition of a child up to age 18 either currently or at any time during the past year. It is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV-TR and that has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Mental Health Rehabilitative (MHR) Services include training and services that help the member maintain independence in the home and community, such as the following:

- **Medication training and support:** Curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community
- **Psychosocial rehabilitative services:** Social, educational, vocational, behavioral, or cognitive interventions to improve the member's potential for social relationships, occupational or educational achievement, and living skills development
- **Skills training and development:** Skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers
- **Crisis intervention:** Intensive community-based one-to-one service provided to members who require services in order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting
- **Day program for acute needs:** Short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting

Targeted Case Management (TCM) Services include:

- Case management for members who have Severe Emotional Disturbance (child, 3 through 17 years of age), which includes routine and intensive case management services
- Case management for members who have Severe and Persistent Mental Illness (adult, 18 years of age or older)

Mental Health Rehabilitative Services and Targeted Case Management Services including any limitations to these services are described in the most current TMPPM, including the Behavioral Health, Rehabilitation, and Case Management Services Handbook. We will authorize these services using the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG) but BCBSTX is not responsible for providing any services listed in the RRUMG that are not covered services.

Providers of MHR Services and TCM Services must use and be trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) tool to assess a member's need for services and recommend a level of care. Providers will submit these forms to BCBSTX in an electronic format as prescribed by HHSC requirements. A provider entity must attest to BCBSTX that the organization has the ability to provide, either directly or through sub-contract, the full array of RRUMG services to members.

HHSC has established qualifications and supervisory protocols for providers of MHR and TCM Services. This criterion is located in Chapter 15.1 of the HHSC Uniform Managed Care Manual.

PRIMARY AND SPECIALTY SERVICES

STAR members have access to the following primary and specialty services:

- Behavioral health clinicians available 24 hours a day/seven day a week to assist with identifying the most appropriate and nearest behavioral health service
- Routine or regular laboratory and ancillary medical tests or procedures to monitor behavioral health conditions of members; these services are furnished by the ordering provider at a lab located at or near the provider's office; in most cases, our network of reference labs is conveniently located at or near the provider's office
- Behavioral health case managers to coordinate with the hospital discharge planner and member to ensure appropriate outpatient services are available
- Support and assistance for network behavioral health care providers in contacting members within 24 hours to reschedule missed appointments

CARE COMMUNITY AND COORDINATION GUIDELINES

PCPs and behavioral health care providers are responsible for actively coordinating and communicating continuity of care. Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. The exchange of information facilitates behavioral and medical health care strategies.

Our care continuity and coordination guidelines for PCPs and behavioral health providers include:

- Coordinating medical and behavioral health services with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning for members with Serious Emotional Disorders (SED) and Serious Mental Illness (SMI), if applicable
- Completing and sending the member's consent for information release to the collaborating provider
- Using the release as necessary for the administration and provision of care

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- Noting contacts and collaboration in the member's chart
- Responding to requests for collaboration within one week or immediately if an emergency is indicated
- Sending a copy of a completed Coordination of Care/Treatment Summary form to us and the member's PCP when the member has seen a behavioral health provider; the form can be found on our website
- Sending initial and quarterly (or more frequently, if clinically indicated) summary reports of a member's behavioral health status from the behavioral health provider to the member's PCP
- Contacting the PCP when a behavioral health provider changes the behavioral health treatment plan
- Contacting the behavioral health provider when the PCP determines the member's medical condition could reasonably be expected to affect the member's mental health treatment planning or outcome and documenting the information on the coordination of care/treatment summary

EMERGENCY BEHAVIORAL HEALTH SERVICES

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention and/or medical attention. and in an emergency and without immediate intervention and/or medical attention, the member would present an immediate danger to himself, herself or others or would be rendered incapable of controlling, knowing or understanding the consequences of his or her actions.

In the event of a behavioral health emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 911 should be contacted if the member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the member is:

- Suicidal
- Homicidal
- Violent towards others
- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living
- Alcohol or drug dependent with signs of severe withdrawal

We do not require precertification or notification of emergency services, including emergency room and ambulance services.

URGENT BEHAVIORAL HEALTH SERVICES

An urgent behavioral health situation is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the member is not an immediate danger to himself or herself or others and is able to cooperate with treatment.

Care for non-life-threatening emergencies should be within six hours.

REFERRALS FOR BEHAVIORAL HEALTH

STAR and CHIP members may self-refer to any BCBSTX network behavioral health services provider by calling Customer Service at **888-657-6061** (TTY: **711**). No precertification or referral is required from the PCP.

Providers may refer members for services by calling Magellan at **800-327-7390** (TTY: **800-735-2988**).

Our staff is available 24 hours a day/seven days a week, 365 days a year for routine, crisis or emergency calls and authorization requests.



Chapter 10

Utilization Management

OVERVIEW

Utilization Management (UM) collaborates with providers to promote and document the appropriate use of health care resources. The program reflects the most current UM standards from the National Committee for Quality Assurance (NCQA).

Utilization Management takes a multidisciplinary approach to help provide access to health care services in the setting best suited for the medical and psychosocial needs of the member based on benefit coverage, established criteria and the community standards of care.

Authorization is based on medical necessity and will be contingent upon eligibility and benefits. It is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications with the exception of Texas Health Steps Service for children from birth through 20 years of age. For these services, medical necessity is based on the clinical documentation received by the utilization management department when requesting a prior authorization.

To initiate a Utilization Management request for prior authorization, call **877-560-8055**.

ROLE OF UTILIZATION MANAGEMENT

The role of Utilization Management is to assist Providers in providing access to the right care to the right member, at the right time, in the appropriate setting. Providers may call Utilization Management toll-free at **877-560-8055** with questions and/or requests, including requests for urgent/expedited prior authorization and urgent concurrent/continued stay review.

Utilization Management attempts to return calls the same day they are received during normal business hours. Calls received after normal business hours will be returned the next business day. All routine requests will be responded to within 24 hours.

Providers may fax Utilization Management at **855-653-8129** with requests for urgent/expedited and non-urgent prior authorization and concurrent/continued stay review. Faxes are accepted during normal business hours as well as after hours. Faxes received after hours will be processed the next business day.

Eligibility verification, benefits and network information may be available after normal business hours at www.availity.com.

Providers who need to reach Utilization Management after hours should call **877-560-8055**. An on-call nurse will provide assistance.

For after-hours assistance, not available on the website, call the Customer Service at **877-560-8055** to be connected to after-hours support staff.

BCBSTX offers TTY services for deaf, hearing and speech-impaired members. Language assistance is available at no cost to members and providers to discuss Utilization Management issues, upon request. Interpreters are available to members by calling the Customer Service or TTY numbers in the Provider Manual or Member Handbook.

Service Reviews

Utilization Management provides prior authorization, concurrent/continued stay and post-service reviews using clinical criteria based on sound clinical evidence. These criteria are available to members, physicians and other health care providers upon request by contacting Utilization Management at **877-560-8055** or via fax at **855-653-8129**. Both numbers are toll-free.

Provider Notifications of Changes to Authorization Procedures

We notify providers of changes to authorization procedures via provider bulletins. Provider bulletins are distributed to all network providers and then posted on the BCBSTX website. The Provider Manual is then updated with changes during its next scheduled revision.

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Decision Making

Utilization Management does not make decisions affecting the coverage or payment of members.

Utilization Management makes decisions regarding medically necessary services based on the member's active enrollment. We do not reward practitioners and other individuals conducting utilization review for issuing denials of coverage or care.

There are no financial incentives for Utilization Management decision-makers to encourage decisions that result in under-utilization. If you disagree with a Utilization Management decision and would like to discuss the decision with the physician reviewer, you can call Utilization Management at **877-560-8055**.

Decision and Screening Criteria

The TX Medicaid time lines for decisions are in alignment with the Texas Department of Insurance requirements and the HHSC UMCM requirements.

Utilization Management applies MCG Care Guidelines and BCBSTX's medical policy and clinical guidelines for utilization management screening and decisions. Utilization Management does not rely solely on these guidelines; we also give consideration to the clinical information provided as well as the individual health care needs of the member.

Decision criteria incorporates nationally recognized standards of care and practice from sources such as the:

- American College of Cardiology
- American College of Obstetricians and Gynecologists
- American Academy of Pediatrics
- American Academy of Orthopedic Surgeons, current professional literature
- Cumulative professional expertise and experience

The decision criteria used by the clinical reviewers are evidenced-based and consensus-driven. We periodically update criteria as standards of practice and technology change. We also involve actively practicing physicians in the development and adoption of the review criteria.

These criteria are available to members, physicians and other professional providers upon request by contacting Utilization Management at **877-560-8055**.

PRIOR AUTHORIZATION

SERVICES REQUIRING PRIOR AUTHORIZATION

The services listed below require authorization prior to providing services to STAR and CHIP members. This list will be updated as needed.

All providers are responsible for verifying eligibility and obtaining authorization for non-emergent services provided to a BCBSTX member by out-of-network providers prior to rendering services. The exception to this rule is the services for which members can self-refer with no authorization needed, such as family planning.

For benefits to be paid the member must be eligible on the date of service and benefits may be subject to limitations and/or qualifications, with the exception of Texas Health Steps services for children from birth through 20 years of age. These services are based on medical necessity. Failure to obtain prior authorization for the designated services below may result in a denial for reimbursement. (Except in the case of an emergency.)

iExchange, our Web based prior authorization tool, provides you with real-time responses for direct submission of inpatient admissions and select outpatient medical services, and enables you to send prior authorization submissions after hours and on weekends. For additional information about iExchange, including how to register, visit the Provider Tools page on our Provider website at www.bcbstx.com/provider/tools/iexchange_index.html.

BCBSTX offers a variety of forms for use when obtaining authorization prior to rendering services. You will find this toolkit on the Provider Resources webpage under **Prior Authorization Requirements** at <http://bcbstx.com/provider/Medicaid/index.html>. You can also call Utilization Management at **877-560-8055** or Fax **855-653-8129**.

Here are some tips for getting the fastest response to your authorization request:

- Fill forms out completely and legibly. Unanswered questions or unreadable text typically result in delays.
- Access forms online when needed, rather than pre-printing and storing them. We revise forms periodically, and outdated forms can delay your request.

BCBSTX does not accept and review medical records attached to claims in place of required prior authorization (PA). If a claim for services requiring PA is received with medical records attached in place of the required PA, that claim will be denied due to lack of prior authorization.

Note: BCBSTX will receive claims with medical records attached only if that review relates to an appeal request on a claim previously denied for no PA. Administrative denial on such claims will be upheld through appeal, regardless of attached medical records, unless the services are deemed to be a true medical emergency.

TO REQUEST PRIOR AUTHORIZATION

To request Prior Authorization (PA), report a medical admission, or ask questions regarding PA, please contact Utilization Management at **877-560-8055**.

Services Requiring Prior Authorization

Service / Request	Is Prior Authorization (PA) required for in-network providers?
Air Ambulance	Yes.
Ambulance – Ground	Yes. Non-emergent transport from facility to facility requires authorization prior to services being rendered.
Behavioral/Mental Health	Yes. Please contact Magellan at 800-327-7390 for referrals and authorizations.
Biofeedback	Yes.

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Service / Request	Is Prior Authorization (PA) required for in-network providers?
Dental Services	<p>Dental coverage through the medical plan is limited to emergency needs only. Facility services and dental anesthesia services provided in an inpatient or outpatient facility require PA from BCBSTX.</p> <p>For preventive dental care, please call the member's selected dental plan:</p> <p>STAR</p> <p>DentaQuest 800-516-0165 MCNA Dental 855-691-6262</p> <p>CHIP</p> <p>DentaQuest 800-508-6775 MCNA Dental 855-691-6262</p>

Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p>Durable Medical Equipment (DME) and Disposable Supplies</p> <p>For DME not listed or any other questions regarding DME, contact Utilization Management at 877-560-8055.</p>	<p>Yes. Rental of DME and purchase of custom equipment will require PA request.</p> <p>Providers are required to get Prior Authorization for the following:</p> <ul style="list-style-type: none"> • Altered Auditory Feedback (AAF) Devices for the Treatment of Stuttering • Augmentative and Alternative Communication (AAC) Devices/ Speech Generating Devices (SGD) • Automated External Defibrillators for home use • Bone-Anchored Hearing Aids • Continuous local delivery of analgesia to operative sites using an Elastomeric Infusion Pump during the post-operative period • Custom Durable Medical Equipment • Electrical bone growth stimulation • Electrical stimulation as a treatment for pain and related conditions: surface and percutaneous devices • External (portable) Continuous Insulin Infusion Pump • Functional Electrical Stimulation (FES); Threshold Electrical (TES) • Hospital beds • Implantable Cardioverter Defibrillator • Implantable Infusion Pumps • Implantable Left Atrial Hemodynamic (LAH) Monitor • Implantable Middle Ear Hearing Aids • Implanted devices for spinal stenosis • Implanted Spinal Cord Stimulators (SCS) • Lifts • Microprocessor Controlled Lower Limb Prosthesis • Myoelectric Upper Extremity Prosthetic Devices • Oscillatory Devices for airway clearance including High Frequency Chest Compression (Vest™ Airway Clearance System) and Intrapulmonary Percussive Ventilation (IPV) • Partial-hand Myoelectric Prosthesis • Patient-operated Spinal Unloading Devices • Certain prosthetic and orthotic devices • Self-operated Spinal Unloading Devices • Standing frames • Trans tympanic Micro pressure for the treatment of Meniere's Disease • Ultrasound Bone Growth Stimulation • Ultraviolet Light Therapy Delivery Devices for home use under pads • Vacuum Assisted Wound Therapy in the outpatient setting • Wearable Cardioverter Defibrillators • Wheelchair/wheelchair accessories • Wheeled Mobility Devices: Manual wheelchairs-ultra lightweight • Wheeled Mobility Devices: Wheelchairs-powered, motorized, with or without power Seating Systems and Power Operated Vehicles (POVs)

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Service / Request	Is Prior Authorization (PA) required for in-network providers?
Gene Testing	Yes.
Home Health Care Services	Yes.
Injection Therapy and Specialty Medication (not covered under pharmacy)	Yes.
Inpatient Hospital Services <ul style="list-style-type: none"> • Newborn Stays Beyond Mother • Inpatient Skilled Nursing Facility (SNF) • Long-term Acute Care Facility (LTAC) • Rehabilitation Facility Admissions 	Providers are required to get Prior Authorization for the following: <ul style="list-style-type: none"> • All elective inpatient admissions. • Notify BCBSTX of emergent admissions within 24 hours or the next business day of inpatient admission. • Routine vaginal or cesarean section deliveries do not require medical necessity review; however, both delivery types require notification. • All newborn deliveries require notification. Complete and submit a Newborn Enrollment Notification Report form within three days of delivery.
Laboratory Services	Providers are to utilize an in-network hospital/laboratory for all laboratory needs. Out-of-network lab services and tests that are potentially investigational require Prior Authorization.
Pharmacy and/or Over-the-Counter (OTC) Products	Prescription drugs are covered by BCBSTX through Prime Therapeutics LLC for details about pharmacy Prior Authorization requirements, please contact 866-533-7008 for STAR and 866-323-2088 for CHIP. See listing on page 20 of this manual. For information about the formulary and drugs requiring Prior Authorization, you may also visit the Texas Medicaid Vendor Drug Program at www.txvendordrug.com .
Physician Services – Referrals to Specialists	Required when referring a member to an out-of-network specialist.

Service / Request	Is Prior Authorization (PA) required for in-network providers?
Radiology Services	<p>Prior Authorization is required for all PET/SPECT scans including: CT, CTA, MRI, and MRA. PA is also required for the following:</p> <ul style="list-style-type: none"> • MR Spectroscopy • QCT Bone Densitometry • Myocardial Perfusion Imaging • Infarct Imaging • Intensity Modulated Radiation Therapy (IMRT) • Cardiac Blood Pool Imaging • PET/CT Fusion • Screening CT colonoscopy • Diagnostic CT Colonography • Functional MRI Brain • CT Heart for Calcium Scoring • CT Heart for Structure & Morph • CTA Heart Including Structure & Morph • MEG • Add-on Procedures • Radiology services that are potentially investigational

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Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p>Inpatient & Outpatient Surgeries/Procedures</p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact Utilization Management at 877-560-8055 for questions regarding Prior Authorization.</p>	<p>All elective inpatient procedures (excluding labor and delivery) and some outpatient procedures require Prior Authorization. Surgeries/procedures that are potentially cosmetic and/or investigational require Prior Authorization. Outpatient procedures include:</p> <ul style="list-style-type: none"> • Ablative techniques as a treatment for Barrett’s Esophagus • Adoptive Immunotherapy and Cellular Therapy • Anterior Segment Optical Coherence Tomography • Antineoplastic Therapy • Artificial Anal Sphincter for the treatment of severe fecal incontinence • Artificial Retinal Devices • Allogeneic, Xerographic, Synthetic and Composite products for wound healing and soft tissue grafting • Autologous Cellular Immunotherapy for the treatment of prostate cancer • Automated Evacuation of Meibomian Gland • Automated Nerve Conduction Testing • Axial Lumbar Interbody Fusion • Balloon Sinus Ostial Dilation • Behavioral health treatments for Pervasive Developmental Disorders • Bicompartamental Knee Arthroplasty • Bio impedance Spectroscopy Devices for the detection and management of lymphedema • Bio magnetic Therapy • Blepharoplasty, Blepharitis’s Repair, and Brow Lift • Breast Ductal Examination and Fluid Cytology Analysis • Breast Procedures; including reconstructive surgery, implants and other breast procedures • Bronchial Thermoplastic • Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the treatment of heart failure • Carotid Sinus Baroreceptor Stimulation Devices • Carotid, Vertebral and Intracranial Artery Angioplasty with or without stent placement • Coblation® Therapies for musculoskeletal conditions • Cochlear Implants and Auditory Brainstem Implants • Cognitive Rehabilitation • Computer Analysis and Probability Assessment of Electrocardiographic-Derived Data

Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p>Inpatient & Outpatient Surgeries/Procedures Continued</p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact Utilization Management at 877-560-8055 for questions regarding Prior Authorization.</p>	<p>All elective inpatient procedures (excluding labor and delivery) and some outpatient procedures require Prior Authorization. Surgeries/procedures that are potentially cosmetic and/or investigational require Prior Authorization. Outpatient procedures include:</p> <ul style="list-style-type: none"> • Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures • Convection Enhanced Delivery of Therapeutic Agents to the brain • Cooling Devices and Combined Cooling/Heating Devices • Cosmetic and Reconstructive Services of the head and neck • Cosmetic and Reconstructive Services of the trunk and groin • Cosmetic and Reconstructive Services: skin related • Cryoablation for Plantar Fasciitis and Plantar Fibroma • Cryopreservation of oocytes or ovarian tissue • Cryosurgical Ablation of solid tumors outside the liver • Deep Brain Stimulation • Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems • Electric Tumor Treatment Field (TTF) • Electroencephalography (EEG) Testing: ambulatory and video • Electromagnetic Navigational Bronchoscopy • Electrothermal Shrinkage of joint capsules, ligaments, and tendons • Endobronchial Valve Devices • Endothelial Keratopathy • Endovascular/Endoluminal repair of aortic aneurysms • Epiduroscopy • Extracorporeal Shock Wave Therapy for orthopedic conditions • Facet Joint Allograft Implants for Facet Disease • Fetal Surgery for prenatally diagnosed malformations • Functional Endoscopic Sinus Surgery (FESS) • Gastric Electrical Stimulation • Growth Factors, Silver-based Products and Autologous Tissues for wound treatment and soft tissue grafting • Hepatic Activation Therapy • High Intensity Focused Ultrasound (HIFU) for the treatment of prostate cancer • High Resolution Anoscopy Screening Hip Resurfacing • Hippotherapy • Hyperbaric Oxygen Therapy (systemic/topical) • Hypoxemic Reperfusion Therapy • Hyperthermia for Cancer Therapy

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Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p>Inpatient & Outpatient Surgeries/ Procedures Continued</p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact Utilization Management at 877-560-8055 for questions regarding Prior Authorization.</p>	<p>All elective inpatient procedures (excluding labor and delivery) and some outpatient procedures require Prior Authorization. Surgeries/procedures that are potentially cosmetic and/or investigational require Prior Authorization. Outpatient procedures include:</p> <ul style="list-style-type: none"> • Idiopathic Environmental Illness (IEI) • Imaging Techniques for Screening and identification of cervical cancer • Injection Treatment for Morton’s Neuroma • In Vivo Analysis of gastrointestinal lesions • Inhaled Nitric Oxide for the Treatment of respiratory failure • Intervertebral Stabilization Devices • Intracardiac Ischemia Monitoring • Intradiscal Annuloplasty Procedures Percutaneous Intradiscal Electrothermal Therapy [IDET] • Intraocular Anterior Segment Aqueous Drainage Devices • Intraocular Epiretinal Brachytherapy • Intraocular Telescope • Intravitreal Corticosteroid Implants • Keratoprosthesis • Laparoscopic and Percutaneous MRI-Image Guided Techniques for Myolysis as a Treatment of Uterine Fibroids • Locally Ablative Techniques for treating primary and metastatic liver malignancies • Low-Frequency Ultrasound Therapy for wound management • Lung Volume Reduction Surgery • Lysis of Epidural Adhesions • Mandibular/Maxillary (Orthognathic) Surgery • Manipulation Under Anesthesia of the spine and joints other than the knee • Mastectomy for Gynecomastia • Maze Procedure • Mechanical Embolectomy for treatment of acute stroke • Mechanized Spinal Distraction Therapy for low back pain • Melanoma Vaccines • Microvolt T-Wave Alternans • MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids • Nasal Surgery for the treatment of Obstructive Sleep Apnea • Nasal Valve Suspension • Nerve Graft after Prostatectomy • Neural Therapy • Non-Invasive Measurement of Left Ventricular End Diastolic Pressure (LVEDP) in the Outpatient Setting

Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p>Inpatient & Outpatient Surgeries/ Procedures Continued</p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact Utilization Management at 877-560-8055 for questions regarding Prior Authorization.</p>	<p>All elective inpatient procedures (excluding labor and delivery) and some outpatient procedures require Prior Authorization. Surgeries/procedures that are potentially cosmetic and/or investigational require Prior Authorization. Outpatient procedures include:</p> <ul style="list-style-type: none"> • Occipital Nerve Stimulation • Open Treatment of Rib Fracture(s) Requiring Internal Fixation • Ophthalmologic Techniques for Evaluating Glaucoma • Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea • Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome • Panniculectomy and Abdominoplasty • Pain Management Injections and Procedures • Partial Left Ventriculectomy • Penile Prosthesis Implantation • Percutaneous and Endoscopic Spinal Surgery • Percutaneous Neurolytic for Chronic Back Pain • Percutaneous (Vertebroplasty, Kyphoplasty and Sacroplasty) • Photocoagulation of Macular Drusen • Presbyopia and Astigmatism-Correcting Intraocular Lenses • Prolotherapy for Joint and Ligamentous Conditions • Prostate Saturation Biopsy • Quantitative Muscle Testing devices • Quantitative Sensory Testing • Radiofrequency ablation • Radiofrequency and Pulsed Radiofrequency • Radiofrequency Pallidotomy • Neurolytic for Trigeminal Neuralgia (TGN) • Real-Time remote heart monitors • Recombinant Human Bone Morphogenetic Protein • Reduction Mammoplasty • Refractive surgery • Rhino phototherapy • Sacral Nerve Stimulation as a treatment of neurogenic bladder secondary to spinal cord injury • Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for urinary and fecal incontinence; urinary retention • Sensory stimulation for brain-injured patients in a coma or vegetative state • Selected sleep testing services • Septoplasty • Sleep studies

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Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p>Inpatient & Outpatient Surgeries/Procedures Continued</p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact Utilization Management at 877-560-8055 for questions regarding Prior Authorization.</p>	<p>All elective inpatient procedures (excluding labor and delivery) and some outpatient procedures require Prior Authorization. Surgeries/procedures that are potentially cosmetic and/or investigational require Prior Authorization. Outpatient procedures include:</p> <ul style="list-style-type: none"> • Stereotactic Radiofrequency Pallidotomy • Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT) • Subtalar Arthroereisis • Suprachoroidal injection of a pharmacologic agent • Surgery for clinically severe obesity • Surgical and minimally invasive treatments for Benign Prostatic Hyperplasia (BPH) and other genitourinary • Surgical Treatment of femoroacetabular impingement syndrome • Surgical and ablative treatments for chronic headaches • Technologies for the evaluation of skin lesions • Procedures related to temporomandibular disorders • Tonsillectomy and Adenoidectomy • Total ankle replacement • Trans anal Endoscopic Microsurgical (TEM) excision of rectal lesions • Trans anal radiofrequency treatment of fecal incontinence • Trans catheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation • Trans catheter closure of patent foramen oval and left atrial appendage for stroke prevention • Trans catheter heart valves • Trans catheter uterine artery embolization • Transcranial Magnetic Stimulation for behavioral and non-behavioral health indications • Trans endoscopic Therapy for gastroesophageal reflux disease • Trans myocardial Revascularization • Treatment for obstructive sleep apnea in adults • Treatment of hyperhidrosis • Treatment of osteochondral defects of the knee and ankle • Treatment of varicose veins (lower extremities) • Treatments for urinary incontinence and urinary retention • Unicondylar Interpositional Spacer • Vagus nerve stimulation • Viscocanalostomy and Canaloplasty • Venous angioplasty with or without stent placement for the treatment of Multiple Sclerosis • Vertebral body stapling for the treatment of Scoliosis

Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p>Inpatient & Outpatient Surgeries/ Procedures Continued</p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact</p>	<p>All elective inpatient procedures (excluding labor and delivery) and some outpatient procedures require Prior Authorization. Surgeries/procedures that are potentially cosmetic and/or investigational require Prior Authorization. Outpatient procedures include:</p> <ul style="list-style-type: none"> • Wearable Cardioverter Defibrillators • Wireless Capsule for the evaluation of Suspected Gastric and Intestinal Motility Disorders
<p>Inpatient & Outpatient Surgeries/Procedure</p>	<ul style="list-style-type: none"> • Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered. <p>Please contact the Utilization Management department at 1-877-560-8055 for information regarding PA.</p>
<p>Therapy Services – Physical, Occupational or Speech Therapies</p>	<p>Initial evaluation for Therapy Services does not require prior authorization. Therapy visits following the initial evaluation and continuation of services must be authorized prior to services being rendered. Re-evaluations of therapy must be authorized prior to services being rendered.</p>
<p>Transplant Services</p>	<p>Yes.</p>
<p>Vision Services</p>	<p>Vision services for routine eye care: Contact Davis Vision at 800-773-2847 for vision benefits.</p>

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The services listed below DO NOT require Prior Authorization (PA) for in-network providers:

- Chiropractic Services – Limited to 12 visits per benefit period
- Dialysis
- Emergency Services – Notify BCBSTX of admissions within 24 hours or the next business day of inpatient admission
- Formulary glucometers and nebulizers
- Family Planning/Well-Check Up-Member may self-refer to any Medicaid provider for the following services:

- Pelvic and breast examinations
- Lab work
- Birth Control
- Genetic counseling
- FDA approved devices and supplies related to family planning (such as IUD)
- HIV/STD screening
- Standard x-rays and ultrasounds

What to have ready when calling Utilization Management

To request prior authorization and report medical admission, call Utilization Management at **877-560-8055**. To help the process go as smoothly and quickly as possible, please have the following information ready:

- Member name and identification (ID) number
- Clinical justification for the request
- Diagnosis with the International Classification of Diseases, current edition
- Level of care
- Procedure with the Current Procedural Terminology (CPT) code
- Lab tests, radiology and pathology results
- Date of injury/date of hospital admission and third-party liability information (if applicable)
- Medications
- Facility name (if applicable)
- Treatment plan with time frames
- Primary Care Provider (PCP) name
- Prognosis
- Specialist or attending physician name
- Psychosocial status
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans

Physicians, hospitals and ancillary providers are required to provide information and documentation to Utilization Management. Physicians are also encouraged to review their utilization and referral patterns.

– Obstetrical Care: No authorization is required for in-network physician visits and routine testing.

Pregnancy and newborn deliveries require notification. Please notify BCBSTX of member pregnancies using the Notification of Pregnancy Report. Please complete and submit this form online or print and complete the form legibly before faxing to BCBSTX at 855-653-8129. Notify BCBSTX of

newborn enrollments within three days of delivery by calling 877-560-8055.

– No PA required for physician referrals if referring member to an in-network specialist for consultation or a nonsurgical course of treatment

Prior Authorization Time Frame

For routine non-urgent requests, Utilization Management will complete prior authorization within three business days from receipt of information reasonably necessary to make a decision. We will send requests that do not meet medical policy guidelines to the medical director for review.

We will notify providers within three business days from the receipt of the request by phone of Utilization Management's decision, and will send the member and requesting provider a written notification by mail within three business days from receipt of the request of any denial or deferral decision.

Requests with Insufficient Clinical Information

For prior authorization requests with insufficient clinical information, BCBSTX contacts the provider with a request for the clinical information reasonably necessary to determine medical necessity. We will make at least one attempt to contact the requesting provider to obtain the additional information. If we do not obtain a response within three business days of receipt of the request, we will send a Denial–Lack of Medical Information letter to the member and provider.

Urgent Requests

The UM department completes the prior authorization review within 72 hours from receipt of the clinical information necessary to render a decision. Generally speaking, the provider is responsible for contacting us to request Prior Authorization review for both professional and institutional services.

Emergency Medical Conditions and Services

BCBSTX does not require authorization for treatment of emergency medical conditions. In the event of an emergency, members can access emergency services 24 hours a day/seven day a week. In the event an emergency room visit results in the member's admission to the hospital, you must contact BCBSTX within 24 hours of the admission.

Stabilization and Post-Stabilization

The emergency department's treating physician determines the services necessary to stabilize the member's emergency medical condition. After the member's emergency, medical condition is stabilized, the emergency department's treating physician must contact the member's PCP for authorization of further services. If the PCP does not respond within one hour, the needed services will be considered authorized. The member's PCP is noted on the back of the ID card.

The emergency department should send a copy of the emergency room record to the PCP's office within 24 hours. The PCP should file the chart copy in the member's permanent medical record. The PCP should review the emergency room chart, contact the member, and schedule a follow-up office visit or a specialist referral, if appropriate.

All providers who are involved in the treatment of a member share responsibility in communicating clinical findings, treatment plans, prognosis and the psychosocial condition of the member with the member's PCP to help ensure effective coordination of care.

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REFERRALS TO SPECIALISTS

Utilization Management is available to assist providers in identifying a network specialist and/or arranging for specialist care. Here are some other items to keep in mind when referring members:

- Authorization from Utilization Management is not required if referring a member to an in-network specialist for consultation or a nonsurgical course of treatment.
- Authorization from Utilization Management is required when referring to an out-of-network specialist.

All providers are responsible for documenting referrals in the member's chart and requesting that the specialist provide updates as to the diagnosis and treatment plan.

CONCURRENT REVIEW - ADMISSION AND CONTINUED STAY REVIEWS

When continued, stay is expected to exceed the number of days authorized during prior authorization, the hospital must contact us for continued stay review. In such cases, we require clinical reviews on all members admitted as inpatients in an acute care hospital, intermediate facility, or skilled nursing facility. We perform the reviews to assess that the medical care rendered is medically necessary and that the facility and level of care are appropriate. BCBSTX identifies members admitted to the inpatient setting by:

- Facilities reporting admissions.
- Claims submissions for services rendered without authorization.
- Physician or other professional provider reporting admissions.
- Prior authorization requests for inpatient care.
- Members or their representatives reporting admissions.

Utilization Management will complete continued stay inpatient reviews within 24 hours of receipt of clinical information or sooner, consistent with the member's medical condition. UM nurses will request clinical information from the hospital on the same day they are notified of the member's admission/continued stay.

If the information provided meets medical necessity review criteria, we will approve the request within 24 hours from the time the information is received. We will send requests that do not meet medical policy guidelines to the medical director for review.

We will notify providers within 24 hours of the decision. If it appears that the requested service does not meet medical necessity, we will send written or electronic notification of our intent to deny or modify the request to the requesting provider. If the requesting provider does not agree with the decision and wishes to provide additional information or discuss the case with our physician reviewer, contact information will be provided for a physician-to-physician consultation. The provider and member will receive a written or electronic notification of all denials decisions.

Inpatient Admission Notification

Hospitals must notify us of inpatient admissions within 24 hours of admission or by the next business day. For medical admissions, notification can be made by calling Utilization Management at **877-560-8055** or by faxing **855-653-8129**.

For behavioral health or substance abuse admissions, notification must be made to Magellan for STAR and CHIP members at **800-327-7390**.

Once notification of an inpatient admission is received, a request for clinical information supporting the medical necessity of the admission is made. Evidence-based criteria are used in medical necessity and appropriate level of care determinations.

Clinical Information for Continued Stay Review

Facilities are required to provide clinical information within 24 hours of the admission notification in order to facilitate concurrent review, certify approved inpatient days, expedite discharge planning and authorizations and help ensure proper claims payment. Decisions are made within 24 hours of the receipt of the request for continued stay services. The request must be accompanied by the clinical documentation and the physicians order.

The Utilization Management nurse performs ongoing, follow-up and continued stay reviews in collaboration with hospital Utilization Management staff and provides assistance with discharge planning as needed to facilitate and coordinate the timely transition of care when medically indicated.

DENIAL OF SERVICE

Only a medical or behavioral health physician who possesses an active Texas professional license or certification can deny a service (procedure, hospitalization or equipment) for lack of medical necessity. When a determination that a request is not medically necessary is made, the BCBSTX medical director will contact the requesting provider and provide an opportunity to discuss the decision peer-to-peer to ensure that no additional clinical information is available that might result in an authorization of the service. If agreement cannot be reached between the requesting provider and the BCBSTX medical director, the provider will be informed that the request is being denied. We inform the provider of the opportunity for an appeal should the final determination result in a denial.

Utilization Management policies and procedures address the availability of physician reviewers to discuss, by telephone, adverse determinations of any type, including those based on medical necessity.

Providers may contact the physician clinical reviewers to discuss any Utilization Management decision by calling **877-560-8055** from 8 a.m. to 8 p.m., Monday through Friday, excluding holidays.

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SELF-REFERRAL

Members may self-refer to in-network physicians and other professional providers for family planning services, including:

- Health education and counseling
- Limited history and physical examinations
- Laboratory tests
- Diagnosis and treatment of sexually transmitted diseases, if medically indicated
- HIV testing and counseling
- Contraceptive pills, devices/supplies
- Sterilization (vasectomy and tubal ligation)
- Pregnancy testing and counseling
- Annual examination with a network OB/GYN

STAR members may go to any Texas Health Steps-enrolled provider for medical checkups. If the Texas Health Steps provider is other than the primary care provider, the information must be shared with the PCP to update the member's medical record.

SECOND OPINIONS

Most second opinions regarding medically necessary covered services are offered at no cost to members. Some CHIP members may have a copayment.

A second opinion must be given by an appropriately qualified health care professional. When the request is regarding care from a specialist, the second opinion must come from a provider of the same specialty. This specialist must be within BCBSTX's network and may be selected by the member.

For cases in which there is no network provider who meets the specified qualification, we may authorize a second opinion by a qualified provider outside of the network, upon request by the member or provider.

UTILIZATION MANAGEMENT REPORTING REQUIREMENTS

Consistent with National Committee for Quality Assurance (NCQA) standards, BCBSTX analyzes relevant utilization data against established thresholds for each health plan to detect potential under- and over-utilization. This analysis occurs at least once per year.

The purpose of this analysis is to facilitate the delivery of appropriate care and to identify and correct potential over and underutilization. This is achieved by:

- Analyzing both quantitative and qualitative data to detect barriers and identify trends,
- Monitoring areas with the potential for over/under utilization specific to the membership population, local practice patterns and national health care trends, and
- Acting on the opportunities identified by implementing interventions and evaluating the effectiveness of those interventions.

ADDITIONAL SERVICES

Behavioral Health and Substance Abuse

Contact Magellan at **800-327-7390** for prior authorization of all behavioral health or substance abuse services.

Vision Care

Contact Davis Vision Provider Services at **800-77DAVIS** or **800-773-2847**; (TTY **800-523-2847**) for prior authorization of all vision services.



Chapter 11

CASE MANAGEMENT

CASE MANAGEMENT OVERVIEW

The BCBSTX Case Management department offers expert assistance in the coordination of complex health care. Case Management is provided at no cost to the member or provider.

Case Management is a collaborative process that assesses, develops, coordinates, monitors and evaluates care plans designed to optimize members' health care benefits and promote quality outcomes.

The case manager, through interaction with the member, member representative and/or providers, collects and analyzes data and information about the actual and potential care needs for the purpose of developing a care plan. Cases may be identified by disease state or condition, dollars spent or high utilization of services.

REFERRAL PROCESS

Physicians and other professional providers, nurses, social workers and members or their representatives may refer members for case management in one of two ways:

- Calling Case Management at **877-560-8055**
- Faxing a completed Case Management Referral form to **855-653-8129**; a case manager will respond to the person who submitted the faxed request within three business days

Physician and other Professional Provider Responsibility

It is the responsibility of Physicians and other Professional Providers, nurses and social workers to participate in the case management process through information sharing (such as medical records) and facilitation of the case management process by:

- Referring members who could benefit from case management
- Sharing information as soon as possible (for example, during the Initial Health Assessment the Primary Care Provider (PCP) may identify case management needs)
- Collaborating with Case Management staff on an ongoing basis
- Monitoring and updating the care plan to promote goal achievement
- Calling Case Management if members are referred to ‘carved out’ services. Carved out refers to services that a BCBSTX member is entitled to by the State of Texas, but not covered under the BCBSTX agreement

TEXAS CASE MANAGEMENT PROGRAM FOR MEDICAID CHILDREN AND PREGNANT WOMEN

Case Management for Children and Pregnant Women is a Medicaid benefit. Through the program, case managers help families get medical services, school services, medical equipment and supplies and other services that are medically necessary.

Case managers can help children and young adults age 20 and younger who have a health condition or health risk who are covered by Medicaid. They can also help women of any age with a high-risk pregnancy. The person or family must require help getting services or they must be having trouble finding or connecting with the services they need related to their health condition or health risk.

Providers may contact Texas Health Steps (THSteps) for a referral at **1-877-847-8377**. More information regarding the Texas Case Management Program for Medicaid Children and Pregnant Women can be found at www.dshs.state.tx.us/caseman.

Potential Referrals

Physicians and other professional providers, nurses, social workers and members or their representatives may request case management services.

Examples of cases appropriate for referral include:

- Children with special health care needs (CSHCN)
- Adults with special health care needs requiring coordination of care
- Potential transplants
- Complex or multiple-care needs such as multiple trauma or cancer
- Chronic illness such as asthma, diabetes and heart failure
- High-risk pregnancies
- Preterm births
- Autoimmune diseases (HIV/AIDS)
- Frequent hospitalizations or emergency room utilization

Chapter 11

ROLE OF THE CASE MANAGER

Case managers develop a health care plan and:

- Facilitate communication and coordination within the health care team, involving the member and family in the decision-making process.
- Educate the member and all providers of the health care team about case management, community resources, benefits, cost factors and all related topics so that informed decisions can be made.
- Encourage appropriate use of medical facilities and services, with the goal of improving the quality of care and maintaining cost-effectiveness on a case-by-case basis.

Case Management includes credentialed, experienced registered nurses, some of whom are Certified Case Managers (CCMs), as well as social workers. Social workers add valuable skills that allow us to address not only members' medical needs, but also their psychological, social and financial issues.

Procedures

Upon identification of a potential member for case management, the case manager contacts the referring physician or other professional provider and member for an initial assessment. Then, with the involvement of the member, the member's representative and the referring physician or other professional provider, the case manager develops an individualized care plan. The provider and case manager will coordinate services with public health, behavioral health, schools and other community resources as needed.

The case manager periodically re-assesses the care plan to monitor the following:

- Progress toward goals
- Necessary revisions
- New issues that need to be addressed to help ensure that the member receives support and teaching to achieve care plan goals

Once goals are met or the case can no longer be impacted by Case Management, the case manager closes the member's case.

Accessing Specialists

Case Managers are available to assist PCPs with accessing Specialists when needed. For assistance locating a Specialist, please call BCBSTX Case Management at **855-390-6573**. Access to in-network Specialists does not require prior authorization; however, out-of-network referrals to Specialists do require prior authorization.



Chapter 12

COMPLAINTS AND APPEALS

STAR MEMBER COMPLAINTS INTRODUCTION

We will help members solve problems or complaints about their health care.

BCBSTX resolves complaints and appeals related to all service aspects of BCBSTX, including services provided by subcontractors.

Complaints include, but are not limited to:

- Access to health care services
- Care and treatment by a provider
- Issues having to do with how we conduct business

A BCBSTX member advocate is available to assist STAR members with their rights and responsibilities and the filing of complaints and appeals.

Complaints and appeals submitted to BCBSTX are tracked and trended, resolved within established time frames and referred to peer review when needed.

The member and his or her representative are given an opportunity to present evidence and any allegations of fact or law in person as well as in writing.

Chapter 12

BCBSTX will inform the member of the time frame for providing necessary information, and make clear that limited time is available for expedited appeals.

Network physicians and other professional providers understand and agree that the Texas Health and Human Services Commission (HHSC) reserves the right and retains the authority to make reasonable inquiries and conduct investigations into provider and member complaints for STAR members.

BCBSTX and its providers are prohibited from discriminating and/or taking any punitive action against members or their representatives for making a complaint.

STAR MEMBER COMPLAINTS

A member, or his or her authorized representative, has the right to file an oral or written complaint at any time regarding any aspect of BCBSTX's services if it is not related to an action. A complaint related to an action is considered an appeal, which is covered later in this chapter.

HOW TO FILE A COMPLAINT

Members may call Customer Service with a complaint or mail a complaint in writing.

Submit a complaint by phone

Customer Service

STAR **888-657-6061**

TTY **711** (for members with hearing or speech loss)

Submit a complaint by email

GPDTXMedicaidAG@bcbsnm.com

Submit a complaint by mail

Blue Cross Blue Shield of Texas

Attn: Complaints and Appeals Department

P.O. Box 27838

Albuquerque, NM 87125-7838

Acknowledgement of STAR Member Complaints

STAR members will receive an acknowledgement letter from BCBSTX acknowledging their complaint. BCBSTX will send the letter within five business days of receipt of a member's complaint.

Resolution of STAR Member Complaints

BCBSTX will investigate members' complaints to develop a resolution. The investigation includes reviews by appropriate staff of the Complaints and Appeals Unit (C&A Unit) and, if necessary, the medical director.

BCBSTX may request medical records or an explanation from a provider about the issues raised in the complaint in order to help resolve a complaint. Providers may be notified by BCBSTX by phone, mail or fax. Written correspondence to providers will include a signed and dated letter. All providers are expected to comply with requests for additional information within 10 calendar days.

STAR Member Complaints about Clinical Quality Issues

Clinical quality issues are reviewed by the medical director, who assigns a severity level and makes recommendations. All practitioners are evaluated for a history of trends during the 36 months prior to the current complaint. High-risk and high-volume complaints are presented to the Clinical Quality Improvement Committee (CQIC). When warranted, the CQIC presents the case to the Credentials Committee (CC).

OTHER OPTIONS FOR FILING COMPLAINTS

How to File a Complaint with the Texas Health and Human Services Commission

If a member is still not satisfied after completing BCBSTX's complaint procedures, the member may file a complaint directly with the Texas Health and Human Services Commission (HHSC).

Submit a complaint by phone

Toll-free: **877-787-8999**
TTY (for hearing and speech impaired):
800-735-2989 or
National Relay Service **711**

Submit a complaint by mail

Texas Health and Human Services Commission
Office of the Ombudsman, MC H-700
P.O. Box 13247
Austin, TX 78711-3247

Submit a complaint by email

GPDTXMedicaidAG@bcbsnm.com

STAR MEMBER APPEALS

Actions

1. Denial or limited authorization of a requested service, including the type or level of service
2. Reduction, suspension, or termination of a previously authorized service
3. Denial, in whole or in part, of payment for a service
4. Failure to provide services in a timely manner, as defined by the State
5. Failure of BCBSTX to act within the timeframes provided in § 438.408(b); or
6. For a resident of a rural area with only one plan, the denial of a STAR member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

Chapter 12

Appeals

An appeal is a request by a member to have BCBSTX reconsider an adverse determination. Two types of appeals are explained in detail in this chapter:

- Standard Appeals - A Standard Appeal is when a STAR member or his or her authorized representative requests that BCBSTX reconsider the denial of a service or payment for services, in whole or in part.
- Expedited Appeals – A member may request an Expedited Appeal when the amount of time necessary to participate in a standard appeal process could jeopardize the member’s life, health or ability to attain, maintain or regain maximum function.

STAR Member Standard Appeals

BCBSTX members have the right to appeal any services denied by BCBSTX because it was determined that they were not medically necessary. A denial of this type is called an ‘Action’.

A STAR member or his or her authorized representative may submit an oral or written appeal regarding an Action within 30 days from receipt of the denial letter.

With the exception of expedited appeals, all oral appeals must be confirmed in writing and signed by the member or his or her authorized representative.

The member and his or her authorized representative are given an opportunity, before and during the appeal process, to examine the Member’s case file, including medical records and any other documents considered during the appeal process. BCBSTX will inform the member of the time line available for providing additional information and that limited time is available for expedited appeals.

When the appeal is the result of a medical necessity determination, a Physician Clinical Reviewer (PCR) of the same or similar specialty and who was not involved in the initial decision reviews the case. The PCR contacts the provider, as necessary, to discuss possible alternatives.

Appeals should be submitted to BCBSTX at the following address:

Blue Cross and Blue Shield of Texas

Attn: Complaints and Appeals

PO Box 27838

Albuquerque, NM 87125-7838

TIMELINE FOR STAR MEMBER APPEALS

Acknowledgement of STAR Member Appeals

STAR members will receive an Acknowledgement Letter from BCBSTX acknowledging their appeal. BCBSTX will send the letter within five business days of receipt of a member's appeal.

Response to STAR Member Appeals

Once an oral or written appeal request is received, the case is investigated by the Complaints and Appeals Unit. The member, the member's authorized representative and the physician or other professional provider are all given the opportunity to submit written comments, documentation, records and other information relevant to the appeal. BCBSTX may request medical records or a physician or other professional provider explanation of the issues raised in the appeal by telephone or with a signed and dated letter by mail or fax. Physicians and other professional providers are expected to comply with the request for additional information within 10 calendar days.

If the information requested from the provider is not submitted to BCBSTX within 16 business hours, we will send a letter to the member indicating the request cannot be acted upon until the documentation/information is provided. We will include a copy of the letter sent to the physician or other professional providers describing the documentation/information that needs to be submitted.

Resolution of Standard Appeals

Standard appeals are resolved within 30 calendar days of receipt of the initial written or oral request. Members are notified in writing of the appeal resolution, including their appeal rights within 30 calendar days from receipt of the appeal request.

Extensions

The resolution time frame for an appeal not related to an ongoing hospitalization or emergency may be extended up to 14 calendar days if:

- The member or his or her representative requests an extension
- BCBSTX shows that there is a need for additional information and how the delay is in the member's interest

If the resolution time frame is extended for any reason other than by request of the member, BCBSTX will provide written notice of the reason for the delay to the member.

While an appeal of medical necessity of services is pending, the provider may ask the member to sign a financial responsibility form in order to continue services during the appeal period. The member and provider may also choose to discontinue services to await the final decision. If the final determination of the appeal is in the member's favor, we will authorize coverage of and arrange for provision of the appealed services promptly and as expeditiously as the member's health condition requires. If the final determination is in the member's favor and the member received the appealed services, we will pay for those services.

Chapter 12

STAR MEMBER EXPEDITED APPEALS

If the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health or ability to attain, maintain or regain maximum function, the member may request an expedited appeal.

BCBSTX will inform the member of the time available for providing information, and that limited time is available for expedited appeals.

A STAR member may request an expedited appeal in the same manner as a standard appeal, but should include information informing BCBSTX of the need for the expedited appeal process.

Members may call Customer Service or write to BCBSTX to request an Expedited Appeal:

Request an expedited appeal by phone

Customer Service
STAR: **888-657-6061**
CHIP: **888-657-6061**; TTY **711**

Request an expedited appeal by mail

Blue Cross Blue Shield of Texas
Attn: Complaints and Appeals Department
P.O. Box 27838
Albuquerque, NM 87125-7838

Timeline for STAR Members to Request an Expedited Appeal

Members have the right to request an expedited appeal within 30 days of receipt of the denial letter.

STAR – Acknowledgement of Expedited Appeals

Expedited appeals are acknowledged by telephone, if possible, within one business day. BCBSTX will follow up with an acknowledgement in writing.

If BCBSTX denies a request for an expedited appeal, BCBSTX must:

- Transfer the appeal to the time frame for standard resolution.
- Make a reasonable effort to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

Response to Expedited Appeals

BCBSTX may request medical records or a physician or other professional provider explanation of the issues raised in the appeal by telephone or with a signed and dated letter by mail or fax. Physicians or other professional providers are expected to comply with the request for additional information within one business day.

Resolution of Expedited Appeals

BCBSTX resolves expedited appeals as quickly as possible and within three business days. The member is notified by telephone of the resolution, if possible, and a written resolution is sent. However, if the appeal is for an ongoing emergency or denial of continued hospitalization, the appeal will be completed according to the medical or dental immediacy of the case but not later than one business day after the request for the expedited appeal is received.

Specialty Provider Reviews

When an appeal is denied the provider can request for a Specialty Provider Review. The provider must make the request within 10 days and provide a good reason why the specialty review is needed. The denial will be reviewed by a health care provider who works in the same or similar specialty as the condition, procedure or treatment under discussion for review. This specialty review will be completed within 15 working days from receipt of the request.

Continuation of STAR Member Benefits during Appeal

To help ensure continuation of currently authorized services, members must file the appeal within 10 calendar days after BCBSTX mails a denial letter, or within 10 calendar days of the intended effective date of the proposed Action.

BCBSTX will continue the benefits currently being received by the member, including the benefit that is the subject of the appeal, if all of the following criteria are met:

- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- The services were ordered by an authorized physician or other professional provider
- The period covered by the original authorization has not expired
- The member requests an extension of benefits
- If, at the member's request, BCBSTX continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
 - The member withdraws the appeal.
 - 10 Calendar days pass after BCBSTX mails the notice resolving the appeal against the member, unless the member, within the 10-day time frame, has requested a Fair Hearing with continuation of benefits until the Fair Hearing decision can be reached.
 - A Fair Hearing officer issues a hearing decision adverse to the member, or the time period, or service limits of a previously authorized service have been met.

The member may be required to reimburse BCBSTX for the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

If BCBSTX reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, BCBSTX will authorize or provide the disputed services as promptly and expeditiously as the member's health condition requires.

If such a decision was made by BCBSTX and the member received the disputed services while the appeal was pending, BCBSTX will be responsible for payment of the services.

STATE FAIR HEARING INFORMATION

Can a member ask for a State Fair Hearing?

If a member, as a member of the health plan, disagrees with the health plan's decision, the member has the right to ask for a fair hearing. The member may name someone to represent him or her by writing a letter to the health plan telling BCBSTX the name of the person the member wants to represent him or her. A provider may be the member's representative. The member or the member's representative must ask for the fair hearing within 90 days of the date on the health plan's letter that tells of the decision being challenged. If the member does not ask for the Fair Hearing within 90 days, the member may lose his or her right to the fair hearing. To ask for a fair hearing, the member or the member's representative should either send a letter to the health plan at:

Blue Cross Blue Shield of Texas

Attn: Complaints and Appeals Department

P.O. Box 27838

Albuquerque, NM 87125-7838

Or, call Customer Service at **888-657-6061**.

Timeline for STAR Members to Request a State Fair Hearing

If the member asks for a fair hearing within 10 days from the time the member gets the hearing notice from the health plan, the member has the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If the member does not request a fair hearing within 10 days from the time the member gets the hearing notice, the service the health plan denied will be stopped.

Response to STAR Member Request for a State Fair Hearing

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

Resolution of STAR Member Request for a State Fair Hearing

HHSC will give the member a final decision within 90 days from the date the member asked for the hearing. If the hearing officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, BCBSTX will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

If such a decision was made by the hearing officer and the member received the disputed services while the appeal was pending, BCBSTX will be responsible for payment of services.

BCBSTX members have the right to access the fair hearing process at any time during the appeal process. The only exception is when a member is requesting an expedited fair hearing. In the case of an expedited fair hearing, the member must first exhaust the BCBSTX expedited appeal process prior to requesting an expedited fair hearing.

CHIP MEMBER COMPLAINTS AND APPEALS INTRODUCTION

BCBSTX resolves complaints and appeals related to any aspect of service provided by BCBSTX or any subcontractor providing services on behalf of BCBSTX.

Complaints include, but are not limited to:

- Access to health care services
- Care and treatment by a provider
- Issues having to do with how we conduct business.

BCBSTX Customer Service can assist CHIP members with filing complaints and appeals.

Complaints submitted to BCBSTX are tracked and trended, resolved within established time frames and referred to peer review when needed.

The member and his or her representative are given an opportunity to present evidence and any allegations of fact or law in person as well as in writing.

BCBSTX will inform the member of the time available for providing the information, and that limited time is available for expedited appeals.

Network physicians and other professional providers understand and agree that the Texas Department of Insurance (TDI) reserves the right and retains the authority to make reasonable inquiries and conduct investigations into provider and member complaints for Medicaid (CHIP) members.

BCBSTX and its providers are prohibited from discriminating and/or taking any punitive action against a member or his or her representative for making a complaint.

Members who are not satisfied with BCBSTX's resolution of their complaint may file a complaint with the TDI. These procedures are outlined in this chapter.

Complaints

A member, or his or her authorized representative, has the right to file an oral or written complaint at any time regarding any aspect of BCBSTX's services that are not related to an Adverse Determination. A complaint related to an Adverse Determination is considered an appeal. Appeals are covered later in this chapter.

Adverse Determination

An Adverse Determination is defined as: a denial, modification, reduction or determination by BCBSTX or a PCP of a request for services based on eligibility, benefit coverage or medical necessity. Claims denials also are considered Adverse Determinations.

Chapter 12

Appeals

An appeal is a request by a member to have BCBSTX reconsider an Adverse Determination. There are two types of Appeals that are explained in detail in this chapter:

- **Standard Appeals:** A Standard Appeal is when a CHIP member or his or her authorized representative requests that BCBSTX reconsider the denial of a service or payment for services, in whole or in part
- **Expedited Appeals:** An Expedited Appeal is available when the amount of time necessary to participate in a standard appeal process could jeopardize the member's life, health or ability to attain, maintain or regain maximum function

CHIP MEMBER COMPLAINTS

HOW TO FILE A COMPLAINT

If a member has a problem or a complaint, the member, or someone they choose to act on their behalf, may call the Customer Service or mail the complaint in writing. A complaint may have to do with:

- Access to health care services
- Care and treatment by a provider
- Issues that have to do with how we conduct business

Submit a complaint by phone

Customer Service:
CHIP **888-657-6061**
TTY **711** (for members with hearing or speech loss)

Submit a complaint by email

GPDTXMedicaidAG@bcbsnm.com

Submit a complaint by mail

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
PO Box 27838
Albuquerque, NM 87125-7838

Members can talk to their primary care provider (PCP) if they have questions or concerns about their care. If they still have questions or concerns, they should call BCBSTX Customer Service at the number above. Translators are available for those who do not speak English. Those with hearing or speech loss may call the TTY line above.

We will help members or the person they choose to act on their behalf to solve problems or complaints about their health care. Members will not be penalized for filing a complaint.

If a member wants to file a complaint for any reason, he or she should fill out a complaint form or write a letter to tell us about the problem. They can get complaint forms at the places where they get care, such as their PCP's office. Here are the things they need to tell us as clearly as they can:

- Who is part of the complaint?
- What happened
- When did it happen
- Where did it happen
- Why they were not happy with their child's health care services
- Attach any documents that will help us look into the problem

If the member cannot mail the form or letter, the member, or someone they choose to act on their behalf, can call our Customer Service and tell us about their problem.

Acknowledgement of CHIP Member Complaints

After we get the member's complaint by phone or in the mail, we will send an acknowledgment letter within five business days.

Resolution of CHIP Member Complaints

BCBSTX will investigate members' complaints to develop a resolution. The investigation includes reviews by appropriate staff of the Complaints and Appeals Unit and, if necessary, the medical director.

BCBSTX may request medical records or an explanation from a provider about the issues raised in the complaint in order to help resolve a complaint. Providers may be notified by BCBSTX by phone, mail or fax. Written correspondence to providers will include a signed and dated letter.

All providers are expected to comply with requests for additional information within 10 calendar days.

What are the requirements and time frames for filing a complaint?

The member will get a complaint resolution letter within 30 calendar days of the date we get their complaint. The letter will:

- Describe their complaint
- Tell what will be done to solve their problem
- Tell how to ask for a second review of their complaint with BCBSTX
- Tell how to ask for an internal appeal of our decision

CHIP MEMBER COMPLAINT APPEALS

When do members have the right to ask for a complaint appeal?

If a member would like to file a complaint appeal about how we solved the problem, the member must tell us within 30 calendar days after they get the complaint resolution letter. The complaint appeal must be filed in writing.

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Complaint Appeals Not Involving Ongoing Emergencies or Continued Hospitalization

The Complaint Appeal Panel is composed of an equal number of BCBSTX staff members, physicians or other professional providers, and members. The physicians or other professional providers on the Complaint Appeal Panel must have experience in the area of care that is in dispute and must be independent of any provider who made any previous determination.

If specialty care is in dispute, the Complaint Appeal Panel must include a person who is a specialist in the field of care to which the appeal relates. BCBSTX members on the Complaint Appeal Panel may not be employees of BCBSTX.

No later than the fifth business day before the Complaint Appeal Panel is to meet, BCBSTX will provide the claimant or the claimant's designated representative with any documentation to be presented to the Complaint Appeal Panel by BCBSTX, the specialization of any physicians or other professional providers consulted during the investigation and the name and affiliation of each BCBSTX representative on the Complaint Appeal Panel.

The complainant or complainant's authorized representative is entitled to appear in person before the Complaint Appeal Panel, present alternative expert testimony and request the presence of and question any person responsible for making the disputed decision.

Complaints filed concerning dissatisfaction or disagreements with an Adverse Determination are addressed in the CHIP section of this manual on CHIP Member Appeals of Adverse Determinations.

Resolution of the Complaint Appeal

We will send the member a letter that tells them the final decision of the complaint appeal panel within 30 days of their request.

If a member is not happy with our decision, and the complaint appeal process is complete, they may file for a review by the Texas Department of Insurance. The member, or someone they choose to act on their behalf, may write to:

Texas Department of Insurance HMO Quality Assurance Section

Mail Code 103-6A
P.O. Box 149104
Austin, TX 78714-9104

Complaint Appeals Involving Ongoing Emergencies or Continued Hospitalization

If the complaint appeal concerns an ongoing emergency or a denial of continued hospital stay that does not involve an Adverse Determination, BCBSTX will investigate and resolve the complaint in accordance with the medical immediacy of the case but no later than one business day after the receipt of the complaint.

At the member's request and in lieu of an appeal panel, BCBSTX will have a physician or other professional provider who works in the same specialty review the issues raised in the appeal. This professional health care provider will be reviewing the case for the first time. The reviewing physician or provider may interview the member or the member's authorized representative.

The reviewing physician or other professional provider will make a decision and give written notice of the decision to the member or the member's authorized representative within three calendar days of the decision.

OTHER OPTIONS FOR FILING COMPLAINTS

CHIP Member Complaint to the Texas Department of Insurance

After exhausting BCBSTX's complaint appeal process, if a CHIP member is still dissatisfied with the decision, the member may file a complaint with the Texas Department of Insurance at:

Texas Department of Insurance
HMO Quality Assurance Section
Mail Code 103-6A
P.O. Box 149104
Austin, TX 78714-9104

STANDARD APPEALS QUESTIONS AND ANSWERS

How will members find out if services are denied?

We may review some of the services the child's doctor suggests. We may ask the doctor why the child needs some services. If we do not approve a service the child's doctor suggests, we will send the member and the doctor a letter stating why it was denied.

What can members do if their doctor asks for a service for them that's covered, but BCBSTX denies or limits it?

If we deny or limit a doctor's request for service coverage, we will send the member a letter telling them how they can appeal our decision. The member or the child's doctor can appeal a denial of medical service or payment for service. Call Customer Service line to learn more:

Customer Service **888-657-6061**

TTY (for members with hearing or speech loss) **711**

Do member requests have to be in writing?

We will take an oral or written request for an appeal. However, if the member files the appeal request orally, he or she must also send it to us in writing. With the exception of expedited appeals, all oral appeals must be confirmed in writing and signed by the member or his or her authorized representative.

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Members have the right to have someone they trust act on their behalf and help them with their appeal request. Confidentiality is maintained throughout the process. The member, or someone they choose to act on their behalf, may ask for a complaint appeal in writing to:

Blue Cross and Blue Shield of Texas

Attn: Complaints and Appeals Department

P.O. Box 27838

Albuquerque, NM 87125-7838

What can a member do if they disagree with the appeal decision?

When an appeal is denied the provider can request for a specialty provider review. The provider must make the request within 10 days and provide good reason why the specialty review is needed. The denial will be reviewed by a health care provider in the same or similar specialty as typically manages the medical or dental condition, procedure, or treatment under discussion for review. This specialty review will be completed within 15 working days from receipt of the request.

If the member still does not agree with the decision, the member or their doctor can ask for a review by an Independent Review Organization (IRO). The member may ask for an IRO review at any time during the appeal process. But they must go through our expedited (rush) appeal process before asking for an IRO review.

What are the time frames for an appeal?

Members must file a request for an appeal with BCBSTX within 30 days after getting the Notice of Action letter. We will send the member a letter within five business days to let them know that we received their appeal request.

The member may supply proof, or any claims of fact or law that supports the appeal, in person or in writing. We will let the member know when to do so. We will send a letter with the final decision of our internal review within 30 days of the request.

EXPEDITED APPEALS QUESTIONS AND ANSWERS

What is an expedited appeal?

An expedited (rush) appeal means we need to decide quickly because of the child's health status. In other words, an expedited appeal is triggered if taking the time for a standard appeal may put the child's life or health at risk.

What happens if BCBSTX denies the request for an expedited appeal?

If we deny a member's request for a rush appeal, we must:

- Call the member to let them know that we denied their rush appeal.
- Follow up within two calendar days with a written notice.
- Let the member know what we decide within 30 days.

What can a member do if he/she disagrees with the appeal decision?

When an appeal is denied the provider can request a specialty provider review. The provider must make the request within 10 days and provide good reason why the specialty review is needed. The denial will be reviewed by a health care provider in the same or similar specialty as typically manages the medical or dental condition, procedure, or treatment under discussion for review. This specialty review will be completed within 15 working days from receipt of the request.

If the member still does not agree with the decision, the member or his or her doctor can ask for a review by an Independent Review Organization (IRO). The member may ask for an IRO review at any time during the appeal process. However, the member must complete our expedited (rush) appeal process before asking for an IRO review.

If the member has a life-threatening condition and services have not been received, the member does not have to request an appeal or reconsideration before requesting an independent review. This also applies if BCBSTX does not meet the time frames for processing the appeal.

What are the time frames for an expedited appeal?

We must decide no later than one working day after we get a member's request.

How does a member ask for an expedited appeal?

A member or someone the member chooses to act on his or her behalf can ask for an expedited appeal orally or in writing. If the appeal request is filed over the phone, the member does not need to duplicate the request in writing.

Who can help members in filing an expedited appeal?

We can help Members or someone they choose to act on their behalf to file their appeals.

INDEPENDENT REVIEW ORGANIZATION QUESTIONS AND ANSWERS

What is an Independent Review Organization (IRO)?

An Independent Review Organization is the state system that may be used for a case's final review. The IRO determines if members are getting the right health care services for medically necessary reasons. After members exhaust their right to appeal with us, they can ask for a review of the denial by using the IRO process. The member does not have to pay for an IRO review.

Members cannot always get an IRO review. It can be used only if we decide that the covered service or treatment is not medically necessary. It cannot be requested if the service they asked for is not covered in their contract.

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How does a member ask for a review by an IRO?

Members may file for an IRO review by mailing the Texas Department of Insurance (TDI) IRO forms to:

Blue Cross Blue Shield of Texas

Attn: Complaints and Appeals Department

P.O. Box 27838

Albuquerque, NM 87125-7838

This form will be attached to the appeal decision letter sent to the member. The form is also available on the Texas Department of Insurance website at www.tdi.texas.gov/forms.

How the Independent Review Organization (IRO) Process Works

We will send the member's IRO request, the IRO form the member filled out, medical records and the information needed for an IRO review to the Texas Department of Insurance (TDI). The IRO must receive the information within three business days from the date of the review request.

The Texas Department of Insurance (TDI) will assign the member's case to an Independent Review Organization (IRO) within one business day after it receives the member's request. TDI will assign the member's case between 7 a.m. and 6 p.m., Monday through Friday, except holidays. TDI will also inform all parties who is assigned to the member's case.

What are the time frames for this process?

The normal time frame in which the IRO must reach a decision is:

- Within 15 days after getting the necessary information.
- No later than 20 days after the IRO gets its assignment.

When there is a condition that puts the member's life at risk, the IRO must reach a decision:

- Within five days after it gets the information needed.
- No later than eight days after the IRO gets its assignment.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER COMPLAINTS

Physician and other professional provider complaints and appeals are classified into categories for processing by BCBSTX as follows:

- Complaints relating to the operations of BCBSTX
- Physician and other professional provider appeals related to Adverse Determinations
- Physician and other professional provider appeals of non-medical necessity claims determinations

Complaints Relating to the Operations of BCBSTX

Physicians and other professional providers may file written complaints involving:

- Dissatisfaction or concerns about another physician and other professional providers
- Operation of BCBSTX
- Members, if the complaints are not related to a claim determination or Adverse Determination

Complaints related to claim determination or Adverse Determination should be submitted in accordance with the procedures set forth later in this section.

Complaints submitted to BCBSTX are tracked and trended, resolved within established time frames and referred to peer review if needed.

BCBSTX may request medical records or an explanation of the issues raised in the complaint by telephone or a signed and dated letter by fax or mail. Providers are expected to comply with the request for additional information within 10 calendar days.

Providers are notified in writing of the resolution of the complaint including their appeal rights, if any. Findings or decisions of peer review or quality of care issues are not disclosed.

Network providers understand and agree that the Texas Department of Insurance (TDI) reserves the right and retains the authority to make reasonable inquiries and conduct investigations into provider and member complaints for CHIP members.

Physician and other professional provider complaints relating to operational issues may be submitted to the following address:

Blue Cross Blue Shield of Texas
Attn: Complaints and Appeals Department
P.O. Box 27838
Albuquerque, NM 87125-7838
Fax: **855-235-1055**

The complaint must include the provider's name, date of the incident, and a description of the incident.

Providers may also submit provider appeals through the Availity online tool at www.availity.com.

A Complaints and Appeals Representative receives and logs the physician and other professional provider's complaint and sends an acknowledgement letter to the provider within five business days of receipt of the complaint. The Complaints and Appeals representative will investigate the provider complaint and respond to the provider in writing within 30 calendar days of receipt of the complaint.

STAR — Provider Appeals Related to Actions

A STAR member's provider of record may submit an Adverse Determination appeal in accordance with the procedures set forth in STAR Member Appeals of Adverse Determinations. For post-service Adverse Determination appeals for which the provider is unable to obtain the member's consent, a provider may use the Provider Claims and Appeal Process procedures outlined in the Claims and Billing Chapter.

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CHIP — Provider Appeals Related to Adverse Determinations

A CHIP member's physician and other professional providers of record may submit an Adverse Determination appeal in accordance with the procedures set forth in CHIP Member Appeals of Adverse Determinations. For post-service Adverse Determination appeals for which the physician or other professional provider is unable to obtain the member's consent, a physician or other professional provider may use the Provider Claims and Appeal Process procedures set forth in the Claims and Billing chapter.

Provider Appeals of Non-Medical Necessity Claims Determinations

A physician or other professional provider may appeal a decision regarding payment for any service NOT related to Non-medical necessity determinations. For these appeals, the physician or other professional provider should follow the Provider Claims and Appeal Process procedures set forth in the Claims and Billing chapter.

Provider Complaint Process through the Texas Health and Human Services Commission (STAR)

If the Provider is dissatisfied with the resolution of the appeal for a STAR member service, and the provider has exhausted the BCBSTX complaints and appeals process, the provider has the right to complain through HHSC at:

Texas Health and Human Services Commission

Attn: Provider Complaints

Health Plan Operations, H-320

P.O. Box 85200

Austin, Texas 78708

Providers may also file a complaint or submit an inquiry via email to HPM_Complaints@hhsc.state.tx.us.

Provider Complaint and Appeal Process through the Texas Department of Insurance (CHIP)

If the provider is dissatisfied with the resolution of the appeal for a CHIP member service, and the provider has exhausted BCBSTX complaints and appeals process, the provider has the right to complain through TDI at:

Texas Department of Insurance

Consumer Protection (111-1A)

P.O. Box 149091

Austin, Texas 78714-9091

Phone: **512-463-6500** or **800-252-3439**

Fax: **512-475-1771**

Email ConsumerProtection@tdi.state.tx.us

Chapter 13

MEMBER RIGHTS AND RESPONSIBILITIES

STAR MEMBER RIGHTS

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
 - a. Be treated fairly and with respect.
 - b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
 - a. Be told how to choose and change your health plan and your primary care provider.
 - b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
 - c. Change your primary care provider.
 - d. Change your health plan without penalty.
 - e. Be told how to change your health plan or your primary care provider.

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3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
 - a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
 - b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
 - a. Work as part of a team with your provider in deciding what health care is best for you.
 - b. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:
 - a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
 - b. Get a timely answer to your complaint.
 - c. Use the plan's appeal process and be told how to use it.
 - d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
 - a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
 - b. Get medical care in a timely manner.
 - c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
 - d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
 - e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

STAR MEMBER RESPONSIBILITIES

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
 - a. Learn and understand your rights under the Medicaid program.
 - b. Ask questions if you do not understand your rights.
 - c. Learn what choices of health plans are available in your area.

2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
 - a. Learn and follow your health plan's rules and Medicaid rules.
 - b. Choose your health plan and a primary care provider quickly.
 - c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
 - d. Keep your scheduled appointments.
 - e. Cancel appointments in advance when you cannot keep them.
 - f. Always contact your primary care provider first for your non-emergency medical needs.
 - g. Be sure you have approval from your primary care provider before going to a specialist.
 - h. Understand when you should and should not go to the emergency room.

3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
 - a. Tell your primary care provider about your health.
 - b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
 - c. Help your providers get your medical records.

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

Chapter 13

CHIP MEMBER RIGHTS

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plans 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 a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.

14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

CHIP MEMBER RESPONSIBILITIES

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. Talk to your child's provider about all of your child's medications.

CHIP PERINATE MEMBER RIGHTS

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

CHIP PERINATE MEMBER RESPONSIBILITIES

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. Talk to your provider about all of your medications.

MEMBER'S RIGHT TO DESIGNATE AN OB/GYN

Attention Female Members

BCBSTX allows members to pick an OB/GYN, but this doctor must be in the same network as their Primary Care Provider. Members have the right to designate an OB/GYN as their Primary Care Provider.

Members have the right to pick on OB/GYN without referral from their Primary Care Provider. An OB/GYN can provide the member with:

- One well-checkup each year
- Care related to pregnancy,
- Care for any female medical condition, and
- Referral to specialist doctor within the network.



Chapter 14

PROVIDER ROLES AND RESPONSIBILITIES

PRIMARY CARE PROVIDER (PCP) SCOPE OF RESPONSIBILITIES – STAR, CHIP AND CHIP PERINATE

The PCP's scope of practice includes the development and oversight of the member's treatment and care plan, which includes access to health care 24 hours a day, seven days a week.

Services should be provided without regard to race, religion, sex, color, national origin, age, or physical or behavioral health status, upon the written or verbal prescription order or refill from a prescribing provider. Blue Cross and Blue Shield of Texas (BCBSTX) members select a contracted primary care provider (PCP) as their main provider of health care services within the first 30 days of the effective date of enrollment. If, after 30 days of the effective date of enrollment, the member has not selected a PCP, BCBSTX assigns a PCP to the member.

BCBSTX furnishes each PCP with a current list of enrolled members assigned to the PCP and, from time to time, we provide each PCP with information about enrolled members' potential medical needs so that PCPs can better provide and coordinate their care.

The PCP provides routine, preventive and urgent services. The PCP also provides information to the member or legal representative about the illness, the course of treatment and prospects for recovery in terms the member or representative can understand. PCP responsibilities include providing or arranging for:

- Routine and preventive health care services, including immunizations
- Emergency care services
- Hospital services
- Ancillary services
- Specialty referrals
- Interpreter services
- Coordination and continuity of care for members
- Case coordination and enhanced services for children with special health-care needs and children with disabilities

PCPs also coordinate care with clinic services, such as therapeutic, rehabilitative or palliative services for outpatients. PCPs must cooperate with any court-ordered services.

Note: The screening provider is responsible for administration of immunizations and should not refer children to local health departments to receive immunizations.

PCPs can offer behavioral health services when:

- Clinically appropriate and within the scope of his or her practice
- The member's current condition is not so severe, confounding or complex as to warrant a referral to a behavioral health provider
- The member is willing to be treated by the PCP
- The services rendered are within the scope of the benefit plan

Chapter 14

SPECIALTY CARE PHYSICIAN AND OTHER PROFESSIONAL PROVIDER RESPONSIBILITIES

Specialist physicians or other professional providers, licensed with additional training and expertise in a specific field of medicine, supplement the care given by primary care providers (PCPs). Access to contracted network specialists is through the member's PCP.

In limited cases, such as family planning and evaluation, diagnosis, treatment and follow-up of sexually transmitted diseases (STDs), the member can self-refer. In addition, members with disabling conditions, special health care needs, and chronic or complex conditions may request that their PCP be a specialist as long as that specialist agrees. Specialist physicians or other professional providers acting as a PCP must follow all responsibilities of a PCP.

PCPs refer members to plan-contracted network specialist physicians or other professional providers for conditions beyond the PCP's scope of practice that are medically necessary. Specialists diagnose and treat conditions specific to their area of expertise. Specialist care is limited to plan benefits.

If the member's condition requires urgent care, the specialist should see the member within 24 hours. For routine care, the specialist should see the member within two weeks.

Specialist physicians or other professional providers and facilities are responsible for ensuring the necessary prior authorization has been obtained prior to providing services.

Specialists must follow all provider responsibilities and Texas Health and Human Services Commission (HHSC) mandated provisions as outlined in the HHSC-mandated provisions section.

PHARMACY PROVIDER RESPONSIBILITIES

Texas Medicaid & Healthcare Participation Enrollment

BCBS TX will no longer pay for any prescriptions written by providers who are not enrolled with Texas Medicaid & Healthcare Participation (TMHP) starting October 16, 2017, for STAR members and January 1, 2018, for CHIP members. This includes refills and prescriptions filled out-of-state. To ensure your patients, continue to receive their medications, please visit: <http://www.tmhp.com/Pages/default.aspx>

Pharmacy Providers Are Responsible for:

- Adhering to the Formulary and Preferred Drug List (PDL)
- Coordinating with the prescribing physician
- Ensuring members receive all medications for which they are eligible
- Coordination of benefits when a member also has other insurance benefits

Emergency Prescriptions

A pharmacist may use his or her clinical judgment to dispense a 72-hour emergency supply of a medication if prior authorization is not available within 24 hours through the Prime Point-of-Sale System.

For questions or assistance with a 72-hour supply override, contact Prime's help desk, which is available 24 hours a day, 7 days a week at:

STAR **1-855-457-0405**

CHIP **1-855-457-0403**

OUT-OF-NETWORK R E F E R R A L S

BCBSTX recognizes that there may be instances when an out-of-network referral is justified. Case Management will work with the medical director and the primary care provider to find appropriate out-of-network providers when medical necessity for services has been determined.. Out-of-network referrals will be authorized on a limited basis. Case Management may be contacted at **877-560-8055** for questions regarding referrals to out-of-network providers.

ACCESS TO NETWORK OPHTHALMOLOGIST AND THERAPEUTIC OPTOMETRIST

Members have the right to select a network ophthalmologist or therapeutic optometrist for eye care services other than surgery without a referral from their primary care provider (PCP).

UPDATING PROVIDER INFORMATION

Plan providers are required to inform both BCBSTX and Maximus, the Administrative Services Contractor for HHSC, of any changes to their address, telephone number, group affiliation, and other material facts.

TEXAS HEALTH STEPS PROGRAM

Texas Health Steps is the user-friendly name given to the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program. The program is one of the most comprehensive medical and dental screening, prevention and treatment programs for children of low-income families.

Texas Health Steps provides payment for periodic, comprehensive evaluations of a child's health, development and nutritional status, as well as vision, dental and hearing services for STAR recipients from birth to age 20. The periodic medical evaluations are based on American Academy of Pediatrics (AAP) recommendations for preventive health care with modifications to meet federal or state regulations. BCBSTX provides medical screening visits following federally mandated Texas Health Step program guidelines:

- STAR Program: Children from birth through 20 years of age.

For more information, refer to the Texas Medicaid Provider Procedures Manual.

Texas Health Steps primary care providers (PCPs) are an integral part of this program. PCPs will offer age-appropriate preventive care screening and testing during each medical checkup and during an acute illness episode, if appropriate. The Texas Medicaid Provider Procedures Manual provides a list of periodicity and screening requirements.

CHILDREN OF MIGRANT FARMWORKERS

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

OFFICE HOURS

To maintain continuity of care, the physician or other professional provider must be available 24 hours a day by telephone or have an on-call physician or other professional provider take calls. Office hours must be conspicuously posted and members must be informed about the provider's availability at each site. Please review the **Medical Appointment Standards** in the Access to Care chapter of this manual.

AFTER-HOURS SERVICES

Plan members have access to quality, comprehensive health care services 24 hours a day/seven day a week. Members can call their primary care provider (PCP) with a request for medical assessment after PCP normal office hours.

The PCP must have an after-hours system in place to help ensure that members can reach their PCP or an on-call physician with medical concerns or questions. Answering service or after-hours personnel must forward member calls directly to the PCP or on-call physician, or instruct members that the provider will contact the member within 30 minutes of the call.

The answering service or after-hours personnel must ask members if the call is an emergency. In the event of an emergency, they must immediately direct members to dial 911 or to proceed directly to the nearest hospital emergency room.

If staff or an answering service is not immediately available, an answering machine may be used but is required to instruct members with emergency health care needs to call 911 or go directly to the nearest hospital emergency department. Further answering machine instructions are required to direct members to an alternative contact number so the member can reach the PCP or an on-call provider with medical concerns or questions. The answering machine must also provide instructions in both English and Spanish.

BCBSTX prefers that the PCP use a plan-contracted, in-network physician and/or other professional providers for on-call services. When that is not possible, the PCP must use best efforts to help ensure that covering/on-call physicians who are not contracted with BCBSTX abide by the terms of the BCBSTX provider contract.

BCBSTX monitors PCP compliance with after-hours access standards on a regular basis. Failure to comply with after-hours access standards may result in corrective action.

Members can call the 24-Hour Nurse Advice Line to speak to a registered nurse. Nurses provide health information regarding illness and options for accessing care, including emergency services, if appropriate.

24 Hour Nurse Advice Line: **844-971-8906**

TTY: **711**

Non-English speaking members who call their PCP after hours can expect to receive language appropriate messages with appropriate care instructions. These instructions direct the member to dial 911 or to proceed directly to the nearest hospital emergency room in the event of an emergency. In a non-emergency situation, they will receive instructions on how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone interpreter for the member. All calls answered by an answering service must be returned.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER CONTRACT TERMINATION

A terminated physician or other professional provider who is actively treating members must continue to treat members until the provider's date of termination. That date is the 90-day period following written notice of termination, or time lines determined by the medical group contract.

Once we receive a physician's or professional provider's notice to terminate a contract, we notify members impacted by the termination. BCBSTX sends a letter to inform the affected members of:

- The impending termination of their physician or other professional provider
- Their right to request continued access to care
- The Customer Service telephone number to make PCP changes or forward referrals to Case Management for continued access to care consideration

If the PCP's contract is ending, we arrange for continuity of care by the terminating provider for members who need continued access to care. The PCP and members can call Customer Service for their specific plan (STAR or CHIP) or the TTY line for members with speech or hearing loss.

Customer Service - Providers: **877-560-8055**

Customer Service - Members: **888-657-6061**

TTY (for hearing and speech impaired) **711**

Members under the care of specialists can also submit requests for continued access to care, including continued care after the transition period, by calling Customer Service. They should request a 'care management referral for continuity of care' using the **Case Management Referral Form** located on our website at <http://www.bcbstx.com/provider/medicaid/forms.html> in the section titled Forms.

TERMINATION OF THE ANCILLARY PROVIDER/ PATIENT RELATIONSHIP

Under certain circumstances, a provider may terminate the professional relationship with a member as provided for and in accordance with the provisions of this manual. Providers may not terminate the relationship between themselves and a member because of the member's medical condition or the amount, types or cost of covered services required by the member.

Disenrollees

Case managers are responsible for assisting in the transition of a disenrolling member when the member requests that Case Management be transferred to another health plan. This must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The case manager works with the member, involved providers and the case manager at the new health plan to help ensure an orderly transition.

REFERRALS

Primary care providers (PCPs) coordinate and make referrals to appropriate specialists, ancillary providers, or community services. Providers are expected to refer members to network facilities and contractors as appropriate. When this is not possible, providers should follow the appropriate process for requesting out-of-network referrals.

Members have the right to select an obstetrics/gynecologist (OB/GYN) doctor without referrals from their PCPs.

All PCPs:

- Are expected to refer members to specialists for specialty care, including Texas Health Steps, behavioral health care services, other services such as pharmacy and programs provided by the State of Texas, health education classes and community resource agencies when appropriate.
- Must coordinate with the Women, Infants, and Children (WIC) Program Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. (Also refer to the HHSC-Mandated Provisions in this section for WIC requirements.)
- Must coordinate with the local tuberculosis (TB) control program to help ensure that all members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT), if necessary.
- Must report to the Texas Department of State Health Services (DSHS) or the local TB control program any member who is noncompliant, drug resistant, or who is or may be posing a public health threat. (Also, see HHSC-Mandated Provisions for tuberculosis requirements.)
- Are responsible for screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

Providers must document referrals, including referrals to ‘carved-out services.’ Carved-out services include those that a BCBSTX member is entitled to that are covered by the State of Texas, but not covered under the BCBSTX benefit agreement.

- Must inform members of the costs for non-covered services prior to rendering such services and must obtain a signed Member Private Pay Form Agreement from the member.
- Are expected to help members schedule appointments with other providers and health education programs.
- Are expected to track and document appointments, clinical findings, treatment plans and care received by members referred to specialists, other health care providers or agencies regarding continuity of care.

MEDICAL RECORDS STANDARDS

Providers are required to maintain medical records in a manner that permits effective and confidential member care and quality review. BCBSTX performs medical record reviews upon signing of a contract and at a minimum, every three years thereafter to help ensure that providers are in compliance with these standards.

Medical records are stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. The Act prohibits health care providers from disclosing any individually identifiable information regarding a patient’s medical history, behavioral and physical condition, or treatment without the patient’s or the patient’s legal representative’s consent or specific legal authority.

Records required through a legal instrument may be released without patient or patient representative consent. Physicians and their professional providers must be familiar with the security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and be in compliance.

Providers may not charge Medicaid members for their medical records when requested.

Security

The medical record must be secure and inaccessible to unauthorized personnel in order to prevent loss, tampering, disclosure of information and alteration or destruction of the record. Information must be accessible only to authorized personnel within the provider’s office, BCBSTX, the Texas Health and Human Services Commission (HHSC) or to persons authorized through a legal instrument. Records must be made available to us for purposes of quality review, Healthcare Effectiveness Data and Information Sets (HEDIS) and other studies.

Storage and Maintenance

Active medical records should be stored in one central medical record area and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, and that permits effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Availability of Medical Records

The medical records system must allow for prompt retrieval of each record when the patient comes in for an encounter. Physicians and other professional providers are required to maintain comprehensive and accurate medical records to ensure quality and continuity of care. Each provider must maintain and make available medical records in accordance with the applicable provider agreement.

Medical Record Documentation Standards

Every medical record is, at a minimum, to include:

- The patient's name or identification (ID) number on each page in the record
- Personal biographical data including home address, employer, emergency contact name and telephone number, home and work telephone numbers, and marital status
- All entries dated with month, day and year
- All entries containing the author's identification (for example, handwritten signature, unique electronic identifier or initials) and title
- Identification of all physicians or other professional providers participating in the member's care and information on services furnished by these providers
- A problem list, including significant illnesses and medical and psychological conditions
- Presenting complaints, diagnoses, and treatment plans, including the services to be delivered
- Physical findings relevant to the visit including vital signs, normal and abnormal findings, and appropriate subjective and objective information
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions)
- Information on advance directives
- Past medical history, including serious accidents, operations, illnesses and, for patients 14 years old and older, substance abuse. For children and adolescents, past medical history relates to prenatal care, birth, operations and childhood illnesses.
- Physical examinations, treatment necessary and possible risk factors for the member relevant to the particular treatment
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- For patients 14 years and older, appropriate notation concerning the use of cigarettes, alcohol and substance abuse (including anticipatory guidance and health education)
- Information on the individuals to be instructed in assisting the patient
- Legible medical records that are dated and signed by the physician, physician assistant, nurse practitioner or nurse midwife providing patient care
- An up-to-date immunization record for children or an appropriate history for adult
- Documentation attempts to provide immunizations. If the member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian of the member shall be documented in the member's medical record.

- Evidence of preventive screening and services in accordance with BCBSTX’s preventive health practice guidelines
- Documentation of referrals, consultations, test results and inpatient records
- Include notations of information about the patient’s test results
- Notations of patient appointment cancellations or ‘no shows’ and the attempts to contact the patient to reschedule
- No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure
- Documentation on whether an interpreter was used, and, if so, that the interpreter also was used in follow-up

ADVANCE DIRECTIVES

Recognizing a person’s right to dignity and privacy, our members have the right to execute a living will to identify their wishes concerning health care services should they become incapacitated. Physicians and/or providers may be requested to assist members in procuring and completing necessary forms. Refer to BCBSTX’s website at <http://bcbstx.com/provider/medicaid/index.html> for more information.

Also see www.dads.com for more information.

COORDINATION WITH THE TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

Physicians and other professional providers must cooperate and coordinate with the Texas Department of Family and Protective Services (DFPS) and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS.

Physicians and other professional providers participate, whenever possible, in the preparation of the medical and behavioral care plan in conjunction with DFPS. They also continue to provide all covered services to a member receiving services from or in the protective custody of DFPS, until the member is disenrolled from us or placed into foster care.

Physicians and other professional providers are responsible for providing medical records to DFPS, recognizing and referring suspected cases of abuse or neglect within 48 hours, using the appropriate referral process to DFPS, and scheduling medical and behavioral health appointments within 14 days, unless required earlier by DFPS.



Chapter 15

ACCESS STANDARDS AND ACCESS TO CARE

MEDICAL APPOINTMENT STANDARDS

Standards for scheduling appointments follow guidelines published by the American College of Obstetricians and Gynecologists (ACOG); the National Committee for Quality Assurance (NCQA); as well as the Texas Health and Human Services Commission (HHSC).

Primary care providers (PCPs) and specialists must meet standards for appointment scheduling to help ensure that members have timely access to medical care and services. BCBSTX monitors provider compliance with appointment access standards on a regular basis. Failure to comply with outlined standards may result in corrective action.

PCPs and specialists must make appointments for members from the time of request as follows:

General Appointment Scheduling

- Emergency examinations: immediate access during office hours
- Urgent examinations: within 24 hours of request
- Non-urgent, routine, primary care examinations: within 14 days of request
- Specialty care examinations, within 30 days of request
- Outpatient behavioral health examinations, within 14 days of request; Routine Behavioral Visits, within 10 days of request; outpatient treatment, post-psychiatric inpatient care, within seven days from date of discharge

Services for Members Under the Age of 21 Years

- Well-child check with assigned PCP:
 - Within 14 days of enrollment for newborns
 - Within 90 days of enrollment for other eligible child members
- Preventive care visits: according to the American Academy of Pediatrics (AAP) periodicity schedule found within the Preventive Health Guidelines (PHG)

Services for Members 21 Years of Age and Older

- Preventive care visit within 90 days

Prenatal and Postpartum Visits

- First and second trimesters: Within 14 days of request
- Third trimester: Within five days of request or immediately if an emergency
- High-risk pregnancy: Within five days of request or immediately if an emergency
- Postpartum: Between 21 and 56 days after delivery

Missed Appointment Tracking

When members miss appointments, providers must document the missed appointment in the member's medical record. providers must make at least three attempts to contact the member to determine the reason for the missed appointment.

The medical record must reflect the reason for any delays in performing an examination, including any refusals by the member.

AFTER-HOURS SERVICES

Plan members have access to quality, comprehensive health care services 24 hours a day, seven days a week. Members can call their primary care provider (PCP) with a request for medical assessment after PCP normal office hours.

The PCP must have an after-hours system in place to help ensure that members can reach their PCP or an on-call physician with medical concerns or questions. Some answering service or after-hours personnel must forward member calls directly to the PCP or on-call physician, or instruct the member that the provider will contact the member within 30 minutes of the call.

The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, they must immediately direct the member to dial 911 or to proceed directly to the nearest hospital emergency room.

If staff or an answering service is not immediately available, an answering machine may be used but is required to instruct members with emergency health care needs to call 911 or go directly to the nearest hospital emergency department. Further answering machine instructions are required to direct members to an alternative contact number so the member can reach the PCP or an on-call provider with medical concerns or questions. The answering machine must also provide instructions in both English and Spanish.

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BCBSTX monitors providers' appointment availability and afterhours access to ensure members receive timely access to quality care and to ensure compliance to HHSC standards. As a provider in network, you may receive an annual request to demonstrate compliance to this contract standard. Providers who do not meet the standards will receive written notification of the non-compliance from the BCBSTX medical director, will be resurveyed and, if continued to be non-compliant, corrective action may be taken to address the issue(s).

Unacceptable After-Hours Coverage

BCBSTX outlines unacceptable after-hours coverage as:

- The office telephone is only answered during office hours
- The office telephone is answered after hours with a recording instructing patients to leave a message
- The office telephone is answered after hours with a recording that directs patients to the emergency room for any services needed
- Returning after-hours calls over 30 minutes after the call is received

BCBSTX prefers that the PCP use plan-contracted, in-network physicians or other professional providers for on-call services. When that is not possible, the PCP must use best efforts to help ensure that out-of-network on-call physicians or other professional providers abide by the terms of the BCBSTX Provider contract.

BCBSTX monitors PCP compliance with after-hours access standards on a regular basis. Failure to comply with after-hours access standards may result in corrective action.

Members can also call the 24-Hour Nurse Advice Line to speak to a registered nurse. Nurses provide health information regarding illness and options for accessing care, including emergency services, if appropriate.

Non-English speaking members who call their PCP after hours can expect to receive language appropriate messages with appropriate care instructions. These instructions direct the member to dial 911 or to proceed directly to the nearest hospital emergency room in the event of an emergency. In a non-emergency situation, they will receive instructions on how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone interpreter for the member. All calls answered by an answering service must be returned.

CONTINUITY OF CARE

BCBSTX helps ensure continued access to care for members with qualifying conditions when:

- They are newly enrolled.
- They move out of the service area.
- Services are not available within the network.
- The physician's or other professional provider's contract terminates.
- They are disenrolling to another health plan.

- A qualifying condition is a medical condition that may qualify a member for continued access to care/continuity of care, including, but not limited to:
 - An acute condition (for example, cancer).
 - A serious chronic condition (for example, hemophilia).
 - Pregnancy, with 12 weeks or less remaining before the expected delivery date, through immediate postpartum care.
 - A terminal illness.
 - A degenerative and disabling condition, (a condition or disease caused by a congenital or acquired injury or illness that requires either a specialized rehabilitation program or a high level of care, service, resources or continued coordination of care in the community).

BCBSTX will help ensure that each member has access to a second opinion regarding the use of any medically necessary covered service. The member will be allowed access to a second opinion from a network physician or other professional provider, or out-of-network provider if a network physician or other professional provider is not available, at no cost to the member.

Continuity of Care Process

BCBSTX physicians or other professional providers, hospitals, ancillary and behavioral health providers help ensure continuity and coordination of care through collaboration. Primary care providers, other professional providers and ancillary providers must maintain accurate and timely documentation in the member's medical record. This documentation must include, and is not limited to:

- Referrals to specialists
- Authorizations
- Consultations
- Treatment plans
- Other information to help ensure continuity of the member's medical care

All physicians and other professional providers share responsibility in communicating clinical findings, treatment plans, prognosis and the member's psychosocial condition to help ensure coordination of the member's care.

Case management nurses review member physician or other professional provider requests for continuity of care and facilitate continuation with the current provider until a short-term regimen of care is completed or the member transitions to a new practitioner.

Only a BCBSTX physician can make adverse determination decisions, which are sent in writing and mailed to the member and physician within three business days of the decision. Members and physicians or other professional providers can appeal the decision by following the procedures in the **Complaints and Appeals** section of this manual.

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Reasons for continuity of care denials include, but are not limited to, the following:

- Not a qualifying condition
- Treating physician or other professional provider is not currently contracted with our plan
- Request is for change of primary care provider (PCP) only and not for continued access to care
- Member is ineligible for coverage
- Course of treatment is complete
- Services rendered are covered under a global fee
- Requested services are not a covered benefit

BCBSTX does not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provider coverage to any BCBSTX STAR or CHIP member.

Emergency and Non-Emergency Ambulance Transportation

BCBSTX covers emergency transportation without prior authorization. When a member's condition is life threatening and requires use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest appropriate facility, we will provide emergency transportation by ambulance.

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

Emergency transportation is also available for facility-to-facility transfers when the required emergency treatment is not available at the first facility. Non-emergent ambulance transportation will require prior authorization.

Medicaid Non-Emergency Transportation for STAR Members Only

The Texas Medical Transportation Program (MTP) provides non-emergency transportation (NEMT) to Medicaid-eligible STAR members who need help getting to medical appointments, dental appointments and the pharmacy, providing that the member:

- Has a current Medicaid identification (ID) card or Medicaid Verification Letter?
- Has no other means of transportation?
- Receives prior authorization from MTP, if required.

To obtain transportation, STAR members should call MTP at **877-633-8747 (877-MED-TRIP)** between the hours of 8 a.m. and 5 p.m., Monday through Friday (except on federal holidays). Upon calling to schedule transportation, Members will be asked to provide the following information:

- Member's nine-digit Medicaid number
- Medical physician or other professional's name, address and phone number
- Date and time of the medical appointment, as well as service being provided

If STARBCBSTX members are not able to get transportation services through MTP they may access the BCBSTX VAS NEMT services through Medical Transportation Management (MTM). For more information on our VAS NEMT services through MTM see the VAS information in Chapter 4 of this manual.

CHIP and CHIP Perinate members are only eligible for transportation services through the BCBSTX VAS NEMT through MTM (MTM is the BCBSTX VAS transportation vendor). This is part of our Value-Added Services Program. For more information for VAS transportation benefits for CHIP and CHIP Perinate members see our VAS section in Chapter 4 of this manual.

Call Customer Service for more information of routine and special transportation available to Members either through MTP or our VAS NEMT program.

PROVISION OF NON-COVERED SERVICES

Providers must inform members of the costs for non-covered services prior to rendering such services. They must also obtain a signed Acknowledgement Statement from the member stating that the member has been informed of these costs. A sample Member Acknowledgement Statement form is available on our website at <http://bcbstx.com/provider/Medicaid/index.html>.

NEW ENROLLEES — CONTINUITY OF CARE

BCBSTX will help ensure that the care of newly enrolled members is not disrupted or interrupted. BCBSTX will take special care to provide continuity in the care of newly enrolled members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

BCBSTX will pay a member's existing out-of-network provider for medically necessary covered services until the regimen of care is completed. The member's records, clinical information and care can then be transferred to a network physician or other professional provider.

Payment to out-of-network physicians and other professional providers is made within the same time period required for those within the network. In addition, we will comply with out-of-network provider reimbursement rules as adopted by HHSC. However, we are not obligated to reimburse members' existing out-of-network physicians or other professional providers for on-going care for:

- More than 90 days after a member enrolls in BCBSTX, or
- More than nine months in the case of a member who, at the time of enrollment in BCBSTX, was diagnosed with and receiving treatment for a terminal illness and remains enrolled in BCBSTX.

BCBSTX will allow pregnant members past the 24th week of pregnancy to remain under the care of their current OB/GYN, even if provider is out-of-network. This remains in effect through the member's postpartum checkup.

If a member wants to change from their OB/GYN doctor to one who is in the network, they must be allowed to do so if the physician or other professional provider to whom they wishes to transfer agrees to accept the member in the last trimester of pregnancy. BCBSTX's obligation to reimburse the member's existing out-of-network physician or other professional provider for services provided to a member past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care and follow-up checkup within the first six weeks of delivery.

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MEMBERS WHO MOVE OUT OF THE SERVICE AREA

If a member moves out of the service area, BCBSTX will continue to provide services and pay out-of-network physicians and other professional providers for a specific period of time, which is the time left for which capitation on the member has been paid. That means that if a member's capitation covers the month of June, BCBSTX will provide and pay for medically necessary covered services through the end of that month.

SERVICES NOT AVAILABLE WITHIN NETWORK

BCBSTX will provide members with timely and adequate access to out-of-network services for as long as those services are necessary and not available within the network. However, BCBSTX will not be obligated to provide members with access to out-of-network services if such services become available from a network physician or other professional provider.

When a physician or other professional provider refers a member to another provider for additional treatment or services, the referring provider must forward the National Provider Identifier (NPI), with the notification of the member's eligibility. The member should be informed of whether the provider he/she is being referred to is an in- or out-of-network provider.

EMERGENCY DENTAL SERVICES

STAR Emergency Dental Services

BCBSTX is responsible for emergency dental services provided to STAR members in a hospital or ambulatory surgical center setting. We will pay for devices for craniofacial anomalies, hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- Treatment of oral abscess of tooth or gum origin.

CHIP Emergency Dental Services

BCBSTX is responsible for emergency dental services provided to CHIP members and CHIP Perinate Newborn members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- Treatment of oral abscess of tooth or gum origin.

NON-EMERGENCY DENTAL SERVICES

Medicaid Non-Emergency Dental Services

BCBSTX is **not responsible** for paying for routine dental services provided to Medicaid members. These services are paid through Dental Managed Care Organizations. BCBSTX is **responsible** for paying for treatment and devices for craniofacial anomalies, and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for members' age 6 months through 35 months. OEFV benefits includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.

- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist members with establishing a Main Dental Home and document member's Main Dental Home choice in the member's file.

CHIP Non-Emergency Dental Services

BCBSTX is **not responsible** for paying for routine dental services provided to CHIP and CHIP Perinate members. These services are paid through Dental Managed Care Organizations. BCBSTX is **responsible** for paying for treatment and devices for craniofacial anomalies. Please see Value Added Services (VAS) for Adult Pregnant Members on page 78 of this manual to learn about our Dental VAS during pregnancy.

ROLE OF A MAIN DENTAL HOME

Main Dental Home is the dental provider who supports an ongoing relationship with a member that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a member's Main Dental Home begins no later than six months of age and includes referrals to dental specialists when appropriate. Provider types that can serve as Main Dental Home Providers are federally qualified health centers and individuals who are general dentists and pediatric dentists.

How to Help a Member Find Dental Care

The Dental Plan Member ID card lists the name and phone number of a member's Main Dental Home provider. The member can contact the dental plan to select a different Main Dental Home provider at any time. If the member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan's system, and the member is mailed a new ID card within five business days.

If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can contact the

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Medicaid/CHIP enrollment broker's (Maximus) toll-free telephone number at **800-964-2777**.

PROVIDER TRAINING AND COORDINATION OF SERVICES

BCBSTX will make training and coordination of services available to providers to help ensure that the needs of STAR and CHIP members with special access requirements are met. This includes, but is not limited to:

- General transportation (ambulance, wheelchair vans, etc.)
- Interpreters and translation services
- Member materials in print and other formats (digital, audio, Braille), written in plain language/appropriate grade level/culturally sensitive
- Communication strategies for successful interaction of physicians and physically/visually/speech/hearing impaired Members, as well as cultural sensitivity
- Physical access to provider offices, equipment and services

Providers may call Customer Service at **877-560-8055** for assistance.



Chapter 16

CLINICAL PRACTICE AND PREVENTIVE HEALTH CARE GUIDELINES

PREVENTIVE HEALTH CARE GUIDELINES

Good health begins with good lifestyle habits and regular exams. Preventive health care guidelines help physicians and other professional providers keep members on track with necessary screenings and exams based on age and gender.

Several national organizations produce tools that physicians and other professional providers can use to improve the health of our members, such as educational materials, health management programs and preventive health care guidelines. These guidelines will be posted and available at <http://bcbstx.com/provider/Mmedicaid/index.html>.

This website offers the most up-to-date clinical resources for preventive screenings, immunizations and counseling for our members.

If you do not have Internet access, you can request a hard copy of the Health Care Guidelines by contacting your Network Representative or by calling **855-212-1615**.

Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined in accordance with the requirements set forth by the state.

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CLINICAL PRACTICE GUIDELINES

BCBSTX supports physicians in following nationally accepted clinical practice guidelines to improve the health of our members. Several national organizations produce guidelines for the following conditions:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease
- Chronic/Congestive Heart Failure
- Depression in Primary Care
- Diabetes
- Hypertension
- Chronic Pain
- Metabolic Syndrome
- Oncology
- Lifestyle Management Programs

You can access these recommended guidelines through the BCBSTX website at <http://bcbstx.com/provider/Medicaid/index.html>. This will give you the most up-to-date clinical resources and references from nationally recognized sources.

If you do not have Internet access, you can request a hard copy of the Clinical Practice Guidelines by contacting your Network Representative or by calling **855-212-1615**.

Our recommendation of these guidelines is not an authorization, certification, explanation of benefits, or a contract. Benefits and eligibility are determined in accordance with the requirements set forth by the state.



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HEALTH SERVICES PROGRAMS

INITIAL HEALTH ASSESSMENT

Primary care providers (PCPs) or other professional providers should perform an Initial Health Assessment (IHA) with new members within 90 days of enrollment in BCBSTX. The IHA consists of:

1. A history and physical examination.
2. A developmental assessment.

An IHA is not necessary if the member is an existing patient of the PCP group (but new to us). Follow-up is not required if there is an established medical record that shows a baseline health status. This record must include sufficient information for the PCP to understand the member's health history and to provide treatment recommendations as needed. Transferred medical records can meet the requirements for an IHA if a completed health history is included.

STAR children ages 0 through 21 must have a Texas Health Steps visit within 90 days of joining the Plan, even if they had a visit on another plan. The claim should be billed as an exception to periodicity with Modifier 32.

REDUCTION OF NON-EMERGENT VISITS TO THE EMERGENCY ROOM

Our nurses and other health management staff work in many ways to reduce non-emergent visits to the emergency room. The goal is to help members establish a medical home in a primary care setting. Our methods include the promotion of behavior change in how members seek health services and thus reduce inappropriate ER visits.

This initiative is designed to cut down on the number of emergency room visits for non-emergencies by expanding our members' knowledge of medical resources and decision-making skills.

We have based our ER Initiative on three core components:

- Empowering members by providing education and a strong knowledge base to make informed decisions when seeking care for non-emergency events
- Collaborating with PCPs to actively provide access to care and treatment to their assigned members who are identified as frequent ER users
- Working with members and providers to identify and reduce barriers to access

The underlying purpose of this initiative is to promote behavior change in how members seek health services and reduce inappropriate ER visits. The effectiveness of the interventions and the ability of this initiative to produce successful outcomes are dependent on the members' willingness to change, and support from network providers.

Ultimately, the goal of this program is to help members establish a medical home in a primary care setting. This program utilizes a multifaceted approach to educate members about the appropriate utilization of 'first stop' resources, including their primary care provider and 24 Hour Nurse Advice Line.

To promote continuity of care and access to a primary care provider, targeted member and physician interventions are based on the member's frequency of emergency room (ER) visits within a 12-month rolling period.

Member interventions include:

- Dissemination of self-care books, letters and/or ER member packets
- Educational materials
- Outreach phone calls
- Case management (if appropriate)

Provider interventions include:

- Monthly mailed reports to PCPs. The mailed reports are member-specific with the dates, locations and the primary diagnosis of each member's ER visits.
- Member-specific mailed sheets you can place in the member's medical record.
- Following up with members regarding emergency room visits to help coordinate their care.

24 HOUR NURSE ADVICE LINE

How the 24-Hour Nurse Advice Line Assists Members

The 24-Hour Nurse Advice Line is a phone line staffed by registered nurses and is available to members 24 hours a day, seven days a week, to help with health-related questions. The 24-Hour Nurse Advice Line phone number for STAR and CHIP is **844-971-8906** (TTY: **711**).

Members can contact the 24-Hour Nurse Advice Line for:

- Assistance with self-care information (symptoms, medications and side effects, reliable self-care home treatments, etc.).
- Information about more than 300 health topics through the Nurse Advice Line audio tape library.
- A specialized nurse who is trained to discuss health issues specific to our teenage members.

The nurses at the Nurse Advice Line have access to a telephone interpreter service for callers who do not speak English. All calls are confidential.

PREVENTIVE CARE PROGRAMS

BCBSTX has developed Preventive Care Programs to help promote and maintain good health for members, and to remind them about the importance of regular checkups. Physicians and other professional providers are an integral part of these programs.

Although the programs target different needs, they all share the same goal: Helping members' live healthier lives. For additional information including a list of Preventive Care Programs, please go to <http://bcbstx.com/provider/Medicaid/index.html>.

TEXAS HEALTH STEPS PROGRAM

Texas Health Steps is the user-friendly name given to the state's Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program for members within the Texas Medicaid (STAR) program. It is one of the most comprehensive medical and dental screening, prevention and treatment programs for children of low-income families.

Texas Health Steps provides payment for comprehensive and periodic evaluations of a child's health, development and nutritional status, as well as vision, dental and hearing services for STAR recipients from birth through age 20. The THSteps periodicity schedule was based on the American Academy of Pediatrics (AAP) recommendations for preventive health care, however may vary slightly to meet federal or state regulations. The THSteps periodicity schedule can be found online at www.dshs.state.tx.us/thsteps/providers.shtm. For CHIP members, the AAP periodicity schedule is recommended. Medical Policies with periodicity schedules can be found at <http://bcbstx.com/provider/Medicaid/index.html> under **Medical Policies**.

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BCBSTX provider medical screening visits for children in the STAR program from birth through 20 years of age. In the CHIP Program, the age range is from birth through 18 years of age, following federally mandated Texas Health Steps program guidelines. For more information, see **Provider Roles and Responsibilities**.

Texas Health Steps primary care providers and other professional providers are an integral part of this program. PCPs will offer age-appropriate preventive care screening and test during each medical checkup and during an acute illness episode, if appropriate.

TEXAS HEALTH STEPS PROGRAM –AUTHORIZED PROVIDERS

The following provider types may provide Texas Health Steps preventive services within their individual scope of practice:

- Physician or physician group (MD or DO)
- Physician Assistant (PA)
- Clinical Nurse Specialist (CNS)
- Nurse Practitioner (NP)
- Certified Nurse Midwife (CNM)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)

Health-care provider or facility with physician supervision including but not limited to a:

- Community-based hospital and clinic
- Family planning clinic
- Home health agency
- Local or regional health department
- Maternity clinic
- Migrant health center
- School-based health center

In the case of a clinic, a physician is not required to be present at all times during the hours of operation unless otherwise required by federal regulations. A physician must assume responsibility for the clinic's operation.

Texas Health Steps Screening Requirements

Physicians and other professional providers of Texas Health Steps services are required to follow these guidelines: Compile a comprehensive health and developmental history, including both physical and behavioral health development. Texas Health Steps is congruent with the Bright Futures/American Academy of Pediatrics (2014) recommendations for Pediatric Preventive Care.

As part of our Value-Added Service (VAS), BCBSTX will cover Sports and Camp Physicals provided by STAR and CHIP providers once a year to encourage children's participation in physical fitness programs and sports activities.

AUTISM SCREENINGS

Texas Health Steps includes an autism screening, using specific, standardized screening tools. Developmental screening is already a part of the program exams. Autism screening is done at both the 18 and 24 month checkups. The screening is discussed on the CDC website at <http://www.cdc.gov/ncbddd/autism/hcp-screening.html> and the tool, the Modified Checklist for Autism in Toddlers (M-CHAT or M-CHAT-R/F™), is available without charge at <http://mchatscreen.com/>.

Billing Instructions for Developmental and Autism Screenings

Billing for Developmental and Autism Screenings must be done separately. Providers are required to bill these two screenings separately from the checkup when performed on the same day. Reimbursements, however, will be combined.

CPT Codes

- The CPT code for developmental screening is 96110.
- The CPT code for autism screening is 96110 with a U6 modifier.
- These screenings are only reimbursable if the tools specified in the policy (those identified by the Texas Health and Human Services Commission) are administered. Other checkups which do not require a standardized tool, or in which the provider administers a different tool, do not meet the criteria for separate reimbursement.
- Conduct a comprehensive unclothed physical exam.
- Give appropriate immunizations according to age and health history.
- Offer health education, including anticipatory guidance. An evaluation of age appropriate risk factors should be performed at each visit. PCPs must provide counseling or guidance to members/parent/guardian as appropriate.
- Offer nutritional assessment.
- Document immunizations and help ensure that they are current.
- Perform sensory screening (vision and hearing).
- Perform a dental assessment.
- Run a tuberculosis screening
- Perform a lead screening.

Depending on the child's blood test results, a physician or other professional provider may need to submit a request for Environmental Lead Investigation (ELI) services. An ELI may be considered medically necessary if the blood test results indicate any of the following:

- One venous blood lead test at 20 micrograms per deciliter (mcg/dL) or higher, or
- Persistent: two venous blood lead tests at least 12 weeks apart at 10-19 mcg/dL.

If the eligibility criteria are met, the provider can request an ELI by completing and submitting Form Pb-101, 'Environmental Lead Investigation Request,' to the Texas Childhood Lead Poisoning Prevention Program (TX CLPPP). The form is available at www.dshs.state.tx.us. If an ELI request meets the criteria, a referral for an ELI will be sent to a state or local health department for follow up.

For more information, contact the TX CLPPP at: **800-588-1248** or www.dshs.state.tx.us/lead.

MEDICAL CHECKUP AND IMMUNIZATION PROGRAM

Texas Vaccines for Children Program

BCBSTX provides immunization information to improve childhood immunization rates. All PCPs who administer childhood immunizations to STAR members must be enrolled in the Texas Vaccines for Children program, administered by the Texas Health and Human Services Commission (HHSC).

The Texas Vaccines for Children (TVFC) Program is a federally-funded, state-operated vaccine distribution program. It provides vaccines free of charge to enrolled providers for administration to individuals from birth through 18 years of age.

Qualified Medicaid STAR and CHIP providers can enroll in the TVFC Program by completing the TVFC Provider Enrollment Application form from the DSHS TVFC web page www.dshs.state.tx.us/immunize/tvfc/default.shtm.

BCBSTX will pay for TVFC Program provider's private stock of vaccines, but only when the TVFC posts a message on its website that no stock is available. In that case, providers should submit claims for vaccines with the 'U1' modifier, which indicates private stock. Providers should only submit claims for private stock until the vaccine is available from TVFC again. BCBSTX will no longer reimburse providers for private stock when the TVFC stock is replenished.

To participate in the Texas Vaccines for Children program, PCPs must be enrolled as a state Medicaid physician or other professional provider and must register in the Texas Vaccines for Children program to receive free vaccines.

BCBSTX maintains an intervention strategy to keep children current with the immunization schedule. Physicians and other professional providers are to follow the Advisory Committee on Immunization (ACIP) schedule, the American Academy of Pediatrics (AAP) periodicity schedule for CHIP members and the Texas Department of Health Services (TDHS) periodicity schedule for STAR members. Screening providers are responsible for administering immunizations and should not refer children to local health departments to receive immunizations.

Physicians and other professional providers are to:

- Obtain current immunization records.
- Give immunizations at each appointment as indicated and document them in the member's medical record.
- Request parental consent for participation in the Texas Immunization Registry (ImmTrac) and report immunization information to ImmTrac as appropriate.

Billing

Vaccines will be provided by the TVFC program and are not billed to BCBSTX. Physicians and other professional providers may only bill BCBSTX for the administration of the vaccine.

WELL MEMBER PROGRAM

The Well Member Program was designed to encourage members to have regular cervical and breast cancer screenings. The program reminds and encourages members to call their PCP to make an appointment to schedule screenings.

Physician and other Professional Providers Care for Women

PCP responsibilities for the care of female members include:

- Informing and referring members for cervical and breast cancer screenings.
- Educating members on the Preventive Care Guidelines for women.
- Scheduling screening exams for members.

Physicians and other professional providers can access our Preventive Health Care Guidelines in this manual. These guidelines also are on our website at <http://bcbstx.com/provider/medicaid/index.html>.

HEALTH MANAGEMENT PROGRAMS

BCBSTX seeks to improve the health of our members by offering disease management programs that educate and encourage self-care. BCBSTX has designed the following programs to help members learn to follow self-care regimens and treatment therapies for existing medical conditions and chronic diseases.

Condition Care Program

The Condition Care program is designed to help participants improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The Condition Care program helps members better understand and control certain medical conditions, such as:

- Diabetes (Type 1 and 2)
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart failure
- Asthma (pediatric and adult)
- Coronary Artery Disease

A team of nurses with added support from other health professionals, such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor's orders and how to become a better self-manager of their condition. Members are stratified into three different risk levels.

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Engagement methods vary by risk level, but can include:

- **Education** about their condition through mailings, telephonic outreach, and/or online tools and resources
- **Round-the-clock phone access** to registered nurses
- **Guidance and support** from nurse coaches and other health professionals

Physician benefits:

- **Saves time** for the physician and staff by answering patient questions and responding to concerns, freeing up valuable time for the physician and staff
- **Supports the doctor-patient relationship** by encouraging participants to follow their doctor's treatment plan and recommendations
- **Informs** the physician with updates and reports on the patient's progress in the program

Nurse coaches encourage participants to follow physicians' plan of care and do not offer medical advice. To help ensure that our service complements physicians' instructions, we collaborate with treating physicians to understand the members' plan of care and educate members on options for treatment plans. Providers are given a quarterly report for members currently enrolled in the program. The report includes the members' current educational goals.

If you have any questions or comments about the program, call **877-560-8055**. Nurses are available Monday through Friday from 8 a.m. to 5 p.m. Central Time.

Physicians and other Professional Providers Care for Asthmatic Members

Primary care providers and other professional providers are to provide each asthmatic member with ongoing treatment and prescribe medication following the NIH/NHLBI Guidelines for the diagnosis and management of asthma. PCPs should:

- Assess members for asthma using the NIH risk categories
- Provide each diagnosed member with a written Asthma Action Plan that describes medication dosage and level of care needed, based on peak-flow readings
- Refer members to asthma education classes by calling our Health Services department at **877-560-8055**
- Coordinate care with Case Management, pharmacy and specialists as needed
- Document all referrals and treatments related to asthma in the member's medical record
- File the member-specific report with the member's risk stratification in the medical record
- Participate in our Condition Care program
- Request asthma educational materials by calling **877-560-8055**

Physicians and other Professional Providers Care for Diabetic Members

PCPs are to provide each diabetic member with ongoing treatment and perform the appropriate physical and laboratory examinations following the **Diabetes Care Guidelines** from the American Diabetes Association.

Physicians and other professional providers are required to:

- Assess and treat members according to the Diabetes Care Guidelines
- Refer members for appropriate laboratory and screening tests
- Refer adult and child members to the Condition Care program. File the member-specific report with the member's risk stratification and the date of the last diabetic screening in the medical record
- Coordinate Case Management, pharmacy and specialists as needed
- Document all referrals and treatments related to diabetes in the member's medical record
- Request diabetes educational materials by calling **877-560-8055**

Physicians and other Professional Providers Care for Members with Cardiovascular Conditions

PCPs are encouraged to provide each member with a cardiovascular condition ongoing treatment and perform the appropriate physical and laboratory examinations following guidelines from the American Heart Association (AHA) and the National Institutes of Health (NIH).

Physicians and other Professional Providers are encouraged to:

- Improve quality of care in accordance with the AHA clinical practice guidelines for congestive heart failure (CHF) and coronary artery disease (CAD).
- Improve quality of life for members with CHF or CAD.
- Promote an interactive approach toward cardiovascular care by using action/goal plans, facilitating patient/professional provider communication and encouraging members to take a more active role in managing their condition.
- Urge member adherence to physician or other professional provider -prescribed treatment plans.
- Increase member self-management and knowledge of cardiovascular disease, including early detection and management of symptoms.
- Reduce exacerbation of the conditions and secondary complications.
- Request cardiovascular educational materials by calling **877-560-8055**



Chapter 18

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

QUALITY IMPROVEMENT STUDIES AND PROJECTS

The Healthcare Effectiveness Data and Information Sets (HEDIS) is a core set of performance measures that gauges the effectiveness of BCBSTX and its providers. BCBSTX measures the effectiveness of our care and services through:

- HEDIS and HEDIS hybrid measures
- Internal quality improvement projects. These include focused studies that measure quality of care and service in specific clinical and service areas

We submit the results of HEDIS and quality studies annually to the Texas Health and Human Services Commission (HHSC).

HEDIS ACTIVITIES

Providers are asked to support and contribute to our efforts to improve HEDIS measures rates. Detailed information on HEDIS is available at www.ncqa.org.

HEDIS Training and Consultation for Office Staff

BCBSTX provides assistance for medical office staff training in HEDIS activities. Physicians and other professional providers can request a consultation by calling Member Outreach at **877-375-9097**. Training and consultation includes:

- Information about the year's selected HEDIS measures
- How data for those measures will be collected
- Codes associated with each measure for administrative data
- Tips for smooth coordination of medical record data collection

Access to Medical Records for HEDIS Audits

BCBSTX's Quality Improvement staff will contact the provider's office to arrange for a review or to copy any medical records required for quality improvement studies. Office staff must give access to medical records for review and copying.

PREVENTABLE ADVERSE EVENTS

The breadth and complexity of today's health care system means there are inherent risks, many of which can be neither predicted nor prevented. However, the occurrence of preventable adverse events should be tracked and reduced, with the ultimate goal being to eliminate them.

Physicians and health care systems, as patient providers and advocates, are responsible for the continuous monitoring, implementation, and enforcement of applicable standards. We will work with network physicians and hospitals to identify preventable adverse events that are measurable and preventable as a means of improving the quality of patient care.

Preventable adverse events should not occur. We firmly support the concept that a health plan and patients should not pay for services that resulted from a preventable adverse event.

Focusing on patient safety, we are committed to working collaboratively with network physicians and hospitals to ensure that physicians and hospitals identify preventable adverse events and implement appropriate strategies and technologies to prevent them. Our goal is to enhance the quality of care received not only by our members but all patients receiving care in these facilities.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations specify that Protected Health Information (PHI) can be disclosed for the purpose of health care operations in relation to quality assessment and improvement activities.

Also, the information you share with us is legally protected through the peer review process; as such, it will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide them within 10 days from the date of request.

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We will continue to monitor activities related to the list of adverse events from federal, state, and private payers, including ‘Serious Reportable Events.’ As defined by the National Quality Forum (NQF), ‘Serious Reportable Events’ are adverse events that are serious, but largely preventable, and of concern to both the public and health care providers. **Medicaid is prohibited from paying for certain health care acquired conditions (HCAC). This applies to all hospitals.**

SATISFACTION SURVEYS

Member Satisfaction Surveys

Member satisfaction with our services is measured every year. The Texas External Quality Review Organization (EQRO) conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS), an annual survey of members to measure satisfaction with the service and care provided by BCBSTX and its physicians and other professional providers. The survey measures access to care, member satisfaction with BCBSTX, and satisfaction with physicians and other professional providers’ communications and office staff performance.

The EQRO releases the results of the survey to members, physicians and other professional providers.

Physicians and other Professional Providers Satisfaction Surveys

BCBSTX conducts provider surveys on an annual basis to monitor and measure satisfaction your satisfaction with BCBSTX’s services and access to care and to identify areas for improvement. We inform providers of the results and plans for improvement through physicians’ and other professional providers’ bulletins, newsletters, meetings or training sessions.

The participation of physicians and other professional providers in the survey process is highly encouraged. Your feedback is very important to us to address areas needing improvements.

MEDICAL RECORD AND FACILITY SITE REVIEWS

BCBSTX conducts medical record reviews and facility site reviews in order to:

- Determine the physicians and other professional provider office’s ongoing compliance with standards for provision and documentation of health care services, and compliance with processes that maintain safety standards and practices.
- Confirm physician and other professional provider involvement in the continuity and coordination of care for our members.

Texas HHSC and BCBSTX have the right to enter the premises of providers to inspect, monitor, audit or otherwise evaluate the work performed. We will perform all inspections and evaluations in such a manner as not to unduly delay work in accordance with the provider agreement.

Medical Record Review and Facility Site Review survey tools are available upon request. The tools indicate which elements are reviewed.

Medical Record Review

BCBSTX completes a medical record review annually according to our medical records standards. We complete medical record reviews at select primary care sites and high volume provider offices. The Medical Records Documentation Standards are outlined in Chapter 14, Provider Roles and Responsibilities.

Scheduling a Medical Record Review

Plan Quality Improvement staff will call the physician's or professional provider's office to schedule an appointment date and time within 30 days. On the day of the review, plan Quality Improvement staff will:

- Request the number and type of medical records required
- Review the appropriate type and number of medical records per physician and other professional provider
- Complete a medical record review
- Meet with the provider or office manager to review and discuss the results of the medical record review
- Provide a copy of the medical record review results to the office manager or doctor, or send a final copy within 10 days of the review
- Schedule follow-up reviews for any corrective actions identified

Physicians and other professional providers must attain a score of 80 percent or greater in order to pass the Medical Record Review.

Facility Site Review

All primary care provider sites participating in BCBSTX must undergo an initial site inspection regardless of other accreditation or certification. A site review is completed as part of the initial credentialing process for new physicians and other professional providers if that site has not been previously reviewed and accepted as part of BCBSTX's credentialing process.

Obstetrics/gynecology (OB/GYN) specialty sites participating in BCBSTX (and not serving as PCPs) must undergo an initial site inspection.

A plan Quality Improvement associate will call the physician and other professional provider's office to schedule an appointment date and time before the facility site review due date. The associate will fax or send a confirmation letter with an explanation of the audit process and required documentation.

During the facility site review, our associate will:

- Lead a pre-review conference with the provider or office manager to review and discuss the process of facility review and answer any questions.
- Conduct a review of the facility, complete a facility site review and develop a corrective action plan, if applicable.

After the facility site review is completed, our associate will meet with the physician and other professional provider or office manager to:

- Review and discuss the results of the facility site review and explain any required corrective actions.

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- Provide a copy of the facility site review results and the corrective action plan to the office manager or physician and other professional provider or send a final copy within 10 days of the review.
- Schedule a follow-up review for any corrective actions identified.
- Educate the provider and office staff about our standards and policies.

Facility Site Review Scoring

BCBSTX will notify physicians and other professional providers of the site review score, all cited deficiencies and corrective action requirements at the time of a non-passing survey. Physician and other professional provider office sites will complete corrective action plans. Follow-up site visits will occur every six months until the site complies with the standards.

Physician and Other Professional Provider Support of the Facility Site Review Process

The Physician and other professional provider and office staff will:

- Provide an appointment time for the review.
- Be available to answer questions and participate in the exit interview.
- Schedule a time for follow-up reviews, if applicable.
- Complete a corrective action plan.
- Sign an attestation that corrective actions are complete.
- Submit completed corrective action plan, supporting documents and signed attestation to our quality improvement analyst.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER PROFILING

BCBSTX believes that provider profiling contributes to ongoing improvements by assessing provider performance against established benchmarks. Provider profiling helps ensure that our providers receive valuable feedback concerning their performance to support the delivery of high quality care.

Primary care providers (PCPs) and select providers such as OB/GYN are profiled by BCBSTX in order to assess our providers' ability to render appropriate services, order medically necessary diagnostic tests, and provide preventive services consistent with clinical guidelines and pharmacy utilization protocols.

The profiles enable us to identify opportunities for improvements by comparing a provider's practice to that of his/her peers. Profiles are created utilizing the claims, enrollment and encounter data submitted by all providers.

The provider profiles include, at a minimum, the following measures:

- Distribution of established patient E/M visits with 10 most frequent diagnoses
- Established and new patient preventive care
- Average specialist visits per year

- Average emergency room visits
- Average inpatient hospital admission
- Percent of admissions that are readmissions.
- Member satisfaction or number of complaints

Specific scores from medical record reviews, access availability and HEDIS scores

- TX HealthSteps Annual MRR results
- Access and Availability annual results (if available)
- HEDIS W34 – Health Care Effectiveness Data and Information Set (HEDIS) Well-child Visits (3-6 years of age)
- HEDIS AWC – Health Care Effectiveness Data and Information Set (HEDIS) Adolescent Well-care visits
- ASM – Health Care Effectiveness Data and Information Set (HEDIS) Use of appropriate medications for people with asthma
- AMR – Health Care Effectiveness Data and Information Set (HEDIS) Asthma medication ratio

BCBSTX defined performance measures used as part of the provider profile reporting:

- Preventive visits measured by the percentage of assigned members seen during the reporting period
- The top diagnoses, which provides an opportunity to educate the provider about case management or disease management programs that may be appropriate for the population
- Peer comparisons on the frequency of Evaluation and Management (E&M) codes as well as ER visits to evaluate the appropriateness of provider practices and to provide an opportunity to educate
- Educating the provider about the availability of the ER Census program for members who are frequent ER users
- Specialty referral distribution comparison, which may indicate overuse or underuse of key specialties or indicate an opportunity for recruitment of specific types of providers to the network.

Provider Profile Reporting

The Provider Profile report is generated annually by BCBSTX and delivered to providers either in face-to-face meetings or by mail with a follow-up call or visit to explain the findings. PCPs with 40 or more STAR members on average per year on their panel will receive profile reports. This volume requirement allows production of a meaningful profile with enough information to allow comparisons.

Improving Performance of Profiled Providers

In order to promote continuous quality improvement, BCBSTX's Network Management team, Quality Improvement team and medical director(s) work directly with PCPs to interpret profile results, review performance measures and discuss new medical guidelines, if needed. by working proactively with providers, we promote accountability and improve the quality of care provided to our members.

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PROCESS AND TIMELINE FOR IMPROVING PERFORMANCE

For those providers whose performance falls significantly below average, or represents unsafe practice patterns, the local medical director follows up with the provider to develop a corrective action plan.

Providers found to be out of compliance with medical management standards are closely monitored and, if necessary, subjected to corrective interventions. A follow-up is scheduled to determine the effectiveness of interventions, and if necessary, to implement further corrective measures for possible disciplinary action or contract termination.

SHARING BEST PRACTICE METHODS

Network Management teams share best practice methods with providers during provider visits. We also offer educational toolkits to help guide improvements. Toolkits may include examples of best practices from other offices along with BCBSTX policies and procedures, resources for improving compliance with preventive health services, clinical practice guidelines, and care for members with special or chronic care need.

QUALITY MANAGEMENT

Consistent with National Committee for Quality Assurance (NCQA) standards, BCBSTX analyzes relevant utilization data against established thresholds for each health plan to detect potential under- and over-utilization on at least a semi-annual basis.

If the findings fall outside specified target ranges or thresholds and indicate potential under- or over-utilization that may adversely affect members, further drill-down analyses will occur based upon the recommendation of BCBSTX's Medicaid Quality Improvement Committee and Medicaid Provider Advisory Committee. The drill-down analyses may include the following data from specific provider and practice sites:

- Case management services as needed for members
- Retrospective reviews of services provided without authorization
- Investigation and resolution of member and provider complaints and appeals within established time frames
- Coordination with physicians, other professional providers and agencies
- Claims payment for covered services

Focus Studies

BCBSTX performs focus studies to objectively and systematically monitor and evaluate the quality of care and service provided to members. The studies utilize topics and tools agreed upon by the Quality Improvement Committee and include, but are not limited to, the following:

- Medical records review utilizing HEDIS measures
- Provider surveys
- Member surveys
- Random audits of member medical records
- Claims and encounter data review

Providers are notified of audits (if medical record review is necessary) at least two weeks prior to the medical record review visit. BCBSTX submits findings from these focus studies to providers. If necessary, quality improvement plans with defined outcomes and deadlines are initiated for providers by BCBSTX.

Practice Guidelines

In order to achieve the best possible success, our Quality Improvement Committee requires provider cooperation in the following areas:

- Upon request, allowing BCBSTX access to medical records concerning our members,
- Responding promptly to all communications from BCBSTX regarding quality improvement or management issues,
- Maintaining the confidentiality of all BCBSTX member information, and
- Cooperating with all Quality Improvement Committee proceedings.

For more information on proper practice guidelines, please see **Chapter 14: Provider Roles and Responsibilities** and **Chapter 15: Access Standards and Access to Care**.



Chapter 19

ENROLLMENT AND MARKETING RULES

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER ROLES IN STAR AND CHIP MARKETING AND ENROLLMENT

Limitations

Trusted physicians and other professional providers may be in a unique position to influence patients on the selection of a health plan. For that reason, the Texas Health and Human Services Commission (HHSC) have created policies for marketing practices by physicians and other professional providers for state programs.

Policies **prohibit** network providers from making false or misleading claims that:

- The primary care provider (PCP) office staffs are employees or representatives of the state, county or federal government.
- BCBSTX is recommended or endorsed by any state agency, county agency or any other organization.
- The state or county recommends that a prospective member enroll with a specific health plan.

A prospective member or medical recipient loses benefits under the Medicaid Managed Care (STAR) program or the Children's Health Insurance Program (CHIP), or other welfare benefits if the prospective member does not enroll with a specific health plan

Policies **prohibit** network providers from:

- Making marketing presentations or advising or recommending to an eligible individual that he or she select membership in a specific managed care plan.
- Offering or giving away any form of compensation, reward or loan to a prospective member to induce or procure member enrollment in a specific health plan.
- Engaging in direct marketing to members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- Using any list of members obtained originally for enrollment purposes from confidential state or county data sources, or from the data sources of other contractors.
- Marketing practices that discriminate against potential members based on marital status, age, religion, sex, national origin, language, sexual orientation, ancestry, pre-existing psychiatric problem or medical condition (such as pregnancy, disability or acquired immune deficiency syndrome), other than those specifically excluded from coverage under our contract.
- Reproducing or signing an enrollment application for the member.
- Displaying materials from certain managed care organizations that the provider holds a contract with and not others.
- Marketing activities that involve unsolicited personal contact, including door-to-door solicitation at a child-care facility or other type of facility, direct mail or telephone, with a Medicaid client or a parent whose child is enrolled in Medicaid
- Marketing activities directed at the client or parent solely because the client or the parent's child is receiving Medicaid
- Marketing materials intended to influence the client's or parent's choice of provider.

Providers may:

- Help the member apply for benefits; direct him or her to call the Texas State Medicaid Managed Care Program Help Line at **800-964-2777** for enrollment information.
- File a complaint with BCBSTX if a provider or member objects to any member marketing, either by other providers or our representatives. Please refer to the Complaints and Appeals chapter of this manual for more information on the complaint process.

For more information regarding Provider Marketing Guidelines, visit the TMHP website at:

- <http://www.tmhp.com/Pages/Topics/Marketing.aspx>

PROGRAM ENROLLMENT PROCESS

HHSC determines the eligibility and enrollment for STAR and CHIP members.

CHIP eligibility is for 12 continuous months. HHSC or Maximus, the Administrative Services Contractor, presents health plan options to individuals and families eligible for STAR or CHIP. STAR or CHIP eligible members enroll in the managed care plan of their choice and select a primary care provider or primary care site (PCS). If HHSC does not receive this enrollment information within 45 days, it assigns the member to a STAR plan, and then submits the member information to BCBSTX. We then assign a PCP or PCS for the member.

CHIP eligible members must enroll in a CHIP health maintenance organization (HMO) plan in 90 days or they will not be eligible for CHIP services. CHIP eligible members are not defaulted into a plan.

HHSC or Maximus informs BCBSTX of new member enrollment, and notifies BCBSTX after enrollment of any changes in member eligibility, status or contact information (such as change of address).

Physicians and other professional providers will be given notice of new members signed up or assigned to their care through monthly eligibility reports mailed to them by BCBSTX.

BCBSTX sends each new member an enrollment kit within five business days after receiving the HHSC monthly membership file. This includes a member identification (ID) card, letter and PCP choice or assignment. The ID card includes PCP contact information as well as the procedures for changing a PCP or PCS.

HHSC will automatically re-enroll any member who loses STAR or CHIP eligibility but becomes eligible again within six months or less. Members will automatically return to the same health plan and PCP as they had prior to disenrollment, if available. Members may choose to switch plans.

To support the member enrollment process, PCPs are encouraged to maintain open panels. The state requires that 90 percent of BCBSTX's PCPs have open panels, and your open panel will assist us in meeting this requirement.

CHIP Plan Changes

CHIP members may request a change:

- For any reason within 90 days of CHIP enrollment and once thereafter
- For cause at any time
- If the member moves to a different service delivery area
- During the annual re-election period

HHSC will make the final decision.

CHIP Member Enrollment Renewal

Around the ninth month of the 12-month coverage period, the vendor mails a renewal packet to families enrolled in CHIP. The packet contains a CHIP renewal form; a letter requesting current income and deduction verification and instructing the family how to renew for another term of coverage immediately following the expiration of the current term of coverage; and a postage paid, return addressed envelope. The letter instructs the family to complete and return the renewal form within seven days of receipt.

The CHIP renewal form is the CHIP application pre-populated with all currently available and most recent data except for income and deduction information. Additionally, a separate enrollment/transfer form is included for the family to indicate whether they wish to reconsider their health plan choice and a line for signature and date. The instructions on both the letter and the CHIP renewal form direct the family to review and to update the form by either completing any missing information or correcting pre-populated information.

CHIP PERINATAL PROGRAM MEMBER ENROLLMENT AND DISENROLLMENT FROM HEALTH PLAN

CHIP Perinatal Member Enrollment:

- 12-Month eligibility for CHIP and CHIP Perinatal members (newborn).
- The mother of the CHIP Perinatal has 15 calendar days from the time the enrollment packet is sent by the enrollment broker to enroll in a Managed Care Organization.

When a member of a household enrolls in the CHIP Perinatal Program, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Program member's health plan if those health plans are different. All members of the household must remain in the same health plan until the latter of (1) the end of the CHIP Perinatal Program member's enrollment period or (2) the end of the traditional CHIP program members' enrollment period. Copayments, cost sharing, and enrollment fees still apply to children enrolled in CHIP.

In the ninth month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP members' information. Once the child's CHIP perinatal coverage expires, the child will be added to his or her siblings' existing CHIP case.

Maximus, the State's Administrative Services Contractor, is responsible for providing Blue Cross and Blue Shield of Texas with new member and member change information within five days of the beginning of the month, for that month's eligibility information. However, HHSC makes the final decision of enrollment for all CHIP members.

Disenrollment occurs due to loss of eligibility, including, but not limited to the following events:

- Failure to re-enroll at the conclusion of the 12-month eligibility period
- Change in health insurance status, such as a child enrolling in an employer sponsored insurance plan
- Permanent move out of the state
- Enrollment in Medicaid

A provider cannot take retaliatory action against a member for disenrollment.

The switch of the CHIP members from their Managed Care Organization to the Managed Care Organization providing CHIP Perinatal coverage does not count as their one Managed Care Organization plan change per year. Members may request to change Managed Care Organizations for exceptional reasons or good cause.

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CHIP Perinate Plan Changes

A CHIP Perinate (unborn child) who lives in a family with an income at or below the Medicaid eligibility threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and will receive 12 months of continuous Medicaid coverage (effective on the date of birth) after the birth is reported to HHSC's enrollment broker.

A CHIP Perinate mother in a family with an income at or below the Medicaid eligibility threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under the Medicaid eligibility threshold will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to HHSC's enrollment broker.

A CHIP Perinate will continue to receive coverage through CHIP as a 'CHIP Perinate Newborn' if born to a family with an income above the Medicaid eligibility threshold and the birth is reported to HHSC's enrollment broker.

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

CHIP Perinate mothers must select an MCO within 15 calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.

When a member of a household enrolls in CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member's health plan if the plan is different. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal member's enrollment period, or (2) the end of the traditional CHIP members' enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP members' information. Once the child's CHIP perinatal coverage expires, the child will be added to his or her siblings' existing CHIP case.

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

- For any reason within 90 days of enrollment in CHIP Perinatal;
- If the member moves into a different service delivery area, or
- For cause at any time.

ENROLLING NEWBORNS

Encourage your patients to call a Texas Department of State Health Services (DSHS) social worker to let them know about the pregnancy.

STAR

For hospitals: At the time of delivery, please complete the HHSC form 7484, Hospital Report (Newborn Child or Children), and mail to the address identified on the form within five days of the birth. Prompt submission of this form to HHSC will expedite the process of assigning the newborn the Medicaid identification number needed for submission of claims to the assigned plan.

For members: After the baby is born, the member will receive a Medicaid ID Form 3087 that says Newborn Call Plan. The baby is part of the mother's health plan for 90 days following the date of birth if the mother applies for Medicaid. The state will retroactively, to the date of birth, enroll newborns in BCBSTX designated by the mother.

Once enrolled, if the member hasn't called BCBSTX to choose a primary care provider (PCP) or other professional provider for their baby, they can call 888-657-6061 to choose one. If the parent does not choose, one will be chosen for the newborn member.

CHIP

When seeing a member who is pregnant, remind her of the importance of calling both DSHS and BCBSTX to report the pregnancy. We offer a prenatal program that will assist her during pregnancy.

Pregnant CHIP members should be referred to Medicaid for eligibility determination. For eligible members, the baby will be enrolled in the mother's plan unless the mother asks for an exception. If CHIP members do not qualify for Medicaid, the mother is covered through delivery until eligibility is terminated. The baby is not covered under CHIP or STAR in this case.

Newborn Process

When a member of a household enrolls in the CHIP Perinatal Program, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member's health plan if those health plans are different. All members of the household must remain in the same health plan until the latter of (1) The end of the CHIP Perinatal Member's enrollment period, or (2) the end of the traditional CHIP members' enrollment period. Copayments, cost-sharing, and enrollment fees still apply to children enrolled in CHIP.

In the ninth month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP Renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP members' information. Once the child's CHIP perinatal coverage expires, the child will be added to his or her siblings' existing CHIP case.

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Maximus, the State's Administrative Services Contractor is responsible for providers BCBSTX new member and member change information within five days of the beginning of the month for that month's eligibility information. However, HHSC makes the final decision of enrollment for all CHIP members.

Disenrollment occurs due to loss of eligibility, including, but not limited to the following events:

- Failure to re-enroll at the conclusion of the 12-month eligibility period
- Change in health insurance status, such as a child enrolling in an employer sponsored insurance plan
- Permanent move out of the state
- Enrollment in Medicaid

The switch of CHIP members from their Managed Care Organization to the Managed Care Organization providing CHIP Perinatal coverage does not count as their one Managed Care Organization plan change per year. Members may request changing Managed Care Organizations for exceptional reasons or good cause.

PREGNANT TEENS

Provider Responsibility

Network providers are required to notify us immediately upon identification of a pregnant CHIP member for Medicaid eligibility determinations. A CHIP member who is potentially eligible for Medicaid must apply for Medicaid. A pregnant CHIP member who is determined to be Medicaid-eligible will no longer be eligible for CHIP and will be disenrolled from the program. Medicaid coverage will be coordinated to avoid gaps in health care coverage.

If BCBSTX remains unaware of a CHIP member's pregnancy until delivery, the delivery will be covered by CHIP. Eligibility of newborns must be determined for CHIP before enrollment can occur. For newborns determined to be CHIP-eligible, the baby will be covered from the beginning of the month of birth for the period of time specified in the Member Handbook.

Since Medicaid provides a much more comprehensive scope of services for both the pregnant teen and her newborn, it is in the best interest of the pregnant teen to receive Medicaid coverage as early as possible. For this reason, it is critical that providers notify BCBSTX immediately upon learning about a CHIP member's pregnancy and/or delivery.

PHYSICIANS AND OTHER PROFESSIONAL PROVIDERS' ROLE IN STAR AND CHIP MARKETING AND ENROLLMENT

As network physicians and other professional providers who serve STAR or CHIP members, you may not provide prospective members with an enrollment form. Moreover, you may not assist prospective members (who are patients) in completing the enrollment form.

If someone expresses interest in our plan during a medical visit, you may help that person preliminarily find out what program he or she may qualify for, then provide resources for more information.



Chapter 20

MEMBER TRANSFERS AND DISENROLLMENT

MEMBER-INITIATED PRIMARY CARE PROVIDER AND OTHER PROFESSIONAL PROVIDER TRANSFERS

Members have the right to change their primary care provider or other professional provider at any time. When a member enrolls in any of our programs, we provide instructions to call our Customer Service Department (CSD) if the member wants to choose another PCP. Our CSD staff will consider special needs when changing a PCP and will work with the member to make a new selection. We accommodate member requests for transfers whenever possible, and have policies to maintain continued access to care/continuity of care during the transfer process.

STAR and CHIP members may request a PCP transfer by calling Customer Service at: **888-657-6061**.

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When a member calls to request a PCP change:

1. The Customer Service Representative (CSR) checks the availability of the member's choice. If the member can be assigned to the selected PCP, the CSR will reassign the member. If the PCP is not available, the CSR will assist the member in finding an available PCP. If the member advises the CSR that he/she is hospitalized, the PCP change will take effect upon discharge.
2. BCBSTX notifies PCPs of member transfers through monthly enrollment reports. PCPs can find these reports by calling our Customer Service Department.
3. The effective date of a PCP transfer will be the same as the date of the member request. We may assign a member retroactively.
4. To support member transfers between PCPs, PCPs are encouraged to maintain open panels. The state requires that 90 percent of BCBSTX's PCPs have open panels, and your open panel will assist us in meeting this requirement.

TRANSFERS TO OTHER PLANS

STAR Members

Members can change health plans by calling the Texas Medicaid Managed Care program help line at: **800-964-2777**. However, a member cannot change from one health plan to another health plan during an inpatient hospital stay.

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

1. If a request for plan change is made on or before April 15, the change will take effect May 1.
2. If a request for plan change is made between April 16 and April 30, the change will take effect on June 1.

CHIP Members

Effective October 1, 2009, the CHIP Reauthorization Act (CHIPRA) requires the state, enrollment broker and managed care entities to allow CHIP enrollees to terminate and/or change enrollment without cause during the 90-day period beginning on the date the individual receives notice of enrollment.

DISENROLLMENT FROM BCBSTX

Medicaid Managed Care Member Disenrollment from BCBSTX

If a member requests disenrollment from the managed care program, BCBSTX will provide the member with information on the disenrollment process and direct the member to Maximus, the HHSC Administrative Services Contractor. If the request for disenrollment includes a member complaint, the complaint will be processed separately from the disenrollment request through the complaint process.

Members' disenrollment requests from managed care will require medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment from managed care. HHSC will make the final determination.

CHIP/CHIP Perinatal Program Member Disenrollment

Disenrollment from the CHIP/CHIP Perinatal Program occurs due to loss of eligibility, including, but not limited to the following events:

- Failure to re-enroll at the conclusion of the 12-month eligibility period
- Change in health insurance status, such as a child enrolling in an employer sponsored insurance plan
- Permanent move out of the state
- Enrollment in Medicaid

HHSC will make the final decision.

Physicians and other professional providers may not take retaliatory action against STAR or CHIP members for requesting transfer or disenrollment.

When a CHIP member switches from his or her Managed Care Organization to the Managed Care Organization providing CHIP Perinatal coverage, it does not count as their one Managed Care Organization plan change per year. Members may request a change in their Managed Care Organization for exceptional reasons or good cause.

Who Can Initiate Disenrollment?

Two sources may initiate a disenrollment:

1. The member
2. Blue Cross and Blue Shield of Texas

Member-Initiated Disenrollment

Members can voluntarily disenroll and choose another managed care health plan at any time, except during an inpatient stay. When members enroll in our plan, we provide instructions on where to call or write to disenroll and choose another managed care health plan. Disenrollment become effective the first day of the second month after Texas Health and Human Services Commission (HHSC) or a contractor receives all documentation necessary as determined by HHSC. Physicians and other professional providers may not take retaliatory action against STAR or CHIP members for requesting transfer or disenrollment.

Disenrollment may result in any of the following:

- Enrollment with another plan
- Termination of eligibility

If a member asks a physician or other professional how to disenroll from BCBSTX, the physician or other professional provider can direct the member to call the Customer Service phone number on the back of the member's identification (ID) card: **888-657-6061**.

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BCBSTX Response to Member Disenrollment Calls

When BCBSTX's Customer Service Department (CSD) receives a call from a member who wants to disenroll from us, the Customer Service Representative (CSR) follows these steps:

1. The CSR will attempt to find out the reason for the request.
2. If the situation is something that the CSR can address and resolve, the CSR reminds the member that he or she has the right to request disenrollment, but also offers to resolve the issue. The CSR also asks the member if he or she wants to delay the disenrollment process pending the resolution.
3. If a member agrees to allow us to attempt resolution, BCBSTX's CSR initiates the process that would properly address the situation.
4. If the member declines, the CSR will refer the member to the Texas Medicaid Managed Care program help line at **800-964-2777**.
5. The CSR informs the member that the disenrollment process will take 15 to 45 days.

Physician and other professional provider Request for Termination of Professional Relationship with Member

A physician or other professional provider may request the termination of the professional relationship between the provider and the member. The request for termination must be approved by BCBSTX. For continuity of care, if the physician requesting the termination is the member's PCP, that physician must continue to manage the member's care until we can reassign the member to another PCP, or 30 days from the day we receive the Provider Request for Member Deletion from PCP Assignment form, whichever comes first. This form is available on our website at <http://bcbstx.com/provider/medicaid/index.html>. Upon completion of this form, providers must mail it to BCBSTX at:

Blue Cross and Blue Shield of Texas

Attn: Membership

P.O. Box 51422

Amarillo, TX 79159-1422

The reasons a provider may terminate his/her professional relationship with a member include, but are not limited to, the following:

- Fraudulent use of services or benefits
- Threats of physical harm to a physician or office staff
- Uncooperative or disruptive behavior on the part of the member/patient or member's/patient's family
- Member/patient continuously misses appointments
- Medical needs that could be better met by a different provider
- Evidence of receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or necessary

- The member accesses care from providers other than the selected or assigned provider
- Breakdown in provider and member relationship
- Previously approved termination

Reasons a provider may not terminate his/her professional relationship with a member include, but are not limited, to the following:

- Discriminating against a member or potential member because of race, creed, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care
- Amount, variety, or cost of covered health services required by the member
- Patterns of high utilization, either known or experienced

Once we receive a request for termination from the physician and/or other professional provider, we will contact the physician and/or other professional provider to determine if the request meets the performance standards allowed for termination. If the performance standards for termination are not met, we will explain why the physician/member relationship may not be terminated.

If the termination request meets the performance standards, a termination date of the physician/member relationship will be given to the provider. The term date must be the last day of the month following the initial 30 calendar day timeframe. Immediate termination may be considered if a safety issue or gross misconduct is involved and must be reviewed and approved by BCBSTX.

The provider is required to send a notification letter to the member. The notification letter must include:

- Name of the member – (if terming a family, list all members affected)
- Member identification number(s)
- Group number
- Effective date of termination

A copy of the letter sent to the member must be sent simultaneously to BCBSTX Network Management via email, fax, or regular mail. The provider must continue to provide medical services for the member until the termination date stated in the provider's letter. Once we receive the letter from the provider, we will notify the provider of receipt of the letter.

BCBSTX will send a letter to the member, 30 days prior to the termination date, outlining the steps the member must take to select a new physician or other professional provider.

Prior to disenrollment, BCBSTX makes every attempt to resolve any issues and keep the member in our plan. If these attempts fail, BCBSTX will either reassign the patient to another PCP or forward the disenrollment request form to the appropriate state agency requesting member reassignment to another health plan.

For more information, please call our Provider Services Department at **877-560-8055**.

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Plan-Initiated Member Disenrollment

BCBSTX may request disenrollment for a member who has moved out of the service area. If members move out of the service area, they are responsible for notifying their state eligibility worker of the address change. After that, HHSC will disenroll the member from the health plan.

BCBSTX may also request disenrollment if:

- The member misuses or loans their membership card to another person
- The member is disruptive, unruly, threatening or uncooperative
- The member refuses to comply with managed care restrictions

State Agency–Initiated Member Disenrollment

BCBSTX receives daily changes and monthly full replacement files from HHSC and contracted agencies containing all active membership data and incremental changes to eligibility records. BCBSTX disenrolls member who are not listed on the monthly full replacement file effective as of the designated disenrollment date with consideration of the following disenrollment reasons:

- Death
- Permanent change of residence out of service area
- County changes
- Loss of benefits
- Voluntary disenrollment
- Change in eligibility status
- Incarceration
- Admission to a long-term care or intermediate care facility beyond the month of admission and the following month
- Member has other non-government or government sponsored health coverage



Chapter 21

CREDENTIALING AND RE-CREDENTIALING

CREDENTIALING PROCESS FOR OFFICE-BASED PHYSICIANS OR OTHER PROFESSIONAL PROVIDERS

The BCBSTX credentialing process is consistent with NCQA guidelines and the State of Texas requirements to practice.

BCBSTX requires full credentialing of the following office-based physicians and other professional providers for participation in the Medicaid (STAR) and CHIP networks.

- Advanced Practice Nurse (APN)
- Audiologist (AUD)
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Nurse Midwife (CNM)
- Clinical Nurse Specialist (CNS)
- Medical Doctors (MD)
- Doctor of Chiropractic (DC)
- Doctor of Dental Surgery (DDS)
- Doctor of Dental Medicine (DMD)
- Doctor of Osteopathy (DO)
- Doctor of Podiatric Medicine (DPM)
- Medical Doctors (MD)
- Occupational Therapist (OT)
- Licensed Physical Therapist (LPT)
- Physician Assistant (PA)
- Registered Dietician (RD)
- Speech and Language Pathologist (SLP)

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Behavioral health professionals and physicians must contact Magellan at **800-788-4005** or www.magellanprovider.com for questions regarding the credentialing or re-credentialing process for the Medicaid (STAR) and CHIP networks.

Expedited Credentialing Process

BCBSTX will provide an expedited credentialing process which allows for a 'provisional network participation' status if the provider applicant:

- Has enrolled as a Medicaid Provider with TMHP for Medicaid (STAR);
- Has a valid BCBSTX Provider Record ID for claim payment;
- Has submitted a current signed BCBSTX contract/agreement;
- Has completed the CAQH UPD database online application with 'global' or 'plan specific' authorization to BCBSTX or submits a completed TDI application, as appropriate; and
- Has a current, valid license in good standing with the State of Texas licensing board applicable to provider type.

Important: If the applicant does not meet the provisional network participation requirements above, the applicant must be fully credentialed and approved prior to becoming effective in the Medicaid (STAR) & CHIP networks.

Credentialing is a very involved process. Please allow a sufficient period of time for the full credentialing process to be completed before calling BCBSTX for a status update.

Initial Credentialing and Re-Credentialing Process

BCBSTX requires Texas Physicians and other professional providers to use the Council for Affordable Quality Healthcare's (CAQH®) Universal Provider Datasource (UPD®) for initial credentialing and re-credentialing.

UPD, a free online service, allows physicians and other professional providers to fill out one application to meet the credentialing data needs of multiple organizations. The UPD database online credentialing application process supports our administrative streamlining and paper reduction efforts. This solution also helps to ensure the accuracy and integrity of our provider database. Providers will be able to utilize the UPD database at no cost.

GETTING STARTED WITH THE COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE

Council for Affordable Quality Healthcare (CAQH) Approved Provider Types

CAQH will only accept providers from among the following approved provider types:

CAQH Approved Provider Types List	
<ul style="list-style-type: none"> • Medical Doctor (MD) • Doctor of Dental Surgery (DDS) • Doctor of Dental Medicine (DMD) 	<ul style="list-style-type: none"> • Doctor of Podiatric Medicine (DPM) Doctor of Chiropractic (DC) • Doctor of Osteopathy (DO)
<ul style="list-style-type: none"> • Audiologist (AUD) • Biofeedback Technician (BT) • Christian Science Practitioner (CSP) • Clinical Nurse Specialist (CNS) • Licensed Practical Nurse (LPN) • Massage Therapist (MT) • Naturopath (ND) • Neuropsychologist (NEU) • Midwife (MW) 	<ul style="list-style-type: none"> • Nurse Midwife (NMW) • Nurse Practitioner (NP) • Nutritionist (LN) • Occupational Therapist (OT) • Registered Nurse (RN) • Certified Registered Nurse Anesthetist (CRNA) • Registered Nurse First Assistant (RNFA) • Respiratory Therapist (RT) • Speech Pathologist (SLP)

Exceptions to Required Use of CAQH Database

Texas physicians and other professional providers who are not among those listed in the CAQH Approved Provider Types list must go to the TDI website to access and complete a Texas Standardized Credentialing Application. The application should be faxed or mailed, along with the following required supporting documents, to BCBSTX:

- State license(s) - applicable to your provider type
- Current Drug Enforcement Administration (DEA) Certificate, if applicable
- Current Controlled and Dangerous Substances (DPS) Certificate, if applicable
- Current Malpractice Insurance Face Sheet
- Summary of any pending or settled malpractice case(s) - if within the past 10 years
- Curriculum Vitae
- Current Signed Attestation (page 18 of online application – print and sign)
- Written Protocol (Advanced Nurse Practitioners only)
- Supervision Form (Physician Assistant only)
- Hospital Coverage Letter (This form is required to be submitted to BCBSTX for providers who do not have admitting privileges at a participating network hospital)

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Forward completed application packet to BCBSTX via fax to: **512-349-4853** (preferred method) or mail to:

Blue Cross and Blue Shield of Texas
9442 II Capital Texas Highway North, Suite 500
Arboretum Plaza II
Austin, TX 78759

Activating your Universal Provider Datasource (UPD) Registration with CAQH

Blue Cross and Blue Shield of Texas Medicaid (STAR) and CHIP participating physicians and other professional providers must have a CAQH Provider ID to register and begin the credentialing process.

First Time Users (If you are not registered with CAQH)

Once you obtain a BCBSTX Provider Record ID and submit a current signed BCBSTX agreement, BCBSTX will add your name to its roster with CAQH. CAQH will then mail you access and registration instructions, along with your personal CAQH Provider ID, allowing you to obtain immediate access to the CAQH UPD database via the Internet. When you receive your CAQH Provider ID:

- Go to the CAQH website to register, or
- Physicians and other professional providers that do not have Internet access may submit their application via fax to CAQH by first contacting the CAQH Help Desk at **888-599-1771**
- After successfully authenticating key information, you will be able to create your own user name and unique password to begin using the CAQH UPD database

Note: Registration and completion of the online application is free.

Completing the Application Process

The UPD standardized application is a single, standard online form that meets the needs of all participating health care organizations. When completing the application, you will need to indicate which participating health plans and health care organizations you authorize to access your application data. All provider data you submit through the UPD service is maintained by CAQH in a secure, state-of-the-art data center.

Referring to these materials that will be helpful while completing the UPD online application:

- Previously completed credentialing application
- List of previous and current practice locations
- Various identification numbers (UPIN, NPI, Medicare, Medicaid, etc.)
- State license(s) applicable to your provider type
- Current Drug Enforcement Administration (DEA) Certificate, if applicable
- Current Controlled and Dangerous Substances (DPS) Certificate, if applicable

- IRS Form W-9(s)
- Current Malpractice Insurance Face Sheet
- Summary of any pending or settled malpractice cases – if within the past 10 years
- Curriculum Vitae

Note: When you are ready to begin entering your data, log into the UPD database with your user name and password.

After completing the online credentialing application, you will also be asked to:

- Authorize access to your information – Check the box beside BCBSTX, or you may select ‘global authorization’
- Verify your data entry/attest – Review the summary of your data for accuracy and completeness, and make any necessary changes
- Submit supporting documents – via email to supportingdocsupd@acsgs.com or fax to **866-293-0414**. If submitting supporting documents via email, please utilize the email cover sheet, available at <https://upd.caqh.org/OAS>
- State license(s) applicable to your provider type
- Current Drug Enforcement Administration (DEA) Certificate, if applicable
- Current Controlled and Dangerous Substances (DPS) Certificate, if applicable
- Current Malpractice Insurance face sheet
- Summary of any pending or settled malpractice case(s) - if within the past 10 years
- Curriculum Vitae
- Current Signed Attestation (page 18 of online application – print and sign)
- Written Protocol (Advanced Nurse Practitioners only)
- Supervision Form (Physician Assistant only)
- Hospital Coverage Letter (This form is required to be submitted to BCBSTX for providers who do not have admitting privileges at a participating network hospital)

If you have any questions on accessing the UPD database, you may contact the CAQH Help Desk at **888-599-1771** for assistance.

Note: BCBSTX may contact you to supplement, clarify or confirm certain responses on your application. Therefore, you may be required to submit additional documentation in some situations, in addition to the information you submit through the UPD database.

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Forward additional documentation to BCBSTX via fax to **512-349-4853** (preferred method) or mail to:

Blue Cross and Blue Shield of Texas
9442 II Capital Texas Highway North, Suite 500
Arboretum Plaza II
Austin, TX 78759

Existing Users

If you have already registered your CAQH Provider ID and completed your UPD online application through your participation with another health plan, log into the UPD database and add BCBSTX as one of the health plans that can access your information.

To authorize BCBSTX to access your data follow these four (4) easy steps:

- Go to <http://upd.caqh.org/>
- Under 'providers', select 'GO TO UNIVERSAL PROVIDER DATASOURCE', then enter your username and password
- Click the 'Authorize' tab (located under the CAQH logo)
- Scroll down, locate BCBSTX, and check the box beside BCBSTX, or you may select 'global authorization'
- Click 'Save' to submit your changes

Visit the CAQH website for more information about the CAQH UPD database and the application process. Or you can view the CAQH Provider Credentialing Application now.

ADDITIONAL CAQH RESOURCES

CAQH Contact Information

Help Desk	888-599-1771
Help Desk Email Address:	caqh.uphelp@acsgs.com
Help Desk Hours:	Monday – Thursday 6 a.m. – 8 p.m., Central Time Friday 6 a.m. – 6 p.m., Central Time
Fax Supporting Documentation:	Fax to 866-293-0414
Email Supporting Documentation:	supportingdocsups@acsgs.com

CREDENTIALING PROCESS FOR HOSPITAL OR FACILITY-BASED PROVIDERS

For your convenience, we have outlined the steps necessary for hospital or facility based providers to submit a request for contracting/participating in the Blue Cross and Blue Shield of Texas Medicaid (STAR) and CHIP networks.

Eligible hospital-based specialties include, but are not limited to:

- Anesthesia
- Emergency Medicine
- Radiology
- Pathology
- Neonatology
- Hospitalist

The **Facility-based Application** (located below) only applies to providers who practice exclusively in a facility, either a hospital OR a freestanding outpatient facility.

Hospital or Facility-Based Providers must have the following:
<ul style="list-style-type: none"> • Hospital privileges • Type 1 NPI # • Texas Medical Board License (temporary permit is acceptable) or appropriate Texas licensure applicable to provider type. • Certificate/AANA# (applicable to CRNA providers only) <p>Note: Obtaining a BCBSTX Provider Record ID does not automatically activate the Medicaid (STAR) and CHIP networks. Claims will be processed out-of-network until the provider has applied for network participation and has been approved and activated in the Medicaid (STAR) and CHIP networks</p>

If the Provider is:	Then:
A medical group that has a Group Medicaid Agreement and is adding a provider to the group as a facility-based provider with the Medicaid (STAR) and CHIP networks	Complete the Medicaid (STAR) and CHIP Facility-based Provider Application (a sample on the next page) and fax the completed application to your local Network Management office in Austin. Fax: 512-349-4853

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If the Provider is:	Then:
<p>A solo practitioner or medical group that is currently contracted with the BCBSTX and/or HMO Blue Texas networks and is interested in contracting as a facility-based provider with the Medicaid (STAR) and CHIP networks and does not currently have a Medicaid Agreement.</p>	<p>Please follow the steps below:</p> <ol style="list-style-type: none"><li data-bbox="831 445 1416 625">1. Complete the Medicaid (STAR) and CHIP Online Agreement Request form or request an agreement to be mailed or faxed to you by contacting your local Network Management office in Austin at: 800-336-5696.<li data-bbox="831 642 1425 932">2. Complete and sign the Solo or Medical Group Agreement, whichever is applicable, and return to your local Network Management office in Austin by fax at 512-349-4853 or mail to: Blue Cross and Blue Shield of Texas 9442 Capital of Texas Highway N Suite 500, Arboretum Plaza II Austin, TX 78759-6839<li data-bbox="831 949 1442 1239">3. Complete the Medicaid (STAR) and CHIP Facility-based Provider Application (located below) and return to your local Network Management office in Austin by fax to 512-349-4853 or by mailing to: Blue Cross and Blue Shield of Texas 9442 Capital of Texas Highway N Suite 500, Arboretum Plaza II Austin, TX 78759-6839



**BlueCross BlueShield
of Texas**

Facility Based Provider Application for Network Participation

*This application is used for providers who practice **exclusively** in an inpatient or freestanding facility. Eligible specialties include, but are not limited to, Anesthesia, Emergency Medicine, Radiology, Pathology, Neonatology & Hospitalist.*

Please complete all blanks below and include appropriate required attachments as indicated.

NOTE: Incomplete or inaccurate applications will be returned resulting in processing delays.

BCBSTX Agreements: <input type="checkbox"/> Group agreement(s) on file <input type="checkbox"/> Individual Agreement(s) attached		
Group Name:		Organizational Type 2 NPI #:
Provider Name:		Professional Provider Type 1 NPI #:
Degree:	Maiden Name, if applicable:	
Social Security #:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Tax Identification # Used for Billing:	Start Date With Group:	
Practice Location – Physical Address/City/State/Zip:		
Billing Address/City/State/Zip:		
Billing Phone #:	Fax #:	
Correspondence Address/City/State/Zip:		
Name of Primary Hospital/Facility:		City of Primary Facility:
Practicing Specialty:	<input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible	
Practicing Sub-Specialty:	<input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible	
Texas License Number (if temporary, attach copy):	License Effective Date:	
Anesthesia Assistants & CRNAs Only – Certificate or AANA# (MUST attach copy of certificate)		Date Certified:
Does applicant have professional liability insurance limits of at least \$200,000/600,000? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the applicant active military? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is applicant a Medicare Participant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is applicant currently in Residency Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is applicant currently in Fellowship Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Add Provider to: <input type="checkbox"/> Medicaid Star <input type="checkbox"/> Star Kids <input type="checkbox"/> CHIP If yes, please indicate TPI numbers below:		
Group TPI:	Individual TPI:	
Application Submitted By:		
Application Submitted By:	Title:	Date:
Email Address:	Phone #:	Fax #:

Chapter 21

CREDENTIALING UPDATES

Keeping your information current with CAQH and BCBSTX is your responsibility.

CAQH UPD Database

CAQH will send you automatic reminders to review and attest to the accuracy of your data. Use the UPD database to report any changes to your practice.

Note: You must enter your changes into the UPD database for BCBSTX to access during the credentialing and re-credentialing process. Only health plans that participate in the UPD database and that you have given authorization to access will receive these changes.

BCBSTX Provider File Updates

BCBSTX members rely on the accuracy of the provider information in our online Provider Finder®. That's why it is so important that you also inform BCBSTX of changes to your practice. If you are a participating provider with BCBSTX, you may request most changes online by using the online Change Your Information form.

RE-CREDENTIALING

If you are an existing user of CAQH, you are required to review and attest to your data once every four (4) months.

At the time you are scheduled for re-credentialing, BCBSTX will send your name, via its roster, to CAQH to determine if you have already completed the UPD credentialing process and authorized BCBSTX or selected 'global authorization'. If so, BCBSTX will be able to obtain current information from the UPD database and complete the re-credentialing process without having to contact you.

If your credentialing application (for re-credentialing) is not available to BCBSTX through CAQH because:

1. You have not completed the UPD initial credentialing process - CAQH will mail you a welcome kit that includes access and registration instructions, along with your personal CAQH Provider ID, allowing you to obtain immediate access to the UPD database via the Internet to complete and submit your application, or
2. You are a physician or other professional provider who does not have a provider type included in the CAQH 'Approved Provider Types' list, you must go to the TDI website to access and complete a Texas Standardized Credentialing Application, and fax or mail the completed application along with the required supporting documents referenced below:
 - State license(s) applicable to your provider type
 - Current Drug Enforcement Administration (DEA) Certificate, if applicable
 - Current Controlled and Dangerous Substances (DPS) Certificate, if applicable
 - Current Malpractice Insurance face sheet
 - Summary of any pending or settled malpractice case(s) - if within the past 10 years
 - Curriculum Vitae

- Current Signed Attestation (page 18 of online application – print and sign)
- Written Protocol (Advanced Nurse Practitioners only)
- Supervision Form (Physician Assistant only)
- Hospital Coverage Letter (for providers who do not have admitting privileges at a participating network hospital, – this form is required to be submitted to BCBSTX)

Forward completed application packet to BCBSTX.

Fax to: **512-349-4853** (preferred method) or mail to:

Blue Cross and Blue Shield of Texas
9442 II Capital Texas Highway North, Suite 500
 Arboretum Plaza II
 Austin, TX 78759

FREQUENTLY ASKED QUESTIONS

Q1. What is CAQH?

CAQH is the Council for Affordable Quality Healthcare, Inc., a not-for-profit collaborative alliance of the nation’s leading health plans and networks. The mission of CAQH is to improve health care access and quality for patients and reduce administrative requirements for physicians and other health care providers and their office staffs. CAQH’s participating organizations provide health care coverage for more than 165 million Americans.

Q2. What is the CAQH Universal Provider Datasource® (UPD)?

The CAQH Universal Provider Datasource® (UPD) service is the industry standard for collecting provider data used in credentialing. A single, standard online form—the CAQH application—is the centerpiece of the UPD service. Providers in all 50 states and the District of Columbia are able to enter their information free of charge through an interview-style process.

Through its streamlined, electronic data collection process, UPD is helping to reduce unnecessary paperwork while saving millions of dollars in annual administrative costs for more than 800,000 physicians and other health professionals, as well as more than 550 participating health plans, hospitals and health care organizations.

Q3. Is there a charge for providers to utilize CAQH?

No. Providers may utilize the UPD at no cost.

Q4. Are Accrediting Bodies in support of the CAQH application?

Yes. The CAQH application (UPD form) meets the data-collection requirements of URAC, the National Committee for Quality Assurance (NCQA) and the Joint Commission (JC) standards. Indiana, Kansas, Kentucky, Louisiana, Maryland, Missouri, New Jersey, New Mexico, Ohio, Rhode Island, Tennessee, Vermont, and the District of Columbia have adopted the CAQH standard form as their mandated or designated provider credentialing application.

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Q5. Why did Blue Cross and Blue Shield of Texas (BCBSTX) choose to work with CAQH?

BCBSTX chose to work with CAQH because the UPD is a proven solution for simplifying administrative burdens placed on providers during the credentialing/re-credentialing process. The easy-to-use online data collection and application process means less paperwork for BCBSTX providers, with built-in auditing tools to help increase efficiency and maintain data security and integrity. BCBSTX was also impressed by the UPD track record detailed by independent user studies.

Based on figures from a Medical Group Management Association (MGMA) cost analysis, CAQH estimates that the UPD has already eliminated more than 2.4 million legacy-credentialing applications. That resulted in savings of \$95 million per year and more than 3.2 million hours of provider and support staff time required to complete and send redundant application forms.

Q6. Am I required by BCBSTX to use the CAQH database?

Yes. All Providers required submitting a credentialing or re-credentialing application must use the CAQH database. Exception: Texas physicians and other professional providers who do not have a provider type listed in the 'CAQH Approved Provider Types' list below must go to the TDI website to access and complete a Texas Standardized Credentialing Application, and fax or mail the completed application along with the required supporting documents referenced below to BCBSTX:

CAQH Approved Provider Types List	
Standard Provider Types	Medical Doctor (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatric Medicine (DPM) Doctor of Chiropractic (DC), Doctor of Osteopathy (DO)
Allied Provider Types	Audiologist (AUD), Biofeedback Technician (BT), Christian Science Practitioner (CSP), Clinical Nurse Specialist (CNS), Licensed Practical Nurse (LPN), Massage Therapist (MT), Naturopath (ND), Neuropsychologist (NEU), Midwife (MW), Nurse Midwife (NMW), Nurse Practitioner (NP), Nutritionist (LN), Occupational Therapist (OT), Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Registered Nurse First Assistant (RNFA), Respiratory Therapist (RT), Speech Pathologist (SLP)

Note: Behavioral health professionals and physicians for the Medicaid (STAR) and CHIP networks, contact Magellan at **800-788-4005** or www.magellanprovider.com for questions regarding the credentialing or re-credentialing for the Medicaid (STAR) and CHIP networks.

Required Supporting Documents

- State license(s) applicable to your provider type
- Current Drug Enforcement Administration (DEA) Certificate, if applicable
- Current Controlled and Dangerous Substances (DPS) Certificate, if applicable
- Current Malpractice Insurance face sheet
- Summary of any pending or settled malpractice case(s) - if within the past 10 years
- Curriculum Vitae
- Current Signed Attestation (page 18 of online application – print and sign)
- Written Protocol (Advanced Nurse Practitioners only)
- Hospital Coverage Letter (for those providers who do not have admitting privileges at a participating network hospital, this form is required to be submitted to BCBSTX)

Forward completed application packet to BCBSTX.

Fax to: **512-349-4853** (preferred method) or mail to:

Blue Cross and Blue Shield of Texas

9442 Capital Texas Highway

Arboretum Plaza II

Austin, TX 78759

Q7. I have been told I must be ‘rostered’ in order to input my information into the CAQH UPD. What does this mean?

When you apply for network participation, BCBSTX will add you to its roster with CAQH. If you do not have a CAQH ID number, CAQH will send you a registration letter with your ID. If you already have a CAQH ID and your information is complete and current and you have authorized BCBSTX to access the information, CAQH will provide your information to BCBSTX.

Q8. When will CAQH send my registration letter after I have been ‘rostered’ by BCBSTX?

CAQH will typically send a registration letter within 24 hours of receiving a provider on a roster.

Q9. I am already a BCBSTX provider and would like to get my information into CAQH. How do I do this?

If you already have a CAQH ID number, you may update your information at any time. BCBSTX will roster you in advance of your next re-credentialing due date. If you do not have a CAQH ID number, CAQH will send you a registration letter with your ID.

Q10. How can I access the CAQH database?

Once you are ‘rostered’ by BCBSTX, access and registration instructions will be sent to you from CAQH. You will use a personal ID and password to obtain immediate access to the UPD via the Internet. You may submit your completed application online and fax supporting documents to a specified toll-free fax number **866-293-0414**. If you have any questions on accessing the database, you may contact the CAQH Help Desk at **888-599-1771** for assistance or you may send an email to caqh.updhelp@acsqs.com.

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Q11. Is the CAQH Universal Provider Datasource applicable in states where there is a state-mandated application?

Yes. In states where legislation has passed mandating the use of a standard credentialing application form, the data collected through CAQH UPD and data collection process will include the data elements and/or form as is required by the state. The system will automatically ask the necessary questions to fulfill the requirements for the state in which the provider's primary office address is located.

Q12. Will I be required to give BCBSTX information to supplement what I entered in UPD?

The primary goal of CAQH UPD is to simplify the administrative process with a robust and streamlined data system. While the CAQH credentialing data set is substantially complete, BCBSTX may need to supplement, clarify, or confirm certain responses in the application with individual physicians and other health care providers on a case-by-case basis. Therefore, you may be required to provide supplemental documentation in some situations, in addition to the information you submit through UPD.

Q13. Can I use the CAQH database to report any changes to my practice, such as address, phone numbers, and new providers?

BCBSTX has selected CAQH UPD as its data collection source for credentialing and re-credentialing applications. We will access CAQH UPD for your data at initial credentialing and during your scheduled re-credentialing cycle every third year. You must continue to directly notify BCBSTX of any changes to your practice information or status.

Q14. How will my confidentiality be maintained within the CAQH database?

The confidentiality and security of provider information and the privacy of system users are critical priorities for CAQH. The UPD design is compliant with laws, rules and regulations relating to the privacy of individually identifiable health information. In addition, CAQH complies with applicable laws and regulations pertaining to confidentiality and security in development of the database and the data collection process. The CAQH database is housed in the U.S. within a secure Network Operations Center. You may contact the CAQH Help Desk with additional questions by calling **888-599-1771** or by emailing caqh.updhelp@acsgs.com.

Q15. How often must my information be updated?

You will be sent automatic reminders to review and attest to the accuracy of your data. You must review and authorize data once every four (4) months. This is easily accomplished through a quick online visit to <https://upd.caqh.org/oas/> or by calling the CAQH Help Desk at **888-599-1771** for assistance.

Q16. Why do I need to review and attest to my information three (3) times a year?

Because BCBSTX will be using this system for credentialing and re-credentialing, it is important that the CAQH/UPD database contains the most accurate and up-to-date information. By reviewing and attesting to your data three (3) times a year, you will enable BCBSTX to obtain current information from the CAQH/UPD database at the time of re-credentialing or database updates, without having to contact you repeatedly. This will help you continue to conform to the requirements of your network contract.

Q17. Can any health plan access my data?

No. You control which health plan(s) have access to your CAQH application information. When completing the application, you will have the option of granting global access to your application data, or you may choose to select which participating health plan(s) and health care organization(s) you want to view your data.

Q18. Who will have access to my data?

Only the health plan(s) that you have authorized can access your application data.

Q19. Do I have to give you my Social Security Number?

Yes. Your Social Security Number is required to complete the application and will be used to verify your credentials.

Q20. How do I input my data if I do not have Internet access?

If you do not have Internet access, you may call the CAQH Help Desk at **888-599-1771** and complete the application by telephone. Supporting documents may be faxed toll free to **866-293-0414**.

Q21. Are hearing/sight challenged persons able to use the CAQH database?

Yes. Hearing/sight challenged Providers may call the CAQH Help Desk at **888-599-1771** and complete the application by telephone. Supporting documents may be faxed toll free to **866-293-0414**.

Q22. Who do I contact for administrative support if I have questions when using the database?

The CAQH Help Desk provides telephone service Monday through Thursday, from 6 a.m. to 8 p.m., Central Time and Friday, from 6 a.m. to 6 p.m., Central Time, to assist with questions. You may reach the Help Desk by calling **888-599-1771** or by emailing to caqh.updhelp@acsgs.com.



Chapter 22

STAR And CHIP Physician and Other Professional Provider Resources

INTERPRETER SERVICES, INCLUDING SERVICES FOR MEMBERS WITH HEARING LOSS

The best kind of interaction between providers and members happens when both sides can communicate clearly and be understood. To support this kind of communication, BCBSTX offers linguistic services to providers and members at no cost.

Following is a list of linguistic services. More detailed information and access numbers are located online at <http://bcbstx.com/provider/medicaid/index.html>.

Telephone interpreters are available 24 hours a day, seven days a week by calling Customer Service during business hours and the 24-Hour Nurse Advice Line after hours.

Customer Service: **877-560-8055**

24 Hour Nurse Advice Line: **844-971-8906**

24HourNurseAdviceLine TTY: **711**
(for the hearing impaired)

Services for Members with Speech or Hearing Loss

Sign language interpreters may be scheduled in advance by calling Customer Service. We request three business days' notice to schedule an interpreter and 24 hours (Monday through Friday) to cancel an interpreter service. TTY services are available from BCBSTX during regular business hours and from Relay Texas services 24 hours a day, seven days a week.

Go online to bcbstx.com/provider/network/medicaid.html for information about the availability of additional services for members with speech or hearing loss.

Assistance for Members with Vision Loss

Members with vision loss can request verbal assistance or request printed materials in alternative formats.

Assistance for Members with Vision and Hearing Loss

Members with vision and hearing loss can request tactile interpreting services, a form of communication that involves the use of signs and gestures through direct touch and body contact.

Face-to-face Interpreters

Face-to-face interpreters may be used at key points of medical contact by calling Customer Service three business days in advance to schedule an interpreter. To cancel an interpreter service, give 24 business hours' notice.

Physician and other Professional Provider Responsibilities

Physicians and other professional providers are responsible for ensuring that members know of available interpreter services by providing the following:

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Please Note: Physicians and other professional providers must notify members of the availability of health plan interpreter services, at no cost to you or our members, and strongly discourage the use of minors, friends and family members who may act as interpreters.

After-Hours Linguistic Access

We encourage physicians and other professional providers to accommodate non-English proficient members by having multilingual messages on answering machines and by training their answering services and on-call personnel on how to access BCBSTX's free interpreter services. The 24-Hour Nurse Advice Line has access to interpreters after hours.

CULTURAL COMPETENCY INCLUDING HEALTH AND READING LITERACY

BCBSTX acknowledges the diversity of its membership and provider network. We appreciate the challenges providers may encounter integrating appropriate culturally diverse behaviors, values, norms, practices, attitudes and beliefs about the causes of disease, prevention and treatment into the delivery of health care, known as cultural competence. In addition, consideration of a member's health and reading literacy level may add to the complexity of the relationship.

Although medical advances and increased efforts regarding preventive medicine have contributed to increased life expectancies and improved general health for many Americans, health disparities are still very evident in the African American, Hispanic, Asian/Pacific Islander and Native American/Alaskan Native and other populations.

We are eager to assist your office with increasing your cultural competence and decreasing health disparities. We also recognize that such competence is a process that evolves over time, and that you and your office staff may be at various levels of awareness, knowledge and skills. We encourage you to increase your cultural sensitivity by using the cultural and linguistic resources included on our website.

It is important to assess the individual health beliefs and practices of your patients and to consider the role of culture and ethnicity in their lives. In doing so, your assessment efforts should uncover specific cultural health beliefs, attitudes and traditions. Although some beliefs may be associated with various groups of people, there may be a great deal of diversity within cultural groups. Categorizing groups of people according to their cultural or ethnic backgrounds when addressing their health care needs may lead to misunderstandings and possible transfer of misinformation. Understanding your patients helps to support your decisions in providing the best health care choices.

Low Literacy and Its Impact on the Health Professional

Accurately assessing members' reading and health literacy helps to improve communication between providers and members. As a health professional, you need to make sure members understand their medical conditions and instructions for health care. Tips to assist you in determining a member's health and reading literacy levels and successfully educating your members may be found online.

The information included above about cultural competency is meant to assist physicians and professional providers in complying with the requirements of Title VI of the Civil Rights Act of 1964 and other federal regulations enacted since 1964, including, but not limited to, the American's with Disabilities Act, and the Texas Health and Human Services Commission policies for delivery of culturally competent health care.

Interpreter Services are Available

As a reminder, providers should discourage BCBSTX members from using friends and family members, especially children, as interpreters. Multilingual staff should self-assess their non-English language speaking and comprehension skills prior to interpreting on the job. Using a bilingual skill set is not the same as interpreting and office staff should not serve as interpreters unless they have been tested for use of those skills. This can be a particular problem with medical terminology. You will find the current recommended employee language skills self-assessment tool on our website.

To support the best health care opportunities and treatment for members, we offer free interpreter services. To request interpreter services, contact BCBSTX Customer Service at the number listed below.

For instances when you cannot communicate with a member due to a language barrier, interpreter services are available at no cost to you or the member. Face-to-face interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required.

Here are the phone numbers to call for telephone and face-to-face interpreter services:

Customer Service (STAR and CHIP):	888-292-4487
24 Hour Nurse Advice Line:	877-560-8055
24 Hour Nurse Advice Line TTY: (for speech or hearing impaired)	844-971-8906
National TTY:	711

Provider Directory Updates

Physicians and other professional providers must notify the local Network Management office of changes in the language capability of their medical and administrative staff. The website Provider Directory is updated as changes are received. Printed copies of the directory are updated quarterly. You can update your language capability information by using the **Provider Data Update Notification Form** found on our website at <http://bcbstx.com/provider/Mmedicaid/index.html>. Directions on how to access this online form are outlined below.

Other information on the BCBSTX website includes:

- How to use Relay Texas
- Information about additional Relay Texas services
- Internet resources about communicating with non-English proficient patients and members with speech or hearing loss

The above services and physician and professional provider responsibilities are in compliance with Title VI of the Civil Rights Act of 1964 and Texas Health and Human Services Commission policies for linguistic services.

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Change in Status or Changes Affecting Your BCBSTX Provider Record ID

Whenever your information changes, it's important to notify us by submitting a **Provider Update Notification Form**. Examples of changes we should be notified of immediately include:

- Name
- Physical address (primary, secondary, tertiary)
- Billing address
- Email address
- Telephone number
- Tax ID or other information
- Specialty or sub-specialty
- Practice information/status
- Board certification
- NPI Number change
- TIN/SS number change
- Additional language services
- Moving from group to solo practice
- Moving from solo to group practice
- Moving from group to group practice
- Back up/covering physicians or other professional providers

You may submit your changes directly to BCBSTX by going to: www.bcbstx.com/provider/network/Mmedicaid.html. Select **Network Participation: Update Your Information** on the left side of the page and complete and submit the **Provider Data Update Notification Form**. Or you can call your local Network Management office at **512-349-4847**.

Note: If requesting termination from a network, please contact your local Professional Provider Network office.

You should submit all changes at least 30 days in advance of the effective date of the change. These updates keep our records current, and help you avoid delays in claim payments. Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new provider record.

Reminders:

- BCBSTX will not change, add or delete information related to your Provider Record ID on a retroactive basis. All changes to your Provider Record ID will be effective with a future date.
All Provider Record ID effective dates will be established as of the date that complete applications are received in the corporate BCBSTX office. This will apply to all additions, changes and cancellations.
- Retroactive Provider Record ID effective dates will not be established
- Retroactive network participation effective dates will not be established
- Keeping BCBSTX informed of any changes you make allows for accurate claims handling and prompt payment processing. It also allows us to maintain the Provider Directory with current and accurate information.

Note: You must also notify TMHP of changes using their **Provider Information Change Form**.

If you have questions about the provider information that we currently have on file for you, or need help downloading the Provider Change Form, please contact Customer Service at **877-560-8055**.



Chapter 23

FRAUD, ABUSE AND WASTE

UNDERSTANDING FRAUD, ABUSE AND WASTE

We are committed to protecting the integrity of the program we offer and the efficiency of our operations by preventing, detecting and investigating fraud, abuse, and waste. Combating fraud, abuse and waste begins with knowledge and awareness.

Fraud is any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to him- or herself or some other person. The attempt itself is fraud, regardless of whether or not it is successful.

Abuse is any practice that is inconsistent with sound fiscal, business or medical practices, and results in an unnecessary cost to the Medicaid program including administrative costs from acts that adversely affect providers or members.

Waste is generally defined as activities involving careless, poor or inefficient billing or treatment methods causing unnecessary expenses and/or mismanagement of resources.

Examples of Physician and other Professional Provider Fraud, Abuse and Waste

These are typical examples of provider fraud and abuse:

- Billing for services not provided
- Billing for medically unnecessary tests
- Unbundling/upcoding
- Misrepresentation of diagnosis or services
- Under-utilization and over-utilization
- Soliciting, offering or receiving kickbacks or bribes
- Billing professional services performed by untrained personnel
- Altering medical records

Examples of Member Fraud, Abuse and Waste

These are examples of member fraud, abuse and waste:

- Frequent emergency room visits with non-emergent diagnoses
- Obtaining controlled substances from multiple providers
- Violation of pain management contract
- Using more than one physician or professional provider to obtain similar treatments and/or medications
- Using physicians or professional providers not approved by the primary care provider (PCP)
- Forging, altering or selling prescriptions
- Loaning insurance identification (ID) cards
- Disruptive or threatening behavior
- Relocating to out-of-service area

REPORTING PHYSICIAN AND PROFESSIONAL PROVIDER OR RECIPIENT FRAUD, ABUSE OR WASTE

If you suspect a member (a person who received benefits) or a provider (for example, doctor, dentist, counselor and so on) has committed fraud, abuse or waste, you have a responsibility and a right to report it.

Providers can report allegations of fraud, abuse or waste to us by telephone at:

Medicaid Managed Care (STAR) Program: **877-560-8055**

Children's Health Insurance Program (CHIP): **877-560-8055**

Or, you may complete a Fraud Referral Form and mail or fax it to:

BCBSTX

Special Investigations Department

1001 E. Lookout Drive, Building A

Richardson, Texas 75082

Fax: **972-996-9211**

Do you want to report waste, abuse, or fraud?

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

For example, tell us if you think someone is:

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

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To report waste, abuse, or fraud, choose one of the following:

Call the Office of the Inspector General (OIG) Hotline at **800-436-6184**;

Visit <https://oig.hhsc.state.tx.us/> and under the box labeled 'I Want To' click 'Report Waste, Abuse, and Fraud' to complete the online form; or

Report waste, abuse or fraud to BCBSTX:

Website: www.bcbstx.com/ut/resources/fraud.html

Phone: **800-543-0867**

Address: **BCBSTX**
Special Investigations Department
1001 E. Lookout Drive, Building A
Richardson, Texas 75082

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

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility, if you have it.
- Type of provider (doctor, dentist, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can help in the investigation.
- Dates of events.
- Summary of what happened.

When reporting about someone who receives benefits, include:

- The person's name.
- The person's date of birth, Social Security Number, or case number if you have it.
- The city where the person lives.
- Specific details about the waste, abuse or fraud.

Anonymous Reporting of Suspected Fraud, Abuse and Waste

Although you may report the incident to us anonymously, we must know the following information should there be any question or missing information in the report:

- Name of the person reporting and their relationship to the person suspected
- A call-back phone number for the person reporting the incident

What Happens After Reporting an Incident of Fraud, Abuse or Waste?

BCBSTX thoroughly investigates all fraud, abuse and waste referrals. We report all referrals to regulatory agencies and appropriate law enforcement agencies.

Reporting Fraud, Abuse or Waste to the State

If you have access to the Internet, go to the Texas Health and Human Services Commission (HHSC) Office of the Inspector General (OIG) website at 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 or prefer to talk to a person, call the HHSC Office of the Inspector General (OIG) Fraud Hotline at: **800-436-6184** or, you may send a written statement to the following addresses:

Address to Report Providers:

**Office of Inspector General
Medicaid Provider Integrity**

Mail Code 1361

P.O. Box 85200

Austin, TX 78708-5200

To Report Clients (Recipients):

**Office of Inspector General
Investigations Mail Code**

1362

P.O. Box 85200

Austin, TX 78708-5200

ROLE OF THE FRAUD, ABUSE AND WASTE DEPARTMENT

We do not tolerate acts that adversely affect our physicians or professional providers or members. We investigate all reports of fraud, abuse and waste. Allegations and the investigative findings are reported to the HHSC regulatory and law enforcement agencies. In addition to reporting, we take corrective action, such as:

- **Written warning and/or education:** We send certified letters to the physician or professional provider or member documenting the issues and the need for improvement. Letters may include education or request for recoveries, or may advise of further action.
- **Medical record audit:** We may review medical records to substantiate allegations or validate claims submission.
- **Special claims review:** Special claims review places payment or system edits on the file to prevent automatic claim payment; this requires a medical reviewer evaluation.
- **Recoveries:** We recover overpayments directly from the provider within a reasonable time frame of receiving notice of the error or overcharge.

QUALITY OF CARE

We refer physicians or other professional providers who compromise patient care to the Quality Management department. The Physicians or other professional providers may be presented to the credentials committee and/or peer review committee for disciplinary action, which may include any of the following:

- **Provider termination:** Failure to comply with program policies and procedures or any violation of the contract will result in termination from our plan.
- **Member disenrollment:** Fraud, threatening behavior or failure to correct issues may result in involuntary disenrollment from our health plan (with state approval). See the PCP-initiated Member Transfers section.
- **Referral to law enforcement:** We refer criminal activity to the appropriate local and/or regulatory enforcement agency.

FALSE CLAIMS ACT

We are committed to complying with all applicable federal and state laws including the Federal False Claims Act (FCA).

The FCA is a federal law that provides the federal government with the means to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages, or loss, to the government plus civil penalties of \$5,500 to \$11,000 per false claim.

The FCA also contains Qui Tam or 'whistleblower' provisions. A 'whistleblower' is an individual who in good faith reports an act of fraud, abuse, or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.



Chapter 24

DEFINITIONS AND MAPS

Chapter 24

Abuse

Abuse involves provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid or CHIP programs including administrative costs from acts that adversely affect providers or members, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of health care; it also includes member practices that result in unnecessary costs to the Medicaid or CHIP programs.

Abuse or Neglect (CPS)

'Abuse' includes the following acts or omissions by a person:

- Mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning
- Causing or permitting a child to be in a situation in which a mental or emotional injury that results in an observable and material impairment in growth, development, or psychological functioning
- Physical injury that results in substantial harm to a child, or the genuine threat of substantial harm from physical injury, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk of harm
- Failure to make a reasonable effort to prevent an action by another person resulting in physical injury is sustained results in substantial harm to the child;
- Sexual conduct harmful to a child's mental, emotional, or physical welfare, including conduct that constitutes the offense of continuous sexual abuse of a young child or children, indecency with a child, sexual assault or aggravated sexual assault
- Failure to make a reasonable effort to prevent sexual conduct harmful to a child;
- Compelling or encouraging a child to engage in sexual conduct including conduct that constitutes an offense of trafficking of persons, prostitution or compelling prostitution
- Causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of a child if the person knew or should have known that the resulting photograph, film, or depiction of the child is obscene or pornographic;
- The current use by a person of a controlled substance in a manner or to the extent that the use results in physical, mental, or emotional injury to a child;
- Causing, expressly permitting, or encouraging a child to use a controlled substance
- Causing, permitting, encouraging, engaging in, or allowing a sexual performance by a child
- Knowingly causing, permitting, encouraging, engaging in, or allowing a child to be trafficked in a manner punishable as an offense or the failure to make a reasonable effort to prevent a child from being trafficked in a manner punishable as an offense

Abuse, Neglect or Exploitation (APS)

Abuse, neglect or exploitation includes the failure of one's self to provide the protection, food, shelter, or care necessary to avoid emotional harm or physical injury or a negligent act or omission that caused or may have caused emotional harm, physical injury, or death.

Active Course of Treatment

Medical care in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits to the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol.

Acute Care Hospital

An institution providing medical care and treatment to sick and/or injured persons who cannot be cared for at a lower level of care (such as at a home or skilled nursing facility).

Acute Condition

A medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.

Action (Medicaid Only)

The denial or limited authorization of a requested service, including the type or level of service:

- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- Failure to provide services in a timely manner and in time frames set by law.

Advance Directive

A legal document (health care instruction or power of attorney) used by persons to give their doctor instructions regarding their own health care if they cannot speak for themselves. Usually, the Advance Directive instructs physicians or other professional providers to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition, when the persons would be unable to make their wishes known at that time. All health care declarations are unconditionally revocable at any time, effective immediately upon communicating the change to the attending physician or health care provider.

Adverse Determination

A denial, modification, reduction or determination by BCBSTX or a PCP of a request for services based on eligibility, benefit coverage or medical necessity. Claims denials also are considered adverse determinations.

Chapter 24

Adverse Determination Appeal (CHIP only)

The formal process by which a Utilization Review agent addresses an Adverse Determination.

Adverse Determination Review (STAR only)

A review and resolution of a provider claim payment after the Appeal or Expedited Appeal of an Adverse Determination.

After-hours Services

Services provided outside the PCP's normal business hours.

Ambulatory Care

Health services that are on an outpatient basis, in contrast to services provided while confined at home or in a hospital.

Ancillary Providers

Providers who perform professional services such as laboratory tests and radiology exams.

Appeal

A request for review of an adverse determination.

Appeal (Medicaid Only)

The formal process by which a member, or his or her representative, requests a review of BCBSTX's action, as defined above.

Appellant

A member, authorized representative or a treating physician or other professional provider who files an appeal of an Adverse Determination.

Authorization

Approval needed for members to receive certain types of specialty care and health services. The PCP or specialist can request authorizations for most health care services from BCBSTX.

Authorized Representative

Any person or entity acting on behalf of the member with the member's written consent. A provider or physician may be an authorized representative.

Behavioral Health Services

Psychoanalysis, psychotherapy, counseling, medical management or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage and family therapist, for diagnosis or treatment of behavioral or emotional disorders or the behavioral or emotional problems associated with an illness, injury or any other condition.

Benefit Agreements

The Member Handbook, which describes and explains the health care benefits BCBSTX provides, indemnifies or administers for Members.

Benefit Year

The 12-month period from September 1 to August 31.

Benefits

The health, dental, vision and pharmacy services set forth in the Member's benefit agreement.

Binding Arbitration

The process by which disputes are reviewed by a neutral, non-governmental entity. After reviewing all facts and hearing both sides, the neutral person/entity makes a decision.

Capitation

Capitation is the term for paying an organization a set amount of money in advance to provide comprehensive health care benefits for an individual.

Cardiopulmonary Resuscitation (CPR)

Artificial respiration and cardiac compressions.

Case Management

A process of arranging, negotiating and coordinating medically appropriate care in a more cost-effective and coordinated manner during prolonged periods of intensive medical care.

Carved-Out Services

Services that a BCBSTX Member is entitled to that are covered by the State of Texas, but are not covered under the BCBSTX benefit agreement.

Chapter 24

Centers for Disease Control and Prevention (CDC)

The federal agency responsible for protecting the health and safety of people at home and abroad. The agency establishes and publishes immunization guidelines for children two years of age and under. These guidelines are a requirement for plan physicians and other professional providers, and are adopted by BCBSTX annually.

Centers for Medicare and Medicaid Services (CMS)

The federal agency responsible for the Medicaid health care program. CMS was formerly referred to as the Health Care Finance Administration (HCFA).

Children's Health Insurance Program (CHIP)

The health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. 1397aa-1397jj) and administered by HHSC. The state of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate covered services for enrolled CHIP members.

Member Outreach

Local staff that provides members and community agencies ready access to BCBSTX's staff, many of whom are bilingual and/or bicultural. The staff is also well acquainted with local community resources to assist members with their needs related to obtaining access to health care services and other needs.

Competent Interpreter

A person who is proficient in both English and the other language being used, has had orientation or training in the ethics of interpreting, including accuracy and impartiality in interpretation

Complainant

A member or authorized representative who files a complaint.

Complaint Appeal

A written expression of dissatisfaction regarding a BCBSTX complaint resolution, not related to an Adverse Determination.

Complaint (CHIP only)

Any verbal or written dissatisfaction expressed to BCBSTX by a complainant regarding any aspect of BCBSTX's operation including, but not limited to:

- Dissatisfaction with plan administration.
- Procedures related to the review or appeal process of an Adverse Determination.
- The denial, reduction or termination of a service for reasons not related to medical necessity.

Complaint (Medicaid (STAR) only)

A verbal or written expression of dissatisfaction expressed to BCBSTX by a complainant about any matter related to BCBSTX other than an Action. Possible subjects for complaints include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

Concurrent Review

The assessment of clinical information during the member's current inpatient stay or ongoing course of medical service over a period of time.

Consumer Assessment of Health Care Providers and Systems (CAHPS)

A random survey of members to measure satisfaction with the service and care provided by BCBSTX and our primary care providers (PCPs) and specialists.

Continued Access to Care

The process of authorizing continuation of services with a terminating provider under specified conditions and for a limited period of time. This process involves having a plan of care to transition the member to a network physician or other professional provider.

The medical conditions that qualify for continued access to care include, but are not limited to:

- Second or third trimester of pregnancy through at least six weeks of postpartum evaluation
- Terminal illness
- A serious chronic condition

Continuity of Care

The coordination of health care services encompassing BCBSTX, PCPs, specialist physicians or other professional providers, ancillary providers and the member.

Coordination of Benefits

The method of determining primary responsibility for payment of benefits under the terms of the applicable benefit agreement and applicable laws and regulations, when more than one payer may be liable for payment of the member's benefits.

Coordination of Health Care Services

The timely coordinated exchange of patient information between health care providers to help ensure delivery of an effective plan of treatment.

Chapter 24

Copayment

A payment that a member makes at the time of receiving certain services, such as visits to a doctor and prescription drugs.

Corrective Action

A written plan from BCBSTX to a physician or other professional provider to remedy items that are out of compliance with BCBSTX's standards and regulatory standards.

Coverage

The list of services for which benefits are available subject to deductibles, copayments or limitations from a health plan.

Covered Billed Charges

The charges billed by a provider or hospital at normal rates for services covered by the Benefit Agreement under which a claim is submitted.

Credentialing

The process of validating professional or technical competence of physicians or other professional providers which involves verifying licensure, board certification, education and identification of malpractice or negligence claims through the applicable state agencies and the National Practitioner Data Base (NPDB).

Credentials Committee

A credentials committee reviews the credentialing files and determines the acceptance or denial of an applicant as a contracted physician or provider.

Critical Event or Incident

An event or incident that may harm, or create the potential for harm to, an individual. Critical events or incidents include:

- Abuse or Neglect (CPS);
- Abuse, Neglect, or Exploitation (APS);
- Unauthorized use of restraint, seclusion, or restrictive interventions;
- Serious injuries that require medical intervention or result in hospitalization;
- Criminal victimization;
- Unexplained death;
- Medication errors; and
- Other incidents or events that involve harm or risk of harm to a member

Cultural Competence

A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among and between groups. This requires a willingness and ability to draw on community-based values, traditions and customs and to work with knowledgeable persons from the community in developing focused interventions, communications and other supports.

Cultural Diversity

Differences in race, ethnicity, language, nationality or religion among various groups within a community, organization or nation. A city is said to be culturally diverse if its residents include members of different groups.

Cultural Sensitivity

An awareness of the nuances of one's own and other cultures and an awareness that differences exist.

Culture

The shared values, norms, traditions, customs, arts, history, folklore and institutions of a group of people. It is a shared set of beliefs, assumptions, values and practices that determines how we interpret and interact with the world.

Current Procedural Terminology (CPT)

A listing of descriptive terms and identifying codes used nationwide for reporting medical, surgical and diagnostic services and procedures performed by physicians. CPT codes are updated annually in November by the American Medical Association.

Customer Service

BCBSTX Customer Service unit for members and providers. Representatives can answer questions on benefits, PCP assignments, and authorizations for care, eligibility and member information.

Deferrals

An action taken by us to:

- Delay a decision to approve, modify or deny a request for authorization of a covered service to receive additional documentation from the requesting provider, or
- Determine if other medical coverage exists that is primary to BCBSTX.

Delegation of Credentialing

The assignment of responsibilities to perform the process of credentialing to another party contracted with BCBSTX.

Denial

A decision by BCBSTX to deny coverage of a member representative's or provider's request for health care services.

Discharge Planning

The process of assessing the medical and psychosocial needs of members in an inpatient setting and arranging transfers, in-home support or linkage with community resources in preparation for release from the inpatient setting or a change in the level of care.

Discrimination

As used in this context, discrimination means treating a member differently from others in the provision of a health care service or access to a facility on the basis of race, color, creed, religion, ancestry, marital status, sexual orientation, financial status, national origin, age, sex, physical or behavioral disability, diagnosis or advance directive status.

Disenrollment

The process that ensues when a member's entitlement to receive services from a health plan is terminated.

Electronic Data Interchange (EDI)

Also known as electronic billing, EDI is a computer-to-computer transfer of business-to-business document transactions and information. Many health care organizations and their business partners, including physicians, payers, vendors, and fiscal intermediaries, choose EDI as a fast, inexpensive and safe method for automating their cooperative business processes.

Eligibility

The determination of whether a person is a member on the date of service.

Emergency Behavioral Health Condition

Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson-a person possessing an average knowledge of health and medicine - (1) requires immediate intervention or medical attention without which members would present an immediate danger to themselves or others, or (2) which renders members incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Care

The initiation of the emergency response system and/or the diagnosis and/or treatment of an emergency.

Emergency Medical Condition

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

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious and/or permanent dysfunction of any bodily organ or part.
- Serious disfigurement.
- Other serious medical or psychiatric consequences.
- Serious jeopardy to the health of a pregnant member or their unborn child.

Emergency Services

Covered inpatient and outpatient services furnished by a provider who is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition or an emergency behavioral health condition, including post-stabilization care services.

Enrollment

The process by which an eligible beneficiary becomes a member of our plan.

Exclusion

A service or condition not covered by BCBSTX pursuant to the member's benefit agreement.

Expedited Adverse Determination Appeal (CHIP only)

An appeal of an Adverse Determination related to the denials of:

- Emergency care.
- Care for life-threatening conditions.
- Continued stays for hospitalized members.

Expedited Appeal

An appeal to BCBSTX in which the decision is required quickly based on the member's health status, and the amount of time necessary to participate in a standard appeal could jeopardize the member's life, health or ability to attain, maintain or regain maximum function.

Explanation of Benefits

A form sent to the member or provider after a claim for payment has been processed by the health plan that explains the action taken on that claim. This explanation might include the amount paid, the benefits available and reasons for denying payment.

Family Planning Services

Services, supplies or medications provided to members of childbearing age to temporarily or permanently prevent or delay pregnancy. The following are not considered family planning services:

- Therapeutic abortion services
- Routine infertility studies or procedures to promote fertility
- Hysterectomy for sterilization purposes only
- Transportation, parking or child care

Fee Schedule

A listing of allowed charges or established allowances for specified procedures. It represents a provider's or third party's standard or maximum charges accepted or recognized for listed procedures.

Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him- or herself or some other person; fraud includes any act that constitutes fraud under applicable federal or state laws and regulations.

Generally Accepted Standards of Medical Practice

Standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Health Care Effectiveness and Data and Information Sets (HEDIS®)

Measures include the review of administrative and chart data to determine how effective BCBSTX and its physicians/providers are in the provision of quality care and services to adults, children, pregnant women and persons with behavioral health illness.

Health and Human Services Commission (HHSC)

The administrative agency with the executive department of Texas state government established under Chapter 531, Texas Government Code or its designee, including, but not limited to, the Texas Health and Human Services Agency.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is designed to streamline health care delivery by employing standardized, electronic transmission of administrative and financial transactions, along with protection of confidential protected health information (PHI).

Health Plan Members

Eligible adults, adolescents, children and infants actively enrolled with BCBSTX.

High-Volume Specialists

Physicians, other than PCPs, determined by BCBSTX to treat a significant number of plan members (for example, OB/GYN physicians).

Hospital

A health care facility licensed by the State of Texas, and accredited by the Joint Commission on Accreditation of Health Care Organizations, as either (a) an acute care hospital; (b) a psychiatric hospital; or (c) a hospital operated primarily for the treatment of alcoholism or substance abuse. A facility which is primarily a rest home, nursing home or home for the aged, or a distinct part skilled nursing facility portion of a hospital is not included.

Hospital Services

Those acute care inpatient and hospital outpatient services which are covered by the benefit agreement. Hospital services do not include long-term non-acute care.

Infection Control

The processes used to prevent the spread of pathogenic disease.

Infusion Therapy

The therapeutic use of drugs or other substances ordered by a physician and prepared, compounded or administered by a qualified Provider and given to the patient any way other than by mouth, and all medically necessary supplies and durable medical equipment used in relation to the infusion therapy in any setting other than an acute inpatient hospital unit.

Initial Health Assessment (IHA)

A complete medical history, a head-to-toe physical examination, and an assessment of health behaviors. For children up to 20 years of age, a developmental history, assessment of nutritional status, dental evaluation, vision screening and hearing screening are required in addition to the physical examination. Age-appropriate preventive screening is included for both adults and children.

Inpatient

Hospitalization in a medical or psychiatric hospital for treatment requiring at least one overnight stay.

Institutionalized

Involuntarily or voluntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a behavioral hospital or other facility for the care and treatment of behavioral illness.

Intermediate Rehabilitation Facility

An institution providing an active dynamic program aimed at enabling an ill or disabled person to achieve the highest level of physical, mental, social and economic self-sufficiency of which he or she is capable.

Internal Quality Improvement Projects

These include focused studies that measure the quality of care and service in specified clinical and service areas. BCBSTX is required to demonstrate statistically significant improvement for all measures.

Interpreter Services

Language services provided to non-English speaking Members to help ensure clear communication between the Member, Provider and plan.

Chapter 24

Licensed Clinical Social Worker (LCSW)

Behavioral health professionals licensed by the State of Texas who are trained to help individuals, groups, families and organizations deal with emotional problems and assist in resolving conflicts or problems relating to others at home, at work, in school and in society in general.

Managed Care Network (MCN)

The network of health care providers who have entered into contracts with us and/or one or more of our affiliates pursuant to which those providers have agreed to participate in our programs and provider services pursuant to the member's benefit agreements.

Managed Care

A combined clinical and administrative approach that coordinates health care services. Managed care emphasizes preventive services and the use of a PCP.

Medical Information

Individually identifiable information in electronic or physical form, in possession of, or derived from a provider of health care, regarding a member's medical history, behavioral or physical condition, or treatment.

Medical Office Equipment Requiring Calibration or Safety Checks

Equipment in a provider's office for which the manufacturer, state or federal agency recommends or requires routine evaluation of the functioning, readings and settings.

Medical Record Review (MRR)

A process to assess provider documentation of a member's physical and psychosocial assessments and the medical services rendered.

Medical Review

The process involving provider audits in which claims or procedures are evaluated for medical necessity.

Medical Services

Those services provided by a participating provider and covered pursuant to a member's benefit agreement.

Medically Necessary or Medical Necessity

Medically Necessary means:

For Medicaid members from birth through age 20, the following Texas Health Steps services:

- Screening, vision, and hearing services; and
- Other health care services, including behavioral health services, that are necessary to correct or ameliorate a defect or physical or behavioral illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or behavioral illness or condition:
 - Must comply with the requirements of the Alberto N., et al. v. Suehs, et al. partial settlement agreements; and
 - May include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b-g) of this definition.

For Medicaid and CHIP members, non-behavioral health related health care services (that are not available to Medicaid members from birth through age 20 through Texas Health Steps) 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 endorsed by professionally recognized health care organizations or governmental agencies;
- d. Consistent with the member's diagnoses;
- e. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- f. Not experimental or investigative, and
- g. Not primarily for the convenience of the member or provider.

For Medicaid and CHIP members, behavioral health services (that are not available to Medicaid members from birth through age 20 through Texas Health Steps) that are:

- a. Reasonable and necessary for the diagnosis and treatment of a behavioral 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 be safely provided;
- e. Could not be omitted without adversely affecting the member's behavioral 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 the provider.

Chapter 24

Medically Needy

A category of public assistance. These are families of people who are aged, blind or disabled, and whose income is too high to qualify for Temporary Assistance to Needy Families (TANF) or Supplemental Security Income/State Supplemental Program (SSI/SSP).

Member Complaint

A written or oral expression of dissatisfaction, including quality of care concerns, regarding a physician or other professional provider or member, and which includes a complaint, dispute, or request for appeal made by a member or the member's representative. If BCBSTX is unable to determine whether the expression of dissatisfaction is a grievance or an inquiry, it shall be considered a complaint.

Member Identification Card

The identification card provided to members by BCBSTX that includes the member's ID number, physician or other professional provider information and important phone numbers.

Members

Eligible beneficiaries who are enrolled with BCBSTX.

Members with Hearing Loss Services

A system of communication provided by us to facilitate communication between members with hearing loss and their primary care provider (PCP) or BCBSTX. These services include a sign language interpreter service for medical appointments. If one is not available in the physician's office, access is available by calling BCBSTX Customer Service.

Members with Special Health Care Needs

Member, including a child enrolled in the DSHS CSHCN Program, who:

- Has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or is anticipated to last for a significant period of time, and
- Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

Mental Health Targeted Case Management

Services designed to assist members with gaining access to needed medical, social, educational, and other services and supports. Members are eligible to receive these if they have been assessed and diagnosed with a severe and persistent mental illness (SPMI) or a severe emotional disturbance (SED) and they are authorized to receive mental health rehabilitative services.

Mid-Level Practitioners

Advanced registered nurse practitioners (including certified nurse midwives), and physician assistants licensed by the state and working under the supervision of a licensed physician as mandated by state and federal regulations.

Minor Consent Services

Services a minor can consent to without parental involvement. In Texas, these services include, but are not limited to:

- Family planning
- Prenatal care
- STD and HIV treatment
- Drug or alcohol abuse treatment
- Behavioral health services
- Abortion (with a court order)

National Committee for Quality Assurance (NCQA)

An independent, nonprofit organization whose mission is to improve the health care quality of the nation's managed care plans through their accreditation and performance measurement programs. This is accomplished through quality oversight and improvement initiatives at all levels of the health care system.

Serious Reportable Events

As defined by the National Quality Forum (NQF), adverse events that are serious, but largely preventable, and of concern to both the public and health care providers.

Outpatient Hospital Services

Diagnostic, therapeutic, and rehabilitative services provided to members in an organized medical facility, for less than a 24-hour period, by or under the direction of a physician or other professional provider.

Participating Hospital

A hospital that has entered into an agreement with BCBSTX to provide hospital services as a participating provider.

Participating Physician or other Professional Provider

A physician or other professional provider who has entered into an agreement with BCBSTX to provide medical services as a participating Provider.

Participating Provider

A health facility or health professional that has entered into an agreement with BCBSTX to provide covered services to members.

Chapter 24

Physician or Professional Provider Complaint

A written request for a formal investigation into an issue or concern that is unrelated to a denial of service. A complaint may involve clinical quality or administrative issues. Examples of possible issues for review are:

Clinical Quality Issues: Any actual, possible or potential adverse outcome in the member's health status secondary to a physician or professional provider's care or possible inappropriateness of a plan physician or professional provider's behavior.

Administrative Issues: Denials of benefits, inability to maintain a satisfactory patient/physician or professional provider relationship, problems with BCBSTX's staff or other contracted providers.

Physician or Professional Provider Satisfaction Survey

A series of questions asked of the Physician or other Professional Provider to measure satisfaction with BCBSTX's services.

Post-service

A request for a service or procedure after the service or procedure has taken place.

Prior Authorization Request or Pre-Certification Request

A request for a service or procedure before the date the requested service or procedure is to occur.

Preventive Health Care

Health screenings, immunizations, and programs that help members prevent the development of certain diseases.

Primary Care Provider (PCP)

A pediatrician, general practitioner, family practitioner, internist, or sometimes an obstetrician/gynecologist or other provider who has contracted with us to provide primary care services to members and to refer, authorize, supervise and coordinate the provision of benefits to members in accordance with the member's benefit agreement.

Primary Care Site

The PCP's office or facility.

Protected Health Information (PHI)

Protected Health Information (PHI) under HIPAA includes any information about health status, provision of health care, or payment for health care that can be linked to an individual. It includes any part of a patient's medical record or payment history.

Provider Manual

This Blue Cross and Blue Shield of Texas Provider Manual is a comprehensive document designed to inform managed care network providers of BCBSTX's guidelines and requirements. The Provider Manual offers tools and information to assist providers in caring for our members.

Prudent Layperson

A person who possesses an average knowledge of health and medicine.

Quality Assessment and Performance Improvement (QAPI) Program

The QAPI is a written description of the quality program's goals, objectives and structure. It details the role, function and reporting relationships of the Quality Improvement Committee (QIC) and the participation of practitioners and plan medical directors. This document serves as an outline of BCBSTX's efforts to monitor and improve the quality of service and care to members.

Quality Specialists

A Quality Specialist is a CRC registered nurse who performs participating provider site reviews and medical record reviews and trains office staff on quality management techniques.

Receipt of Request

The date BCBSTX receives an appeal or complaint from a member or provider.

Re-Credentialing

Every three years the continuing participation of participating providers in BCBSTX's managed care network is reviewed and re-evaluated.

Retrospective Review

A review of clinical information after the requested service has been rendered.

Routine Care

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

Self-Referral

Self-referral is the ability of a member to access a health care practitioner without having to see or be referred by anyone else first. A member may self-refer for special services that do not require prior authorization by us or the PCP.

Chapter 24

Serious Chronic Condition

A medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration.

Service Management

Administrative service performed by the MCO to facilitate development of a service plan and coordination of services among a member's PCP, specialty providers and non-medical providers to ensure members with Special Health Care Needs have access to, and appropriately utilize, medically necessary covered services, non-capitated services, and other services and supports

Skilled Nursing Facility (SNF)

A facility licensed to provide a level of inpatient nursing care that is not of the intensity required of a hospital.

Significant Traditional Provider

The Medicaid definition for a Significant Traditional Provider (STP) means primary care providers and long-term care providers, identified by Texas HHSC as having provided a significant level of care to fee-for-service clients. Disproportionate Share Hospitals (DSH) are also Medicaid STPs.

The CHIP definition for STP means primary care provider or professional providers participating in the CHIP HMO Program prior to May 2004, and Disproportionate Share Hospitals (DSH).

Specialist Physician or other Professional Provider

A plan physician who provides services to a member within the range of his or her designated specialty area of practice and who is specialty board certified or specialty board eligible in such specialty. Some specialty services do not require a referral; for example, obstetrical services.

Spell-of-Illness

The spell-of-illness limitation applies to clients in the STAR+PLUS program. A spell-of-illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

STAR or STAR Program

The State of Texas Access Reform, which means the State of Texas Medicaid Managed Care program in which HHSC contracts with HMOs to provide, arrange for and coordinate preventive, primary and acute care covered services to non-disabled children, families and pregnant women.

State Fair Hearing

An administrative hearing by the state for beneficiaries to resolve issues regarding benefits. All plan members have the right to access the Fair Hearing process at any time during the appeal process.

Sterilization

Any medical treatment, procedure or operation performed on a person (male or female) that permanently prevents the person from being able to reproduce.

Temporary Assistance to Needy Families (TANF)

Provides assistance and work opportunities to needy families by granting states the federal funds and wide flexibility to develop and implement their own welfare programs. Formerly known as Aid to Families with Dependent Children (AFDC).

Texas Health Steps

The name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program. It includes the state's Comprehensive Care program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 U.S.C. 1396d (r), and defined and codified at 42 C.F.R. 440.40 and 441.56-62. HHSC's rules are contained in 25 TAC, Chapter 243 (relating to Early and Periodic Screening, Diagnosis and Treatment Services).

Universal Precautions

The process of 'universal blood and body precautions' developed by the Centers for Disease Control and Prevention (CDC) to address concerns regarding transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C, and other blood-borne diseases. The concept assumes all patients are infectious for all blood borne diseases.

Urgent Behavioral Health Situation

A behavioral health condition that requires attention and assessment within 24 hours but which does not place the members in immediate danger to themselves or others; members are able to cooperate with treatment.

Urgent Care

Services needed to prevent serious deterioration of a member's health resulting from unforeseen illness or injury for which treatment cannot be delayed.

Urgent Condition

A health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing an average knowledge of medicine, to believe that his or her condition requires medical evaluation or treatment within 24 hours by the member's PCP or PCP designee to prevent serious deterioration of the member's condition or health.

Chapter 24

Urgent Examination

An examination performed by physician for a member with a non-life-threatening condition that could lead to a potentially harmful outcome, if not treated within 24 hours.

Utilization Management (UM)

The process of ascertaining that health care services are medically necessary, provided in the appropriate setting, and provided by the appropriate physician or professional provider.

Utilization Review

A function performed by an organization or entity acting as an agent of BCBSTX, and selected by BCBSTX, to review and approve whether health care services provided, or to be provided, are medically necessary.

Waste

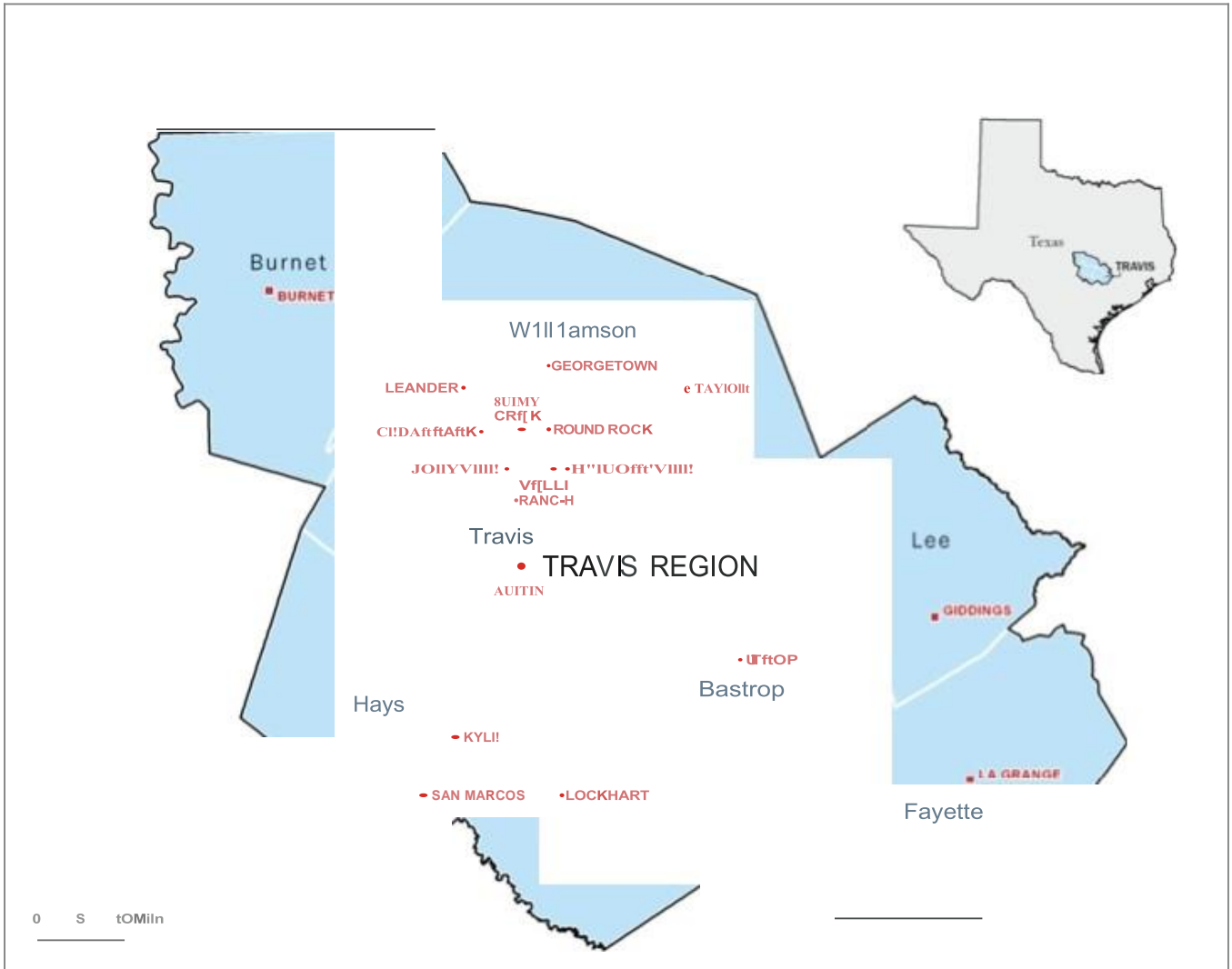
Involves health care practices that are not cost-efficient.

Women, Infants, and Children (WIC) Program

A supplemental food and nutrition program for low income, pregnant, breastfeeding and postpartum women and children under age five who have a nutritional risk. WIC provides nutrition education, breastfeeding promotion, medical care referrals, and specific supplemental nutritious foods that are high in protein and/or iron. The specific nutritious foods provided to participants include peanut butter, beans, milk, cheese, eggs, iron-fortified cereal, iron-fortified infant formula and juices.

Working Day

Monday through Friday, excluding holidays and legal holidays observed by the Health and Human Services Commission.





**APPENDIX
A**

**BEHAVIORAL
HEALTH
ASSESSMENTS**

BEHAVIORAL HEALTH ASSESSMENTS – CAGE-AID

C:	Have you ever felt you should cut down on your drinking?
A:	Have people annoyed you by criticizing your drinking?
G:	Have you ever felt bad or guilty about your drinking?
E:	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Eye opener)

A 'yes' answer to any of these questions is likely to indicate drug abuse and should spur further investigation.

PATIENT HEALTH QUESTIONNAIRE PHQ-9 FOR DEPRESSION

Using PHQ-9 Diagnosis and Score for Initial Treatment Selection

A depression diagnosis that warrants treatment or treatment change, needs at least one of the first two questions endorsed as positive (little pleasure, feeling depressed) indicating the symptom has been present more than half the time in the past two weeks.

In addition, the 10th question about difficulty at work or home or getting along with others should be answered at least 'somewhat difficult.'

When a depression diagnosis has been made, patient preferences should be considered, especially when choosing between treatment recommendations of antidepressant treatment and psychotherapy.

PHQ-9 Score	Provision Diagnosis	Treatment Recommendation
5-9	Minimal symptoms*	Support, educate to call if worse; return in one month
10-14	Minor depression††	Support, watchful waiting
15-19	Dysthymia* Major depression, mild	Antidepressant or psychotherapy
≥ 20	Major depression, severe	Antidepressant or psychotherapy

*If symptoms present ≥ two years, then probably chronic depression which warrants antidepressant or psychotherapy (ask, 'In the past two years have you felt depressed or sad most days, even if you felt okay sometimes?').

††If symptoms present ≥ one month or severe functional impairment, consider active treatment.

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APPENDIX A

Using the PHQ-9 to Assess Patient Response to Treatment

The goal of acute phase treatment is remission of symptoms as indicated by a PHQ-9 score of <5 points. Patients who achieve this goal enter into the continuation phase of treatment. Patients who do not achieve this goal remain in acute phase treatment and require some alteration in treatment (dose increase, augmentation, combination treatment).

Patients who do not achieve remission after two adequate trials of antidepressant and/or psychological counseling by 20 to 30 weeks would benefit from a formal or informal psychiatric consultation for diagnostic and management suggestions.

PHQ-9 Score	Treatment Response	Treatment Plan
Drop of ≥ 5 point from baseline	Adequate	Support, educate to call if worse; return in one month.
Drop of 2-4 points from baseline	Probably inadequate	Often warrants an increase in antidepressant dose.
Drop of 1 point or no change or increase.	Inadequate	Increase dose; augmentation; switch, informal or formal psychiatric consultation, add psychological counseling.

Initial Response to Psychological Counseling after Three Sessions over Four-Six Weeks

PHQ-9 Score	Treatment Response	Treatment Plan
Drop of ≥ 5 point from baseline	Adequate	No treatment change needed. Follow up in four weeks.
Drop of 2-4 points from baseline	Probably inadequate	Possibly no treatment change needed. Share PHQ-9 with psychological counselor.
Drop of 1 point or no change or increase.	Inadequate	<p>If depression-specific psychological counseling (CBT, PST, IPT*) discuss with therapist, consider starting an antidepressant.</p> <p>For patients satisfied in other type of psychological counseling, consider starting antidepressant.</p> <p>For patient dissatisfied in other psychological counseling, review</p>

*CBT – Cognitive Behavioral Therapy. PST – Problem Solving Treatment. IPT- Interpersonal therapy.

APPENDIX A

Use of the PHQ-9 to Make a Tentative Depression Diagnosis

PHQ-9 Patient Health Questionnaire

Over the last two weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling tired, fatigued	0	1	2	3
3.	Difficulty concentrating	0	1	2	3
4.	Thoughts of death or suicide	0	1	2	3
5.	Poor appetite or overeating		1	2	3
6.	Feeling bad about yourself or have let yourself or you down		1	2	3
7.	Trouble concentrating on newspaper or watching television		1	2	3
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				3
9.	Thoughts that you would be better off dead, or hurting yourself in some way				3

Step 1: Need one or both questions endorsed as '2' or '3' (More than half the days,' or 'Nearly every day.').

Step 2: Need a total of five or more boxes endorsed within the shaded areas of the form to arrive at the total SYMPTOM COUNT.

Step 3: FUNCTIONAL IMPAIRMENT is endorsed as 'somewhat difficult' or greater.

TOTAL SYMPTOMS endorsed more than half the days (except question 9 – any positive endorsement).

10.	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Little interest or pleasure in doing things	Not difficult at all	
		Somewhat difficult	
		Very difficult	
		Extremely difficult	

Use of the PHQ-9 for Treatment Selection & Monitoring (Determining a Severity Score)

PHQ-9 Patient Health Questionnaire

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
things	0	1	2	3
ss	0	1	2	3
sleeping to	0	1	2	3
	0	1	2	3
	0	1	2	3
you are a failure	0	1	2	3
own	0	1	2	3
chas reading the	0	1	2	3
other people – being so	0	1	2	3
n moving	0	1	2	3
off dead, or of	0	1	2	3

Step 1: Count each item in the column labeled ‘Several Days’ and multiply by one. Enter that number below that column.

Step 2: Count each item in the column labeled ‘More than half the days’ and multiply by two. Enter that number below that column.

Step 3: Count each item in the column labeled ‘Nearly every day’ and multiply by three. Enter that number below that column.

Step 4: Add the totals for each of the three columns together. This is the SEVERITY SCORE.

Add the totals for each of the three columns together.		+		+	
Enter the TOTAL. This is the SEVERITY SCORE.	Total =				

10.	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Little interest or pleasure in doing things	Not difficult at all	
		Somewhat difficult	
		Very difficult	
		Extremely difficult	

APPENDIX A

PHQ-9 Patient Health Questionnaire

Name:

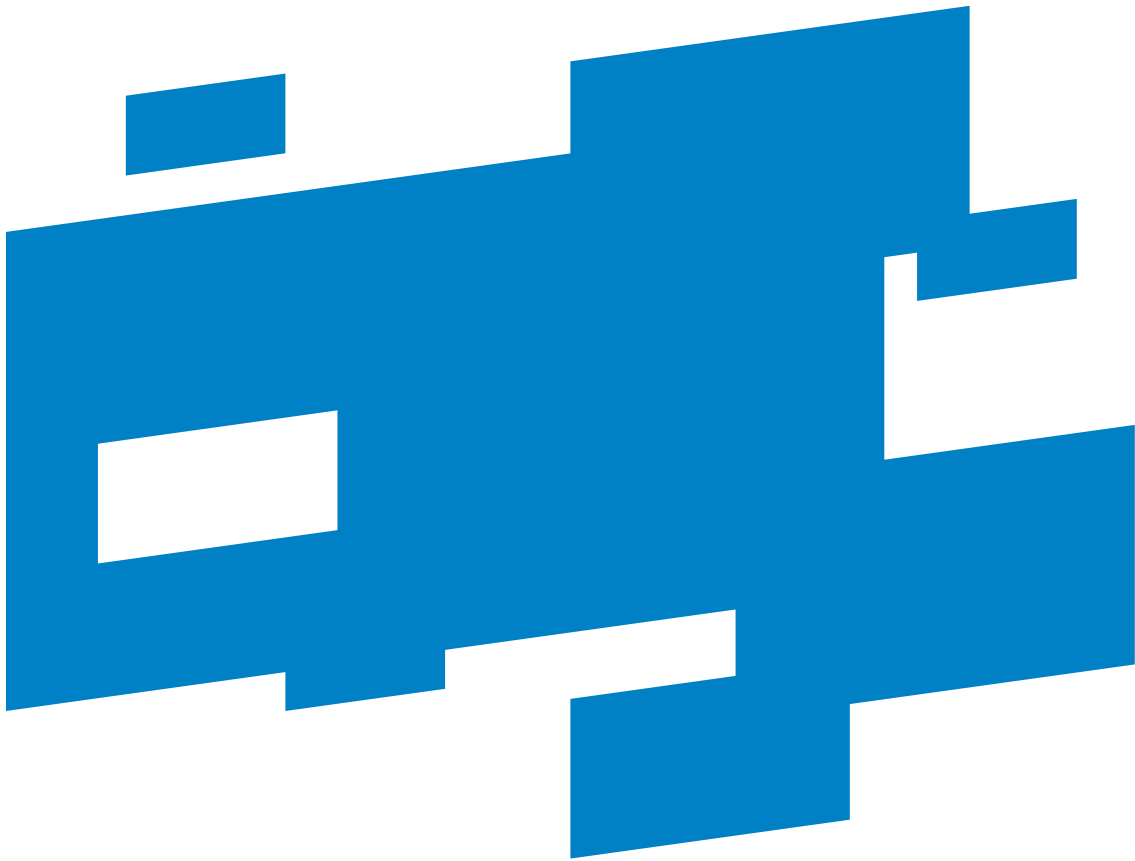
Date:

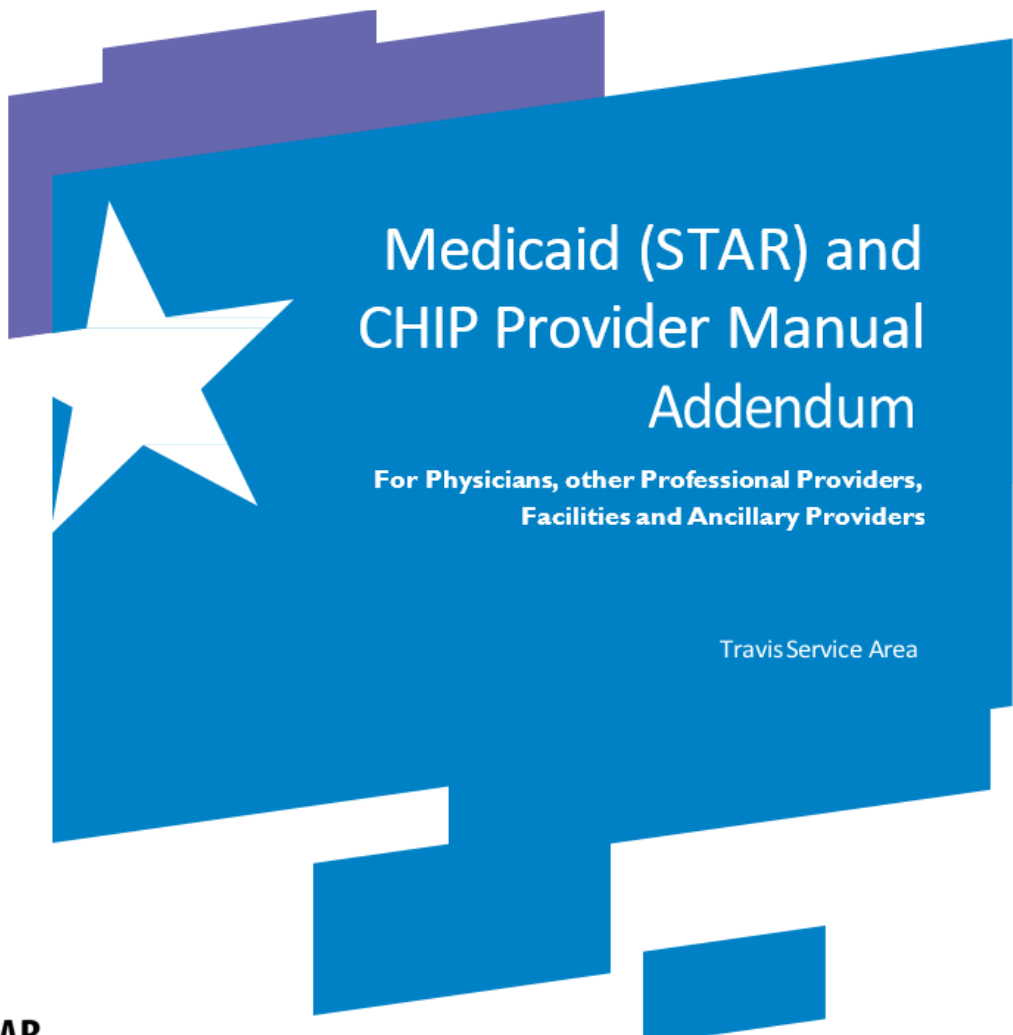
Over the last two weeks, how often have you been bothered by any of the following problems? Use a check mark (✓) to mark your answers.		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Add columns		+		+	
Total =					

10.	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Little interest or pleasure in doing things	Not difficult at all	
		Somewhat difficult	
		Very difficult	
		Extremely difficult	

PHQ-9 is adapted from PRIME MD TODAY, developed by Dr Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at www.pfizer.com. Copyright © 1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.





Medicaid (STAR) and CHIP Provider Manual Addendum

**For Physicians, other Professional Providers,
Facilities and Ancillary Providers**

Travis Service Area

TEXAS STAR
Your Health Plan ★ Your Choice

 **CHIP**

Provider Customer Service: 1-877-560-8055

bcbstx.com/provider/Medicaid/index.html

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STAR & CHIP Addendum

Chapter 3 STAR Member Benefits

Prior Authorization Guidelines

Blue Cross and Blue Shield of Texas (BCBSTX) has contracted with eviCore, an independent specialty medical benefits management company, to provide utilization management services for pre-service authorization for the services listed below for BCBSTX members covered under Medicare and Medicaid plans. Effective May 22, 2017 providers may contact eviCore directly at www.eviCore.com to obtain preauthorization for specialty services with dates of service beginning June 1, 2017 and beyond. For a full list of services, visit the BCBSTX eviCore webpage at BCBSTX.com/provider under Clinical Resources.

- Cardiology
- Lab
- Medical Oncology/Specialty Drug
- Musculoskeletal-Joint, Spine & Pain (Inpatient/Outpatient Spine & Joint)
- Musculoskeletal-Therapies
- Radiation Therapy
- Radiology
- Sleep

Services performed in conjunction with a 23 hour observation, or emergency room visit are not subject to authorization requirements.

To request an authorization:

- Log onto www.evicore.com/pages/ProviderLogin.aspx
- Call 1-855-252-1117

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please call eviCore's toll-free number for expedited authorization reviews. Be sure to tell the eviCore representative the authorization is for medically urgent care.

EviCore recommends that ordering physicians secure authorizations and pass the authorization numbers to the rendering facilities at the time of scheduling. Authorizations contain authorization numbers and one or more CPT codes specific to the services authorized. If the service requested is different than what is authorized, the rendering facility must contact eviCore for review and authorization prior to claim submission.

EviCore healthcare's Clinical Guidelines and request forms are available at: www.evicore.com. Please call eviCore Customer Service department at 1-855-252-1117 if you have any questions or need more information.

Chapter 5 Member Eligibility

Eligibility Verification

Verifying Member Medicaid Eligibility and MCO Enrollment

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's Medicaid eligibility and BCBSTX enrollment for the date of service prior to services being rendered. There are several ways to do this:

- Swipe the patient's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.
- Use TexMedConnect on the TMHP website [at www.tmhp.com](http://www.tmhp.com).
- Call the Your Texas Benefits provider helpline at 1-855-827-3747.
- Call Provider Services at the patient's medical or dental plan.

Important: Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling 1-855-827-3748. Medicaid members also can go online to order new cards or print temporary cards.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients or proof of client eligibility from the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com. A copy is required during the appeal process if the client's eligibility becomes an issue.

Your Texas Benefits gives providers access to Medicaid health information

Medicaid providers can log into the site to see a patient's Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). All of this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It's FREE and requires a one-time registration.

To access the portal, visit YourTexasBenefitsCard.com and follow the instructions in the 'Initial Registration Guide for Medicaid Providers'. For more information on how to get registered, download the 'Welcome Packet' on the home page.

YourTexasBenefitsCard.com allows providers to:

- View available health information such as:
 - Vaccinations
 - Prescription drugs
 - Past Medicaid visits
 - Health Events, including diagnosis and treatment
 - Lab Results
- Verify a Medicaid patient's eligibility and view patient program information.
- View Texas Health Steps Alerts.
- Use the Blue Button to request a Medicaid patient's available health information in a consolidated format.

Patients can also log in to www.YourTexasBenefits.com to see their benefit and case information, print or order a Medicaid ID card, set up Texas Health Steps Alerts and more. If you have questions, call 1-855-827-3747 or email ytb-card-support@hpe.com.

Chapter 5 Member Eligibility

Adoption Assistance Permanency Care Assistance (AAPCA)

Beginning September 1, 2017, most Adoption Assistance and Permanency Care Assistance (AAPCA) clients will begin receiving their benefits through managed care. The Texas Department of Family and Protective Services operates AAPCA, Medicaid benefits will not change. Medicaid will continue covering doctor's visits, hospital visits, therapies, specialists, medical equipment and medical supplies. To learn more, visit hhs.texas.gov/AAPCA.

Most AAPCA children and youth in AAPCA will get services through STAR. AAPCA children who meet STAR Kids criteria will be placed in the STAR Kids plan.

STAR AAPCA members will receive Service Management. This is a new term that is specific for the care management of the AAPCA members. STAR Kids AAPCA members get Service Coordination.

Authorizations for basic care such as specialist visits, medical supplies, etc., are honored for 90 days, until the authorization expires or until the health plan issues a new one. Authorizations for long-term services and supports are honored for six months or until a new assessment is completed (STAR Kids). During the transition period, members can continue seeing current providers, even if they are out of the health plan's network. Approved and active prior authorizations for covered services will be forwarded to the STAR or STAR Kids health plans prior to Sept. 1, 2017.

Chapter 12 Member Rights and Responsibilities

Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- The Explanation of Benefits (EOB) showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- The EOB showing the recoupment and/or the plan's "demand" letter for recoupment. If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- Completed clean claim. All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:
Texas Health and Human Services Commission HHSC
Claims Administrator Contract Management Mail Code-91X
P.O. Box 204077 Austin, Texas 78720-4077

Chapter 14 Provider Roles and Responsibilities

(Excludes STAR Dual Eligible Members) MEMBER'S RIGHT TO DESIGNATE AN OB/GYN: ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the Member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

MCO LIMITS TO NETWORK:

BCBSTX allows the Member to pick an OB/GYN but this doctor must be in the same network as the Member's Primary Care Provider.

Chapter 15 Access Standards and Access to Care

Dental plan Members may choose their Main Dental Homes. Dental plans will assign each Member to a Main Dental Home if he/she does not timely choose one. Whether chosen or assigned, each Member who is 6 months or older must have a designated Main Dental Home.

Role of Main Dental Home

A Main Dental Home serves as the Member's main dentist for all aspects of oral health care. The Main Dental Home has an ongoing relationship with that Member, to provide comprehensive, continuously accessible, coordinated, and family-centered care. The Main Dental Home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists can serve as Main Dental Homes.

Chapter 16 Health Services Programs

Documentation of completed Texas Health Steps components and elements

Each of the six components and their individual elements according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual must be completed and documented in the medical record.

Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

THSteps checkups are made up of six primary components. Many of the primary components include individual elements. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. Comprehensive health and developmental history which includes
 2. Nutrition screening, developmental and mental health screening and TB screening
- A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
3. Comprehensive unclothed physical examination which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening

A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.

4. Immunizations, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.

- Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP “Recommended Childhood and Adolescent Immunization Schedule-United States,” unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
- The screening providers are responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
- Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
- Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit <https://www.dshs.texas.gov/immunize/tvfc/>.

5. Laboratory tests, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia

- Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member’s mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
- Anemia screening at 12 months.
- Dyslipidemia Screening at 9 to 12 years of age and again 18-20 years of age
- HIV screening at 16-18 years
- Risk-based screenings include:
- Dyslipidemia, diabetes, and sexually transmitted infect

6. Health education (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.

7. Dental referral every 6 months until the parent or caregiver reports a dental home is established.

- Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

Use of the THSteps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Their use is optional, and recommended. Each checkup form includes all checkup components, screenings that are required at the checkup and suggested age appropriate anticipatory guidance topics. They are available online in the resources section at www.txhealthsteps.com.

Notification for Post stabilization Care following an Emergency admission

Acute Care Facility/Hospital allows BCBSTX to evaluate the appropriateness of the setting of care and other criteria for coverage purposes. It aids in early identification of members who may benefit from specialty programs available from BCBSTX, such as Case Management, Care Coordination and Early intervention (CCEI), or Longitudinal Care Management (LCM). Notification also allows BCBSTX to assist the member with discharge planning. Thus, for stabilized members, BCBSTX requires notification of admission for post stabilization care services within one business day following treatment of an emergency medical condition.

Failure to timely notify BCBSTX and obtain pre-approval for further post-stabilization care services may result in denial of the claim(s) for such post-stabilization care services, charges for which cannot be billed to the member pursuant to your provider agreement with BCBSTX. In the event of a claim denial that includes emergency care services, the provider is instructed to rebill the claim for the emergency services (including stabilization services), as well as post-stabilization care services for which BCBSTX may be financially responsible pursuant to 42 CFR 422.113(c), if any, for adjudication by BCBSTX. You can submit a notification for post stabilization care services through our secure provider portal via iExchange, or by phone, using the number on the member's ID card. Timely post stabilization notification of inpatient admission does not guarantee payment.

Chapter 23 Fraud, Abuse and Waste

REPORTING ABUSE, NEGLECT, OR EXPLOITATION (ANE)

Report suspected Abuse, Neglect, and Exploitation:

MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to the Department of Aging and Disability Services (DADS) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and DADS;
- Adult day care centers; or
- Licensed adult foster care providers

Contact DADS at 1-800-647-7418

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
 - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DADS;
 - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
 - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
 - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
 - a managed care organization;
 - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above
- An adult with a disability receiving services through the Consumer Directed Services option Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, DADS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Appendix B

Span of Coverage (Hospital) - Responsibility during a Continuous Inpatient Stay ¹

	Scenario	Hospital Facility Charge	All Other Covered Services
1	Member Moves from FFS to (STAR)	FFS	New MCO
2	Member Moves from STAR+PLUS to (STAR)	Former MCO	New MCO
3	Member Moves from CHIP to (STAR)	New MCO	New MCO
4	Adult Member Moves from (STAR) to STAR+PLUS	Former (STAR) MCO	New STAR+PLUS MCO
5	Member Moves from (STAR) to STAR	Former (STAR)	New Star Health MCO
6	Member Retroactively Enrolled in (STAR)/ New MCO	Member Retroactively Enrolled in (STAR)	Member Retroactively Enrolled in (STAR)
7	Member Moves between (STAR) MCO	Member Moves between (STAR) MCO	Member Moves between (STAR) MCO

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