



BlueCross BlueShield  
of Texas



# STAR Kids Provider Manual

For physicians, professional providers, facilities,  
ancillary providers and LTSS providers.



**Medicaid Rural Service Area  
(MRSA) Central**

**Travis Service Area**

**Effective February 2019**

**Provider Customer Service: 1-877-784-6802**

**[bcbstx.com/provider/Medicaid/index.html](http://bcbstx.com/provider/Medicaid/index.html)**

# Welcome!

Welcome to the Blue Cross and Blue Shield of Texas STAR Kids Provider Manual. This manual is for Blue Cross and Blue Shield of Texas (BCBSTX) contracted STAR Kids physicians, other professional providers, facilities, ancillary providers and long term supports and services (LTSS) providers who serve our members enrolled in BCBSTX STAR Kids. Please note that pharmacy providers have a separate manual. For information on how to access the BCBSTX STAR Kids Pharmacy Manual, please see the Pharmacy Providers section in Chapter 13.

**BCBSTX is contracted by the Texas Health and Human Services Commission (HHSC) to serve STAR Kids members who reside in the following counties:**

#### **Medicaid Rural Service Area (MRSA) Central**

- Bell
- Blanco
- Bosque
- Brazos
- Burleson
- Colorado
- Comanche
- Coryell
- Dewitt
- Erath
- Falls
- Freestone
- Gillespie
- Gonzales
- Grimes
- Hamilton
- Hill
- Jackson
- Lampasas
- Lavaca
- Leon
- Limestone
- Llano
- Madison
- McLennan
- Milam
- Mills
- Robertson
- San Saba
- Somervell
- Washington

#### **Travis Service Area:**

- Bastrop
- Burnet
- Caldwell
- Fayette
- Hays
- Lee
- Travis
- Williamson

**The manual will use the following terms and abbreviations:**

- BCBSTX = Blue Cross and Blue Shield of Texas
- STAR Kids = State of Texas Access Reform (Medicaid)
- HHSC = Texas Health and Human Services Commission
- Providers = Physicians, other professional providers, facilities, ancillary provider and LTSS 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, ancillary providers and LTSS providers who serve our members enrolled in the BCBSTX STAR Kids Program. Please note that pharmacy providers have a separate manual. For information on how to access the Pharmacy Manual, please see the **Pharmacy Providers** information in this section at <http://www.bcbstx.com/provider/medicaid/index.html>.

BCBSTX is contracted by the Texas Health and Human Services Commission (HHSC) to serve STAR Kids members who reside in the Medicaid Rural Service Area (MRSA) Central and the Travis Service Area.

#### **The manual will use the following terms and abbreviations:**

- BCBSTX = Blue Cross and Blue Shield of Texas
- STAR Kids = State of Texas Access Reform (Medicaid)
- HHSC = Texas Health and Human Services Commission
- Providers = Physicians, other professional providers, facilities, ancillary provider and LTSS providers

# IMPORTANT INFORMATION

## **Our Website - [www.bcbstx.com](http://www.bcbstx.com)**

Throughout this manual, we will refer to our provider 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 Kids 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**

Acute care and long term care services and supports 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 BCBSTX 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 STAR Kids 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 STAR Kids 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 Kids Member Handbook is available online at [www.bcbstx.com/starkids](http://www.bcbstx.com/starkids).

## 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 update the provider manual annually. If new procedures and processes take effect after this manual has been published, BCBSTX will communicate updates via its website, fax, email or special mailings. Updates will be posted on the BCBSTX provider website at [http://www.bcbstx.com/provider/medicaid/education\\_reference.html](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: **1-877-688-1811**

Local Network Management Office: **1-855-212-1615**

Email: [TexasMedicaidNetworkDepartment@bcbstx.com](mailto:TexasMedicaidNetworkDepartment@bcbstx.com).

# OBJECTIVES OF THE STAR KIDS PROGRAMS

STAR Kids will be the first Medicaid managed care program specifically serving youth and children who get disability-related Medicaid.

Children and youth age 20 or younger who either receive Supplemental Security Income (SSI) Medicaid or are enrolled in the Medically Dependent Children Program (MDCP) will receive all of their services through a STAR Kids health plan. Children on other waivers will continue to receive their waiver services directly from the HHSC agencies but will receive their acute care services from BCBSTX STAR Kids. Children, youth, and their families will have the choice of at least two STAR Kids health plans and will have the option to change plans. STAR Kids will be tailored to the needs of youth and children with disabilities. The program will provide benefits such as but not limited to prescription drugs, hospital care, primary and specialty care, preventive care, personal care services, private duty nursing, and durable medical equipment and supplies tailored to the needs of children and young adults with disabilities or are medically complex due to chronic conditions. Children and young adults on the MDCP Waiver will receive their acute care services and long term care services and supports from BCBSTX STAR Kids. Through STAR Kids, families also can expect coordination of care. Each health plan will provide service coordination, which will help identify needs and connect members to services and qualified providers. Each member will have their service needs assessed through a standard STAR Kids Assessment Instrument, which will form the basis of that member's individual service plan (ISP).

Objectives of the program are to:

- Provide Medicaid benefits that are customized to meet the health care needs of recipients through a defined system of care.
- Better coordinate care of recipients.
- Improve health outcomes.
- Improve access to health services.
- Achieve cost containment and cost efficiency.
- Reduce administrative complexity.
- Reduce potentially preventable events, including out-of-home institutional care, through provision of care management and appropriate services.
- Include a health home.
- Coordinate with long-term services and supports provided outside the health plan.
- Provide a plan for transitioning provision of benefits from STAR Kids to STAR+PLUS when the member turns 21.



## NETWORK LIMITATIONS AND 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)

Primary Care Providers (PCP) 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, 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.

Long Term Services and Supports (LTSS) Providers deliver a continuum of care and assistance ranging from in-home and community-based services for children and youth who get additional services through MDCP. LTSS Providers have certain responsibilities for the STAR Kids program and the Members they serve. For more information, refer to Chapter 8.

# NETWORK LIMITATIONS AND ACCESS TO CARE

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. BCBSTX Service Coordinators are available to assist with the process of obtaining authorizations for these referrals when authorization is required.

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. STAR Kids members may request that their specialist function as 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.

## 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 pharmacies via an arrangement with Prime Therapeutics LLC (Prime), 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 PCPs, specialists, other providers and pharmacy provider roles and responsibilities, please see **Chapter 13, Provider Roles and Responsibilities**.

## Role of Main Dental Home

STAR Kids members may select a separate 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.

## LTSS Providers

LTSS providers are responsible for providing a variety of long term care services and supports. See Chapter 8.



## Chapter 2

# Important Contact Information

## IMPORTANT CONTACT INFORMATION

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
<b>BCBSTX</b>	Provider Relations and Network Management	<b>1-855-212-1615</b>	Monday – Friday 8 a.m. – 5 p.m. Central Time
<b>Behavioral Health Services</b>	Magellan Healthcare	<b>1-800-424-0324</b> TTY: <b>1-800-635-2883</b> <a href="http://www.magellanprovider.com">www.magellanprovider.com</a>	24 hours day/ seven days a week
<b>Claims Payment</b>	Webportal	<a href="http://www.availity.com">www.availity.com</a>	24 hours day/ seven days a week
	Provider Customer Service	<b>1-877-784-6802</b> TTY: <b>7-1-1</b>	Monday – Friday 8 a.m. – 8 p.m. Central Time
	Paper Claims Address	Blue Cross and Blue Shield of Texas P.O. Box 51422 Amarillo, TX 79159-1422	
<b>Claims Electronic Processing</b>	Electronic Data Interchange (EDI)	Payer ID 66001 <a href="http://www.availity.com">www.availity.com</a>	24 hours day/ seven days a week
<b>Complaints and Appeals</b>	Provider Customer Service	Providers: <b>1-877-784-6802</b> TTY: <b>7-1-1</b> Email: <a href="mailto:GPDTXMedicaidAG@bcbsnm.com">GPDTXMedicaidAG@bcbsnm.com</a> Mail: PO Box 27838 Albuquerque, NM 87125-7838	Monday – Friday 8 a.m. – 8 p.m. Central Time

# Chapter 2

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
<b>Dental Services</b>	DentaQuest Provider Services	<b>1-800-896-2374</b> <a href="http://www.dentaquest.com">www.dentaquest.com</a>	Monday – Friday: 8 a.m. – 7 p.m.  Saturday: 8 a.m. – Noon  Central Time
	MCNA Dental Provider Services	<b>1-800-494-6262</b> <a href="http://www.mcna.net">www.mcna.net</a>	Monday – Friday 8 a.m. – 4 p.m. Central Time (excludes holidays)
<b>Drugs or Prescriptions – Prime Therapeutics</b>  <b>BIN 011552</b> <b>PCN TXCAID</b>	Prime Therapeutics	Prime Therapeutics Customer Service: STAR Kids: <b>1-855-457-0757</b> (Travis service area)  <b>1-855-457-0758</b> (MRSA Central service area)	24 hours day/ seven days a week
	Prior Authorization	Prime Therapeutics Customer Service: <b>1-855-457-1200</b>	Monday – Friday 6 a.m. – 9 p.m. Central Time
	Other resources	<a href="http://www.txvendordrug.com">www.txvendordrug.com</a>	
<b>Early Childhood Intervention Referral</b>	Early Childhood Intervention	<b>1-800-628-5115</b>  TTY: <b>1-866-581-9328</b>  <a href="http://www.dars.state.tx.us/ecis">www.dars.state.tx.us/ecis</a>	Monday – Friday 8 a.m. – 5 p.m. Central Time

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
<b>Eligibility</b> <b>Member Eligibility and Verifying PCP (STAR Kids)</b>	Web Portals	<a href="http://www.availity.com">www.availity.com</a> <a href="http://www.tmhp.com">www.tmhp.com</a>	24 hours day/ seven days a week
	Customer Service	Members: <b>1-877-688-1811</b> TTY: <b>7-1-1</b> Providers: <b>1-877-688-1811</b>	Monday – Friday 8 a.m. – 8 p.m. Central Time
	Automated Inquiry System (AIS)	<b>1-800-925-9126</b>	24 hours day/ seven days a week
<b>Fraud and Abuse</b>	Customer Service	Members: <b>1-877-688-1811</b> TTY: <b>7-1-1</b> Providers: <b>1-877-688-1811</b>	Monday – Friday 8 a.m. – 8 p.m. Central Time
<b>General Assistance</b> <ul style="list-style-type: none"> <li>• Eligibility for Medicaid</li> <li>• State resources for food, housing, child care and after school programs</li> <li>• Senior services</li> <li>• Help after a disaster</li> <li>• Tax help</li> </ul>	2-1-1 Information Service and Search	Call <b>2-1-1</b> From within the service area, call <b>1-512-973-9203</b> Outside the service area call toll-free <b>1-877-541-7905</b> <a href="http://www.211.org">www.211.org</a>	24 hours day/ seven days a week

# Chapter 2

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
<b>Hospital or Facility Admission Notification</b>	Utilization Management Department	Voice: <b>1-877-688-1811</b> Fax: <b>1-855-879-7180</b>	Monday – Friday 8 a.m. – 8 p.m. Central Time
<b>Interpreter Services</b>	Customer Service	Members: <b>1-877-688-1811</b> TTY: <b>7-1-1</b> Providers: <b>1-877-688-1811</b>	Monday – Friday 8 a.m. – 8 p.m. Central Time
<b>Legal Aid</b>	Texas Rio Grande Legal Aid, Inc. 4920 N. I-35 Austin, TX 78751 (Bastrop, Blanco, Burnet, Caldwell, Hays, Llano, Mason, Travis and Williamson counties)	<b>1-512-374-2700</b> <b>1-800-369-9270</b> Fax: <b>1-512-447-3940</b> <a href="http://www.trla.org/office/austin">www.trla.org/office/austin</a>	Monday – Thursday 8 a.m. – 7:30 p.m. Friday 8 a.m. – 5:30 p.m. Central Time
<b>Member Services</b>	Customer Service	Members: <b>1-877-688-1811</b> TTY: <b>7-1-1</b>	Monday – Friday 8 a.m. – 8 p.m. Central Time
<b>Member Outreach or Member Advocate</b>	Member Outreach	TTY: <b>1-855-497-0857</b> <b>7-1-1</b> Fax: <b>1-512-349-4867</b>	Monday – Friday 8 a.m. – 5 p.m. Central Time

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
<b>Member Information Changes* (contact, address, telephone and other changes)</b>	Health and Human Services Commission	Call <b>2-1-1</b> <b>1-877-541-7905</b> TTY: <b>1-877-833-4211</b> <a href="http://www.211texas.org/211">www.211texas.org/211</a>	24 hours a day/ seven days a week
<b>Medical Management, Utilization Management, Case Management, Disease Management</b>		Fax: <b>1-877-784-6802</b> <b>1-855-653-8129</b>	Monday – Friday 8 a.m. – 8 p.m. Central Time
<b>24 Hour Nurse Hotline Questions and After-hours Inquiries</b>	24 Hour Nurse Hotline	<b>1-855-802-4614</b>	24 hours day/ seven days a week
<b>Over-the-Counter Products (Limited)</b>	Prime Therapeutics	BIN: 011552 PCN: TXCAID <b>1-855-457-0757</b> (Travis service area) <b>1-855-457-0758</b> (MRSA Central service area)	24 hours a day/ seven days a week

\* Member must call HHSC for charges to be recorded.



# Chapter 2

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
<b>Prior Authorization and Referrals – Medical</b>	Utilization Management Department	Fax: <b>1-877-784-6802</b> <b>1-855-879-7180</b>	Monday – Friday 8 a.m. – 8 p.m. Central Time
<b>Provider Relations</b>		<b>1-855-212-1615</b>	
<b>Provider Services</b>	Customer Service	<b>1-877-784-6802</b>	Monday – Friday 8 a.m. – 8 p.m. Central Time
<b>Service Coordination</b>	Customer Service	<b>1-877-301-4394</b>	Monday - Friday, 8a.m. to 5 p.m.  Central Time, excluding state-approved holidays.
<b>Special Beginnings</b>		<b>1-888-421-7781</b>	
<b>Texas Health Steps (STAR Kids)</b>	Texas Department of State Health Services (CSHS)	<b>1-877-847-8377</b>	Monday – Friday 8 a.m. – 6 p.m. Central Time
<b>TTY - Members with Hearing Loss</b>	Customer Service	TTY: <b>1-877-688-1811</b> <b>7-1-1</b>	Monday – Friday 7 a.m. – 6 p.m. Central Time
	TexasRelayService	Texas Relay <b>1-800-735-2989</b> <b>7-1-1</b>	24 hours day/ seven days a week

Inquiry Type	Resource	Phone Number or Website	Hours of Availability
<p><b>Transportation Services - STAR Kids</b></p> <p>*See page 38 for Non-emergency Transportation Value-Added Service</p>	<p>HHSC Medical Transportation Program</p>	<p><b>1-877-633-8747</b></p>	<p>Monday – Friday 8 a.m. – 5 p.m. Central Time</p>
<p><b>Vision Services</b></p>	<p>Davis Vision</p>	<p>Member Services: <b>1-888-588-4825</b>            TTY: <b>1-800-523-2847</b></p> <p>Provider Services:  <b>800-77DAVIS (1-800-773-2847)</b>            TTY: <b>1-800-523-2847</b></p> <p>Website: <a href="http://www.davisvision.com">www.davisvision.com</a></p>	<p>Monday - Friday 7 a.m. - 10 p.m. Central Time</p> <p>Saturday 8 a.m. - 3 p.m. Central Time</p> <p>Sunday 11 a.m. - 3 p.m. Central Time</p>
<p><b>Your Texas Benefits Provider Helpline</b></p>		<p><b>1-855-827-3747</b></p>	



## Chapter 3

# STAR Kids Member Benefits

### STARKIDS 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 **1-877-688-1811**.

At a minimum, BCBSTX provides a benefit package to members that includes acute care and LTSS services currently covered by FFS Medicaid. MDCP services are covered for those individuals who qualify and are approved to receive MDCP.

NOTE: STAR Kids members do not have a copay for Medicaid services.

The following services are covered in the monthly capitation received by the MCO:

Covered Benefit	Description
<b>Adaptive Aids</b>	Not limited to MDCP
<b>Audiology services, including hearing aids</b>	The Texas HealthSteps program gives audiology services and hearing aids for ages 0 through 20
<b>Behavioral Health</b>	<ul style="list-style-type: none"> <li>• Inpatient mental health services. The MCO may provide these services in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.</li> <li>• Outpatient mental health services</li> <li>• Psychiatry services</li> <li>• Substance use disorder treatment services, including</li> <li>• Outpatient services, such as:               <ul style="list-style-type: none"> <li>– Assessment</li> <li>– Detoxification services</li> <li>– Counseling treatment</li> <li>– Medication assisted therapy</li> </ul> </li> <li>• Residential services, in lieu of an acute care inpatient hospital setting.</li> <li>• Detoxification services</li> <li>• Substance use disorder treatment (including room and board)</li> </ul>
<b>Birth services</b>	Provided by a physician and CNM in a licensed birthing center
<b>Birth services</b>	Provided by a licensed birthing center
<b>Cancer screening, diagnostic, and treatment service</b>	<ul style="list-style-type: none"> <li>• X-rays and testing that is not invasive and done to find out what is wrong and is ordered and done by (or under the guidance of) your provider</li> <li>• CT, MRI, MRA, PET and SPECT need an OK from us</li> </ul>
<b>Chiropractic services</b>	<p>Covers services that help keep the spine and other body structures straight</p> <p>You do not need an OK from us to see a chiropractor in your network. (Maximum visit limits may apply)</p>

# Chapter 3

Covered Benefit	Description
<b>Clinician Administered Drugs</b>	<p>BCBSTX may reimburse providers only for clinician-administered drugs and biologicals whose manufacturers participate in the Centers for Medicare &amp; Medicaid Services (CMS) Drug Rebate Program and that show as active on the CMS list for the date of service the drug is administered.</p> <p>Clinician-administered drugs that do not have a relatable NDC will not be reimbursed. Please note there may be ingredients in a compound that are not considered a drug under the Federal Food, Drug, and Cosmetic Act.</p> <p>The Texas NDC-to- HCPCS Crosswalk identifies relationships between National Drug Codes (NDC) and Healthcare Common Procedure Coding System (HCPCS) codes. The crosswalk is found on <a href="http://www.txvendordrug.com">http://www.txvendordrug.com</a>.</p> <p>HCPCS codes listed on the NDC-to- HCPCS Crosswalk must have an appropriate NDC to HCPCS combination for the procedure code to be considered for payment; otherwise, these claims will be rejected.</p> <p>Some drug products administered by a provider in outpatient settings are exempt such as vaccines, devices, and radiopharmaceuticals.</p> <p>HCPCS units are billed by the number of units actually administered. The HCPCS procedure code description identifies the unit amount to calculate the number of units to be billed.</p> <p>A provider must bill for only the units administered. Unused or wasted drug is not reimbursable for single or multi-use vials.</p> <p>For more information, please visit <a href="http://www.txvendordrug.com">http://www.txvendordrug.com</a>.</p>
<b>Day Activity and Health Services</b>	<p>Day Activity and Health Services (DAHS) (only for Members 18 of age and older)</p> <p>Day Activity and Health Services (DAHS) are facilities which provide that provide daytime services to members 18 years of age and older who live in the community as an alternative to living in a long-term care facility. These Services, which are usually provided Monday through Friday, address physical, mental, medical and social needs. These are also referred to as adult daycare or adult day services.</p>
<b>Dialysis</b>	Covered as inpatient and outpatient hospital service.
<b>Drugs and biologicals provided in an inpatient setting</b>	Outpatient drugs and biologicals; including pharmacy-dispensed and clinician-administered outpatient drugs and biologicals

Covered Benefit	Description
<b>Durable medical equipment and supplies</b>	<p>These items are:</p> <ul style="list-style-type: none"> <li>• Covered when medically necessary.</li> <li>• Covered within the limits of what is covered by Medicaid.</li> </ul> <p>DME and supplies are not covered if:</p> <ul style="list-style-type: none"> <li>• They are used for exercise.</li> <li>• They are still being tested or research equipment.</li> <li>• More than one piece of equipment serves the same purpose</li> <li>• They are used only for making the room or home comfortable, such as: <ul style="list-style-type: none"> <li>– Air conditioning</li> <li>– Air filters*</li> <li>– Air purifiers*</li> <li>– Exercise equipment</li> <li>– Spas</li> <li>– Swimming pools</li> <li>– Elevators</li> <li>– Supplies for hygiene or looks</li> </ul> </li> </ul> <p>*On a case-by-case basis, these may be approved.</p>
<b>Early Childhood Intervention (ECI) services</b>	<p>ECI is a statewide program that supports families to help their children ages 0 to 36 months who have a medically diagnosed disability or doesn't seem to be developing at the same pace as other babies or toddlers of the same age, reach their potential.</p>
<b>Emergency and Non-Emergency Ambulance Services</b>	<ul style="list-style-type: none"> <li>• Emergency room</li> <li>• Ambulance services</li> </ul>
<b>Family planning services</b>	<p>Includes family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits.</p>
<b>Financial Management Services</b>	<p>Financial Management Services Agencies are the fiscal agents for people who selected the consumer-directed services option. FMSA services include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Managing payroll</li> <li>• Preparing and filing required tax forms and reports</li> <li>• Paying allowable expenses incurred by the employer</li> <li>• Providing status reports concerning the individual's budget, expenditures and compliance with the CDS option requirements.</li> </ul>

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Covered Benefit	Description
<b>Flexible Family Support Services</b>	<p>LTSS benefit for individualized and disability-related services, including personal care supports for basic activities of daily living (ADL), instrumental ADL, skilled care and delegated care supports, to:</p> <ul style="list-style-type: none"> <li>• Assist a child to participate in child care</li> <li>• Assist a person to participate in post-secondary education</li> <li>• Increase a person's independence</li> </ul> <p>Care and services provided to a member with a disability while the primary caregiver is at work, job training or school, and unable to provide these services.</p> <p>For MDCP members only.</p>
<b>Health Home Services</b>	<p>The health home, also known as the patient-centered medical home (PCMH), is a team-based health care delivery model led by a health care provider/ provider teams that is intended to provide comprehensive and continuous medical and behavioral health care to patients with the goal of obtaining maximized health outcomes. BCBSTX will utilize components of the existing NCQA PCMH program model already in place and strive to enhance activities to improve performance with Health Homes. BCBSTX will collaborate with Health Home(s) to identify opportunities for improvement in relation to established performance measures and activities that will engage members in their care provided to improve health outcomes. On an annual basis, Health Homes Work Plan(s) and work description(s) will be evaluated with trends to performance and will be presented for progress to date to the MQIC and MPAC.</p>
<b>Home Health</b>	<p>Services such as nursing care or therapies provided in the home.</p>
<b>Hospital services, inpatient and outpatient</b>	<p>Inpatient:</p> <p>Hospital room with two or more beds</p> <ul style="list-style-type: none"> <li>• Nursing care</li> <li>• Operating room</li> <li>• Surgery</li> <li>• Anesthesia</li> </ul> <p>Outpatient:</p> <ul style="list-style-type: none"> <li>• Dialysis</li> <li>• Giving you someone else's blood</li> </ul>
<b>Laboratory</b>	<p>All authorized lab services</p>
<b>Program (EPSDT) Texas Health Steps</b>	<p>Medical checkups and Comprehensive Care Program (CCP) Services through the Texas Health Steps Program (EPSDT)</p>

Covered Benefit	Description
<b>Mastectomy, breast reconstruction, and related follow-up procedures, including:</b>	<ul style="list-style-type: none"> <li>• Inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for: <ul style="list-style-type: none"> <li>– All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;</li> <li>– Surgery and reconstruction on the other breast to produce symmetrical appearance;</li> <li>– Treatment of physical complications from the mastectomy and treatment of lymphedemas; and</li> <li>– Prophylactic mastectomy to prevent the development of breast cancer.</li> </ul> </li> <li>• External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.</li> </ul>
<b>Medical checkups and Comprehensive Care Program (CCP) Services through the Texas Health Steps</b>	<p>CCP provides medically necessary, federally allowable treatment for Medicaid/THSteps clients who are 20 years of age and younger. Some medical services that usually would not be covered under Medicaid may be available to CCP-eligible clients.</p>
<b>Mental health rehabilitation services</b>	<p>BCBSTX offers mental health rehabilitation services and targeted case management to STAR Kids members through Magellan.</p>
<b>Mental health targeted case management</b>	<p>Targeted Case Management services help members who have one or more chronic mental disorders get the care and services they need.</p>
<b>Minor Home Modifications</b>	<p>Minor home modifications (MCO) are home modifications for accessibility which include but are not limited to bathroom modifications, doorway widening and ramps, which enable the members to live in their homes safely and securely.</p>
<b>Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children six months through 35 months of age</b>	<p>Texas Health Steps dental checkups begin at six months old with the child's PCP. The child can have a dental checkup starting at age six months, and should have a dental checkup every six months.</p>



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Covered Benefit	Description
<p><b>Optometry, glasses, and contact lenses, if medically necessary</b></p>	
<p><b>Outpatient drugs and biologicals</b></p>	<p>STAR Kids 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 Kids 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. To view the formulary, go to the BCBSTX website or go to the VDP website at <a href="http://www.txvendordrug.com">www.txvendordrug.com</a>.</p> <p>Prime Therapeutics offers e-prescribing through Sure Scripts, which allows providers to:</p> <ul style="list-style-type: none"> <li>• Submit prescriptions electronically</li> <li>• Verify client eligibility</li> <li>• Review medication history</li> <li>• Review formulary and PDL information</li> </ul> <p>The formulary is also available for mobile devices on <a href="http://www.epocrates.com">www.epocrates.com</a>.</p> <p>Additional outpatient prescription drug information:</p> <ul style="list-style-type: none"> <li>• No copay is required for prescriptions.</li> <li>• Prior authorization is required for certain drugs.</li> <li>• We do not reimburse claims for diet aids, cosmetic or hair-growth drugs, erectile dysfunction drugs, or infertility drugs.</li> <li>• We limit over-the-counter drugs to those on the Medicaid formulary.</li> <li>• We have limited home health supplies available under the pharmacy benefit. All other medical supplies and equipment are available under the medical benefit.</li> <li>• We do not reimburse claims for nutritional products (enteral or parenteral) under the pharmacy benefit. Medical prior authorization is required.</li> <li>• We offer free prescription delivery from those Texas VDP approved delivery pharmacies in our pharmacy provider service area network.</li> <li>• We will coordinate or provide rides to the pharmacy if no other transportation is available.</li> </ul>

Covered Benefit	Description
<b>Personal Care Services (PCS)</b>	All qualified members may receive medically and functionally necessary Personal Assistance Services under CFC.
<b>Podiatry</b>	Covered services include: <ul style="list-style-type: none"> <li>• Medical problems of the feet.</li> <li>• Medical or surgical treatment of disease, injury or defects of the feet.</li> </ul>
<b>Prenatal care</b>	Provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center
<b>Prescribed pediatric extended care center (PPECC) services</b>	Prescribed Pediatric Extended Care Centers (PPECCs) allow minors from birth through age 20 with medically complex conditions to receive daily medical care in a non-residential
<b>Prescription Drugs - Specialty Medications</b>	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.
<b>Private Duty Nursing (PDN) services</b>	State plan LTSS like Personal Care Services (PCS), Private Duty Nursing (PDN) and Community First Choice (CFC) as well as all MDCP services will be delivered through BCBSTX. Not covered for adults.
<b>Radiology, imaging, and X-rays</b>	<ul style="list-style-type: none"> <li>• X-rays and testing that is not invasive and done to find out what is wrong and is ordered and done by (or under the guidance of) your provider</li> <li>• CT, MRI, MRA, PET and SPECT need an OK from BCBSTX</li> </ul>
<b>Respite Care</b>	Respite Care is the direct care of a member in order to provide their caregiver temporary relief from caregiving activities.
<b>Telehealth</b>	The telehealth option allows members to access a board-certified physician from their home, or on the go, 24 hours a day, seven days per week.
<b>Telemedicine</b>	Telemedicine seeks to improve a patient’s health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.
<b>Tele-monitoring</b>	The ongoing assessment of a condition—in particular cardiac arrhythmias and/or other objectively measurable indicators of disease (e.g., heart failure)—by sensors attached to the patient, signals from which are ported wirelessly to a central station or “node” where abnormalities will trigger a response by healthcare workers.

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Covered Benefit	Description
<b>Therapies – Physical, occupational, and speech</b>	<ul style="list-style-type: none"> <li>• Developmental assessments</li> <li>• Physical, occupational or speech therapy</li> </ul>
<b>Transition Assistance Services</b>	LTSS benefit for a one-time service to help Medicaid-eligible Texans transition from the nursing home to the community. For MDCP members only. Transition Assistance Services are available to help members as they transition from an institutional setting into a home in the community. The services facilitate the necessary set-up and management of the member’s new home.
<b>Transplantation of organs and tissues</b>	<ul style="list-style-type: none"> <li>• Human organ and tissue transplants that are not still being tested</li> <li>• All corneal, bone marrow and peripheral stem cell transplants that are not still being tested</li> </ul>
<b>Value-Added Services</b>	<ul style="list-style-type: none"> <li>• Non- Emergency Transportation Services</li> <li>• Enhanced Eyewear</li> <li>• Texas Health Steps Check-up Incentive</li> <li>• Incentive Gift Card for Attending Parent/ LAR Peer to Peer Orientation and Resource Meeting</li> <li>• Extra help for parents: Respite Care for Parents/LAR</li> <li>• Recreational safety helmets for STAR Kids members</li> <li>• In-Home delivery meal services</li> <li>• Hippotherapy or therapeutic riding services</li> </ul>
<b>Vision services</b>	An eye exam every 12 months

## COORDINATION WITH STATE SERVICES

The State of Texas has chosen to provide certain client 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 our members receive all medically appropriate and necessary services, regardless of payor source.

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.

In addition to HMO coverage, STAR Kids 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
- DADS or DSHS HCBS Waiver programs, authorized under Social Security Act § 1915(c), including Youth Empowerment Services (YES), Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and Home and Community-based Services (HCS)
- Court-Ordered Commitments to inpatient mental health facilities as a condition of probation
- Nursing facility services and intermediate care facility (IFC) services
- Texas Health Steps dental (including orthodontia)

## SERVICE COORDINATION SERVICES

BCBSTX provides service coordination for all STAR Kids members. Service Coordination necessitates active provider participation in order to provide the most value and ultimately better health outcomes for members. Service coordination is a key component of the STAR Kids program and it provides the member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using covered services and other supports to enhance the member’s well-being, independence, integration in the community, and potential for productivity. BCBSTX service coordinators are trained to ensure appropriate Medicaid resources are utilized, services are coordinated and community resources are provided to the members. The service coordination staff works very closely with BCBSTX Utilization Management (UM), Provider Network, Complaints and Appeals Coordinators, Customer Service, member advocates and delegated organizations. The service coordinator coordinates services with the member’s PCP, specialists, service providers, and various community programs when appropriate. Service coordination functions provide a holistic evaluation of the member’s individual dynamics, needs and preferences; help identify the member’s physical, behavioral, functional, and psychosocial needs; help provide education and health-related information to the member, the member’s LAR and others in the member’s support network. Service coordinators engage the member, member’s LAR and other caretakers in the design and development of a comprehensive person-centered Individual Service Plan (ISP). Members are connected to covered and non-covered services ensuring that members have access to all services in a timely and appropriate manner. Service coordinators coordinate all services for members and intervene on behalf of the member.

## Role of the Service Coordinator

BCBSTX employs service coordinators specifically for STAR Kids members. Dependent on a member's risk stratification level (discussed below), the education qualification requirements for a service coordinators may include: registered nurses (RN), licensed social workers or licensed professional counselor, individuals with an undergraduate or graduate degree in social work or a related field, licensed vocational nurses (LVN) with previous service coordination or case management experience and/or individuals with a high school diploma or GED and direct experience working with children and young adults. BCBSTX employs service coordinators who are experienced in meeting the needs of vulnerable populations who have chronic and complex conditions. Personnel have expertise in pediatric care, in addition to physical, behavioral and social health challenges. STAR Kids Service Coordinators are solely dedicated to the BCBSTX STAR Kids Program. Staff employed as service coordinators are encouraged to receive the Certified Case Manager (CCM) Certificate within two years of employment with BCBSTX. Social workers can receive CCM certification through the National Association of Social Workers as well as the CMSA organization. The service coordinators work proactively and collaboratively to identify the member's plan of care based on his/her needs.

The service coordinator is responsible for the following activities:

- Ensuring and coordinating access to a qualified provider who is responsible for developing a comprehensive treatment plan as per applicable provider regulations
- Ensuring appropriate coordination between the physical and behavioral health services and non-managed care services
- Monitoring progress of members to ensure medically necessary services are received, to assist in resolving identified problems and to prevent duplication of services
- Ensuring the development of a member's Individual Service Plan (see Individual Service Plan section for more information)
- Communicating regularly with the Department of Aging and Disability Services or Department of State Health Services staff for members with HCBS Waiver Services (all members who receive LTSS through a nursing facility, the Intermediate Care Facility/Individuals with Intellectual Disabilities program, or through non-capitated HCBS Waiver programs have access to a service coordination team that include representatives from the members STAR Kids MCO, and at least one coordinator representing the individual's non-capitated LTSS).
- Informing members about options available through home and community-based programs, in addition to facility based options
- Providing transition planning information with assistance from transition specialist
- Connecting members to an extended service network to meet their needs. These may include support groups, mental health services, health services, advocacy groups, transition planning, home modification, housing resources, community organizations who may not provide covered services, but who are important to the health and wellness of the member.
- Providing information regarding Consumer Directed Services (CDS) including the option to choose between Consumer Directed Services, Service Related Option and agency option. This information is be provided annually to Members who receive Personal Care Services (PCS), respite services, Supported Employment or Employment Assistance.
- Informing the member or member's LAR about their responsibilities as an employer and and how to utilize a Fiscal Management Services Agency (FMSA) under Consumer Directed Services model and providing a list of contracted FMSA providers.

- Documenting the members or their LAR's decision on whether to use the Consumer Directed Services option in the Individual Service Plan
- Providing the FMSA with authorized schedule of applicable services.
- Coordinating care for dual eligible and Members who have other third party insurance
- Coordinating with the Department of Aging and Disability Services Section 811 Project Rental Assistance (PRA) Program point of contact on an ongoing basis for members with disabilities exiting a nursing facility and receiving services from the Section 811 PRA program.

## **Accessing a Member's Service Coordinator**

BCBSTX provides access to service coordinators for members and providers through a toll-free telephone number Monday through Friday, 8 a.m. to 5 p.m. Central time. The service coordination phone number is **1-877-301-4394**.

Each service coordinator can be reached directly by telephone during regular business hours. Members will receive a letter with the name of their service coordinator and their local phone number. After hours, voice mail is available. All messages are returned within 48 hours or within two business days.

On-call service coordinators are available after-hours.

Health coordinators provide referral and triage support Monday through Friday, 8 a.m. to 5 p.m. through the service coordination toll free line. After hours, weekends, and holidays the line is answered by AxisPoint Health, the vendor for the Nurse Hotline.

AxisPoint contacts the on-call nurse for service coordination calls received after hours that require immediate attention. Members are directed to contact emergency resources for emergent or urgent medical concerns.

## **STAR Kids Screening and Assessment Instrument (SAI)**

Service coordinators reach out to parents or Legally Authorized Representatives (LARs) to schedule the SAI. During the SAI, the BCBSTX Service Coordinator will talk about medication information, services available to the child, diagnoses, and talk about any questions you have.

The screening and assessment process encompasses all screenings, assessments, and other information-gathering methods BCBSTX uses to inform service coordination decisions.

## **STAR Kids Telephonic Health Risk Screening**

The screening and assessment process starts with BCBSTX reviewing historical data on a member, including previous claims data to prioritize outreach to members. BCBSTX performs an outbound telephonic Health Risk Screening on all new members. The Health Risk Screening serves to obtain basic physical health and behavioral health and demographic information about the member, obtaining transition of care information and assisting the service coordinator in determining the level of service coordination needed by the member, and determining the priority level within which the SAI must be completed.

# Chapter 3

## Member Prioritization and Level of Service Coordination

Based on the member's responses to the Health Risk Screening and any historical data BCBSTX has for a member, the member is stratified as a Level 1, Level 2 or Level 3. The screening and assessment process and SAI are used to prioritize which members require the most immediate attention and what level of service meets the member's needs.

### Level 1 Members

Level 1 members include the following member types:

- MDCP STAR Kids members
- Members with complex needs or history of developmental or behavioral health issues (multiple outpatient visits, hospitalization, or institutionalization within the past year)
- Members with serious persistent mental illness (SPMI)
- Members at risk for institutionalization
- Members with psychosocial needs that present significant challenges to the member's health and wellbeing.

All Level 1 members receive a minimum of four face-to-face service coordination contacts annually, in addition to monthly phone calls, unless otherwise requested by the member or member's LAR. All Level 1 members have an assigned service coordinator. The assigned service coordinator sends a letter to the member or caregiver which includes contact information so the member or caregiver can contact the service coordinator as necessary. This information is also posted on the member portal. Level 1 Service Coordinators are Registered nurses, licensed social workers or licensed professional counselors if the member's service needs are primarily behavioral.

### Level 2 Members

Level 2 Members include the following member types:

- Members who do not meet the requirements for Level 1 classification but receive Personal Care Services (PCS), Community First Choice (CFC), or Nursing Services
- Members that BCBSTX determines will benefit from a higher level of service coordination based on results from the STAR Kids SAI and additional findings
- Members with history of substance abuse (multiple outpatient visits, hospitalization, or institutionalization within the past year)
- Members with non-SPMI behavioral health issues.

All Level 2 Members receive a minimum of two face-to-face and six telephonic service coordinator contacts annually unless otherwise requested by the member or member's LAR. All Level 2 Members have an assigned service coordinator. The assigned service coordinator sends a letter to the member or caregiver including contact information so the member or caregiver can contact the service coordinator as necessary. This information is also posted on the member portal. Level 2 service coordinators are RNs, individuals with an undergraduate or graduate degree in social work or a related field, or licensed vocational nurses (LVN) with previous service coordination or case management experience.



## Level 3 Members

Level 3 Members include those that do not qualify as Level 1 or 2. BCBSTX provides access to a service coordinator and will assign a named service coordinator at the member's request. All Level 3 Members receive at least one face-to-face visit annually and three telephonic outreaches yearly. Additionally, Level 3 Members are monitored for any potential change in level through claims review. Claims review will be done via a predictive modeling system, which serves to proactively identify cases for outreach. A member's interaction with the service coordination team is tied to the level and frequency of coordination desired by the member and the member's LAR and appropriate to the member's needs. Level 3 Service Coordinators have a minimum of a high school diploma or GED and direct experience working with children and young adults with similar conditions or behaviors in three of the last five years. The RN service coordinator (POD lead) is responsible for leading the team and works with the interdisciplinary team to ensure team addresses objectives identified in the member's ISP.

## STAR Kids Screening and Assessment Instrument (SAI)

As previously stated, the STAR Kids Screening and Assessment Instrument (SAI) is a tool which makes up the screening and assessment process. The SAI is an electronic assessment and screening tool that all-STAR Kids MCOs are required to administer to all STAR Kids members. The SAI helps determine personal preferences, service needs, and necessity of additional assessments.

BCBSTX prioritizes how quickly individual members receive the SAI based on urgency identified through initial telephonic screening and claims data. Priority 1 are members who become STAR Kids members after the operational start date and request immediate service. They are assessed within seven business days of requesting services. Priority 2 are those with complex medical or behavioral health needs or with an urgent need for services or service coordination; they are assessed within 30 business days of enrollment. Priority 3 include those with needs that are less variable and who are currently receiving the services they require to remain stable; they will be assessed within six months of enrollment. Six months after the operational start date, BCBSTX will attempt to schedule SAI within 15 business days of a new member's enrollment. All members are contacted by the assigned service coordinator to schedule a face-to-face comprehensive SAI in the member's home unless otherwise requested by the member or the member's LAR. The SAI will be completed by a BCBSTX RN Service Coordinator. The SAI core module will be used to:

- Determine member preferences
- Trigger for the Personal Care Assessment Module (PCAM), Nursing Care Assessment Module (NCAM), or both
- Identify follow-up assessment needs
- Help determine service coordination level
- Inform the development of the member's ISP



# Chapter 3

## Individual Service Plan

Upon completion of the SAI, a Person Centered Individual Service Plan (ISP) will be developed for each member and will include the assessment findings, short-and long-term goals mutually agreed upon by the member and member's LAR, service needs, and member preferences. The service coordinator is responsible for:

- Ensuring the creation of the ISP based on a comprehensive assessment of the goals, capabilities and medical condition of the member and with considerations of the needs and goals of the family
- Providing for an evaluation process that measures the member's response to care and ensures revision of the plan as needed
- Involving the PCP, member, and family in the development of the ISP, as appropriate
- Verifying that all necessary information is shared with key providers to facilitate the delivery of optimum care
- Reviewing the ISP no less than twice per year in order to determine if updates are needed
- Each member's ISP will include a combination of the following:
  - A summary document describing the recommended service needs identified through the SAI process
  - Covered services currently received
  - Covered services not currently received, but that the Member might benefit from
  - A description of non-covered services that could benefit the member
  - Member and family goals and services preferences
  - Natural strengths and supports of the member including helpful family members, community supports, or special capabilities of the member
  - A description of roles and responsibilities for the member, their LAR, others in the member's support network, key service providers, the member's Health Home, BCBSTX and the member's school where applicable
  - A plan for coordinating and integrating care between providers and covered and non-covered services
  - Short and long-term goals for the member's health and well-being
  - If applicable, services provided to the member through YES, TxHmL, DBMD, HCS, CLASS, or third party resources, and the sources or providers of those services
  - Plans specifically related to transitioning to adulthood for members age 15 and older
  - Any additional information to describe strategies to meet service objectives and member goals.
- Each member's ISP will be updated:
  - At least annually
  - Following a significant change in health condition that impacts service need
  - Upon request from the member or the member's LAR
  - At the recommendation of the member's PCP
  - Following a change in life circumstance
  - Following the STAR Kids Screening and Assessment process or re-assessment process

BCBSTX provides a printed or electronic copy of the ISP to each member or the member's LAR following any significant update and no less than annually. The ISP will also be provided to the member's providers and other individuals specified by the member or their LAR. The ISP will be written in plain language that is clear to the member or their LAR and can be provided in Spanish or other major languages if requested. Level 1 and 2 Service Coordinators will be responsible for reviewing the ISP prior to face-to-face visits to ensure that the document is up to date and adequately reflects the member's status, goals, preferences and needs. Level 3 Service Coordinator will review and monitor ISP during telephonic contacts/outreach to determine if member has had any change in status. BCBSTX will review and update each member's ISP no less than annually during a face-to-face visit.

## **Discharge Planning**

The service coordinator will also be responsible for supporting discharge planning for a member. The service coordinator will work with the member's PCP, the hospital or inpatient psychiatric facility discharge planner(s), the attending physician, the member, and the member's family to assess and plan for the member's discharge. Upon receipt of notice of a member's discharge from an inpatient psychiatric facility, service coordinators must contact the member within one business day. To the extent possible, the service coordinator will be responsible to ensure discharge planning begins before the member's discharge. Discharge planning will include establishing appropriate service authorizations. When long-term care is needed, the service coordinator will ensure that the member's discharge plan includes arrangements for receiving community-based services, as appropriate.

The service coordinator will work with the member, the member's family, and the member's PCP to ensure they are well informed of all service options available to meet the member's needs in the community. The service coordinator must assure timely access to service coordination and arrange for medically necessary or functionally necessary PCS or Nursing Services immediately upon the member's transition from a Nursing Facility or ICF/IID to the community.

## **Continuity of Care Transition Plan**

BCBSTX will ensure that the healthcare of newly enrolled members is not disrupted, compromised, or interrupted. In particular, BCBSTX will take special care to provide continuity in the care of enrolled members who are Medically Fragile and those whose physical or behavioral health could be placed in jeopardy if Medically Necessary Covered Services are disrupted, compromised, or interrupted.

Upon notification from a member or provider of the existence of a prior authorization, BCBSTX will ensure members receiving services through a prior authorization from either another MCO or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

1. 180 Calendar days after the transition to a new MCO,
2. Until the end of the current authorization period, or
3. Until the BCBSTX has appropriately evaluated and administered the STAR Kids Screening and Assessment Process and issued or denied a new authorization.

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BCBSTX will ensure that clients receiving community-based services prior to the Operational Start Date continue to receive those services for up to six months after the operational start date, unless BCBSTX has completed the STAR Kids Screening and Assessment Process and issued new authorizations as described in the above section.

BCBSTX allows pregnant members past the 24th week of pregnancy to remain under the care of the member's current OB/GYN through the member's postpartum checkup, even if the provider is out-of-network. If a member wants to change her OB/GYN to one who is in the network, she must be allowed to do so if the provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

BCBSTX will pay a member's existing out-of-network providers for medically necessary and functionally necessary covered services and equipment and supplies until the member's records, clinical information, and care can be transferred to a network provider. If the member requires follow-up care, the MCO may transfer the member's care to a network provider with a comparable certification, specialty, and expertise, in coordination with the out-of-network specialist physician and the member or the member's LAR. Payment to out-of-network providers must be made within the time period required for network providers. The MCO must comply with out-of-network provider reimbursement rules as adopted by HHSC.

With the exception of pregnant members who are past the 24th week of pregnancy, this requirement does not extend the obligation of BCBSTX to reimburse the member's existing out-of-network providers for on-going care for:

1. More than 180 days after a member enrolls in BCBSTX, or
2. For more than 12 months in the case of a member who, at the time of enrollment in BCBSTX, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in BCBSTX.

BCBSTX's obligation to reimburse the member's existing out-of-network provider for services provided to a pregnant member past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

BCBSTX must provide or pay out-of-network providers who provide medically necessary covered service to members who move out of the service area through the end of the period for which capitation has been paid for the member.

BCBSTX must 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, in accordance with 42 C.F.R. § 438.206(b)(4). BCBSTX will not be obligated to provide a member with access to Out-of-Network services if the services become available from a network provider. If a member's PCP or other provider determines that disrupting a member's existing relationship with an out-of-network provider would subject the member to unnecessary psychological or medical risk, the MCO must provide the member access to those out-of-network services through an appropriate agreement with the out-of-network provider.

BCBSTX will ensure that each member has access to a second opinion regarding the use of any medically necessary covered service. A member must be allowed access to a second opinion from a network provider or out-of-network provider, if a network provider is not available or does not have the clinical experience in a condition or treatment, at no cost to the member, in accordance with 42 C.F.R. § 438.206(b)(3). The requirements in this Section 8.1.23 regarding access to and payment of out-of-network providers apply only to out-of-network providers who are enrolled Texas Medicaid providers.

## VALUE-ADDED SERVICES

With BCBSTX STAR Kids, you have access to great doctors, hospitals, and pharmacies. We offer the following helpful Value-Added Services (VAS) at no cost to you:

### **Enhanced Eyewear for Kids**

BCBSTX will offer enhanced eyewear for members with a maximum expense not to exceed \$200 annually (above the standard Medicaid benefit) to be used for routine and specialty eyewear, upgrades to eyewear, and medically necessary contacts. Children who feel comfortable in their glasses are more likely to wear them, which can contribute to improved school performance and enhanced self-esteem. Children with special health care needs may need special glasses like goggles.

Limitations: STAR Kids will be limited to the maximum expense of up to \$200 annually above covered benefits after completion of an eye exam. This VAS applies after coverage has been provided by primary and secondary insurances. This benefit is only applicable to routine and specialty eyewear, upgrades to eyewear, medically necessary contacts, and cannot be converted to cash. The expanded benefit must be provided by an in-network Davis Vision provider. STAR Kids members ages 0 through-20 are eligible to receive the enhanced eyewear VAS.

### **Extra Help for Parents: Respite Care for Parents/LAR**

BCBSTX will offer a respite care value-added service for members in the MDCP STAR Kids program. This will be used to supplement the covered benefit of respite services. BCBSTX will offer eight hours of care a month for a total of 96 hours per year. Families may carry over eight hours' maximum from month to month. BCBSTX understands that it may be difficult for parents and LARs of children with special needs to have the time they require to tend to other family and self-care needs. BCBSTX believes allowing the families to use existing respite care providers offers the best continuity of care for the children and prevents them from using external providers who may not be familiar with the child's needs. Respite providers must be willing to bill BCBSTX through invoice for BCBSTX to cover this cost.

Limitations: This service is for MDCP STAR Kids members. Parent or LAR must work with BCBSTX Service Coordinators to receive the respite care value-added service. Parents and LARs will be limited to eight hours per month and a total of 96 hours of respite care per year with their existing or selected respite care provider. Members new to the program will work with their BCBSTX Service Coordinator to select an appropriate respite provider. Families can carry over eight hours' maximum from month to month for a total maximum of 16 hours per month. This respite value-added service does not count against any covered respite benefits. The member must be current on their service coordination plan to be eligible. This service is limited to day time 6 a.m. to 8 p.m. Central Time; not intended for overnight use. Respite providers must be willing to bill BCBSTX via invoice for members to receive this service.

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### **Incentive Gift Card for Attending Parent/LAR Peerto Peer Orientation and Resource Meeting**

BCBSTX will hold regular member orientation and resource meetings conducted by our contracted provider Texas Parent to Parent and our member outreach staff to orient members on services offered by the plan and various programs and resources available to members and their families in the community. BCBSTX will offer an incentive of \$25 for the STAR Kids member or parent/LAR to attend. BCBSTX will also provide transportation to the meeting using our NEMT VAS when face-to-face meetings are held. BCBSTX recognizes that caring for a child with special needs requires assistance with navigating the health care system and more than just taking care of the child's physical and behavioral health needs. Parents and LARs also need to be able to receive assistance understanding their child's benefits and guidance on accessing both plan, state and community services. The meeting will offer an opportunity for parents/LARs to consult with other parents and LARs of children with special needs. This service will be offered in addition to all the services provided through the member's service coordinator.

Limitations: BCBSTX STAR Kids members, and parent/LARs are eligible to attend these meetings as long as their child is enrolled in BCBSTX STAR Kids. One gift card per member family will be distributed for each meeting attended. These meetings will be offered via a phone or webinar session.

### **Hippotherapy or Therapeutic Riding Services**

BCBSTX will offer up to six sessions for a maximum of 1.5 hour each of hippotherapy or therapeutic riding sessions provided by a certified American Hippotherapy Association (AHA) Occupational or physical therapy facility or at a Professional Association of Therapeutic Horsemanship International (PATH) facility to STAR Kids members who meet therapy or therapeutic riding qualifications. Hippotherapy or therapeutic riding services will be provided to children based on their medical clearance by their PCP to participate in these services. Therapeutic riding services are used to engage social and interactive skills of the child while hippotherapy (Equine-Assisted Therapy) is a physical, occupational, and speech-language therapy treatment strategy that utilizes the dynamic movement of the horse to achieve therapy goals. Many children with physical and or behavioral health conditions may benefit from hippotherapy or therapeutic riding services while having a positive wellness experience during horse therapy services.

### **In-Home Delivery Meal Services**

BCBSTX recognizes that nutrition and healthy diet is an important factor in the overall health of our members. We offer a meal benefit that includes frozen meal delivery to qualifying members after hospital discharge. This will provide relief to our members, family and/or LAR so after hospital discharge, they may focus on ensuring the health care and safety of a member transitioning home rather than worrying about grocery shopping and meal preparation. The meals will include breakfast, lunch and dinner options. The meals can be chosen from a menu and options include specialized meals such as: heart friendly (800 mg or less of sodium, less than 30 percent fat per meal), diabetic friendly (75 grams or less of carbohydrates per meal), renal friendly meals designed for members on dialysis, cancer support meals based on nutritional guidelines from the American Institute for Cancer Research, pureed meals for members with dysphagia, gluten-free meals, vegetarian meals, and meals with low sodium (600 mg or less of sodium and less than 10 percent saturated fat).

**Limitations:** STAR Kids members who have been discharged from the hospital will be offered the option of ordering up to 12 meals from the meal services provider. Members will be offered the option of ordering up to three meals per day for up to four days. In-home meal delivery will only be available for two separate incidents per year for a maximum of 24 meals per year. Parents or LARs must work through their service coordinator to determine eligibility and to order the meals.

## **Non-emergency transport services**

BCBSTX can help you get a ride to your health care appointments, health classes or therapy. We will send a wheelchair van if needed.

Please call our Customer Service at **1-877-688-1811** at least 24 hours before your appointment to schedule. Members with hearing or speech loss may call the TTY line at **7-1-1**.

## **Recreational Safety Helmet**

Recreational safety helmets for STAR Kids members ages two through twenty.

Get the Safety Helmet form from the member website at [www.bcbstx.com/starkids](http://www.bcbstx.com/starkids) or by calling the Member Outreach toll-free at **1-877-375-9097**. Members with hearing or speech loss may call the Customer Service TTY line at **7-1-1**. Fill out the form (at the end of this chapter) with your doctor and have the doctor sign the form and add the office stamp. The form may be faxed to the Member Outreach at **1-512-349-4867**. The helmet will be sent to the address you list on the form.

Limitations: Members must have completed the Texas Health Steps Checkup within 90 days of joining the plan with their PCP or an annual Texas Health Steps Checkup and send in the completed paperwork.

## **Texas Health Steps Checkup Incentive**

BCBSTX will offer a \$50 gift card as an incentive for STAR Kids members to complete their Texas Health Steps Checkups for new members within 90 days of joining the plan. Existing members should complete checkups least annually. Timely checkups by the members' primary care physician (PCP) is important to maintain overall health.

Limitations: Must be a member of the plan at the time of the checkup(s). Members must have the checkup annually for existing members. New members can get the gift card for getting their check up with in the first 90 days of joining the plan.

## 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 Kids program. The Care Van Program has delivered hundreds of thousands of immunizations to date.

The Care Van conducts multiple outreach immunization events across Texas each year. BCBSTX sponsors events in our designated service areas. See our outreach event calendar to see when upcoming events will occur in your local area.

To view a listing of Care Van Immunization Events go to the Care Van website at [www.carevan.org/care\\_van\\_program.htm](http://www.carevan.org/care_van_program.htm)

To schedule the Care Van for your clinic or health-related event call **1-800-258-5437** and select Option 1 or send an email to [info@carevan.org](mailto:info@carevan.org).

## CASE-BY-CASE SERVICES

BCBSTX will offer case-by-case services that are non-Medicaid covered benefits based on availability and members' needs. These services can include additional services such as pregnancy-related services and programs above the standard Medicaid benefit for STAR Kids members who become pregnant as well as additional services for STAR Kids members dealing with family crisis. Work with your child's BCBSTX Service Coordinator for more information on case-by-case services.

## 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](http://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 and not therapies for ECI prescribed on IFSP)
- Radiology Services - PET/SPECT scans, CTAs and MRIs
- 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**.



## FORMULARY AND PRIOR AUTHORIZATION (PA)

Select medications on the formulary may require prior authorization. Medication utilization must meet Federal Drug Administration (FDA) approved indications as well as BCBSTX STAR Kids guidelines. Non-dual eligible members have unlimited number of appropriately used prescriptions. 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](http://bcbstx.com/provider/Medicaid/rx_prior_auth.html) or call Prime Therapeutics' Prior Authorization department at **1-855-457-1200**.

Fax: Please fax your PA forms to **1-877-243-6930**. To expedite request and review time, an online PA may be submitted via [covermymeds.com](http://covermymeds.com).

## EMERGENCY PRESCRIPTION SUPPLY

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

NCPDP Segment Name	NCPDP Field Number	NCPDP Field Name	Value
Claim Segment	461-EU	Prior Authorization Type Code	8
Claim Segment	462-EV	Prior Authorization Number Submitted	801
Claim Segment	405-D5	Days' Supply	3
Claim Segment	442-E7	Quantity Dispensed	Varies

Call Prime Therapeutics STAR Kids Pharmacy Help Desk at **1-855-457-0757** (Travis service area) and **1-855-457-0758** (MRSA Central service area) for more information about the 72-hour emergency prescription supply policy.

## PHARMACY SERVICES FOR STAR KIDS DUAL-ELIGIBLE MEMBERS/COORDINATION OF PHARMACY BENEFITS

For STAR Kids, Dual-Eligible members (Individuals who are both Medicare eligible and also eligible for some level of Medicaid prescription coverage), Federal law prohibits states from drawing federal Medicaid funds for drugs covered by Medicare Part D. Under the Medicare Modernization Act that created pharmacy coverage under Part D, certain drugs can be excluded from coverage. Pharmacies should bill directly to Medicare as primary for Part B and Part D drugs. Medicaid is the payor of last resort and provide wraparound benefit.

BCBSTX will continue to pay for some drugs not covered by Medicare (wraparound benefit), including:

- Over-the-counter drugs
- Cough and colds products.
- Vitamins and mineral products.
- Limited home health supplies
- Unlimited prescriptions are available only for members who are not covered by Medicare.

Medicare established the Limited Income Newly Eligible Transition (LI-NET) program January 1, 2010. The purpose of this program is to ensure that individuals with Medicare's Low Income Subsidy (LIS), who are not yet enrolled in a Part D prescription drug plan are still able to obtain immediate prescription drug coverage. The LINET also provides retroactive coverage for new dual eligible (those eligible to both Medicare and Medicaid).

To submit a claim to the LI-NET program, Medicare has provided all pharmacies with the required billing information below:

- BIN = 015599
- PCN = 05440000
- Cardholder ID = Medicare Health Insurance Claim

Number (HICN)

For questions about the LI-NET program:

Call **1-800-783-1307** or visit [www.cms.gov](http://www.cms.gov) and search for Medicare Limited Income NET Program

# Chapter 3

## 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
- Cellular therapy
- Chemolase injection (chymodiactin, chymopapain)
- Custodial care
- Dentures or endosteal implants for adults
- Ergonovine provocation test
- Excise tax
- Fabric wrapping of abdominal aneurysms
- Hair analysis
- Heart–lung monitoring during surgery
- 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
- 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)
- 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
- Parenting skills
- Payment for eyeglass materials or supplies regardless of cost if they do not meet Texas Medicaid specifications
- Payment to physicians for supplies is not an allowable charge. All supplies, including anesthetizing agents such as xylocaine, inhalants, surgical trays, or dressings, are included in the surgical payment
- Podiatry, optometric, and hearing aid services in long term care facilities, unless ordered by the attending physician
- Private room facilities except when a critical or contagious illness 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 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

# Chapter 3

- 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 ineligible, suspended, or excluded providers
- 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 flat foot conditions for solely cosmetic purposes

## **Durable Medical Equipment and Other Products Normally Found in a Pharmacy (also called limited home health supplies [LHHS])**

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](http://www.txvendordrug.com/formulary/limited-hhs.shtml).

BCBSTX will assist members to obtain a glucometer.

Providers are required to submit all claims for limited home health supplies through the Pharmacy Payment System. **These claims are processed as a pharmacy benefit, not 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 **1-855-212-1615** 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 **1-877-688-1811** 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

# Member Eligibility

## ELIGIBILITY VERIFICATION

BCBSTX electronically updates member eligibility received from HHSC. HHSC determines if individuals are eligible for Medicaid.

### **Confirm Member Identity**

To prevent fraud and abuse, providers should confirm the identity of the person presenting the ID card. All acute and LTSS 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.

## HOW TO VERIFY MEMBER ELIGIBILITY AND BCBSTX ENROLLMENT

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.

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](http://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 Medicaid eligibility and enrollment in BCBSTX 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 provider portal, by going online to [www.availity.com](http://www.availity.com). Registration is required to use this site.
  - The Availity portal provides a variety of features including:
    1. Eligibility status
    2. Covered benefits
    3. Claim status
    4. Claims appeals
    5. Medical record attachments
- Call BCBSTX Provider Services at **1-877-688-1811**.
- 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 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. Temporary cards can also be printed from the BCBSTX member website portal called Blue Access for Members.

**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](http://www.YourTexasBenefitsCard.com). A copy is required during the appeal process if the client’s eligibility becomes an issue.

## HOW TO RENEW

What do I have to do if I need help with completing my child’s renewal application?

Individuals enrolled in the STAR Kids program must maintain their Medicaid eligibility. Eligibility determination for Medicaid coverage vary for children enrolled in STAR Kids and is based on income and disability status. Coverage is based on annual eligibility determination, unless a significant change in health or income is identified/reported. The eligibility criteria for STAR Kids program is based on kids under 21 who receive:

- Social Security Income (SSI)/SSI-related Medicaid, &/or
- Home and Community-Based Services (HCBS) 1915 (c) waiver program services, including:
  - Medically Dependent Children Program (MDCP)
  - Deaf Blind with Multiple Disabilities (DBMD)
  - Home and Community-based Services (HCS)
  - Texas Home Living (TxHmL)
  - Community Living Assistance and Supports Services (CLASS)
  - Youth Empowerment Services (YES)



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\*With the exception of MDCP, individuals enrolled in a waiver program will continue to receive waiver services through their respective waiver and will receive Medicaid covered services through the STAR Kids Managed Care program.

BCBSTX will work with members to be sure:

- Members are aware of renewal timeframes
- Remember to update contact information with the Social Security Administration (SSA) and Office of Social Services (OSS), the state and federal resources that serve to evaluate coverage and make necessary determination for maintenance of coverage
- Respond to request made by the SSA and OSS to ensure no lapses in coverage
- Available assistance offered by BCBSTX to connect members' parents or LARs with appropriate eligibility offices or assist the member to understand request/forms. Families can also apply for standard Medicaid but must also apply for SSI if they have not already.

## SAMPLE STATE-ISSUED AND BCBSTX MEMBER ID CARDS




Following enrollment in the Medicaid STAR Kids program, each STAR Kids 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

Note: All providers should request and retain copies of Medicaid eligibility verification (ex H1027 portal transaction ID card) submitted by members as proof of eligibility. A copy is required during the appeal process.

Members may obtain a temporary ID card known as a form 1027A from HHSC if they lose their state issued ID card. They can also request a temporary ID from BCBSTX which they can print themselves from the member portal.


 <b>BlueCross BlueShield of Texas</b> <small>A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Member of the Blue Cross and Blue Shield Association</small>	 <b>TEXAS STAR Kids</b> <small>Your Health Plan • Your Choice</small>	 <b>TEXAS</b> <small>Health and Human Services</small>
Member Name: <b>DALTON R TEST2</b>	PCP: <b>MARTIAL</b>	
Alpha Prefix: <b>ABC</b>	<b>ARTS</b>	
Subscriber ID: <b>987654321</b>	<b>512-555-100</b>	
Medicaid ID Number: <b>123456789</b>		
PCP Effective Date: <b>01/01/2017</b>		
Rx Group No.: <b>123N</b>		
Rx BIN: <b>001155</b>		
Rx PCN: <b>TXCAID</b>		
PBM: <b>PRIME</b>		

## Sample Your Texas Benefits Medicaid Card

### Sample BCBSTX Medicaid (STAR Kids) ID Card


BCBSTX's Member ID card contains the following information:

- Child's name
- Child's Medicaid member ID number
- BCBSTX name and address
- The BCBSTX toll-free Customer Service phone number and TTY line
- Child's PCP's name and phone number
- Child's subscriber ID number
- The date the child's PCP was assigned to he or she (effective date)
- What to do in an emergency
- The phone number for the 24/7 Nurse Hotline, the toll-free nurse help line
- The phone number for behavioral health and prescriptions



**Member Name:**  
**MARLEY S TEST4**  
Alpha Prefix: ABC  
Subscriber ID: **987654321**  
Medicaid ID Number:  
**123456789**

**PCP Effective Date:** **03/01/2017**  
**Rx Group No.:** **555D**  
**Rx BIN:** **001155**  
**Rx PCN:** **TXCAID**  
**PBM:** **PRIME**



**PCP: TRAN WOOD**  
**512-555-1000**

**LONG TERM SERVICES AND SUPPORT BENEFITS ONLY:** You receive primary, acute and behavioral health services through Medicare. You receive only long term care services through BCBSTX.  
**SERVICIOS DE LARGO PLAZO Y DE APOYO ÚNICAMENTE:** Medicare proporciona atención médica básica, especializada y de salud mental. BCBSTX proporciona servicios de atención médica de largo plazo.

Note: A separate ID card is provided for dual-eligible. Dual eligible members are not required to have a PCP.

## Medicare/Medicaid Coordination

BCBSTX coordinates coverage for STAR Kids Dual Eligible members. Acute care services are the responsibility of the members Medicare plan. BCBSTX is responsible for the coverage of the LTSS benefits.

## Pharmacy Electronic Member Eligibility (STAR Kids)

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 **1-877-688-1811** can also assist with determining member eligibility or pharmacies. You can call the Prime Pharmacy Customer Service Help Desk at the number on Page 16.

Your Texas Benefits

Health and Human Services Commission

---

Member name: \_\_\_\_\_

Member ID: \_\_\_\_\_ 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.

Issuer ID: \_\_\_\_\_ Date card sent: \_\_\_\_\_


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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](http://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](http://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](http://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

You will get a new BCBSTX ID card if:

- You change your PCP.
- Your PCP's address or phone number changes.
- You lose your ID card.



**BlueCross BlueShield 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. 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

Claims: PO Box 51422  
Amarillo, TX 79159-

**bcbstx.com/Medicaid**  
(Medical/Prescription Drug/Visitation):  
24 hours/7 days a week  
Customer Service Servicio al Cliente  
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 24 hours/7 days a week  
TTY:  
Service Coordination/ Servicio de coordinación TTY:

**1-877-688-1811**  
**711**  
**1-855-802-4614**  
**711**  
**1-877-688-1811**  
**71**  
**1-800-424-0324**  
**1-800-635-2883**

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

Card Issued March 10



## Chapter 5

# ACUTE CARE 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.

\*For LTSS billing, see Chapter 8.

## 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 Kids) 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 to link to a sample image of that form followed by general instructions on how to complete its more important fields.

# Chapter 5

## 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 time frames.

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.)
<b>CMS-1500 Claim Form</b>	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
<b>CMS-1450 (UB-04) Claim Form</b>	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
<b>Third Party Liability (TPL) or Coordination of Benefits (COB)</b>	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"> <li>• 95 Days for CMS-1500 claims</li> <li>• 95 Days for CMS-1450 (UB-04) claims</li> </ul>
<b>Checking Claim Status</b>	Should you have a question about claims processing, as the first point of contact, contact your electronic connectivity vendor, i.e. Availity, your preferred vendor or by calling Customer Service.	30 business days after BCBSTX's receipt of claim, contact Customer Service at: <b>1-877-688-1811; TTY: 7-1-1</b>
<b>Provider Dispute</b>	To request a claim appeal, send your request in writing to:  <b>Blue Cross and Blue Shield of Texas</b> <b>Attn: Complaints and Appeals</b> PO Box 27838 Albuquerque, NM 87125-7838  You may also use our <b>Provider Appeal Request Form</b> .	120 calendar days from the receipt of BCBSTX Remittance Advice (RA) or notice of action.

## Chapter 5

### 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
<b>Emergency Services</b>	95 days from the date of service or discharge date	365 days
<b>Texas Medicaid Enrolled</b>	95 days with prior authorization if services are not available in Texas	365 days with prior authorization if services are not available in Texas
<b>Newly Enrolled in Texas Medicaid</b>	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
<b>Non-Texas Medicaid Enrolled</b>	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-day 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 **1-877-688-1811**.

# SUBMITTING A CLAIM

## Methods for Submitting Claims

There are three methods for submitting a claim:

1. Electronic Data Interchange (EDI) (preferred)
2. Paper or hard copy
3. Provider Portal Information

## Electronic Claims

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)
- Referring or ordering provider NPI
- 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 **1-877-688-1811**. 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.
- 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.

Contact BCBSTX's **Electronic Commerce Services** at [ecommerceservices@bcbstx.com](mailto:ecommerceservices@bcbstx.com) to:

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



# Chapter 5

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

## 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

## PROVIDER PORTAL

Availity™ Patients, Not Paperwork Overview Availity optimizes the flow of information between health care professionals, health plans and other health care stockholders through a secure internet-based exchange. The Availity Health Information Network encompasses administrative and clinical services, supports both real-time and batch transactions via the Web and electronic data interchange (EDI) and is HIPAA compliant. For more information, visit [www.availity.com](http://www.availity.com), call 1-800-AVAILITY (282-4548) or email [PECS@hcsc.net](mailto:PECS@hcsc.net).

Submit claims electronically through the Availity™ web portal, a plan-approved electronic billing system software vendor and/or clearinghouse. Through the provider portal, you can also check eligibility, benefits, claim status, submit appeals and medical record attachments.

## BEHAVIORAL HEALTH CLAIMS

Claims for 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)

# Chapter 5

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](http://www.nppes.cms.hhs.gov) or by obtaining a paper application by calling the NPPES number at **1-800-465-3203**.

### 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 STAR Kids 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](http://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.

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.

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:

Workgroup for Electronic Data Interchange: [www.wedi.org](http://www.wedi.org)

## 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 11
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 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 Kids 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.

## 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 Coordination of Benefits (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
- Three-digit Julian date
- Two-digit BCBSTX reel identification
- 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 check points 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](http://www.bcbstx.com/provider/claims/era.html).

## 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 **1-877-688-1811**.

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](http://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 **1-877-688-1811**. 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.availity.com](http://www.availity.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 **1-877-688-1811**
- 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

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: **1-855-235-1055**

Email: [GPDTXMedicaidAG@bcbsnm.com](mailto:GPDTXMedicaidAG@bcbsnm.com)

Providers may also submit provider appeals through the Availity online tool at [www.availity.com](http://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.

# Chapter 5

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 Kids 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

## 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.	<b>Use the member's ID number from the BCBSTX ID card.</b> 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 mailback 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.

Problem	Explanation	Resolution
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.
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.

# Chapter 5

Problem	Explanation	Resolution
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 6**

**ACUTE CARE  
BILLING  
PROFESSIONAL  
AND ANCILLARY  
CLAIMS**

## 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

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](http://www.magellanprovider.com).

### Clinician Administered Drugs

BCBSTX may reimburse providers only for clinician-administered drugs and biologicals whose manufacturers participate in the Centers for Medicare & Medicaid Services (CMS) Drug Rebate Program and that show as active on the CMS list for the date of service the drug is administered.

Clinician-administered drugs that do not have a relatable NDC will not be reimbursed. Please note there may be ingredients in a compound that are not considered a drug under the Federal Food, Drug, and Cosmetic Act.

The Texas NDC-to-HCPCS Crosswalk identifies relationships between National Drug Codes (NDC) and Healthcare Common Procedure Coding System (HCPCS) codes. The crosswalk is found on <http://www.txvendordrug.com>.

HCPCS codes listed on the NDC-to-HCPCS Crosswalk must have an appropriate NDC to HCPCS combination for the procedure code to be considered for payment; otherwise, these claims will be rejected.

Some drug products administered by a provider in outpatient settings are exempt such as vaccines, devices, and radiopharmaceuticals.

HCPCS units are billed by the number of units actually administered. The HCPCS procedure code description identifies the unit amount to calculate the number of units to be billed.

A provider must bill for only the units administered. Unused or wasted drug is not reimbursable for single or multi-use vials.

For more information, please visit <http://www.txvendordrug.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 woman, the health of the woman or her unborn child in serious jeopardy,
- Causing serious impairment to bodily functions, and
- 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 percent of the applicable rate when services are billed with 99284 and 99285. Hospital and physician reimbursement will be reduced by 40 percent 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.



# Chapter 6

## 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.

## 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 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

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).

## Texas Health Steps

Newly enrolled STAR Kids 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

## 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

## Chapter 6

### 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

### 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 Kids) 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

## 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 Kids 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.

- 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.)

# Chapter 6

- 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.
- 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 **1-877-688-1811** 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 Kids.

## Chapter 6

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>.

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 year 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 Kids 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 woman 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

## 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
Z9851	Tubal ligation status
Z9852	Vasectomy status



# Chapter 6

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	DiapHealth Risk Screeninggm 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
82646	Dihydrocodeinone

## Chapter 6

HCPCS/CPT	Description
82649	Dihydromorphinone
82654	Dimethadione
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](http://www.tmhp.com/Pages/Medicaid/medicaid_forms.aspx) under the **Legal** heading.

### TEXAS VACCINES FOR CHILDREN

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](http://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 **1-800-252-9152**.

## 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)*

# Chapter 6

\*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.

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

CPT Code	Description
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
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 (tetravalent), 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.)	

# Chapter 6

CPT Code	Description	Immunization Administration
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.)	
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 STAR Kids 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.

## ADDITIONAL BILLING RESOURCES

The following references provide detailed instructions on uniform billing requirements:

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

## 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 **1-800-621-8335**.
- 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 **1-800-621-8335**.

See the Texas Medicaid Provider Procedures Manual for billing tips: [www.tmhp.com/Pages/Medicaid/Medicaid\\_home.aspx](http://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 Kids 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](http://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 <input type="checkbox"/> <input type="checkbox"/>										PICA <input type="checkbox"/> <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> (Medicare#) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid#) <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) <input type="text"/>																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <input type="text"/>										3. PATIENT'S BIRTH DATE MM DD <input type="text"/>					SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial) <input type="text"/>																			
5. PATIENT'S ADDRESS (No., Street) <input type="text"/>										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) <input type="text"/>																			
CITY <input type="text"/>					STATE <input type="text"/>					8. RESERVED FOR NUCC USE <input type="text"/>					CITY <input type="text"/>					STATE <input type="text"/>																			
ZIP CODE <input type="text"/>					TELEPHONE (Include Area Code) ( ) <input type="text"/>					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <input type="text"/>					10. IS PATIENT'S CONDITION RELATED TO: <input type="text"/>					11. INSURED'S POLICY GROUP OR FECA NUMBER <input type="text"/>																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER <input type="text"/>					a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY <input type="text"/>					SEX M <input type="checkbox"/> F <input type="checkbox"/>																								
b. RESERVED FOR NUCC USE <input type="text"/>					b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) <input type="text"/>					b. OTHER CLAIM ID (Designated by NUCC) <input type="text"/>					c. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>																								
c. RESERVED FOR NUCC USE <input type="text"/>					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					10d. CLAIM CODES (Designated by NUCC) <input type="text"/>					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.																								
d. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>										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. <input type="text"/>										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <input type="text"/>																			
SIGNED <input type="text"/>										DATE <input type="text"/>										SIGNED <input type="text"/>																			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD <input type="text"/>					15. OTHER DATE MM DD YY <input type="text"/>					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																								
QUAL <input type="text"/>					QUAL <input type="text"/>					17a. <input type="text"/>					17b. NPI <input type="text"/>																								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <input type="text"/>										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) <input type="text"/>										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES <input type="text"/>																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate to service line below (24E) ICD Ind. <input type="text"/>										22. RESUBMISSION CODE ORIGINAL REF. NO. <input type="text"/>										23. PRIOR AUTHORIZATION NUMBER <input type="text"/>																			
A. <input type="text"/>		B. <input type="text"/>		C. <input type="text"/>		D. <input type="text"/>		E. <input type="text"/>		F. <input type="text"/>		G. <input type="text"/>		H. <input type="text"/>		I. <input type="text"/>		J. <input type="text"/>																					
DATE(S) OF SERVICE From MM DD YY To MM DD YY		PLACE OF SERVICE		EMG		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS POINTER		\$ CHARGES		DAYS OR UNITS		EPST Family Plan ID. QUAL.		RENDERING PROVIDER ID, #																							
1 <input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>																					
2 <input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>																					
3 <input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>																					
4 <input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>																					
5 <input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>																					
6 <input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>																					
25. FEDERAL TAX I.D. NUMBER <input type="text"/>					SSN EIN <input type="text"/>					26. PATIENT'S ACCOUNT NO. <input type="text"/>					27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					28. TOTAL CHARGE \$ <input type="text"/>					29. AMOUNT PAID \$ <input type="text"/>					30. Rsvd for NUCC Use <input type="text"/>									
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.) <input type="text"/>										32. SERVICE FACILITY LOCATION INFORMATION <input type="text"/>										33. BILLING PROVIDER INFO & PH # ( ) <input type="text"/>																			
SIGNED <input type="text"/>										DATE <input type="text"/>										a. <input type="text"/>					b. <input type="text"/>					a. <input type="text"/>					b. <input type="text"/>				

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

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

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

# Chapter 6

## 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](http://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 Kids 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).

# Chapter 6

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 Another 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 Identifier 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.

# Chapter 6

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 28 (M)	Total Charge	Total charge for each single line item.

Field #	Title	Explanation
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 7

# ACUTE CARE 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](http://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).

## Span of Coverage (Hospital) - Responsibility during a Continuous Inpatient Stay

If a member is disenrolled from a STAR Kids MCO and enrolled in another STAR Kids MCO during an inpatient stay, then the former STAR Kids MCO will pay all facility charges until the member is discharged from the hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, or until the Member loses Medicaid eligibility. The new STAR Kids MCO will be responsible for all other covered services on the effective date of coverage with the STAR Kids MCO.

**Note:** Daily rate claims for services rendered in a nursing facility or intermediate care facility for individuals with intellectual disabilities should be sent to TMHP.

## 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.

	Scenario	Hospital Facility Charge	All Other Covered Services
1	Member Moves from FFS to STAR Kids	FFS	New MCO
2	Member Moves from STAR, STAR Health or STAR+PLUS to STAR Kids	Former MCO	New MCO
3	Member Moves from CHIP to STAR Kids	New MCO	New MCO
4	Adult Member Moves from STAR Kids to STAR or STAR+PLUS	Former STAR Kids MCO	New STAR or STAR+PLUS MCO
5	Member Moves from STAR Kids to STAR Health	Former STAR Kids MCO	New STAR Health MCO
6	Member Retroactively Enrolled in STAR Kids	New MCO	New MCO
7	Member Moves between STAR Kids MCOs	Former MCO	New MCO

## 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.
- Value-Added Services, SSI and compound medications

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.
- Revenue codes required are 045X, 0516, 0526, 0700 or 072X, as well as CPT codes 99281-83.
- Bill each service date as a separate line item.

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## 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

**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.

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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.

## 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](http://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)**.

### 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.

1		2		3a PAT CNTL #		4 TYPE OF BILL	
R		B		R		R	
8 PATIENT NAME				9 PATIENT ADDRESS			
a				a			
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION	
R		R		C		C	
14 TYPE		15 SRC		16 DHR		17 STAT	
C		C		C		C	
31 OCCURRENCE DATE				35 CODE			
C				C			
33 OCCURRENCE DATE				36 CODE			
C				C			
32 OCCURRENCE DATE				37 CODE			
C				NR			
38				39 VALUE CODES AMOUNT			
B				C			
40 VALUE CODES AMOUNT				41 VALUE CODES AMOUNT			
C				C			
REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
R		R		C		C	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
R		R		B		NR	
PAGE		OF		CREATION DATE		TOTALS	
R		R		R		R	
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASSG BEN.	
R		B		B		B	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
C		B		R		R	
58 INSURED'S NAME		59 P.REL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
C		R		C		B	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
C		C		B		B	
66 DX		67		68		69	
C		R		NR		NR	
69 ADMIT DX		70 PATIENT		71 PPS		72	
R		B		B		B	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI		77 OPERATING NPI	
C		C		NR		B	
78 OTHER NPI		79 OTHER NPI		80 REMARKS		81CC	
B		B		C		a	
B		B		C		b	
B		B		C		c	
B		B		C		d	

SAMPLE

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## 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 Kids) 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](http://www.cms.hhs.gov) for more information.

## 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](http://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	Box Title	Description
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 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.

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Field	Box Title	Description
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.
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	Box Title	Description
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 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)	PATIENTREASON DX	Enter the member's reason for this visit, if applicable.
Field 71	PPS CODE	Prospective payment system (PPS) code. Leave blank.

Field	Box Title	Description
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.
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 AND ACUTE CARE PROVIDERS 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 II 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.



## 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](http://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](http://www.tmhp.com).

# Chapter 7

## 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](http://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](http://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](http://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](http://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 to DADS.

## 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.

## 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.

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## 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 8

# Long Term Services and Support

### INTRODUCTION

Long-term care services and support (LTSS) is a component of STAR Kids, a Texas Medicaid program servicing pediatric members with special needs.

LTSS are services provided on a long-term basis, not acute care as previously discussed in prior chapters.



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## **Personal Care Services**

Personal Care Services (PCS) are available to BCBSTX STAR Kids members based on medical and functional necessity and are provided in the home and community setting. Services include assistance with activities of daily living, household chores and nursing tasks that have been delegated by a registered nurse

## **Adaptive Aids and Medical Supplies/Custom DME**

Adaptive aids and medical supplies are specialized medical equipment and supplies including devices, controls and appliance that enable individuals with functional impairments to perform activities of daily living or perceive, control or communicate with the environment in which they live. BCBSTX is responsible for payment even if BCBSTX is not the MCO who authorized the service.

## **Private Duty Nursing**

Private Duty Nursing (PDN) includes but is not limited to the assessment and evaluation of a member's healthcare needs in the home or community environment and the direct delivery of nursing tasks, treatments and procedures ordered by a physician.

## **Minor Home Modifications**

Home modifications are services that provide adjustments and/or improvements to a member's home based on healthcare needs to enable them to reside in their residences. These modifications ensure safety and accessibility for the eligible member. BCBSTX is responsible to pay for minor home modifications approved by a prior MCO.

## **Respite Care Services**

Respite Care Services provides temporary relief to persons caring for pediatric members with special needs on an in-home and out-of-home basis.

## **Occupational, Physical and Speech Therapy Services**

Occupational, physical and speech therapy services include the evaluation, examination and treatment of physical, functional, speech and hearing disorders or impairments.

## **Consumer Directed Services/Financial Management Services (FMSA)**

Consumer Directed Services (CDS) enables members with disabilities to self-direct their care. This includes the hiring, managing and termination of an individual providing personal care services. CDS can be performed by the member, their Legal Authorized Representative (LAR) or by FMSA. In order to participate as a BCBSTX CDSA, the Provider must be specifically identified to perform to perform CDS by HHSC.

## **Employment Assistance**

Employment assistance (EA) is provided as an MDCP waiver service to a member to help the member locate competitive employment or self-employment. Providers must develop and update a quarterly plan for delivering these services.

## **Supported Employment**

Supported Employment (SE) services provide assistance as an MDCP waiver service to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home, or perform in a work setting at which members without disabilities are employed. Providers must develop and update a quarterly plan for delivering these services.

## **Program Objectives**

The program will provide services that allow children to remain safely in their homes, offer cost-effective alternatives to placement in nursing facilities and hospitals and support families in their roles as the primary caregivers for their children living with disabilities and other medical conditions.

## The Role of the RN Service Coordinator for LTSS

The RN Service Coordinator's responsibilities will include:

- Development of a cost-effective Individual Service Plan (ISP), using a person-centered/family-centered approach, that enables the member to live safely in their homes and the community.
- Determine the annual cost limit for each member's budget ensuring that the plan of care doesn't exceed the member's cost limit.
- Educate the member, their family or LAR regarding the Consumer Directed Services (CDS) option.
- Ensure that the need for minor home modifications and adaptive aids are addressed in the assessment process and the member's care plan.
- Determine that the member meets the disability and medical necessity criteria to participate in the MDCP program on an annual basis and attend all required training
- Sessions, initially and ongoing.

## Provider Responsibilities for Long Term Services and Supports

Long Term Services and Supports (LTSS) providers deliver a continuum of care and assistance ranging from in-home and community-based services for children and youth who get additional services through MDCP. LTSS providers have certain responsibilities for the STAR Kids program and the members they serve. This includes, but is not limited to:

- Contacting BCBSTX to verify member eligibility and/or authorizations for service.
- Providing continuity of care.
- Coordinating with Medicaid and Medicare.
- Notifying BCBSTX of any change in member's physical condition or eligibility.

LTSS providers are required to provide covered health services to members in accordance with their BCBSTX agreement and their licensure.

## Community First Choice (CFC)

### Provider Responsibilities

- The CFC services must be delivered in accordance with the Member's service plan.
- The program provider must maintain current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable)
- The HCS or TxHmL program provider must ensure that the rights of the Members are protected (ex. e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the Member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the Member that are required to ensure the Member's health, safety, and welfare. The program provider must maintain documentation of this training in the Member's record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (ex. e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the Member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline. **(1-800-647-7418)**.
- The program provider must address any complaints received from a Member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the Member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, Member (or someone on behalf of a Member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the Member/LAR of CFC PAS or habilitation (HAB) service providers is procured.

# Chapter 8

- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the MCO financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a Member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a Member, including unauthorized disclosure of information related to a Member's finances and the purchase of goods that a Member cannot use with the Member's funds.

## **Provider Responsibilities for Employment Assistance (EA) and Supported Employment (SE)**

EA services include, but are not limited to, the following:

- Identifying a member's employment preferences, job skills, and requirements for a work setting and work conditions;
- Locating prospective employers offering employment compatible with a member's identified preferences, skills, and requirements; and
- Contacting a prospective employer on behalf of a member and negotiating the member's employment.

SE provides the supports necessary in order to sustain paid employment. SE Services include, but are not limited to, the following:

- Employment adaptations, supervision, and training related to a member's diagnosis; and
- If the member is age 21 or under, ensure provision of SE, as needed, if the services are not available through the local school district

The Provider must develop and update quarterly a plan for delivering EA/SE including documentation of the following information:

- Name of the member.
- Member's employment goal.
- Strategies for achieving the member's employment goal, including those addressing the member's anticipated employment support needs.
- Names of the people, in addition to the member, whose support is or will be needed to ensure successful employment placement, including the corresponding level of support those persons are providing or have committed to providing.
- Any concerns about the effect of earnings on benefits, and a plan to address those concerns,
  - Progress toward the member's employment goal
  - If progress is slower than anticipated, an explanation of why the documented strategies have not been effective, and a plan improve the effectiveness of the member's employment search

## Claims Filing for LTSS Providers

All Providers rendering LTSS services, with the exception of atypical providers, must use the CMS 1500 Claim Form or the HIPAA 837 Professional Transaction when billing claims. Providers will bill and report LTSS in compliance with the STAR Kids LTSS Health Care Common Procedure Codes (HCPC) and STAR Kids Modifiers Matrix (Matrix). The billing requirements will be made on the BCBSTX website at <http://www.bcbstx.com/provider/medicaid/index.html>.

Atypical providers are LTSS providers that render non-health or non-medical services to STAR Kids members. Examples of atypical providers include pest control services, home modification services, etc. Atypical providers will submit appropriate documentation to BCBSTX to accurately populate an 837 Professional Encounter.

Some STAR Kids members receive LTSS services that are not covered by BCBSTX and should be submitted to the appropriate payer. For a list of eligible LTSS services and the appropriate payer, please refer to the reference grid on the following page.

## Important Information for LTSS Service Providers

In summary, LTSS Service providers are required to:

- Verify member eligibility and obtain necessary referrals and authorizations prior to the provision of services.
- Bill and report LTSS services with compliant coding. Refer to the LTSS required billing codes and modifiers on the next page.
- Notify service coordinator if there is a change in the member's physical or mental condition.
- Coordinate Medicare and Medicaid benefits appropriately.

## 1915(i) Home and Community Based Services- Adult Mental Health (HCBS-AMH)

Home and Community Based Services-Adult Mental Health (HCBS-AMH) is a state-wide program that provides home and community-based services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each need, to enable him or her to live and experience successful tenure in their chosen community. Services are designed to support long term recovery from mental illness.

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Refer to the sample LTSS Billing Matrix on Page 301 for details.

Star Kids Coverage Type	LTSS Benefits Covered by BCBSTX		
	Non Waiver	Non Waiver Dual Eligible	MDCP
State Plan LTSS - Requires Prior Authorization			
Personal Care Services (PCS)	X	X	
Private Duty Nursing (PDN)	X	X	X
Prescribed pediatric extended care center (PPECC)	X	X	X
Day Activity and Health Services (DAHS)	X	X	X
CFC Services for Qualified Members - Requires Prior Authorization			
CFCPAS/HAB	X	X	X
ERS	X	X	X
Support Management	X	X	X
Waiver Services - Requires Prior Authorization			
Respite			X
Supported Employment			X
Employment Assistance			X
Adaptive Aids			X
Minor home modification			X
Flexible family support services			X
Transition assistance services			X
Financial management services			X

LTSS Benefits Covered by BCBSTX				
MDCP Dual Eligible	DADS IDD Waiver	DADS IDD Waiver Dual Eligible	YES Waiver	YES Waiver Dual Eligible
X	X	X	X	X
X	X	X	X	X
X	X	X	X	X
X			X	X
X			X	X
X			X	X
X	Submit Claims to DADS for IDD Waiver Services		Submit Claims to DSHS for YES Waiver Services	
X				
X				
X				
X				
X				
X				
X				



## ELECTRONIC VISIT VERIFICATION (EVV)

### What is EVV?

EVV is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends.

EVV is a method by which a person, including but not limited to, a personal care attendant, who enters a STAR Kids member's home to provide a service will document their arrival time and departure time using a telephonic or electronic small alternative device provided by the EVV vendor. This visit information will be recorded and used as an electronic version of a paper time sheet for an attendant and used to support claims to BCBSTX for designated EVV services.

### Can a member or provider elect not to use EVV?

The use of EVV is mandatory in Texas Medicaid for those services noted below, with some exceptions. All providers must select an EVV vendor from one of two options.

EVV will be required to document delivery of the following STAR Kids services:

- Personal care services (PCS)
- Community First Choice attendant care and habilitation (PAS/HAB)
- MDCP In-Home Respite
- MDCP flexible family support services

### Is EVV required for CDS employers?

CDS employers are not required to use EVV.

If you are a CDS Employer, there are three EVV options:

- No EVV Participation: If you do not have access to a computer, assistive devices, or other supports, or you do not feel you can fully participate in EVV, you may choose to use a paper time sheet to document service delivery.
- Phone and Computer (Full Participation): The telephone portion of EVV will be used by your Consumer Directed Services (CDS) Employee(s) and you will use the computer portion of the system to perform visit maintenance.
- Phone Only (Partial Participation): This option is available to CDS Employers who can participate in EVV, but may need some assistance from the FMSA with visit maintenance. You will use a paper time sheet to document service delivery. Your CDS Employee will call-in when they start work and call-out when they end work. Your FMSA will perform visit maintenance to make the EVV system match your paper time sheet.

### Will there be a cost to the provider for the access and use of the selected EVV vendor system?

EVV transaction costs will be paid by BCBSTX through direct contracts with the EVV vendors. No EVV transaction costs will be passed on to service providers or to members.

## Do providers have a choice of EVV vendors?

Yes, providers have choice of EVV vendor.

- Provider selection of EVV vendor
  - During the contracting and credentialing process with BCBSTX, a copy of the Provider Electronic Visit Verification Vendor System Selection Form should be provided in the application packet. Forms are located at <http://www.bcbstx.com/provider/medicaid/forms.html>.
- Provider EVV default process for non-selection
  - Mandated providers that do not make an EVV vendor selection or who do not implement use of their selected vendor, are subject to contract actions and are defaulted to a selected vendor by HHSC. The provider will receive a default letter detailing out the vendor that they have been defaulted to and when they are required to be implemented with the vendor.

## When can a provider change EVV vendors?

- A provider may change EVV vendors 120 calendar days after the submission request by completing the Medicaid EVV Provider System Selection Form.
- A provider may change EVV vendors twice in the life of their contract with BCBSTX.

## How do providers with assistive technology (ADA) needs use EVV?

If you use assistive technology, and need to discuss accommodations related to the EVV system or materials, please contact the HHSC-approved EVV vendors.

DataLogic (Vesta) Software, Inc.

Contact:	Email:	Phone:
Sales & Training	<a href="mailto:info@vestaevv.com">info@vestaevv.com</a>	1-(888)-880-2400
TechSupport	<a href="mailto:support@vesta.net">support@vesta.net</a>	
Website: <a href="http://www.vestaevv.com">www.vestaevv.com</a>		

MEDsys Software Solutions, LLC

Contact:	Email:	Phone:
Texas Dedicated Support and Sales Number	Sales: <a href="mailto:info@medsyshcs.com">info@medsyshcs.com</a>	Support: 1-(877)-698-9392; Option 1
		Sales: 1-(877)-698-9392; Option 2
Website: <a href="http://www.medsyshcs.com">www.medsyshcs.com</a>		

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## **EVV use of small alternative device (SAD) process and required SAD forms.**

- The SAD process is found at: [http://www.dads.state.tx.us/evv/docs/ProviderAlternativeDeviceNotification\\_3-2015.pdf](http://www.dads.state.tx.us/evv/docs/ProviderAlternativeDeviceNotification_3-2015.pdf)
- SAD forms can be found at <http://www.bcbstx.com/provider/medicaid/forms.html>
- Where do I submit the SAD agreement/order form?
  - The form is submitted to the provider-selected EVV vendor.
    - a. DataLogic - email form to: [tokens@vestaevv.com](mailto:tokens@vestaevv.com) or send secure efax to **1-956-290-8728**
    - b. MEDsys - email form to: [tokens@medsysshcs.com](mailto:tokens@medsysshcs.com) or send secure fax to **1-888-521-0692**
    - c. Equipment provided by an EVV contractor to a provider, if applicable, must be returned in good condition.

## **EVV Compliance**

All providers providing the EVV mandated services must use the EVV system and must maintain compliance with the following requirements:

- Providers must enter Member information, Provider information, and service schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual system.
- Provider Agencies must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.
- Provider agencies maintain 90% adherence to HHSC's EVV Initiative Provider Compliance Plan
  - HHSC EVV Initiative Provider Compliance Plan – A set of requirements that establishes a standard for EVV usage that must be adhered to by Provider Agencies under the HHSC EVV initiative.
  - Provider Agencies must achieve and maintain an HHSC EVV Initiative Provider Compliance Plan Score of at least 90 percent per Review Period.
  - Reason Codes must be used each time a change is made to an EVV visit record in the EVV System
  - The HHSC Compliance Plan is located at: [http://www.dads.state.tx.us/evv/complianceplan/HHSC\\_EVV\\_Provider\\_Compliance\\_Plan.pdf](http://www.dads.state.tx.us/evv/complianceplan/HHSC_EVV_Provider_Compliance_Plan.pdf)
- Provider agencies must maintain adherence to the BCBSTX compliance plan which can be found at [www.bcbstx.com/starkids](http://www.bcbstx.com/starkids).
- The Provider Agency must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
- The Provider Agency must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
- Providers should notify BCBSTX, or HHSC, within 48 hours of any ongoing issues with EVV vendors or issues with EVV Systems.
- Any Corrective action plan required by BCBSTX must be submitted by the Network Provider to BCBSTX within 10 calendar days of receipt of request.
- Provider Agencies may be subject to termination from the network for noncompliance and may also be subject to corrective action plans or liquidated damages.

## Will training be offered to providers?

Yes, BCBSTX will offer training on EVV as a component of STARKids provider training. Topics covered in this training will include services requiring EVV, EVV vendor selection, and compliance requirements. Providers will also receive systems training from the EVV vendors. EVV vendor training materials can be found on each EVV vendor website.

## Will claim payment be affected by the use of EVV?

- Providers must submit Electronic Visit Verification data before claims are submitted. This must be done in a timely manner since provider claims cannot be paid until verification of a visit has been completed.
- Submission of EVV data does not guarantee claims payment. Clean claims must still be submitted to BCBSTX within 95 calendar days of the EVV visit.
- Provider agencies must complete any and all required visit maintenance in the EVV system within 60 days of the visit (date of service). Visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. No visit maintenance will be allowed more than 60 days after the date of service and before claims submission, unless an exception is granted.
- Providers must adhere to EVV guidelines in the Provider compliance plan when submitting a claim.

Each time visit maintenance is needed on a visit, providers must explain the specific reason a change was made to an EVV visit record using reason codes. Providers must associate the most appropriate reason code with each change made and enter any required free text in the comment section. A single visit may have more than 1 reason code associated with it. The list of current reason codes can be found at <https://www.dads.state.tx.us/evv/reasoncodes.html>

Reason codes fall into 1 of 2 categories:

- Preferred Reason Codes that document visit maintenance necessitated by a situation in which providers are delivering and documenting services in accordance with HHSC expectations.
- Non-Preferred Reason Codes that document visit maintenance that is necessitated by a situation in which providers are not delivering and documenting services in accordance with HHSC expectations.

## EVV Complaint Process

Provider complaints regarding the EVV process should be submitted in accordance with the procedures set forth in the following BCBSTX Medicaid Managed Care Provider Complaint/Appeal Process section.

Providers may also submit complaints regarding an EVV vendor to [Electronic\\_Visit\\_Verification@hhsc.state.tx.us](mailto:Electronic_Visit_Verification@hhsc.state.tx.us).

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## What if I need assistance?

For questions, please call Provider Relations and Network Management at **1-855-212-1615**.

## Adult Transition Planning

BCBSTX will help to assure that teens and young adult members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. BCBSTX is responsible for conducting ongoing transition planning starting when the member turns 15 years old. BCBSTX must provide transition planning services as a team approach through the named service coordinator if applicable and with a transition specialist within the Member Services Division. Transition specialists will be an employee of BCBSTX and wholly dedicated to counseling and educating members and others in their support network about considerations and resources for transitioning out of STAR Kids. Transition specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the Member in the transition process. Transition planning must include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service.
2. Prior to the age of 10, BCBSTX will inform the member and the member's LAR regarding LTSS programs offered through the Department of Aging and Disability Services (DADS) and, if applicable, provide assistance in completing the information needed to apply. DADS LTSS programs include CLASS, DBMD, TxHmL, and HCS.
3. Beginning at age 15, BCBSTX will regularly update the ISP with transition goals.
4. Coordination with DARS to help identify future employment and employment training opportunities.
5. If desired by the member or the member's LAR, coordination with the Member's school and Individual Education Plan (IEP) to ensure consistency of goals.
6. Health and wellness education to assist the member with self-management.
7. Identification of other resources to assist the member, the member's LAR, and others in the member's support system to anticipate barriers and opportunities that will impact the member's transition to adulthood.
8. Assistance applying for community services and other supports under the STAR+PLUS program after the member's 21st birthday.
9. Assistance identifying adult health care providers.

## Coordination with Non-Managed Care (Non-BCBSTX) Medicaid Covered Services

The State of Texas has chosen to provide certain member services under individual contracts with different 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.

The following Texas programs, services, or benefits have been excluded from BCBSTX STAR Kids Covered Services. Members may be eligible to receive these services on another basis, such as a fee-for-service basis or through a dental MCO (for most dental services). These services are described in the Texas Medicaid Provider Procedures Manual (TMPPM):

- Texas Health Steps dental (including orthodontia);
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) case management/service coordination;
- Early Childhood Intervention Specialized Skills Training;
- Case Management for Children and Pregnant Women;
- Texas School Health and Related Services (SHARS);
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program;
- Tuberculosis services provided by DSHS-approved Providers (directly observed therapy and contact investigation);
- DADS hospice services;
- DADS or DSHS HCBS Waiver programs, authorized under Social Security Act § 1915(c), including Youth Empowerment Services (YES), Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Texas Home Living (TxHmL), and Home and Community-based Services (HCS);
- Court-Ordered Commitments to inpatient mental health facilities as a condition of probation; and
- Nursing facility services and intermediate care facility (ICF) services.
- PASRR screenings, evaluations, and specialized services
- Health and Human Services Commission's Medical Transportation Program (MTP);

# Chapter 8

## Summary of MTP Services

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 **1-877-633-8747** (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 STAR Kids BCBSTX 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 3 of this manual.

Although BCBSTX is not responsible for paying or reimbursing the services above, BCBSTX is responsible for educating members about the availability of these services, and for providing appropriate referrals for Members to obtain or access these services. BCBSTX Providers must submit claims for the services above to HHSC's claims administrator for reimbursement. BCBSTX will not reimburse providers for any of these services performed for BCBSTX STAR Kids members.

Full-risk Broker (FRB) Vendors are vendors that receive capitation payment to provide a full array of transportation services to clients in a specified geographic area. HHSC has contracted with two full-risk brokers: Medical Transportation Management (MTM), Inc. provides service in the Houston/Beaumont area, and Logisticare, LLC provides service in the Dallas/Fort Worth area. Since BCBSTX is in the Travis Service Area these FBV's are not providing services, the services are provided by the HHSC MTP program



## Chapter 9

# BEHAVIORAL HEALTH



## BEHAVIORAL HEALTH – PROGRAM OVERVIEW AND DEFINITION

In order to meet the behavioral health needs of STAR Kids members, Blue Cross and Blue Shield of Texas has contracted with Magellan Providers of Texas, Inc. (Magellan) to provide a continuum of services to individuals at risk of or suffering from mental, addictive, or other behavioral disorders.

Magellan offers a variety of behavioral health services which include: assessment and treatment planning, psychiatric services, medication management, inpatient Hospital services which includes services provided in Freestanding Psychiatric facilities, intensive outpatient services, case management services, outpatient therapy and substance abuse services.

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

Behavioral health is defined as “A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual.

- Is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom
- Must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one
- A manifestation of a behavioral, psychological, or biological dysfunction in the individual
- Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual

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.

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.

## COVERED BEHAVIORAL HEALTH SERVICES

Magellan provides comprehensive behavioral health services for STAR Kids members. Behavioral health and substance abuse services offered include:

- Inpatient mental health services (includes services provided in freestanding Psychiatric facilities)
- Outpatient mental health services
- Psychological Testing
- Psychiatry services
- Counseling services for adults (up to age 20)
- 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
- Partial Hospitalization
- Intensive outpatient care
- \*Telehealth

For more information on covered services and authorization requirements please contact Magellan **1-800-424-0324**.

\*Telecommunications must be the combination of audio and live, interactive video. Magellan requires that providers complete and return an attestation prior to the provision of telehealth services before they can be rendered. If you are a behavioral health provider equipped to provide telehealth services please contact **1-800-327-6860** to obtain an attestation. Providers offering telehealth services are responsible to comply with all Magellan, state and federal telehealth regulations and guidelines. For more information on covered services please contact Magellan at **1-800-424-0324**.

## PRIMARY CARE PROVIDER RESPONSIBILITIES FOR BEHAVIORAL HEALTH (EXCLUDES STAR KIDS DUAL ELIGIBLE)

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.
- 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
- Contact Magellan to request assistance in locating behavioral health providers as is necessary
- 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 any network behavioral health provider. Members and Providers have access to Magellan 24 hours a day 7 days a week to get help or information about the STAR Kids program, please contact Magellan at **1-800-424-0234**.

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.

\* Dual-eligible receive PCP services and behavioral health service from their Medicare plan.

### **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. STAR Kids members can receive assessment and treatment services for ADHD diagnosis by Magellan contracted providers. Individuals with ADHD may be eligible for additional disease management services delivered by Magellan clinicians. The ADHD clinical practice guideline is available to providers by accessing the following link <http://www.magellanprovider.com/providing-care/clinical-guidelines.aspx>. Reimbursement for these services will be determined according to the Provider Agreement.

## **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 any necessary pre-authorizations from Magellan by contacting them at **1-800-424-0324**.

## **Coordination between Behavioral Health and Physical Health Services**

Magellan appreciates the importance of the therapeutic relationship and strongly encourages continuity, collaboration and coordination of care. Collaboration and communication among providers participating in a member's healthcare is essential for the delivery of integrated quality care. Timely and confidential exchange of information is expected, with written authorization from the member, behavioral health providers will communicate key clinical information in a timely manner to all other providers participating in a member's care which includes the member's primary care physician. Behavioral health providers are responsible for explaining to the member the purpose and importance of communicating clinical information with other relevant health care providers. At the initial treatment sessions, behavioral health providers should at the initial treatment session, obtain the names and addresses of all relevant healthcare providers involved in the member's care. Behavioral health providers should obtain written authorization from the member to communicate significant clinical information to other relevant providers. Upon obtaining appropriate authorization, communicate in writing to the PCP, at a minimum, at the following points of treatment: initial evaluation, significant changes in diagnosis, treatment plan, or clinical status, after medications are initiated, discontinued or significantly altered, and at termination of treatment.

## **Coordination with Local Mental Health Authority (LMHA) and State Psychiatric Facilities**

Magellan will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities for treatment of members with Severe and Persistent Mental Illness (SPMI) and Severe Emotional Disturbance (SED), as well as members committed by a court of law to a state psychiatric facility, to support and provide the most appropriate care. In coordination with the LMHA, Magellan will authorize additional behavioral health services for special populations, and will assist its behavioral health providers in meeting with these requirements.

Behavioral health providers are expected to understand STAR Kids standards that are applicable to providers, meet and refer members to LMHAs as appropriate, as well as accept referrals from LMHAs. Magellan will operate a toll-free telephone hotline to respond to questions, comments and inquiries. In addition, Magellan will provide covered services to members with SPMI/SED when medically appropriate. Magellan will coordinate treatment with all providers, including other behavioral health providers, medical providers, and LMHAs as is clinically appropriate.

## **Behavioral Health Assessment Instruments for Primary Care Providers**

In addition to the screening tools provided in the Texas Medicaid Provider Procedures Manual, more tools are available by contacting Magellan Customer Service department at **1-800-424-0324** or by visiting [www.MagellanPCPtoolkit.com](http://www.MagellanPCPtoolkit.com).

## **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

Currently there are no utilization management reporting requirements specific to individual mental health service type.

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

## **Substance Use Disorder or Specialized Service Coordination- The Role of the Provider**

Providers are encouraged to stay engaged with the member's Service Coordinator in order to maintain an appropriate Person-Centered Care Plan which details the supports and services the member may require along with the member's individual health goals. For additional information and to reach a Service Coordinator please contact **1-877-301-4394**.

## **Court-Ordered Commitments**

Magellan will provide inpatient psychiatric services to members less than 21 years of age, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction, under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, related to Court-Ordered Commitments to psychiatric facilities. Behavioral health providers are required to contact the designated Magellan care management team member by telephone if they become aware of a court-ordered commitment. Behavioral health providers should be prepared to provide to Magellan's care manager or physician advisor with the assessment of the member's clinical condition.

## **Follow up after Hospitalization for Behavioral Health Services**

Follow up care begins at inpatient admission. When a member is admitted, Magellan's follow up team is responsible for coordinating with the utilization review or discharge planner at the facility to offer assistance with the member's aftercare. Magellan's Care Manager will review the anticipated discharge and follow up plan for the member and actively collaborates with the facility to support the member's comprehensive discharge plan. Members discharged from inpatient psychiatric facilities need to have a scheduled ambulatory service within seven (7) days of discharge. For questions regarding the follow up process please contact Magellan's Ambulatory Follow Up Team at **1-800-344-1255** for additional information.

## **Magellan's Claims Address**

**Magellan**

**Attn: Claims**

P.O. Box 2154

Maryland Heights, MO 63043

## **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.

## **CONSENT FOR DISCLOSURE OF INFORMATION**

Magellan believes in protecting all member health information which can only be released with written consent. Behavioral health providers are required to obtain the necessary written authorization from the member or their legal representative to communicate key clinical information.

## **Mental Health Rehabilitative Services and Targeted Case Management**

Mental Health Rehabilitative (MHR) Services and Targeted Case Management (TCM) are available to eligible STAR Kids Members with Severe and Persistent Mental Illness (SPMI) or Severe Emotional Disturbance (SED). Mental Health Rehabilitative (MHR) services include adult day program, medication training and support services, crisis intervention, skills training and development and psychosocial rehabilitative services. Targeted Case Management (TCM) includes both routine and intensive case management services. TCM services must be face-to-face, include regular, but at least annual, monitoring of service effectiveness, include proactive crisis planning and management for individuals.

Severe and persistent mental illness (SPMI) means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by: Impaired functioning or limitations of living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder. Impaired emotional or behavioral functioning that interferes substantially with the Member's capacity to remain in the community without supportive treatment or services.

# Chapter 9

Severe Emotional Disturbance (SED) means psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.

Mental Health and Rehabilitative (MHR) Services and Mental Health Targeted Case Management (TCM) services are available to STAR Kids recipients who are assessed and determined to have: A severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorder. Any STAR Kids member with a diagnosis of a mental illness or who exhibit a serious emotional disturbance.

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:** Skill 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 to age 20)

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 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) tools 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.

All providers delivering mental health rehabilitative and mental health targeted case management must undergo training as is outlined in HHSC's UMCM Chapter 15.3. Training and certification to administer the Child and Adolescent Needs and Strengths (CANS) assessment tool for members between the ages of 0-18 years of age and the Adult Needs and Strengths Assessment (ANSA) for members 19 and 20 is required. Providers are required to attest annually as having completed the required trainings as outlined in Chapter 15.3. Providers may choose one format (i.e. DVD or in-person training) and are not required to complete the training in multiple formats. For additional information on completing the attestation please contact Magellan at **1-800-424-0324**.

Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths Assessment (CANS) will be utilized for consistency in assessment for services. Magellan will ensure that providers use, and are trained and certified to administer, the ANSA and CANS assessment tools to recommend a level of care to Magellan by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. In addition, Magellan will also ensure that providers complete the Texas Standard Prior Authorization Request Form for Health Care Services and submit to Magellan. The form may be faxed to **1-888-656-5712** or mailed to: Magellan Healthcare ATTN: TCM/ Rehabilitative Services Authorization Request P.O. Box 1619 Alpharetta, GA 30009-9930.

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

## PRIMARY AND SPECIALTY SERVICES

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

- Behavioral health clinicians available 24 hours day/seven days 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
- 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 Kids members may self-refer to any Magellan network behavioral health services provider by calling Customer Service at **1-800-424-0324**. No precertification or referral is required from the PCP.

Providers may refer members for services by calling Magellan at **1-800-424-0324**.

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

## MEDICAL RECORDS DOCUMENTATION

In support of our commitment to quality care, Magellan requests that its contracted providers maintain organized, well-documented member treatment records that reflect continuity of care for members. We expect that all aspects of treatment will be documented in a timely manner using the most current Diagnostic and Statistical Manual of Mental Disorders (DSM).



## 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 **1-877-688-1811** or fax **1-855-879-7180**.

## 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 **1-877-688-1811** 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 **1-855-879-7180** 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](http://www.availity.com).

Providers who need to reach Utilization Management after hours should call **1-877-688-1811** and use the afterhours prompt. An on-call nurse will provide assistance.

**For after-hours assistance, not available on the website**, call the Customer Service at **1-877-688-1811** 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 STAR Kids Provider Manual or STAR Kids 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 Customer Service at **1-877-688-1811**.

### 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.

# Chapter 10

## 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 members' 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 **1-877-688-1811**.

## Decision and Screening Criteria

The TX Medicaid time lines for decisions are in alignment with the requirements of HHSC and 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 **1-877-688-1811**.

## PRIOR AUTHORIZATION

### ACUTE CARE SERVICES REQUIRING PRIOR AUTHORIZATION

The services listed below require authorization prior to providing services to STAR Kids 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](http://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 **1-877-688-1811** or Fax **1-855-879-7180**.

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.

# Chapter 10

## TO REQUEST PRIOR AUTHORIZATION

To request Prior Authorization (PA), report a medical admission, or ask questions regarding PA, please contact Utilization Management at **1-877-784-6802**.

### Services Requiring Prior Authorization

Service / Request	Is Prior Authorization (PA) required for in-network providers?
Air Ambulance	Yes; authorization requirements vary by level of care.
Ambulance – Ground	Yes. Non-emergent transport from facility to facility requires authorization prior to services being rendered.
Mental Health/Substance Abuse Services	Yes. Please contact Magellan at <b>1-800-424-0324</b> for more information.
Biofeedback	Yes.
Dental Services	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.  For preventive dental care, please call the member's selected dental plan:  DentaQuest <b>1-800-516-0165</b> MCNA Dental <b>1-855-691-6262</b>

Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p><b>Durable Medical Equipment (DME) and Disposable Supplies</b></p> <p>For DME not listed or any other questions regarding DME, contact Utilization Management at <b>1-877-688-1811</b>.</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"> <li>• Altered Auditory Feedback (AAF) Devices for the Treatment of Stuttering</li> <li>• Augmentative and Alternative Communication (AAC) Devices/ Speech Generating Devices (SGD)</li> <li>• Automated External Defibrillators for home use</li> <li>• Bone-Anchored Hearing Aids</li> <li>• Continuous local delivery of analgesia to operative sites using an Elastomeric Infusion Pump during the post-operative period</li> <li>• Custom Durable Medical Equipment</li> <li>• Electrical bone growth stimulation</li> <li>• Electrical stimulation as a treatment for pain and related conditions: surface and percutaneous devices</li> <li>• External (portable) Continuous Insulin Infusion Pump</li> <li>• Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)</li> <li>• Hospital beds</li> <li>• Implantable Cardioverter-Defibrillator (ICD)</li> <li>• Implantable Infusion Pumps</li> <li>• Implantable Left Atrial Hemodynamic (LAH) Monitor</li> <li>• Implantable Middle Ear Hearing Aids</li> <li>• Implanted devices for spinal stenosis</li> <li>• Implanted Spinal Cord Stimulators (SCS)</li> <li>• Lifts</li> <li>• Microprocessor Controlled Lower Limb Prosthesis</li> <li>• Myoelectric Upper Extremity Prosthetic Devices</li> <li>• Oscillatory Devices for airway clearance including High Frequency Chest Compression (Vest™ Airway Clearance System) and Intrapulmonary Percussive Ventilation (IPV)</li> <li>• Partial-hand Myoelectric Prosthesis</li> <li>• Patient-operated Spinal Unloading Devices</li> <li>• Certain prosthetic and orthotic devices</li> <li>• Self-operated Spinal Unloading Devices</li> <li>• Standing frames</li> <li>• Transtympanic Micropressure for the treatment of Ménière’s Disease</li> <li>• Ultrasound Bone Growth Stimulation</li> <li>• Ultraviolet Light Therapy Delivery Devices for home use underpads</li> <li>• Vacuum Assisted Wound Therapy in the outpatient setting</li> <li>• Wearable Cardioverter Defibrillators</li> <li>• Wheelchair/wheelchair accessories</li> <li>• Wheeled Mobility Devices: Manual wheelchairs-ultra lightweight</li> <li>• Wheeled Mobility Devices: Wheelchairs-powered, motorized, with or without power Seating Systems and Power Operated Vehicles (POVs)</li> </ul>



# Chapter 10

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"> <li>• Newborn Stays Beyond Mother</li> <li>• Inpatient Skilled Nursing Facility (SNF)</li> <li>• Long-term Acute Care Facility (LTAC)</li> <li>• Rehabilitation Facility Admissions</li> </ul>	Providers are required to get Prior Authorization for the following: <ul style="list-style-type: none"> <li>• All elective inpatient admissions.</li> <li>• Notify BCBSTX of emergent admissions within 24 hours or the next business day of inpatient admission.</li> <li>• Routine vaginal or cesarean section deliveries do not require medical necessity review; however, both delivery types require notification.</li> <li>• <b>All</b> newborn deliveries require notification. Complete and submit a <b>Newborn Enrollment Notification Report</b> form within three days of delivery.</li> </ul>
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.

Service / Request	Is Prior Authorization (PA) required for in-network providers?																				
Pharmacy and/or Over-the-Counter (OTC) Products	<p>Prescription drugs are covered by BCBSTX through Prime Therapeutics LLC for details about pharmacy Prior Authorization requirements, please contact <b>1-855-457-0757</b> (Travis service area)</p> <p><b>1-855-457-0758</b> (MRSA Central service area) for STAR Kids.</p> <p>For information about the formulary and drugs requiring Prior Authorization, you may also visit the Texas Medicaid Vendor Drug Program at <a href="http://www.txvendordrug.com">www.txvendordrug.com</a>.</p> <p>A 72-hour emergency supply of a prescribed drug may be provided by a network pharmacy with the following override codes:</p> <table border="1" data-bbox="542 779 1458 1159"> <thead> <tr> <th data-bbox="542 779 769 877">NCPDP Segment Name</th> <th data-bbox="769 779 943 877">NCPDP Field Number</th> <th data-bbox="943 779 1349 877">NCPDP Field Name</th> <th data-bbox="1349 779 1458 877">Value</th> </tr> </thead> <tbody> <tr> <td data-bbox="542 877 769 940">Claim Segment</td> <td data-bbox="769 877 943 940">461-EU</td> <td data-bbox="943 877 1349 940">Prior Authorization Type Code</td> <td data-bbox="1349 877 1458 940">8</td> </tr> <tr> <td data-bbox="542 940 769 1039">Claim Segment</td> <td data-bbox="769 940 943 1039">462-EV</td> <td data-bbox="943 940 1349 1039">Prior Authorization Number Submitted</td> <td data-bbox="1349 940 1458 1039">801</td> </tr> <tr> <td data-bbox="542 1039 769 1102">Claim Segment</td> <td data-bbox="769 1039 943 1102">405-D5</td> <td data-bbox="943 1039 1349 1102">Days' Supply</td> <td data-bbox="1349 1039 1458 1102">3</td> </tr> <tr> <td data-bbox="542 1102 769 1159">Claim Segment</td> <td data-bbox="769 1102 943 1159">442-E7</td> <td data-bbox="943 1102 1349 1159">Quantity Dispensed</td> <td data-bbox="1349 1102 1458 1159">Varies</td> </tr> </tbody> </table>	NCPDP Segment Name	NCPDP Field Number	NCPDP Field Name	Value	Claim Segment	461-EU	Prior Authorization Type Code	8	Claim Segment	462-EV	Prior Authorization Number Submitted	801	Claim Segment	405-D5	Days' Supply	3	Claim Segment	442-E7	Quantity Dispensed	Varies
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# Chapter 10

Service / Request	Is Prior Authorization (PA) required for in-network providers?
Physician Services – Referrals to Specialists	Required when referring a member to an out-of-network specialist.
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"> <li>• MR Spectroscopy</li> <li>• QCT Bone Densitometry</li> <li>• Myocardial Perfusion Imaging</li> <li>• Infarct Imaging</li> <li>• Intensity Modulated Radiation Therapy (IMRT)</li> <li>• Cardiac Blood Pool Imaging</li> <li>• PET/CT Fusion</li> <li>• Screening CT colonoscopy</li> <li>• Diagnostic CT Colonography</li> <li>• Functional MRI Brain</li> <li>• CT Heart for Calcium Scoring</li> <li>• CT Heart for Structure &amp; Morph</li> <li>• CTA Heart Including Structure &amp; Morph</li> <li>• MEG</li> <li>• Add-on Procedures</li> <li>• Radiology services that are potentially investigational</li> </ul>

Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p><b>Inpatient &amp; Outpatient Surgeries/Procedures</b></p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact Utilization Management at <b>1-877-688-1811</b> 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"> <li>• Ablative techniques as a treatment for Barrett’s Esophagus</li> <li>• Adoptive Immunotherapy and Cellular Therapy</li> <li>• Anterior Segment Optical Coherence Tomography</li> <li>• Antineoplaston Therapy</li> <li>• Artificial Anal Sphincter for the treatment of severe fecal incontinence</li> <li>• Artificial Retinal Devices</li> <li>• Allogeneic, Xenographic, Synthetic and Composite products for wound healing and soft tissue grafting</li> <li>• Autologous Cellular Immunotherapy for the treatment of prostate cancer</li> <li>• Automated Evacuation of Meibomian Gland</li> <li>• Automated Nerve Conduction Testing</li> <li>• Axial Lumbar Interbody Fusion</li> <li>• Balloon Sinus Ostial Dilation</li> <li>• Behavioral health treatments for Pervasive Developmental Disorders</li> <li>• Bicompartamental Knee Arthroplasty</li> <li>• Bioimpedance Spectroscopy Devices for the detection and management of lymphedema</li> <li>• Biomagnetic Therapy</li> <li>• Blepharoplasty, Blepharoptosis Repair, and Brow Lift</li> <li>• Breast Ductal Examination and Fluid Cytology Analysis</li> <li>• Breast Procedures; including reconstructive surgery, implants and other breast procedures</li> <li>• Bronchial Thermoplasty</li> <li>• Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the treatment of heart failure</li> <li>• Carotid Sinus Baroreceptor Stimulation Devices</li> <li>• Carotid, Vertebral and Intracranial Artery Angioplasty with or without stent placement</li> <li>• Collation® Therapies for musculoskeletal conditions</li> <li>• Cochlear Implants and Auditory Brainstem Implants</li> <li>• Cognitive Rehabilitation</li> <li>• Computer Analysis and Probability Assessment of Electrocardiographic-Derived Data</li> </ul>

# Chapter 10

Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p><b>Inpatient &amp; Outpatient Surgeries/ Procedures</b>Continued</p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact Utilization Management at <b>1-877-688-1811</b> 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.</p> <p>Outpatient procedures include:</p> <ul style="list-style-type: none"> <li>• Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures</li> <li>• Convection Enhanced Delivery of aneurysms Therapeutic Agents to the brain</li> <li>• Cooling Devices and Combined Cooling/Heating Devices</li> <li>• Cosmetic and Reconstructive Services of the head and neck</li> <li>• Cosmetic and Reconstructive Services of the trunk and groin</li> <li>• Cosmetic and Reconstructive Services: skin related</li> <li>• Cryoablation for Plantar Fasciitis and Plantar Fibroma</li> <li>• Cryopreservation of oocytes or ovarian tissue Tissues</li> <li>• Cryosurgical Ablation of solid tumors outside the liver</li> <li>• Deep Brain Stimulation</li> <li>• DiapHealth Risk Screeninggmatic/ of Phrenic Nerve Stimulation and DiapHealth Risk Screeninggm Pacing Systems</li> <li>• Electric Tumor Treatment Field (TTF)</li> <li>• Electroencephalography (EEG) Testing: ambulatory and video</li> <li>• Electromagnetic Navigational Bronchoscopy</li> <li>• Electrothermal Shrinkage of joint Therapy capsules, ligaments, and tendons</li> <li>• Endobronchial Valve Devices</li> <li>• Endothelial Keratoplasty</li> <li>• Endovascular/Endoluminal repair of aortic</li> <li>• Epiduroscopy</li> <li>• Extracorporeal Shock Wave Therapy for orthopedic conditions</li> <li>• Facet Joint Allograft Implants for Facet Disease</li> <li>• Fetal Surgery for prenatally diagnosed malformations</li> <li>• Functional Endoscopic Sinus Surgery (FESS)</li> <li>• Gastric Electrical Stimulation</li> <li>• Growth Factors, Silver-based Products and Autologous for wound treatment and soft tissue grafting</li> <li>• Hepatic Activation Therapy</li> <li>• High Intensity Focused Ultrasound (HIFU) for the treatment prostate cancer</li> <li>• High Resolution Anoscopy Screening Hip Resurfacing</li> <li>• Hippotherapy</li> <li>• Hyperbaric Oxygen Therapy (systemic/topical)</li> <li>• Hyperoxemic Reperfusion Therapy</li> <li>• Hyperthermia for Cancer</li> </ul>

Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p><b>Inpatient &amp; Outpatient Surgeries/ Procedures</b> Continued</p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact Utilization Management at <b>1-877-688-1811</b> 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"> <li>• Idiopathic Environmental Illness (IEI)</li> <li>• Imaging Techniques for Screening and identification of cervical cancer</li> <li>• Injection Treatment for Morton’s Neuroma</li> <li>• In Vivo Analysis of gastrointestinal lesions</li> <li>• Inhaled Nitric Oxide for the Treatment of respiratory failure</li> <li>• Intervertebral Stabilization Devices</li> <li>• Intracardiac Ischemia Monitoring</li> <li>• Intradiscal Annuloplasty Procedures (Percutaneous Intradiscal Electrothermal Therapy [IDET])</li> <li>• Intraocular Anterior Segment Aqueous Drainage Devices</li> <li>• Intraocular Epiretinal Brachytherapy</li> <li>• Intraocular Telescope</li> <li>• Intravitreal Corticosteroid Implants</li> <li>• Keratoprosthesis</li> <li>• Laparoscopic and Percutaneous MRI-Image Guided Techniques for Myolysis as a Treatment of Uterine Fibroids</li> <li>• Locally Ablative Techniques for treating primary and metastatic liver malignancies</li> <li>• Low-Frequency Ultrasound Therapy for wound management</li> <li>• Lung Volume Reduction Surgery</li> <li>• Lysis of Epidural Adhesions</li> <li>• Mandibular/Maxillary (Orthognathic) Surgery</li> <li>• Manipulation Under Anesthesia of the spine and joints other than the knee</li> <li>• Mastectomy for Gynecomastia</li> <li>• Maze Procedure</li> <li>• Mechanical Embolectomy for treatment of acute stroke</li> <li>• Mechanized Spinal Distraction Therapy for low back pain</li> <li>• Melanoma Vaccines</li> <li>• Microvolt T-Wave Alternans</li> <li>• MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids</li> <li>• Nasal Surgery for the treatment of Obstructive Sleep Apnea</li> <li>• Nasal Valve Suspension</li> <li>• Nerve Graft after Prostatectomy</li> <li>• Neural Therapy</li> <li>• Non-Invasive Measurement of Left Ventricular End Diastolic Pressure (LVEDP) in the Outpatient Setting</li> </ul>

# Chapter 10

Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p><b>Inpatient &amp; Outpatient Surgeries/ Procedures</b> Continued</p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact Utilization Management at <b>1-877-688-1811</b> 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"> <li>• Occipital Nerve Stimulation</li> <li>• Open Treatment of Rib Fracture(s) Requiring Internal Fixation</li> <li>• Ophthalmologic Techniques for Evaluating Glaucoma</li> <li>• Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea</li> <li>• Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome</li> <li>• Panniculectomy and Abdominoplasty</li> <li>• Pain Management Injections and Procedures</li> <li>• Partial Left Ventriculectomy</li> <li>• Penile Prosthesis Implantation</li> <li>• Percutaneous and Endoscopic Spinal Surgery</li> <li>• Percutaneous Neurolysis for Chronic Back Pain</li> <li>• Percutaneous (Vertebroplasty, Kyphoplasty and Sacroplasty)</li> <li>• Photocoagulation of Macular Drusen</li> <li>• Presbyopia and Astigmatism-Correcting Intraocular Lenses</li> <li>• Prolotherapy for Joint and Ligamentous Conditions</li> <li>• Prostate Saturation Biopsy</li> <li>• Quantitative Muscle Testing devices</li> <li>• Quantitative Sensory Testing</li> <li>• Radiofrequency ablation</li> <li>• Radiofrequency and Pulsed</li> <li>• Radiofrequency Pallidotomy</li> <li>• Neurolysis for Trigeminal Neuralgia (TGN)</li> <li>• Real-Time remote heart monitors</li> <li>• Recombinant Human Bone Morphogenetic Protein</li> <li>• Reduction Mammoplasty</li> <li>• Refractive surgery</li> <li>• Rhino phototherapy</li> <li>• Sacral Nerve Stimulation as a treatment of neurogenic bladder secondary to spinal cord injury</li> <li>• Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for urinary and fecal incontinence; urinary retention</li> <li>• Sensory stimulation for brain-injured patients in a coma or vegetative state</li> <li>• Selected sleep testing services</li> <li>• Septoplasty</li> <li>• Sleep studies</li> </ul>

Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p><b>Inpatient &amp; Outpatient Surgeries/ Procedures</b> Continued</p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact Utilization Management at <b>1-877-688-1811</b> 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"> <li>• Stereotactic Radiofrequency Pallidotomy</li> <li>• Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)</li> <li>• Subtalar Arthroereisis</li> <li>• Suprachoroidal injection of a pharmacologic agent</li> <li>• Surgery for clinically severe obesity</li> <li>• Surgical and minimally invasive treatments for Benign Prostatic Hyperplasia (BPH) and other genitourinary</li> <li>• Surgical Treatment of femoroacetabular impingement syndrome</li> <li>• Surgical and ablative treatments for chronic headaches</li> <li>• Technologies for the evaluation of skin lesions</li> <li>• Procedures related to temporomandibular disorders</li> <li>• Tonsillectomy and Adenoidectomy</li> <li>• Total ankle replacement</li> <li>• Transanal Endoscopic Microsurgical (TEM) excision of rectal lesions</li> <li>• Transanal radiofrequency treatment of fecal incontinence</li> <li>• Transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation</li> <li>• Transcatheter closure of patent foramen oval and left atrial appendage for stroke prevention</li> <li>• Transcatheter heart valves</li> <li>• Transcatheter uterine artery embolization</li> <li>• Transcranial Magnetic Stimulation for behavioral and non-behavioral health indications</li> <li>• Transendoscopic Therapy for gastroesophageal reflux disease</li> <li>• Transmyocardial Revascularization</li> <li>• Treatment for obstructive sleep apnea in adults</li> <li>• Treatment of hyperhidrosis</li> <li>• Treatment of osteochondral defects of the knee and ankle</li> <li>• Treatment of varicose veins (lower extremities)</li> <li>• Treatments for urinary incontinence and urinary retention</li> <li>• Unicondylar Interpositional Spacer</li> <li>• Vagus nerve stimulation</li> <li>• Viscocanalostomy and Canaloplasty</li> <li>• Venous angioplasty with or without stent placement for the treatment of Multiple Sclerosis</li> <li>• Vertebral body stapling for the treatment of Scoliosis</li> </ul>



# Chapter 10

Service / Request	Is Prior Authorization (PA) required for in-network providers?
<p><b>Inpatient &amp; Outpatient Surgeries/Procedures</b> Continued</p> <p>Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</p> <p>Please contact Utilization Management at <b>1-877-688-1811</b> 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"> <li>• Wearable Cardioverter Defibrillators</li> <li>• Wireless Capsule for the evaluation of Suspected Gastric and Intestinal Motility Disorders</li> </ul>
<p>Inpatient &amp; Outpatient Surgeries/Procedures</p>	<ul style="list-style-type: none"> <li>• Surgeries/procedures that are for cosmetic purposes or considered investigational are not covered.</li> </ul> <p>Please contact the Utilization Management department at <b>1-877-688-1811</b> 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>LTSS Services</p>	<p>All LTSS services require prior authorization.</p>
<p>Transplant Services</p>	<p>Yes.</p>
<p>Vision Services</p>	<p>Vision services for routine eye care: Contact Davis Vision at <b>1-800-773-2847</b> for vision benefits.</p>

## 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 Woman Check Up – Member may self-refer to any Medicaid provider for the following services:
  - Pelvic and breast examinations
  - Birth Control
  - Lab work
  - Genetic counseling

- FDA approved devices and supplies related to family planning (such as IUD)
- HIV/STD screening
- Standard x-rays and ultrasounds
- 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 **1-855-653-8129**. Notify BCBSTX of newborn enrollments within three days of delivery by calling **1-877-688-1811**.
- Outpatient behavioral health services
- No PA required for physician referrals if referring member to an in-network specialist for consultation or a nonsurgical course of treatment (PA not required does not guarantee coverage; member must be eligible and meet medical necessity.)
- PA Not Required does not mean that services is covered.

## What to have ready when calling Utilization Management

To request prior authorization and report medical admission, call Utilization Management at **1-877-688-1811**. 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 signed providers orders, complete progress note by a provider, and history and physical signed by a provider to Utilization Management. Physicians are also encouraged to review their utilization and referral patterns.

## **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" letter for lack of medical information 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' day/seven days 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.

## 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.
- Physician or other professional provider reporting admissions.
- Members or their representatives reporting admissions.
- Claims submissions for services rendered without authorization.
- Prior authorization requests for inpatient care.

Utilization Management will complete continued stay inpatient reviews within 24 hours of receipt of clinical information 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 request 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.

# Chapter 10

## 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 **1-877-784-6802** or by faxing **1-855-653-8129**.

For behavioral health or substance abuse admissions, notification must be made to Magellan at **1-800-424-0324**.

Once notification of an inpatient admission is received, a request for clinical information supporting the medical necessity of the admission to include the provider's orders for the admission, as well as a complete copy of the provider's progress note or history and physical, 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, physician's complete progress notes or history and physical.

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 **1-877-784-6802** from 8 a.m. to 8 p.m., Monday through Friday, excluding holidays.

## SELF-REFERRAL

Children have the right to self-refer. If a child is between 12 and 18 years of age, he or she can see a doctor without consent from their parents or guardian for these services:

- Family planning including birth control
- Services that have to do with pregnancy
- Sexual assault treatment
- Drug and alcohol abuse treatment through Magellan
- Health Services
- Outpatient mental health care for:
  - Sexual or physical abuse
  - When you hurt yourself or others?

You do not need an OK from your child's PCP to get these services.

STAR Kids 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. If services are received from an out-of-network Texas Health Steps provider, authorization is or is not needed.

## SECOND OPINIONS

There is no cost for second opinions.

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 **1-800-424-0324** for prior authorization of all behavioral health or substance abuse services.

### **Vision Care**

Contact Davis Vision Provider Services at **1-800-77DAVIS** or **1-800-773-2847**; (TTY **1-800-523-2847**) for prior authorization of routine vision services. \*

\* Routine vision screening and fulfillment of glasses or medically necessary contacts. For diseases of the eye, a member may go to an in-network ophthalmologist.



# Chapter 11

# COMPLAINTS AND APPEALS

## STAR KIDS COMPLAINTS INTRODUCTION

We will help providers and 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 Kids members with their rights and responsibilities and the filing of complaints and appeals. Provider Relations is available to assist STAR Kids providers with filing 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.



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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 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 Kids 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 KIDS 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**

**STARKIDS1-877-688-1811**

TTY **7-1-1** (for members with hearing or speech loss)

### Submit a complaint by email

[GPDTXMedicaidAG@bcbsnm.com](mailto:GPDTXMedicaidAG@bcbsnm.com)

### Submit a complaint by mail

#### **Blue Cross and Blue Shield of Texas**

**Attn: Complaints and Appeals Department**

P.O. Box 27838

Albuquerque, NM 87125-7838

## **Acknowledgement of STAR Kids Member Complaints**

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 Kids 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.

# 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 **1-877-688-1811**

TTY (for hearing and speech impaired):

**1-800-735-2989** or

National Relay Service **7-1-1**

### 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](mailto:GPDTXMedicaidAG@bcbsnm.com)

# STAR KIDS 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 Kids member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

## 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 Kids 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 Kids 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 Kids 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 MEMBER APPEALS**

### **Acknowledgement of STAR Kids Member Appeals**

STAR Kids 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 Kids 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.

## STAR KIDS 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 Kids member may request an expedited appeal in the same manner as a standard appeal, including orally, 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  
STARKIDS **1-877-688-1811**

### **Request an expedited appeal by mail**

Blue Cross and Blue Shield of Texas  
Attn: Complaints and Appeals Department  
P.O. Box 27838  
Albuquerque, NM 87125-7838

## **Timeline for STAR Kids 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 Kids – 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 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 and Blue Shield of Texas**

#### **Attn: Complaints and Appeals Department**

P.O. Box 27838

Albuquerque, NM 87125-7838

Or, call Customer Service at **1-877-688-1811**.

### Timeline for STAR Kids 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.

# Chapter 11

## **Response to STAR Kids 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 Kids 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.

Panel, present alternative expert testimony and request the presence of and question any person responsible for making Providers initially contact BCBSTX to file a complaint and must exhaust BCBSTX's resolution process prior to filing a complaint with HHSC.

BCBSTX will resolve provider complaints within 30 days from the date the complaint is received.

Providers may file complaints with HHSC if they did not receive due process from BCBSTX.

## **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 **1-877-688-1811**

TTY (for members with hearing or speech loss) **7-1-1**

## **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.

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.

## **How to file a complaint or appeal for physicians and other providers**

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 HSC and TDI reserve the right reserves the right and retains the authority to make reasonable inquiries and conduct investigations into provider and member complaints for members.

Physician and other professional provider complaints relating to operational issues may be submitted to the following address:

**Blue Cross and Blue Shield of Texas**  
**Attn: Complaints and Appeals Department**  
P.O. Box 27838  
Albuquerque, NM 87125-7838  
Fax: **1-855-235-1055**

The complaint must include the provider's name, date of the incident, and a description of the incident.

In addition, providers may call customer service at **1-877-688-1811** to initiate a claims appeal or submit online to [gpptxmedicaidag@bcbsnm.com](mailto:gpptxmedicaidag@bcbsnm.com) or via the Availity provider portal.

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.

## Provider Appeals Related to Actions

A member's provider of record may submit an adverse determination appeal in accordance with the procedures set forth in 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.

# Chapter 11

## 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

If the provider is dissatisfied with the resolution of the appeal for a 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](mailto:HPM_Complaints@hhsc.state.tx.us).

**Note:** Providers must keep copies of submitted complaints and appeals including fax cover letters, emails and telephone logs of communication with the MCO and proof of the member's eligibility.

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 12

# MEMBER RIGHTS AND RESPONSIBILITIES

### STAR KIDS 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.

# Chapter 12

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' day/seven 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 KIDS 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 12

## **What if my child needs OB/GYN care?**

### **Do I have the right to choose an OB/GYN for my child?**

#### ATTENTION FEMALE MEMBERS

BCBSTX allows you to pick an OB/GYN but this doctor must be in the same network as your Primary Care Provider. You have the right to pick an OB/GYN without a referral from your primary care provider. An OB/GYN can give you:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- Referral to a special doctor within the network.



## Chapter 13

# PROVIDER ROLES AND RESPONSIBILITIES



## PRIMARY CARE PROVIDER (PCP) SCOPE OF RESPONSIBILITIES

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 list of selected and assigned members 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
- Coordination of referrals for acute and long term care services for children with special health care needs and 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 PCP 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

PCPs must follow all provider responsibilities and HHSC mandated provisions as outlined in Attachment X of the Provider Agreement.

**Note:** Dual eligible members are not required to select a STAR Kids PCP.

## 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.

## LTSS PROVIDERS

Long Term Services and Supports are covered benefits that are provided to people with chronic medical and mental illnesses and disabilities. These services can be provided in two areas depending on the level of need as determined by the assessment process.

1. In the community called home and community based services;
2. Institutional services in nursing facilities and intermediate care facilities. Home and community based services are intended to help people stay in their homes and in the community when they meet the nursing level of care but prefer to be at home and in the community. There is coverage for institutional care in nursing homes when the person is unable to stay in their homes. LTSS can be provided in two ways. Coordinated by BCBSTX or selected provider care agencies or consumer directed option which is when the member or the member's family hires the caregivers directly.

# Chapter 13

## PHARMACY PROVIDER RESPONSIBILITIES

### Texas Medicaid & Healthcare Participation Enrollment

Starting October 16, 2017, BCBS TX will no longer pay for any prescriptions written by providers who are not enrolled with Texas Medicaid & Healthcare Participation (TMHP). This includes refills and prescriptions filled out-of-state. In order 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 clinical judgment to dispense a 72-hour emergency supply of medication upon request of member, physician or BCBSTX if the medication is urgently needed and prior authorization is not available within 24 hours of the request.

For questions or assistance with a 72-hour supply override, contact Prime's help desk, which is available 24 hours' day/seven days a week at:

Prime phone number: **1-855-457-0757** (Travis service area)

**1-855-457-0758** (MRSA Central service area)

NCPDP Segment Name	NCPDP Field Number	NCPDP Field Name	Value
Claim Segment	461-EU	Prior Authorization Type Code	8
Claim Segment	462-EV	Prior Authorization Number Submitted	801
Claim Segment	405-D5	Days' Supply	3
Claim Segment	442-E7	Quantity Dispensed	Varies

Members have the right to obtain medication from any network pharmacy.

## OUT-OF-NETWORK REFERRALS

BCBSTX recognizes that there may be instances when an out-of-network referral is justified. Service coordination and/or 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 **1-877-784-6802** 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 TMMP, the administrative services contractor for HHSC, of any changes to their address, telephone number, group affiliation, and other material facts.

BCBSTX will send a periodic survey to providers to update and validate demographic and practice information. A provider information update form is available on the BCBSTX website.

## 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 Kids 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 Steps program guidelines:

- STAR Kids Program: Children from birth through 20 years of age.

For more information, refer to the Texas Medicaid Provider Procedures Manual. Refer to Chapter 6 and 7 for billing information.

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. Due to the importance of this service, we require members to be seen by their PCP for their Texas Health Steps visits within 90 days of enrolling on the plan.

Members have the right to designate OB/GYN or other specialists as their PCP as long as the specialist agrees.

### 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' 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. 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 9-1-1 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 9-1-1 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 Hotline 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 Hotline: **1-844-971-8906**

TTY: **7-1-1**

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 9-1-1 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 Kids) or the TTY line for members with speech or hearing loss. Members will receive notification that their PCP has terminated. BCBSTX will ask them to select a new PCP and/or if they do not will assign one to the member. The member can change PCPs at any time in real time by calling customer service.

Customer Service - Providers: **1-877-784-6802**

Customer Service - Members: **1-877-688-1811**

TTY (for hearing and speech impaired) **7-1-1**

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. Continuity of care authorization can also be obtained by calling customer service at the above number.

## TERMINATION OF THE 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

Service coordinators and/or 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 service coordinator 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. BCBSTX Service Coordinators are available to assist with the process of obtaining authorizations for these referrals when authorization is required.

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.

**Note:** Dual eligible members are not required to select a PCP.

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.



# Chapter 13

## 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. Free advance directive forms are available on the DAD.com website and can be downloaded and provided to members as needed.

Also, see [www.dads.com](http://www.dads.com) for more information.

## REPORTING ABUSE, NEGLECT, OR EXPLOITATION (ANE) MEDICAID MANAGED CARE

Report suspected Abuse, Neglect, and Exploitation:

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 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; and
- 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](http://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

## 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 14

# 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)

## 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. 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 9-1-1 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 9-1-1 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.

# Chapter 14

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 Hotline 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 9-1-1 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.

BCBSTX will conduct periodic surveys of provider to monitor access compliance.

## 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.

As noted in Chapter 3 Service Coordination, continuity of care transition plan will allow for the lesser of

- 180 Days
- Until the end of an authorization period
- A new assessment and new authorization is complete



# Chapter 14

## 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.

Service coordination nurses review member physician or other professional provider requests for continuity of care and facilitate continuation with the current provider by obtaining authorizations, if needed, and 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.

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 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

The Texas Medical Transportation Program (MTP) provides non-emergency transportation (NEMT) to 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, or reimbursement for gas members should call MTP at **1-877-633-8747 (1-877-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 STAR Kids BCBSTX 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. 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. Upon notification from a Member or Provider of the existence of a prior authorization, BCBSTX will ensure that members receiving services through a prior authorization from either another MCO or FFS receive continued authorization of those services, including community based services.

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 180 days after a member enrolls in BCBSTX, or
- More than 12 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 her OB/GYN doctor to one who is in the network, she must be allowed to do so if the physician or other professional provider to whom she wishes to transfer agrees to accept her 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.

## 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

BCBSTX is responsible for emergency dental services provided to STAR Kids 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.
- Treatment and devices for correction of craniofacial anomalies and drugs

## 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.
- BCBSTX is responsible for treatment and devices for craniofacial anomalies.

## 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 Medicaid enrollment broker's (Maximus) toll-free telephone number at **1-800-964-2777**.

## PROVIDER TRAINING AND COORDINATION OF SERVICES

BCBSTX will make training and coordination of services available to providers to help ensure that the needs of 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

The number for training is **1-855-212-1615** and the number for coordination is Customer Service at **1-877-688-1811**.



## Chapter 15

# 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/medicaid/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 **1-855-212-1615**.

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.

## 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

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 **1-855-212-1615**.

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.



## Chapter 16

# HEALTH SERVICES PROGRAMS

### TEXAS HEALTH STEPS

Primary Care Providers (PCPs) or other professional providers should perform a Texas Health Steps with new members within 90 days of enrollment in BCBSTX. The checkup consists of:

1. A history and physical examination
2. A developmental assessment

Texas Health Steps may not be necessary if the member is an existing patient of the PCP but is new to our Plan. However, BCBSTX may request records to demonstrate the visits were performed and the appropriate documentation is in the medical record. 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 Initial Health Assessment (IHA) if a completed health history is included.

STAR Kids 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.



## THE TEXAS HEALTH STEPS VISIT INCLUDES:

- Comprehensive health and developmental history including physical and mental health development
- Comprehensive unclothed physical examination
- Immunizations appropriate for age and health history
- Laboratory tests appropriate for age and risk, including lead toxicity at age specific federally mandated ages
- Health education including anticipatory guidance
- Dental documentation and referral

## REDUCTION OF NON-EMERGENCY 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 reducing 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 Hotline.

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 HOTLINE

### How the 24-Hour Nurse Hotline Assists Members

The 24-Hour Nurse Hotline is a phone line staffed by registered nurses and is available to members 24 hours' day/seven days a week, to help with health-related questions. The 24-Hour Nurse Hotline phone number is **1-844-971-8906** (TTY: **7-1-1**).

Members can contact the 24-Hour Nurse Hotline 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 Hotline audio tape library.
- A specialized nurse who is trained to discuss health issues specific to our teenage members.

The nurses at the Nurse Hotline 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 Kids) 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 Kids 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](http://www.dshs.state.tx.us/thsteps/providers.shtm). Medical Policies with periodicity schedules can be found at <http://bcbstx.com/provider/medicaid/index.html> under **Medical Policies**.

BCBSTX provides medical screening visits for children in the STAR Kids program from birth through 20 years of age. 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 testing 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.

# 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](http://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: **1-800-588-1248** or [www.dshs.state.tx.us/lead](http://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 Kids 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 providers can enroll in the TVFC Program by completing the TVFC Provider Enrollment Application form from the DSHSTVFC web page [www.dshs.state.tx.us/immunize/tvfc/default.shtm](http://www.dshs.state.tx.us/immunize/tvfc/default.shtm).

BCBSTX will pay for TVFC Program providers' 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 and the Texas Department of Health Services (TDHS) periodicity schedule 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.

# 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.

## Managed Care Program

The Managed 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 Managed 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.

### 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 **1-877-688-1811**. 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 **1-877-688-1811**
- 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 **1-877-688-1811**

## 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 **1-877-688-1811**

## 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 or goal plans, facilitating patient and 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 **1-877-688-1811**





## Chapter 17

# 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. Detailed information on HEDIS is available at [www.ncqa.org](http://www.ncqa.org).

### HEDIS Information for Office Staff

BCBSTX provides assistance for medical office staff regarding HEDIS activities. Physicians and other professional providers can request a consultation by calling Provider Relations at **1-855-212-1615**. 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.

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 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.

## PROVIDER EXAMINATION SURVEY (AKA PROVIDERS CHALLENGE SURVEY)

The provider examination survey is used to verify provider information. The survey is sent periodically. The information validated includes: provider demographics, appointment wait times, preventive care wait times and acceptance of new patients. Providers should not wait for the survey to update their information. A form for updating information is on the provider website. Details about the survey will be sent in advance.

## 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.

# Chapter 17

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.
- 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.

PCPs and select providers such as OB/GYNs 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 or 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 or by mail with a follow-up call or visit to explain the findings. PCPs with 40 or more STAR Kids 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.

## **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 18

# ENROLLMENT AND MARKETING RULES

## PHYSICIAN AND OTHER PROFESSIONAL PROVIDER ROLES IN 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 PCP office staff 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 STAR Kids program, 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 **1-800-964-2777** 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 Kids members.

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.

# Chapter 18

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.

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.

## ENROLLING NEWBORNS

Encourage your patients to call a Texas Department of State Health Services (DSHS) social worker to let them know about the pregnancy.

## PHYSICIANS AND OTHER PROFESSIONAL PROVIDERS' ROLE IN MARKETING AND ENROLLMENT

As network physicians and other professional providers who serve STAR Kids 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.

## AUTOMATIC RE-ENROLLMENT

Six months (member may choose to switch plans)



## Chapter 19

# 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 and continuity of care during the transfer process.

Members may request a PCP transfer by calling Customer Service at: **1-877-688-1811**.

In cases where a Member loses Medicaid eligibility, if Medicaid eligibility is re-instated or re-established within 6 months from the date of loss, HHSC will retroactively restore a Member's managed care enrollment to avoid a gap in coverage. In these cases, the HHSC Administrator Services Contractor will retroactively enroll the Member into the same MCO the Member was in before losing coverage.

# Chapter 19

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 or 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

Members can change health plans by calling the Texas Medicaid Managed Care program help line at: **1-800-964-2777**. However, a member cannot change from one health plan to another health plan during an inpatient hospital stay.

If a member calls to change 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.

## 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.

## **HHSC will make the final decision.**

Physicians and other professional providers may not take retaliatory action against STAR Kids members for requesting transfer or disenrollment.

## **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 Kids 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: **1-877-688-1811**.

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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 **1-800-964-2777**.
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 or 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 or patient or the member's or patient's family
- Member or 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 or 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 and member relationship may not be terminated.

If the termination request meets the performance standards, a termination date of the physician and 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



# Chapter 19

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 **1-877-688-1811**.

## 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 members 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 20

## CREDENTIALING AND RE-CREDENTIALING

### CREDENTIALING PROCESS FOR OFFICE-BASED PHYSICIANS, OTHER PROFESSIONAL PROVIDERS AND LTSS 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 STAR Kids 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)

# Chapter 20

Behavioral health professionals and physicians must contact Magellan at **1-800-788-4005** or [www.magellanprovider.com](http://www.magellanprovider.com) for questions regarding the credentialing or re-credentialing process for the STAR Kids 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 STAR Kids;
- Has a valid BCBSTX Provider Record ID for claim payment;
- Has submitted a current signed BCBSTX contract or 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 STAR Kids network.

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"> <li>• Medical Doctor (MD)</li> <li>• Doctor of Dental Surgery (DDS)</li> <li>• Doctor of Dental Medicine (DMD)</li> </ul>	<ul style="list-style-type: none"> <li>• Doctor of Podiatric Medicine (DPM)</li> <li>• Doctor of Chiropractic (DC)</li> <li>• Doctor of Osteopathy (DO)</li> </ul>
<ul style="list-style-type: none"> <li>• Audiologist (AUD)</li> <li>• Biofeedback Technician (BT)</li> <li>• Christian Science Practitioner (CSP)</li> <li>• Clinical Nurse Specialist (CNS)</li> <li>• Licensed Practical Nurse (LPN)</li> <li>• Massage Therapist (MT)</li> <li>• Naturopath (ND)</li> <li>• Neuropsychologist (NEU)</li> <li>• Midwife (MW)</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse Midwife (NMW)</li> <li>• Nurse Practitioner (NP)</li> <li>• Nutritionist (LN)</li> <li>• Occupational Therapist (OT)</li> <li>• Registered Nurse (RN)</li> <li>• Certified Registered Nurse Anesthetist (CRNA)</li> <li>• Registered Nurse First Assistant (RNFA)</li> <li>• Respiratory Therapist (RT)</li> <li>• Speech Pathologist (SLP)</li> </ul>

## 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)

# Chapter 20

Forward completed application packet to BCBSTX via fax to: **1-512-349-4853** (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 STAR Kids 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 who do not have Internet access may submit their application via fax to CAQH by first contacting the CAQH Help Desk at **1-888-599-1771**
- 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 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 or 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](mailto:supportingdocsupd@acsgs.com) or fax to **1-866-293-0414**.  
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 **1-888-599-1771** 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.

# Chapter 20

Forward additional documentation to BCBSTX via fax to **1-512-349-4853** (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	<b>1-888-599-1771</b>
Help Desk Email Address:	<a href="mailto:caqh.uphelp@acsgs.com">caqh.uphelp@acsgs.com</a>
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 <b>1-866-293-0414</b>
Email Supporting Documentation:	<a href="mailto:supportingdocsups@acsgs.com">supportingdocsups@acsgs.com</a>

# 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 or participating in the Blue Cross and Blue Shield of Texas STAR Kids Network.

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"> <li>• Hospital privileges</li> <li>• Type 1 NPI#</li> <li>• Texas Medical Board License (temporary permit is acceptable) or appropriate Texas licensure applicable to provider type.</li> <li>• Certificate or AANA# (applicable to CRNA providers only)</li> </ul> <p><b>Note:</b> Obtaining a BCBSTX Provider Record ID does not automatically activate the STAR Kids network. Claims will be processed out-of-network until the provider has applied for network participation and has been approved and activated in the STAR Kids network</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 STAR Kids network	Complete the STAR Kids <b>Facility-based Provider Application</b> (a sample on the next page) and fax the completed application to your local Network Management office in Austin.  Fax: <b>1-512-349-4853</b>



# Chapter 20

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 STAR Kids network 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="824 411 1430 552">1. Complete the STAR Kids network 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: <b>1-800-336-5696</b>.</li><li data-bbox="824 573 1430 863">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 <b>1-512-349-4853</b> or mail to: <b>Blue Cross and Blue Shield of Texas</b> <b>9442 Capital of Texas Highway N</b> Suite 500, Arboretum Plaza II Austin, TX 78759-6839</li><li data-bbox="824 884 1430 1173">3. Complete the STAR Kids Network Facility-based Provider Application (located below) and return to your local Network Management office in Austin by fax to <b>1-512-349-4853</b> or by mailing to: <b>Blue Cross and Blue Shield of Texas</b> <b>9442 Capital of Texas Highway N</b> Suite 500, Arboretum Plaza II Austin, TX 78759-6839</li></ol>



**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 and 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:**     Group agreement(s) on file                       Individual Agreement(s) attached

<b>Group Name:</b>	<b>Organizational Type 2 NPI #:</b>
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<b>Provider Name:</b>	<b>Professional Provider Type 1 NPI #:</b>
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<b>Degree:</b>	<b>Maiden Name, if applicable:</b>
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<b>Social Security #:</b>	<b>Date of Birth:</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
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<b>Tax Identification # Used for Billing:</b>	<b>Start Date With Group:</b>
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**Practice Location – Physical Address/City/State/Zip:**

**Billing Address/City/State/Zip:**

<b>Billing Phone #:</b>	<b>Fax #:</b>
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**Correspondence Address/City/State/Zip:**

<b>Name of Primary Hospital/Facility:</b>	<b>City of Primary Facility:</b>
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<b>Practicing Specialty:</b>	<input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible
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<b>Practicing Sub-Specialty:</b>	<input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible
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<b>Texas License Number (if temporary, attach copy):</b>	<b>License Effective Date:</b>
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<b>Anesthesia Assistants &amp; CRNAs Only – Certificate or AANA# (MUST attach copy of certificate)</b>	<b>Date Certified:</b>
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**Does applicant have professional liability insurance limits of at least \$200,000/600,000?     Yes     No**

<b>Is the applicant active military?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</b>	<b>Is applicant a Medicare Participant?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</b>
---	--

<b>Is applicant currently in Residency Program? <input type="checkbox"/> Yes    <input type="checkbox"/> No</b>	<b>Is applicant currently in Fellowship Program? <input type="checkbox"/> Yes    <input type="checkbox"/> No</b>
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<b>Add Provider to:</b> <input type="checkbox"/> Medicaid Star <input type="checkbox"/> Star Kids	<b>If yes, please indicate TPI numbers below:</b>
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<b>Group TPI:</b>	<b>Individual TPI:</b>
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<b>Application Submitted By:</b>	<b>Title:</b>	<b>Date:</b>
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<b>Email Address:</b>	<b>Phone #:</b>	<b>Fax #:</b>
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## 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: **1-512-349-4853** (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.

## 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 or 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 to submit 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	
<b>Standard Provider Types</b>	Medical Doctor (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatric Medicine (DPM) Doctor of Chiropractics (DC), Doctor of Osteopathy (DO)
<b>Allied Provider Types</b>	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 Texas STAR Kids network, contact Magellan at **1-800-788-4005** or [www.magellanprovider.com](http://www.magellanprovider.com) for questions regarding the credentialing or re-credentialing for the Texas STAR Kids 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: **1-512-349-4853** (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 **1-866-293-0414**. If you have any questions on accessing the database, you may contact the CAQH Help Desk at **1-888-599-1771** for assistance or you may send an email to [caqh.updhelp@acsgs.com](mailto:caqh.updhelp@acsgs.com).

**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 **1-888-599-1771** or by emailing [caqh.updhelp@acsgs.com](mailto: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 **1-888-599-1771** 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 CAQHUPD 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 CAQHUPD 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 **1-888-599-1771** and complete the application by telephone. Supporting documents may be faxed toll free to **1-866-293-0414**.

**Q21. Are hearing and/or sight challenged persons able to use the CAQH database?**

Yes. Hearing and/or sight challenged Providers may call the CAQH Help Desk at **1-888-599-1771** and complete the application by telephone. Supporting documents may be faxed toll free to **1-866-293-0414**.

**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 **1-888-599-1771** or by emailing to [caqh.updhelp@acsgs.com](mailto:caqh.updhelp@acsgs.com).





## Chapter 21

# 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 Hotline after hours.

Customer Service: **1-877-688-1811**

24 Hour Nurse Hotline: **1-844-971-8906**

24 Hour Nurse Hotline TTY: **7-1-1**  
(for the hearing impaired)

### Provider Interpretation Services

Providers also have access to IVerto, over-the-phone interpretation services. For on-demand over-the-phone interpreter services, you can call the On-Demand Hotline at **1-214-865-7715** and access the IVR Interpretation Service. You will be prompted to enter “1” for Spanish or “2” for all other languages. You will then be required to provide your Client ID Number. You will then be connected to an Interpreter. You will be asked for your name and your department name. If your company requires specific questions to be asked, this is when you will be asked for that information.

### 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](http://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.

# Chapter 21

## 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:

**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 Hotline 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, 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. BCBSTX writes all member materials at a sixth-grade reading level.

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 Kids):	<b>1-877-688-1811</b>
24 Hour Nurse Hotline:	<b>1-855-802-4614</b>
National TTY:	<b>7-1-1</b>

## 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/medicaid/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.

## 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 or status
- Board certification
- NPI Number change
- TIN or 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 or covering physicians or other professional providers

You may submit your changes directly to BCBSTX by going to: [www.bcbstx.com/provider/network/medicaid.html](http://www.bcbstx.com/provider/network/medicaid.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 **1-512-349-4847**.

**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 **1-877-688-1811**.



## Chapter 22

# 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 an 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, a 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 Kids) Program: **1-877-688-1811**

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: **1-972-996-9211**

## **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 Kids ID.
- Using someone else's Medicaid STAR Kids ID.
- Not telling the truth about the amount of money or resources a member has to qualify for benefits.



# Chapter 22

## To report waste, abuse, or fraud, choose one of the following:

Call the Office of the Inspector General (OIG) Hotline at **1-800-436-6184**;

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](http://www.bcbstx.com/ut/resources/fraud.html)

Phone: **1-800-543-0867**

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](http://www.hhs.state.tx.us) and select **Reporting Waste, Abuse and Fraud**. The site provides information on the types of waste, abuse and fraud to report.

If you do not have Internet access or prefer to talk to a person, call the HHSC Office of the Inspector General (OIG) Fraud Hotline at: **1-800-436-6184** or, you may send a written statement to the following addresses:

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 23

# DEFINITIONS AND MAPS

## **1915(i) Home and Community Based Services- Adult Mental Health (HCBS-AMH)**

Home and Community Based Services-Adult Mental Health (HCBS-AMH) is a state-wide program that provides home and community-based services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each need, to enable him or her to live and experience successful tenure in their chosen community. Services are designed to support long term recovery from mental illness.

### **Abuse**

Abuse involves provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program 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 program.

### **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 and 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**

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 23

## **Adverse Determination Review**

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**

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.

## **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.



# Chapter 23

## **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).

## **Community Living Assistance and Support Services (CLASS) Waiver Program**

The Community Living Assistance and Support Services (CLASS) program provides home and community-based services to people with related conditions as a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). A related condition is a disability, other than an intellectual disability, that originated before age 22 that affects the ability to function in daily life.

## **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**

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.

## **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.

# Chapter 23

## 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. 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.

## **Deaf Blind with Multiple Disabilities (DBMD) Waiver Program**

The Deaf Blind with Multiple Disabilities (DBMD) program provides home and community-based services to people who are deaf blind and have another disability. This is a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). The DBMD program focuses on increasing opportunities for consumers to communicate and interact with their environment.

## **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.

# Chapter 23

## **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's, 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.

## **Dual-Eligible**

Medicaid recipients who are also eligible for Medicare

## **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 woman or her 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 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.

# Chapter 23

## 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).

## **Home and Community-based Services (HCS) Waiver Program**

The Home and Community-based Services (HCS) program provides individualized services and supports to people with intellectual disabilities who are living with their families, in their own homes or in other community settings, such as small group homes where no more than four people live. The local authority provides service coordination.

## **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.



# Chapter 23

## **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.

## **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.

## **Long Term Services and Supports (LTSS)**

LTSS means assistance with daily healthcare and living needs for individuals with a long-lasting illness or disability.

## **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 Dependent Children Program (MDCP) Waiver Program**

The Medically Dependent Children Program (MDCP) provides services to support families caring for children who are medically dependent and encourages the transition of children in nursing homes back to the community.

## **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.

# Chapter 23

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.

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.

## 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.

## **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.

## **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.

# Chapter 23

## 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.

## **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.

# Chapter 23

## **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.

## **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 Coordination**

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.

## **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 Kids 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. There is no annual limit on inpatient services.

## **STAR Kids Program**

The STAR Kids Managed Care Program is established by the Health and Human Services Commission (HHSC) under Senate Bill 71. The STAR Kids Program will provide Medicaid benefits to children and young adults with disabilities through the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 Waiver.



# Chapter 23

## **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**

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.

## **Texas Home Living (TxHmL) Waiver Program**

The Texas Home Living (TxHmL) program provides selected essential services and supports to people with an intellectual disability or a related condition who live in their own home or their family's home.

## **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.

## **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.

# Chapter 23

## **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.

## **Youth Empowerment Services (YES) Waiver Program**

The Youth Empowerment Services (YES) waiver provides comprehensive home and community-based mental health services to youth between the ages of 3 and 18, up to a youth's 19th birthday, who have a serious emotional disturbance. The YES Waiver not only provides flexible supports and specialized services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbance, but also strives to provide hope to families by offering services aimed at keeping children and youth in their homes and communities.

# BCBSTX STAR KIDS SERVICE AREA

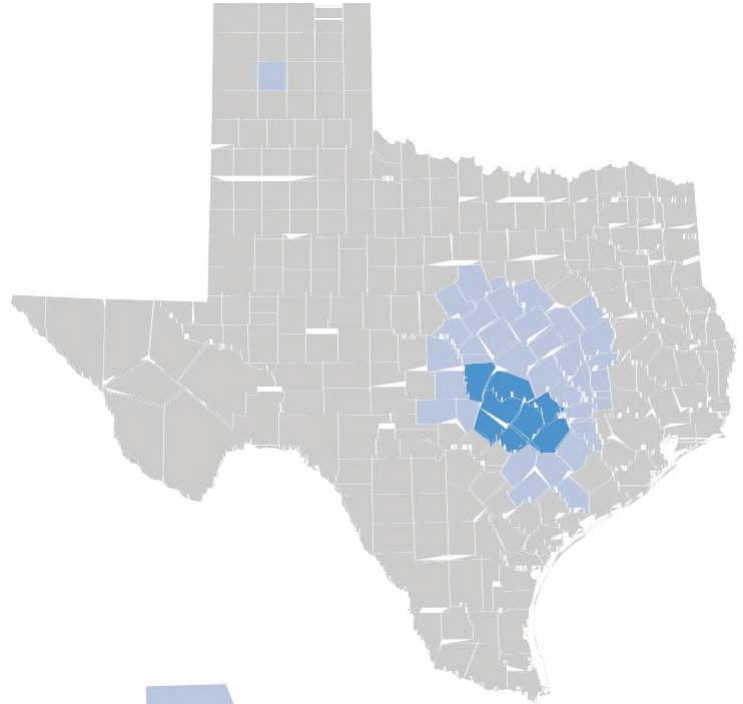
## Travis Service Area

Members may be eligible to enroll with BCBSTX in the STAR Kids Program if you

live in one of these counties:

- Bastrop
- Burnet
- Caldwell

- Fayette
- Hays
- Lee
- Travis
- Williamson



## Medicaid Rural Service Area (MRSA) Central

- Bell
- Blanco
- Bosque
- Brazos
- Burleson
- Colorado
- Comanche
- Coryell
- Dewitt
- Erath
- Falls
- Freestone
- Gillespie
- Gonzales
- Grimes
- Hamilton
- Hill
- Jackson
- Lampasas
- Lavaca
- Leon
- Limestone
- Llano
- Madison
- McLennan
- Milam
- Mills
- Robertson
- San Saba
- Somervell
- Washington



Providers from inside the service as well as outside of the service area may contract with BCBSTX to provide services to members.



**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.

©3CM™ September 2009. Obtained from [www.depression-primarycare.org](http://www.depression-primarycare.org).

## 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 $\geq 5$ 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 $\geq 5$ 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 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 treatment options and preferences.</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 down, depressed, or hopeless	0	1	2	3
3.	Trouble falling asleep, staying asleep, or waking too early in the morning	0	1	2	3
4.	Feeling tired or fatigued	0	1	2	3
5.	Poor appetite or overeating		1	2	3
6.	Feeling bad about yourself or have let yourself or your body get out of control		1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television		1		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 too	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.'s 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](http://www.pfizer.com). Copyright © 1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

# APPENDIX B

## STAR Kids Service Matrix

Capitated Services	MCO Coverage							
	SSI	SSI (dual)	MDCP	MDCP (dual)	DADS IDD Waiver	DADS IDD Waiver (dual)	YES Waiver	YES Waiver (dual)
Capitated Acute Care (non-exhaustive)								
Emergency and non-emergency ambulance services	Y	N*	Y	N*	Y	N*	Y	N*
Audiology services	Y	N*	Y	N*	Y	N*	Y	N*
Behavioral Health Services	Y	N*	Y	N*	Y	N*	Y	N*
Prenatal care	Y	N*	Y	N*	Y	N*	Y	N*
Birthing services	Y	N*	Y	N*	Y	N*	Y	N*
Cancer screening, diagnostic, and treatment service	Y	N*	Y	N*	Y	N*	Y	N*
Chiropractic services	Y	N*	Y	N*	Y	N*	Y	N*
Dialysis	Y	N*	Y	N*	Y	N*	Y	N*
Drugs and biologicals provided in an inpatient setting	Y	N*	Y	N*	Y	N*	Y	N*
Durable medical equipment and supplies	Y	N*	Y	N*	Y	N*	Y	N*
Early Childhood Intervention (ECI) services	Y	N*	Y	N*	Y	N*	Y	N*
Emergency Services	Y	N*	Y	N*	Y	N*	Y	N*
Family planning services	Y	N*	Y	N*	Y	N*	Y	N*
Home health care services	Y	N*	Y	N*	Y	N*	Y	N*
Hospital services, inpatient and outpatient	Y	N*	Y	N*	Y	N*	Y	N*
Laboratory	Y	N*	Y	N*	Y	N*	Y	N*

# APPENDIX B

Capitated Services	MCO Coverage							
	SSI	SSI (dual)	MDCP	MDCP (dual)	DADS IDD Waiver	DADS IDD Waiver (dual)	YES Waiver	YES Waiver (dual)
Capitated Acute Care (non-exhaustive)								
Mastectomy, breast reconstruction, and related follow-up procedures	Y	N*	Y	N*	Y	N*	Y	N*
THSteps medical checkups	Y	N*	Y	N*	Y	N*	Y	N*
Mental health rehabilitation services	Y	N*	Y	N*	Y	N*	Y	N*
Mental health targeted case management	Y	N*	Y	N*	Y	N*	Y	N*
Oral evaluation and fluoride varnish	Y	N*	Y	N*	Y	N*	Y	N*
Optometry, glasses, and contact lenses	Y	N*	Y	N*	Y	N*	Y	N*
Outpatient drugs and biologicals	Y	N*	Y	N*	Y	N*	Y	N*
Podiatry	Y	N*	Y	N*	Y	N*	Y	N*
Primary care services	Y	N*	Y	N*	Y	N*	Y	N*
Radiology, imaging, and X-rays	Y	N*	Y	N*	Y	N*	Y	N*
Specialty physician services	Y	N*	Y	N*	Y	N*	Y	N*
Telemonitoring	Y	N*	Y	N*	Y	N*	Y	N*
Telehealth	Y	N*	Y	N*	Y	N*	Y	N*
PT/OT/ST	Y	N*	Y	N*	Y	N*	Y	N*
Transplantation of organs and tissues	Y	N*	Y	N*	Y	N*	Y	N*
Vision services	Y	N*	Y	N*	Y	N*	Y	N*

Capitated Services	MCO Coverage							
	SSI	SSI (dual)	MDCP	MDCP (dual)	DADS IDD Waiver	DADS IDD Waiver (dual)	YES Waiver	YES Waiver (dual)
Capitated Acute Care (non-exhaustive)								
Capitated State Plan LTSS								
Personal Care Services (PCS)	Y	Y	N**	N**	N***	N***	N**	N**
Private Duty Nursing (PDN) services	Y	Y	Y	Y	Y	Y	Y	Y
Prescribed pediatric extended care center (PPECC) services	Y	Y	Y	Y	Y	Y	Y	Y
Day Activity and Health Services (DAHS)	Y	Y	Y	Y	Y	Y	Y	Y
Capitated CFC Services for Qualified Members								
CFCPAS/HAB	Y	Y	Y	Y	N	N	Y	Y
ERS	Y	Y	Y	Y	N	N	Y	Y
Support Management	Y	Y	Y	Y	N	N	Y	Y
Capitated MDCP services for MDCP members								
Respite	N	N	Y	Y	N	N	N	N
Supported Employment	N	N	Y	Y	N	N	N	N
Employment Assistance	N	N	Y	Y	N	N	N	N
Adaptive Aids	N	N	Y	Y	N	N	N	N
Minor home modification	N	N	Y	Y	N	N	N	N
Flexible family support services	N	N	Y	Y	N	N	N	N
Transition assistance services	N	N	Y	Y	N	N	N	N
Financial management services	N	N	Y	Y	N	N	N	N

# APPENDIX C

Non-capitated Services	Responsible entity, if applicable							
1915(c) waivers								
<b>CLASS services</b>	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Adaptive Aids	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Employment Assistance	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Financial Management Services	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Minor home modification	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Respite	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Supported Employment	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Auditory integration therapy	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Continued family services	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Support family services	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Prevocational habilitation	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
<b>DBMD services</b>	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Adaptive Aids	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Employment Assistance	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Financial Management Services	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Minor home modification	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Respite	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Supported Employment	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Chore	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Intervener	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Orientation/mobility	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Residential services	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A

Non-capitated Services	Responsible entity, if applicable							
1915(c) waivers								
<b>HCS services</b>	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Adaptive Aids	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Employment Assistance	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Financial Management Services	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Minor home modification	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Respite	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Supported Employment	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Residential services	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
<b>TxHmL services</b>	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Adaptive Aids	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Employment Assistance	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Financial Management Services	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Minor home modification	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Respite	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Supported Employment	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
~Community support services	N/A	N/A	N/A	N/A	DADS	DADS	N/A	N/A
<b>YES services</b>	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
~Adaptive Aids	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
~Employment Assistance	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
~Minor home modification	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
~Respite	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
~Supported Employment	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS



# APPENDIX C

Non-capitated Services	Responsible entity, if applicable							
1915(c) waivers								
~Family supports	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
~Non-medical transportation	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
~Paraprofessional services	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
~Pre-engagement services	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
~Specialized therapies	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
~Supportive family-based alternatives	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
~Transitional services	N/A	N/A	N/A	N/A	N/A	N/A	DSHS	DSHS
Other Medicaid services								
Children's dental services	CMDS	CMDS	CMDS	CMDS	CMDS	CMDS	CMDS	CMDS
1915(i) Adult Mental Health (AMH)	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS
Environmental lead investigations (ELI)	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS
Early Childhood Intervention (ECI) Targeted Case Management (TCM)	DARS	DARS	DARS	DARS	DARS	DARS	DARS	DARS
Early Childhood Intervention (ECI) Specialized Skills Training (SST)	DARS	DARS	DARS	DARS	DARS	DARS	DARS	DARS

Non-capitated Services	Responsible entity, if applicable							
1915(c) waivers								
Case Management for Children and Pregnant Women (CPW)	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS
School Health and Related Services (SHARS)	HHSC	HHSC	HHSC	HHSC	HHSC	HHSC	HHSC	HHSC
Tuberculosis services	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS	DSHS
Blind Children's Vocational Discovery and Development Program	DARS	DARS	DARS	DARS	DARS	DARS	DARS	DARS
Medical Transportation Program (MTP)	HHSC	HHSC	HHSC	HHSC	HHSC	HHSC	HHSC	HHSC
Hospice	DADS	DADS	DADS	DADS	DADS	DADS	DADS	DADS
Court-ordered services	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
NF daily rate	DADS	DADS	N/A	N/A	N/A	N/A	N/A	N/A
ICF daily rate	DADS	DADS	N/A	N/A	N/A	N/A	N/A	N/A
Notes								
<p>* Wraparound and crossover for dual eligible STAR Kids members is paid FFS</p> <p>** MDCP and YES clients meet the level of care for CFC, so they need attendant care, they will always get CFC rather than PCS to obtain the higher match</p> <p>*** DADS IDD waiver clients qualify for CFC, which is non-capitated. Because they qualify for CFC, they do not qualify for PCS.</p>								

# APPENDIX C

Service	Procedure Code Qualifier	HCPC Codes	CPT4 Codes	Rev Codes
<b>State Plan Services</b>				
Adult Day Care	HC	S5101		
CCP-CommunityFirstChoiceforChildrenunder21				
CFC Attendant Care Only (CFC-PCS)	HC	T1019		
	HC	T1019		
	HC	T1019		
Attendant Care and Habilitation (CFC-PCS)	HC	T1019		
	HC	T1019		
	HC	T1019		
Emergency Response	HC	S5161		
	HC	S5160		
Personal Care Services (PCS)	HC	T1019		
	HC	T1019		
	HC	T1019		
	HC	T1019		
	HC	T1019		
	HC	T1019		
	HC	T1019		

**DO NOT USE**

Mod 1	Mod 2	Mod 3	Mod 4	Units	Service Description
				3-6 Hours = 1 unit, over 6 Hours = 2 units	Day Activities & Health Services (3-6 hours)
UD				15 minutes = 1 unit	CFC PCS Attendant care only- Agency Model
U1				15 minutes = 1 unit	CFC PCS Attendant care only- Service Responsibility Option Model
U3				15 minutes = 1 unit	CFC PCS Attendant care only- Consumer Directed Services Model
U9				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Agency Model
U2				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Service Responsibility Option Model
U4				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Consumer Directed Services Model
U3	U3			1 month = 1 unit	Emergency Response Services (Monthly)
				1 unit per service	Emergency Response Services (Installation and Testing)
U6				15 minutes = 1 unit	PCS- Agency Model
US				15 minutes = 1 unit	PCS - Service Responsibility Option Model
UC				15 minutes = 1 unit	CS - Consumer Directed Services Model
UA	U6			15 minutes = 1 unit	PCS, BH Condition - Agency Model
UA	US			15 minutes = 1 unit	PCS, BH Condition - Service Responsibility Option Model
UA	UC			15 minutes = 1 unit	PCS, BH Condition - Consumer Directed Services Model


SAMPLE USE  
DO NOT USE

# APPENDIX C

Service	Procedure Code Qualifier	HCPC Codes	CPT4 Codes	Rev Codes
<b>MDCP Services</b>				
Respite Care in a Facility	HC	T1005		
	HC	T1005		
	HC	T1005		
	HC	T1005		
	HC	T1005		
	HC	T1005		
	HC	T1005		
	HC	T1005		
	HC	T1005		
	HC	T1005		
	HC	T1005		
	HC	T1005		
Respite Care in a Facility	HC	T2027		
In Home Respite	HC	H2015		
	HC	H2015		
	HC	H2015		
	HC	H2015		
	HC	H2015		
	HC	H2015		
	HC	H2015		
	HC	H2015		
	HC	H2015		

DO NOT USE

Mod 1	Mod 2	Mod 3	Mod 4	Units	Service Description
U0				15 minutes = 1 unit	Level 10: SE3
U9				15 minutes = 1 unit	Level 9: RAD & SE2
U8				15 minutes = 1 unit	Level 8: SSC, SE1, & RAC
U7				15 minutes = 1 unit	Level 7: SSA, SSB, & RAB
U6				15 minutes = 1 unit	Level 6: RAA
U5				15 minutes = 1 unit	Level 5: CB2, CC1, & CC2
U4				15 minutes = 1 unit	Level 4: BB2, CA1, IB2, PD2, CB1, & PE2
U3				15 minutes = 1 unit	Level 3: PB2, PC2, IB1, CA1, & PD1
U2				15 minutes = 1 unit	Level 2: BA1, PA1, PB1, BA2, & IA2
U1				15 minutes = 1 unit	Level 1: SE1
U0	U3			15 minutes = 1 unit	Level 10: SE3 with personal vent
U9	U3			15 minutes = 1 unit	Level 9: RAD & SE2 with personal vent
				15 minutes = 1 unit	Home Care, Camp Setting
U1				15 minutes = 1 unit	Attendant, Agency Model
U1	US			15 minutes = 1 unit	Attendant, Service Responsibility Option
U1	UC			15 minutes = 1 unit	Attendant, CDS Option
U1	UA			15 minutes = 1 unit	Attendant with RN delegation, Agency Model
U1	US			15 minutes = 1 unit	Attendant with RN delegation, Service Responsibility Option
U1	UC			15 minutes = 1 unit	Attendant with RN delegation, CDS Option
U3				15 minutes = 1 unit	LVN, Agency Model
U3	US			15 minutes = 1 unit	LVN, Service Responsibility Option



# STAR Kids Provider Manual Addendum

For physicians, professional providers, facilities, ancillary providers and LTSS providers.



Medicaid Rural Service Area

(MRSA) Central Service Area

Travis Service Area

Provider Customer Service: 1-877-688-1811

[bcbstx.com/provider/Medicaid/index.html](http://bcbstx.com/provider/Medicaid/index.html)

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# Chapter 1 STAR Kids 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](http://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](http://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](http://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](http://www.evicore.com). Please call eviCore Customer Service department at 1-855-252-1117 if you have any questions or need more information.

# Chapter 1 STAR Kids Member Benefits

## 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. For children and young adults (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.
- Call 1-877-784-6802 for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).
- 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 1-855-212-1615 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 1-877-784-6802 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.

## MEDICAL TRANSPORTATION PROGRAM (MTP)

### What is MTP?

MTP is a state administered program that provides Non-Emergency Medical Transportation (NEMT) services statewide for eligible Medicaid clients who have no other means of transportation to attend their covered healthcare appointments. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place you get Medicaid services.

### What services are offered by MTP?

- Passes or tickets for transportation such as mass transit within and between cities or states, to include rail, bus, or commercial air
- Curb to curb service provided by taxi, wheelchair van, and other transportation vehicles
- Mileage reimbursement for a registered individual transportation participant (ITP) to a covered healthcare event. The ITP can be the responsible party, family member, friend, neighbor, or client.
- Meals and lodging allowance when treatment requires an overnight stay outside the county of residence
- Attendant services (a responsible adult who accompanies a minor or an attendant needed for mobility assistance or due to medical necessity, who accompanies the client to a healthcare service)
- Advanced funds to cover authorized transportation services prior to travel

Call MTP:

For more information about services offered by MTP, clients, advocates and providers can call the toll-free line at 1-877-633-8747. In order to be transferred to the appropriate transportation provider, clients are asked to have either their Medicaid ID# or zip code available at the time of the call.

## Chapter 2 Member Eligibility

### 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 can also 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](http://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](http://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](http://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 [ytc-card-support@hpe.com](mailto:ytc-card-support@hpe.com).

## Chapter 2 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](http://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 3 Long Term Services and Support

## What is EVV?

- Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends.
- EVV is a method by which a person, including but not limited to a personal care attendant, who enters a STAR Kids member's home to provide a service will document their arrival time and departure time using a telephonic or computer-based application system. This visit information will be recorded and used as an electronic version of a paper time sheet for an attendant and used to support claims to BCBSTX for targeted EVV services.

Do providers have a choice of EVV vendors?

- Provider selection of EVV vendor
  - Providers have a choice of EVV vendors. During the contracting and credentialing process with BCBSTX, a copy of the Provider Electronic Visit Verification Vendor System Selection form should be provided in the application packet. Forms are located at <http://www.bcbstx.com/provider/medicaid/forms.html>.
- Provider EVV default process for non-selection
  - Mandated providers that do not make an EVV vendor selection or who do not implement use of their selected vendor, are subject to contract actions and are defaulted to a selected vendor by HHSC. The provider will receive a default letter detailing out the vendor that they have been defaulted to and when they are required to be implemented with the vendor.
- When can a provider change EVV vendors?
  - A provider may change EVV vendors 120 calendar days after the submission request by completing the Medicaid EVV Provider System Selection form.

A provider may change EVV vendors twice in the life of their contract with BCBSTX.

Can a provider elect not to use EVV?

- EVV will be required to document delivery of the following STAR Kids services:
  - Personal care services (PCS)
  - Community First Choice attendant care and habilitation (PAS/HAB)
  - MDCP In-Home Respite
  - MDCP flexible family support services
  -

Is EVV required for CDS employers?

**If you are a CDS Employer, there are 3 EVV options:**

- **Phone and Computer (Full Participation):** The telephone portion of EVV will be used by your Consumer Directed Services (CDS) Employee(s) and you will use the computer portion of the system to perform visit maintenance.
- **Phone Only (Partial Participation):** This option is available to CDS Employers who can participate in EVV, but may need some assistance from the FMSA with visit maintenance. You will use a paper time sheet to document service delivery. Your CDS Employee will call-in when they start work and call-out when they end work. Your FMSA will perform visit maintenance to make the EVV system match your paper time sheet.
- **No EVV Participation:** If you do not have access to a computer, assistive devices, or other supports, or you do not feel you can fully participate in EVV, you may choose to use a paper time sheet to document service delivery.

# How do providers with assistive technology (ADA) needs use EVV?

If you use assistive technology, and need to discuss accommodations related to the EVV system or materials, please contact the HHSC-approved EVV vendors (List 2 Vendor contact numbers).

## DataLogic (Vesta) Software, Inc

Contact:	Email:	Phone:
Sales & Training	<a href="mailto:info@vestaevv.com">info@vestaevv.com</a>	(888) 880-2400
Tech Support	<a href="mailto:support@vesta.net">support@vesta.net</a>	
Website: <a href="http://www.vestaevv.com">www.vestaevv.com</a>		

## EVV use of small alternative device (SAD) process and required SAD forms

- The SAD process is found at: <http://www.dads.state.tx.us/evv/formshandbooks.html>
- SAD forms can be found at (add link to most current version on MCO website)
- Where do I submit the SAD agreement/order form?
  - The form is submitted to the provider-selected EVV vendor.
    - a) DataLogic - email for to: [tokens@vestaevv.com](mailto:tokens@vestaevv.com) or send secure efax to 956-290-8728
    - b) MEDsys - email form to: [tokens@medsyschcs.com](mailto:tokens@medsyschcs.com) or send secure fax to 888-521- 0692
- Equipment provided by an EVV contractor to a Provider, if applicable, must be returned in good condition.

## EVV Compliance

All providers providing the mandated services must use the EVV system and must maintain compliance with the following requirements:

- The Provider must enter Member information, Provider information, and service schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual system.
- The Provider must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.
- 90% Adherence to Provider Compliance Plan
  - **HHSC EVV Initiative Provider Compliance Plan** – A set of requirements that establish a standard for EVV usage that must be adhered to by Provider Agencies under the HHSC EVV initiative.
  - Provider Agencies must achieve and maintain an HHSC EVV Initiative Provider Compliance Plan Score of at least 90 percent per Review Period. Reason Codes must be used each time a change is made to an EVV visit record in the EVV System.

Provider Agencies must complete any and all required visit maintenance in the EVV system within 60 days of the visit (date of service). Visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. Provider Agencies must submit claims in accordance with their contracted entity claim submission policy. No visit maintenance will be allowed more than 60 days after the date of service and before claims submission, unless an exception is granted.

- The HHSC Compliance Plan is located at:  
<https://www.dads.state.tx.us/evv/complianceplans.html>
  - The BCBSTX Compliance Plan is located under the Education and Reference tab of the BCBSTX Provider Website.
- The Provider Agency must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
  - The Provider Agency must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
  - Providers should notify the appropriate MCO, or HHSC, within 48 hours of any ongoing issues with EVV vendors or issues with EVV Systems.
  - Any Corrective action plan required by a MCO is required to be submitted by the Network Provider to BCBSTX within 10 calendar days of receipt of request.

BCBSTX Provider Agencies may be subject to termination from the BCBSTX network for failure to submit a requested corrective action plan in a timely manner

## Chapter 4 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 5 Provider Roles and Responsibilities

(Excludes STAR Kids 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:

- a) One well-woman checkup each year
- b) Care related to pregnancy
- c) Care for any female medical condition
- d) 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.

### 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:

- o One well-woman checkup each year
- o Care related to pregnancy
- o Care for any female medical condition

A referral to a specialist doctor within the network

## Chapter 6 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 7 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 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.

### 2. **Comprehensive unclothed physical examination**

### 3. **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 provider is 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/>.

4. **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

5. **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.

6. **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](http://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.

## Appendix A

### Span of Coverage (Hospital) - Responsibility during a Continuous Inpatient Stay <sup>1</sup>

If a Member is disenrolled from a STAR Kids MCO and enrolled in another STAR Kids MCO during an Inpatient Stay, then the former STAR Kids MCO will pay all facility charges until the Member is discharged from the Hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, or until the Member loses Medicaid eligibility. The new STAR Kids MCO will be responsible for all other Covered Services on the Effective Date of Coverage with the STAR Kids MCO.

	Scenario	Hospital Facility Charge	All Other Covered Services
1	Member Moves from FFS to STAR Kids	FFS	New MCO
2	Member moves from STAR, STAR Health or STAR+PLUS to STAR Kids	Former MCO	New MCO
3	Member Moves from CHIP to STAR Kids	New MCO	<i>New MCO</i>
4	Adult Member Moves from STAR Kids to STAR or STAR+PLUS	Former STAR Kids MCO	New STAR or STAR+PLUS MCO
5	Member moves from STAR Kids to STAR Health	Former STAR Kids MCO	<i>New STAR Health MCO</i>
6	Member Retroactively Enrolled in STAR Kids	New MCO	<i>New MCO</i>
7	Member moves between STAR Kids MCOs	Former MCO	New MCO



## **BlueCross BlueShield of Texas**

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Prime Therapeutics LLC is a separate company that provides pharmacy benefit management services for Blue Cross and Blue Shield of Texas.

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