BlueCross BlueShield of Texas

CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS STAR Kids Your Health Plan ★ Your Choice | TEXAS Health and Human Services

Blue Cross and Blue Shield of Texas Medicaid Provider Manual

For Physicians, other Professional Providers, Facilities, Ancillary Providers and LTSS Providers

September 2024

STAR/CHIP: Travis Service Area
Provider Customer Service **1-877-560-8055**

STAR Kids: Medicaid Rural Service Area (MRSA) Central /Travis Service Area
Provider Customer Service: **1-877-784-6802**

bcbstx.com/provider/medicaid

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

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Section 1: Introduction

Background

Blue Cross and Blue Shield of Texas (BCBSTX) is the only statewide, customer-owned health insurer in Texas and is the largest provider of health benefits in the state. BCBSTX works with over 130,000 physicians and health care practitioners, and 500 hospitals to serve more than 5 million members in all 254 counties. BCBSTX has been around for more than 90 years and come to represent the most experienced health care coverage organization in the state and nation. Our mission is still focused on providing financially sound health coverage to as many Texas as possible. We are collaborating and innovating to deliver efficient, high-quality of care. We contract with the Texas Health and Human Services Commission (HHSC) to provide services to Texas Medicaid (STAR), Children's Health Insurance Program (CHIP), and STAR Kids program enrollees in several programs. In addition, Blue Cross and Blue Shield of Texas provide services to members that take part in the following programs in certain areas of the State of Texas:

Program	Service Area
Children's Health Insurance Program (CHIP) and CHIP Perinatal.	**Travis Service Area:** Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson.
State of Texas Access Reform (STAR)	**Travis Service Area:** Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson
State of Texas Access Reform STAR Kids	**Travis Service Area and 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, and Washington.

Medicaid Program Objectives

State of Texas Access Reform (STAR)

BCBSTX STAR program is a Medicaid managed care program for children, pregnant women and low income families providing clients with acute care medical assistance. BCBSTX provides delivery of primary and acute care services to members, who are not served by, or eligible for, other state-assisted health insurance programs. BCBSTX's program emphasizes early intervention and promotes improved access to quality care with a special focus on prenatal care and Texas Health Steps Checkups for Children.

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

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) provides health coverage for children ages 18 and younger in families that earn too much to qualify for Medicaid but cannot afford private health care coverage. A child must be age 18 or younger, a Texas resident, and a U.S. citizen or legal permanent resident.

Objectives of the CHIP program are to:

- Increase the number of insured children in Texas.
- Ensure children have access to a medical home, a physician or health care provider who serves the physical, mental and developmental health care needs of a growing child through a continuous and ongoing relationship.

CHIP Perinatal Program

Texas residents who are pregnant, uninsured and not able to obtain Medicaid may be eligible for CHIP Perinatal benefits. Coverage starts before the child is born and lasts 12 months from the date the unborn child is enrolled. The objectives of CHIP Perinatal are to improve health status and birth outcomes by ensuring pregnant women who are ineligible for Medicaid due to income or immigration status receive prenatal care.

STAR Kids

STAR Kids is a Medicaid managed care program designed specifically for children and young adults with special needs. Most individuals 20 years old and younger who get Supplemental Security Income (SSI) Medicaid or Home- and Community-Based Waiver services will receive some or all of their Medicaid services through STAR Kids. Children and young adults enrolled in STAR Kids will receive comprehensive service coordination. Objectives of the STAR Kids program include:

- Provide Medicaid benefits customized to meet the health care needs of recipients through a defined system of care.
- Better coordination of care for 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 residential care, through provision of care management and appropriate services.

Quick Reference Guide

Contact Information	
Provider Customer Services	Phone: **1-877-560-8055** – STAR and CHIP Phone: **1-877-784-6802** – STAR Kids TTY: **711** www.availity.com
Provider Relations	Phone: **1-855-212-1615** Email: TexasMedicaidNetworkDepartment@bcbstx.com www.bcbstx.com/provider/medicaid
Eligibility	
Blue Cross and Blue Shield of Texas	Phone: **1-877-560-8055** – STAR and CHIP Phone: **1-877-784-6802** - STAR Kids Phone: **1-800-925-9126** Automated Inquiry System (AIS) www.availity.com www.tmhp.com
Utilization Management	
Prior Authorization and Referrals	Phone: **1-877-560-8055** – STAR and CHIP Phone: **1-877-784-6802** – STAR Kids Fax: **1-855-653-8129** Availity®: www.availity.com Forms: www.bcbstx.com/provider/medicaid/claims-and-eligibility/um
LTSS	Phone: **1-855-212-1615** Fax: **1-512-349-4860**
Case Management Referrals	Phone: **1-877-214-5630** – STAR and CHIP Phone: **1-877-301-4394** – STAR Kids Fax: **1-866-644-5456** – STAR Kids (Fax) TX_Medicaid_HC@bcbstx.com
Electronic Visits Verification (EVV)	Phone **1-877-784-6802** Email: BCBSTX_EVV_Questions <BCBSTX_EVV_Questions@bcbstx.com> www.bcbstx.com/provider/medicaid/education-and-reference/evv
Interpreter Services	Phone: **1-877-560-8055** Providers STAR and CHIP Phone: **1-877-784-6802** Providers STAR Kids

Claims and Payment	
Claims Phone Number and Address	Phone: **1-877-560-8055** - STAR and CHIP Phone: **1-877-784-6802** - STAR Kids TTY: 771 www.availity.com (Payor ID: 66002) Blue Cross and Blue Shield of Texas P.O. Box 650712 Dallas, TX 75265
Refunds and Overpayments	Blue Cross and Blue Shield of Texas Claims Overpayment Dept. 14212 Palatine, IL 60055-4212
Complaints and Appeals	
Provider Complaints	Phone:**1-877-560-8055** Provider STAR and CHIP Phone:**1-877-784-6802** Provider STAR Kids Fax:**1-877-886-2593** Email: TX_Medicaid_A&G_Complaints@bcbstx.com Blue Cross and Blue Shield of Texas Complaints and Appeals P.O. Box 660717 Dallas, TX 75226
Provider Appeals	Phone:**1-877-560-8055** Provider STAR and CHIP Phone:**1-877-784-6802** Provider STAR Kids Appeal Form: www.bcbstx.com/provider/pdf/provider_dispute.pdf Fax:**1-877-886-2593** GPDTXMedicaidAG@bcbsnm.com Blue Cross and Blue Shield of Texas Complaints and Appeals P.O. Box 660717 Dallas, TX 75226 Please see website for instructions on filing appeal
Fraud, Waste and Abuse	Phone: **·1-800-543-0867** TTY:711
Texas Medicaid & Healthcare Partnership Billing	www.tmhp.com
Supporting Vendors	
DentaQuest (Dental Services)	**Phone:**1-800-516-0165 **or** www.dentaquest.com
MCNA Dental (Dental Services)	Phone: **1-800-494-6262** or www.mcna.net/en/home
United Healthcare Dental	Phone: **1-800-822-5353**

Supporting Vendors	
Prime Therapeutics Specialty Pharmacy™	Customer Service Phone:**1-855-457-0405** STAR Phone:**1-855-457-0403** CHIP Phone:**1-855-457-0757** STAR Kids (Travis Service Area) Phone:**1-855-457-0758** STAR Kids (MRSA Central Service Area) Prior Authorization Phone:**1-855-457-0407** STAR and CHIP Phone:**1-855-457-1200** STAR Kids Fax:**1-877-243-6930** -FAX
24 Hours Nurse Line	Phone:**1-844-971-8906** STAR and CHIP Phone:**1-855-802-4614** STAR Kids
ModivCare (Transportation Services)	**Phone:**1-877-564-9835 **Phone:**1-866-824-1565 **(TTY: 711) STAR and CHIP** **Phone:**1-855-933-6993 **STAR Kids** **Monday – Friday** **8 a.m. – 5 p.m. (Central Time)**
Davis Vision℠ (Vision Services)	Phone:**1-800-773-2847** Provider Phone:**1-888-657-6061** Member www.davisvision.com

Section 2: Provider Roles and Responsibilities

The Role of a Primary Care Provider

A primary care provider is a physician who has agreed with BCBSTX to be responsible for providing initial and routine care to patients, initiating referral for care, and maintaining the continuity of patient care. The Primary Care Provider (PCP) is the foundation of Blue Cross and Blue Shield of Texas.

Please note STAR, STAR Kids and CHIP members are required to have a primary care but STAR Kids Dual Eligible members are not required.

STAR Kids PCP network includes:

- General/Family Practice
- Internal Medicine
- OBGYN
- Pediatrician
- Advanced Nurse Practitioner (APN)
- Physician Assistant

The Role of a Medical Health Home

The term "medical health home" refers to a practice-based care team that takes collective responsibility for the patient's ongoing care. The PCP facilitates partnerships between patients, clinicians, medical staff, and families.

The Role of Specialty Care Provider

Specialist is a physician or provider who has education, training, or qualifications in a specialty, other than primary care.

Specialty care means advanced medically necessary care and treatment of specific physical, mental, or behavioral health conditions or those health conditions which may manifest in subpopulations, that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.

The Role of a LTSS Care Provider

Long Term Services and Supports (LTSS) care providers deliver a continuum of care and assistance. These services range from in-home to community- based services for all ages including the elderly and people with disabilities who need assistance in maintaining their independence.

The Role of Service Coordinator

The Service Coordinator develops and implements a person-centered care plan for the member. The Service Coordinator will work directly with the member and/or their legally authorized representative to coordinate the member's clinical and non-clinical support.

The Role of a CHIP Perinatal Provider

CHIP Perinatal providers are responsible for providing OB/GYN services to CHIP Perinatal members/mothers for the duration of the pregnancy and postpartum period, as well as medically necessary services for the unborn child. Once born, the child will receive Medicaid or CHIP benefits, depending on their income.

The Role of BCBSTX Transition Specialist

BCBSTX Transition Specialist works with our adolescent and young adult STAR Kids member(s) and their legally authorized representative (LAR) to prepare the member for a successful transfer out of our STAR Kids program and into adulthood. The Transition Specialist must be an employee of BCBSTX. A transition specialist will work with a member's service coordinator to develop a transition plan beginning when the member turns 15 years old and will continue until the member has successfully transitioned out of the STAR Kids program after the member's 21st birthday.

The Role of Pharmacy

Pharmacies are responsible for providing prescription drug services to all covered members in accordance with the standard practices. Retail and specialty pharmacies may fill prescriptions via arrangement with Prime Therapeutics LLC (Prime), the pharmacy benefits manager. Prime Therapeutics pharmacy operations manual for pharmacy providers is available on the Provider Resources page of our website at **www.bcbstx.com/provider/medicaid/pharmacy.html.** For more information please refer to Section 12 Pharmacy Provider Responsibilities.

The Role of a Main Dental Home

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.

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 the 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.

Network Limitations

BCBSTX works to ensure that members are able to access appropriate medical services within the participating provider network. BCBSTX will determine if medical services can be provided in-network. If BCBSTX determines that services can only provided by a non- participating provider, services will be authorized. BCBSTX will attempt to contract with non-participating providers to enhance provider network.

Section 3: STAR Kids Definitions

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 Member's needs, 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.

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.

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.

Dual – Eligible

Medicaid recipients who are also eligible for Medicare.

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.

Long Term Services and Supports (LTSS)

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

Medically 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.

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.

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.

Section 4: Covered Services

Please note STAR , CHIP and STAR Kids benefits are governed by BCBSTX's contract with the Health and Human Services Commission (HHSC), and include: medical, vision, behavioral health, and pharmacy. For STAR Kids members only covered services also includes Long Term Services and Supports (LTSS).

In addition, MDCP services are covered for individuals who qualify for and are approved to receive MDCP.

Case Management for Children and Pregnant Women (CPW)

What is Case Management?

Case Management for Children and Pregnant Women is a Medicaid benefit that provides health-related case management services to children birth through 20 years of age with a health condition and to high-risk pregnant women of any age. Case managers help clients gain access to needed medical, social, educational, and other services.

Who can be a Case Manager?

Case managers must be a licensed social worker or registered nurse. Case managers may work independently or may be employed or contract with an agency.

Note: Social workers with an LBSW or an LMSW who plan to provide case management services independently or contract with an agency must either:

- Have the Independent Practice Recognition (IPR) or
- Be under a board-approved IPR or LCSW supervision plan.

What do case managers do to connect clients with services?

Case managers help clients with services such as:

- Accessing behavioral health services or developmental testing.
- Coordinating DME, home health nursing, or OT/PT/ST.
- Assisting with the special education process or school issues.

- Helping with transition planning.
- Addressing issues such as substance use disorder, homelessness, or domestic violence.
- Finding other needs, such as respite.

How to become a Case Management Provider?

For more information on how to participate in becoming a CPW provider, please email TexasMedicaidNetworkDepartment@BCBSTX.com.

Texas Health Steps Services

For information about home regarding Texas Health Steps and Comprehensive Care Program (CCP) services regarding Texas Health Steps and Comprehensive Care Program services, including private duty nursing (PDN), prescribed pediatric extended care centers (PPECC), and therapies, please refer to the Texas Medicaid Provider Procedures Manual at www.tmhp.com/resources/provider-manuals.

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** which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening

    - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.

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 **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 infections including HIV, syphilis and gonorrhea/chlamydia.

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.**

For additional information for THSteps see Section 11 Provider Responsibilities.

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.

Medicaid Managed Care (MMC) and CHIP Covered Services

Medicaid (attachment H) and CHIP (Attachment I) members can receive preventive care, diagnostics, and medical treatments called acute care services. Acute care services may include but not limited to:

- Doctor or clinic visits
- Prescription drugs*
- Emergency services
- Hospital inpatient and outpatient care
- Vaccines
- Vision and hearing care
- X-rays and laboratory tests
- Prenatal care and childbirth

Both Medicaid and CHIP cover dental services for children and youth. For more comprehensive list of Medicaid and CHIP covered services, please refer to Attachments H and I (Medicaid/CHIP). For a complete listing of the limitations and exclusions including Fee-For-Service (FFS) services current covered under the Medicaid program, please refer to the current Texas Medicaid Provider Procedures Manual at **www.tmhp.com/resources/provider-manuals** for listing of limitations and exclusions.

*CHIP Members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90 Day supply of a drug.

STAR Kids Managed Care Covered Services

STAR Kids (Attachment J) covered services include but not limited to medical, vision, behavioral health, pharmacy, and long-term services and supports (LTSS). Medically Dependent Children's Program (MDCP) will receive are their acute needs through BCBSTX STAR Kids program. There are no co-payments for STAR Kids Members. Please see Attachment J for a high-level listing of covered services under the STAR Kids program. Please note for a current listing of limitations and exclusions, go to **www.TMHP.com**

STAR Kids Covered LTSS Services

Adaptive aids are specialized medical equipment, including devices, controls, or appliances specified in the plan of care, that enable individuals to increase their abilities to perform activities of daily living or perceive, control, or communicate with the environment in which they live.

Adaptive aids are reimbursed with the goal of providing individuals a safe alternative to nursing facility (NF) placement. Items not of direct remedial benefit (providing a remedy to cure or restore health) or medical benefit to the individual are excluded from reimbursement. The service limit on adaptive aids is $4,000 per individual service plan period. Adaptive aids are limited to the most cost-effective items that can:

- Meet the member's needs.
- Directly aid the member in avoiding premature NF placement.
- Provide NF residents an opportunity to return to the community.

Community First Choice (CFC) services include the following:

- Emergency response services (emergency call button)
- Habilitation services (acquisition, maintenance, and enhancement of skills training) are provided to enable the member to accomplish activities of daily living, instrumental activities of daily living, and other health-related tasks.
- Personal attendant services is assistance to members in performing the activities of daily living and instrumental activities of daily living necessary to maintain the home in a clean, sanitary, and safe environment. Services are available to members based on medical and functional necessity and provided to members living in their own home and community settings. Personal attendant services include, but are not limited to:
  - Assisting with the activities of daily living (for example, feeding, preparing meals, transferring, and toileting)
  - Assisting with personal maintenance (for example, grooming, bathing, dressing, and routine care of hair and skin)
  - with general household activities and chores necessary to maintain the home in a clean, sanitary, and safe environment (for example, changing bed linens, housecleaning, laundering, shopping, storing purchased items, and washing dishes) o Providing protective supervision
  - Providing extension of therapy services
  - Providing ambulation and exercise
  - Assisting with medications that are normally self-administered
  - Performing nursing tasks delegated by registered nurses o Escorting the member on trips to obtain medical diagnosis, treatment, or both

- Support management is voluntary training that may be received on how to select, manage, and dismiss attendants

Day activity and health services (DAHS) All members age 18 and older may receive medically and functionally necessary DAHS. DAHS include nursing and personal care services, physical rehabilitative services, nutrition services, transportation services, and other supportive services. These services are provided at facilities licensed or certified by the Texas Department of Aging and Disability Services (DADS).

Employment assistance is assistance provided to a member to help the member locate paid employment in the community. Employment assistance includes:

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

Financial management services (FMS) is assistance provided to members who elect to participate in the Consumer Directed Services (CDS) option to manage funds associated with services elected for - 59 - self-direction. The assistance is provided by a financial management services agency (FMSA). This includes initial orientation and ongoing training related to the responsibilities of being an employer and adhering to legal requirements for employers. A monthly administrative fee is authorized on the individual service plan and paid to the FMSA.

- Support consultation services are also available only to members participating in the CDS option. This is an optional service. A member's service planning team may recommend the service when the employer (the individual or legally authorized representative [LAR]) or the designated representative (DR) would benefit from additional support with employer responsibilities. Support consultation services must not duplicate or replace services to be delivered through a case manager, a service coordinator, the FMSA, or other sources. A support advisor provides skills-specific training, assistance, and supports to the employer or the employer's designated representative (DR) to meet responsibilities of the CDS option.

Examples of services a support advisor may provide include training related to recruiting and screening applicants for employment and verifying employment eligibility, assistance with developing job descriptions, coaching on problem solving and coordinating employee management activities, training on developing and implementing service backup and corrective action plans, and coaching on handling other employer responsibilities.

Flexible family support services are individualized, disability-related services that support a member to participate in:

- Child care
- Independent living
- Post-secondary education

Flexible family support services include personal care supports for basic activities of daily living (ADL) and instrumental ADL, skilled task and delegated skilled task supports. Flexible family support services promote community inclusion in typical child and youth activities through the enhancement of natural supports and systems and through recognition that these supports may vary by child, provider, setting, and daily routine.

Minor home modifications are those physical adaptations to a member's home necessary to prevent institutionalization or support de-institutionalization and that are necessary to ensure the member's health, welfare, and safety, or that enable the member to function with greater independence in the home. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the member's welfare. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the member, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit.

The minor home modification lifetime limit is $7,500. All services are provided in accordance with applicable state or local building codes and must adhere to Americans with Disabilities Act (ADA) requirements.

Personal care services are support services furnished to a member who has physical, cognitive, or behavioral limitations related to their disability or chronic health condition that limit their ability to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health maintenance activities. Personal care services, also called personal assistance services, include:

- Assistance with feeding, dressing, moving, bathing, or other personal needs or maintenance.
- General supervision or oversight of the physical and mental well-being of a person who needs assistance to maintain a private and independent residence, or who needs assistance to manage his or her personal life, regardless of whether a guardian has been appointed for the person.

Prescribed pediatric extended care (PPECC) is daily medical care away from the member's residence for minors from birth to age 20 who have a medically complex condition. If prescribed by a physician, a member can attend a PPECC up to a maximum of 12 hours per day. Care can include medical, nursing, psychosocial, therapeutic, and developmental services. The types of services provided are based on the needs of the individual's medical condition and developmental status.

Private duty nursing is nursing services in the home of members who require more individual and continuous care than is available from a visiting nurse. Services are provided by a registered nurse (RN) or licensed vocational nurse (LVN) and include both direct skilled nursing care and care-giver education and training.

Respite care is a service that provides temporary relief from caregiving to the member's primary caregiver during the times when the primary caregiver would normally provide care. The primary caregiver may be the member's parent, guardian, family member, or spouse. The following are requirements for this benefit:

- Respite may only be provided during the time the primary caregiver would usually provide care to the member. Respite may not be provided during the time the primary caregiver is at work, attending school, or in job training.
- Respite may not be delivered by the primary caregiver, the member's spouse, or the member's parent, representative, guardian, or managing conservator, if the individual is under 18.
- Respite may be delivered by attendants or nurses employed through the CDS option.
- Respite care is not limited to the member's home.

Supported employment is assistance provided in order to sustain paid employment for 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. Supported employment includes employment adaptations, supervision, and training related to a member's assessed need.

Transition assistance services (TAS) pays for nonrecurring, set-up expenses for individuals transitioning from nursing facilities to a home in the community. A nursing facility resident discharged from the facility into the MDCP waiver program is eligible to receive up to $2,500 in TAS. This benefit is available on a one-time only basis. Allowable expenses are those necessary to enable the individual to establish a basic household and may include:

- Payment of security deposits required to lease an apartment or home
- Set-up fees or deposits to establish utility services for the home, including telephone, electricity, gas, and water
- Purchase of essential furnishings for the apartment or home, including table, chairs, window blinds, eating utensils, food preparation items, and bath linens
- Payment of moving expenses required to move into or occupy the home or apartment
- Payment for services to ensure the health and safety of the individual in the apartment or home, such as pest eradication, allergen control, or a one-time cleaning before occupancy Waiver individuals who are temporarily residing in a nursing facility may also be eligible for TAS.

This benefit may be used if the waiver member's living conditions are inadequate. Inadequate living conditions may include situations in which the individual has lost a residence because of moving into the nursing facility or conditions in the previous residence are so inadequate that the individual cannot return.

Prescribed Pediatric Extended Care Centers

A Member has a choice of Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Center (PPECC), or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services and must be coordinated to prevent duplication. A Member may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the Member's medical condition, or the authorized hours are not commensurate with the member's medical needs. In accordance with 1 Tex. Admin. Code § 363.209(c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are Medically necessary.

Attention Deficit Hyperactivity Disorder (ADHD)

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

Breast Pump Coverage

Texas Medicaid and CHIP cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother's Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's Medicaid client number. For full explanation of breast pump coverage please reference Attachment E.

Nonemergency Medical Transportation (NEMT)

ModivCare

ModivCare provides transportation to covered health care services for STAR and STAR Kids members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. ModivCare does NOT include ambulance trips.

What services are part of ModivCare

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus. BCBSTX may assist members with obtaining money for gas.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.
- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a Member needing assistance while traveling to and from his or her appointment with you, ModivCare will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered health care service is confidential in nature.

STAR and STAR Kids members can call ModivCare at **1-866-824-1565** (TTY: **711**) to schedule NEMT rides.

The NEMT Where's My Ride Line is available 24 hours/7 days a week at **1-866-824-1565** (TTY: **711**) to make changes to their reservation, cancel a trip, get a ride to urgent care, or ask questions about a ride that has already been scheduled.

STAR and STAR Kids members should first call the NEMT program for rides to covered services. If Modivcare is unable to schedule the ride, members can ask for a ride using the BCBSTX transportation VAS. The transportation VAS is available for STAR, CHIP and STAR Kids members.

Transportation VAS: **1-855-933-6993** (TTY:711)

Section 5: Service Coordination Services

The Role of the Service Coordinator is to develop and implement a person-centered plan for the member. The Service Coordinator will work directly with the member and/or their legally authorized representative to coordinate all the members clinical and non-clinical support. STAR Kids providers can access Service Coordination by calling **1-877-301-4394**.

A component of the Star Kids program utilizes the Star Kids Screens and Assessment Instrument (SAI). The purpose of this instrument is for BCBSTX to determine each child's needs as it relates to health and independent living.

BCBSTX will conduct the health risk screening telephonically to prioritize which members require the most immediate attention and then assign a service coordinator to complete the SAI with member and determine what level of service meets the member's needs. The SAI will be completed annually with each member for STAR Kids.

For STAR Kids the service coordinator will provide:

- Clinical and Non-Clinical Support
- Identification of member's needs.
- Referrals/pre-authorizations/certifications.
- Communicate with doctor and other providers to develop an Individual Service Plan (ISP) to address the unique needs of the member.
- Conduct mandatory telephonic and/or face to face contacts.
- Coordinate services with other entities to ensure integration of care (ECI, WIC, DME, Medical Transportation Program, etc.).

Direct Support

- Coordinate Care for members with special health-care needs.
- Conduct asthma and diabetes disease management.
- Conduct complex Care Management.
- Assist with coordination into any specialty programs.
- Conduct intellectual and developmental disabilities management.
- Follow-up and document reported results.
- Monitor adherence to treatment plan to promote optimum health status
- Follow-up and document reported results.
- Coordinate Discharge Planning
- Collaborates in concurrent review when a member is in the hospital and coordinates services and equipment required at discharge.
- Assist with Transition Plan
- Ensures consistent, non-duplicated care without disruption for all new members receiving care at the time of enrollment from in-network and out-of-network providers.
- Promote best practice/evidence-based services
- Includes compliance with Psychotropic Medications on utilization standards.
- Identify and report potential abuse/neglect
- Development of the Individual Service Plan (ISP)

Levels of Service Coordination (STAR Kids only)

For each STAR Kids member, the Service Coordination team identifies the appropriate level assignment using the following criteria:

Level 1

MDCP STAR Kids members.

Members receiving Private Duty Nursing services.

Members with complex needs or a history of developmental or behavioral health issues (multiple outpatient visits, hospitalization, or institutionalization within the past year).

Members with severe emotional disturbance (SED) or severe and persistent mental illness (SPMI).

We define SED as psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.

We define SPMI as 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 daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or

Impaired emotional or behavioral functioning that interferes substantially with the member's capacity to remain in the community without supportive treatment or services.

Members at risk for institutionalization.

All Level1 members must 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.

Level 2

Members who do not meet the requirements for Level 1 classification, but receive Personal Care Services (PCS),or Community First Choice (CFC).

- Members that BCBSTX believes would benefit from a higher level of Service Coordination based on results from the STAR Kids Screening and Assessment Instrument (SAI) and additional BCBSTX findings.
- Members with a history of substance use disorder (multiple outpatient visits,
- Members without SED or SPMI, but who have another behavioral health condition that significantly impairs function.

All Level 2 members must receive a minimum of two (2) face-to-face and six (6) telephonic Service Coordination contacts annually, unless otherwise requested by the member or member's LAR.

Level 3

Level 3 members include those who do not qualify as Level 1 or Level 2. All Level 3 members must receive a minimum of one (1) face-to-face and at least three telephonic Service Coordination outreach contacts yearly.

How a Provider Can Access a STAR Kids Member's Service Coordinator

Service Coordination provides the members with initial and ongoing assistance with 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.

Individual Service Plan (ISP)

The ISP is a regularly updated document developed by working with members, their LAR and other caretakers, and their providers in a person-centered, culturally competent manner. The purpose of the ISP is to articulate assessment findings, goals, service needs and member preferences, as well as to measure outcomes over time.

Coordinate services with other entities to ensure integration of care (ECI, WIC, DME, Medical Transportation Program, etc.).

Team with member and/or legal representative with the development of a plan of care to address the needs of the member, make necessary updates as required by the member's health needs.

Ensuring an initial health risk assessment is performed within 30 days of enrollment into BCBSTX.

Each member will have their own personalized care plan to ensure the member is respected and served with dignity. The service coordinator is responsible for coordinating the member's health care needs in the least restrictive environment.

ISPs include:

Summary information describing the recommended service needs identified through STAR Kids Screening and Assessment 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 service preferences.

Natural strengths and supports of the member including helpful family members, community supports or special capabilities of the member.

With respect to maintaining and maximizing the health and well-being 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 (if 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 is updated:
- At least annually.
- Following a significant change in health condition that impacts service needs.
- 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.

Discharge Plan:

Please refer to Adult Transition Planning Section Below.

Continuity of Care

There are situations that arise when BCBSTX may need to approve services out-of-network. BCBSTX may need to provide authorization for continuity in the care of a member whose health condition has been treated by a specialty care provider or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted. In these cases, BCBSTX may provide authorization to a non-contracted provider to provide the medically necessary services until the transition to a network provider may be completed. The following are circumstances in which continuity of care apply. Pre- existing conditions are not imposed. 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.
- Receiving Community Based Services
- Existing prior authorization from previous MCO
- For STAR Kids, any member receiving any other services on the STAR Kids operational start date.

Limitations for the qualifying conditions listed above may include prior authorizations except for emergency/ urgent care services. Also exceptions for out of network include if a provider is not accessible within the network or premature continuity of care with newly enrolled member.

For STAR Kids members receiving Community Based services BCBSTX will provide continued authorization for services prior authorized for a period not to exceed six months or until a new assessment is completed and a new authorization is issued, whichever comes first.

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 passed the 24th week.
- 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).

For additional assistance, please contact BCBSTX Provider Relations Team: 1-855-212-1615 or Utilization Management at STAR and CHIP at: 1-877-560-8055; STAR Kids: 1-877-784-6802.

Members Diagnosed with a Terminal Illness

Continuity of care also applies to prior authorization requests for members diagnosed with a terminal illness. A member can continue receiving care from their current provider for a period of nine months (twelve months for STAR Kids) from the date the member became eligible with BCBSTX.

Providers can contact a service coordinator at **1-877-214-5630** STAR and CHIP and **1-877-301-4394** STAR Kids.

Section 6: 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 must 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 must 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 must 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 healthcare providers.

Providers can contact a service coordinator at **1-877-214-5630** STAR and CHIP and **1-877-301-4394** STAR Kids.

Section 7: Non-Medicaid Managed Care Covered Services (Non-Capitated Services)

Other services are available outside of BCBSTX provider network. These services are known as "Non-Medicaid" Managed Care Covered Services, these services can be found in the Texas Medicaid Provider Manual, which can be found at **www.TMHP.com**. Below is a listing of those services, please note these services are high-level and subject to change. Please refer to the TMPPM for updated information.

- Texas Health Steps Environmental Lead Investigations (ELI).
- Early Childhood Intervention - Specialized Skills Training.
- Admissions to inpatient mental health facilities as a condition of probation.
- For STAR, Texas Health Steps Personal Care Services for members birth through age 20.
- PASRR screenings, evaluations and specialized services for STAR+PLUS members, or STAR Kids members in a nursing facility.
- HHSC contracted providers of Long-Term Services and Supports (LTSS), for individuals who have intellectual or developmental disabilities.
- HHSC contracted providers of Case Coordination or Service Coordination for individuals who have intellectual or developmental disabilities.
- Department of State Health Services (DSHS) mental health rehabilitation services and targeted Case Management
- Texas Health Steps dental services (including orthodontia for STAR, STAR Kids, and STAR Health).

Note: Medicaid children who are ages birth through 20 years and CHIP children receive dental services through a managed care dental services model. Members must select a dental plan and a primary dentist.

- Early Childhood Intervention (ECI) targeted Case Management and developmental rehabilitative services.
- Local Mental Health Authority (LMHA) targeted Case Management.
- Case Management for Children and Pregnant Women (CPW) - Medicaid only.
- Texas Health Steps Medical Case Management - Medicaid only.
- Texas School Health and Related Services (SHARS) - Medicaid only.
- HHSC Blind Children's Vocational Discovery and Development program.
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation).
- Texas agency administered programs and case management services
- HHSC hospice care.
- HHSC or DSHS HCBS Waiver programs, including CLASS, DBMD, HCS, TxHmL and YES
- Department of Assistive and Rehabilitative Services (DARS) Blind children's vocational discovery and development program.
- Court-Ordered Commitments to inpatient mental health facilities as a condition of probation.
- Essential Public Health Services

Section 8: Behavioral Health Services (STAR, CHIP, and STAR Kids)

Behavioral Health Services

BCBSTX Behavioral Health services are STAR, CHIP, and STAR Kids and for a comprehensive list of covered services and benefits, please visit **www.bcbstx.com/provider/medicaid/clinical-resources/clinical**.

A PCP referral is not needed to access behavioral health services.

Behavioral Health Services are Medicaid covered services for the treatment of mental or emotional disorders which also includes treatment of substance use disorders. Behavioral health includes a range from acute and chronic mental health and substance use disorders. BCBSTX Behavioral Health network providers include psychiatrists and nurse practitioners, psychologists, social workers, licensed professional counselors, hospitals, Federal Qualified Health Centers (FQHCs), and LMHA facilities.

To meet the needs of its members, BCBSTX provides a continuum of services to individuals at risks, or suffering from, mental health and substance use disorders. BCBSTX offers a variety of behavioral health services to STAR and CHIP Members in the Travis Service Area and to STAR Kids in the MRSA Central service area. These services include:

- Assessment and treatment planning
- Psychiatric services
- Medication management
- Inpatient services
- Intensive outpatient services (IOP)*
- Case management services
- Outpatient therapy
- Substance use disorder

*IOP services are available benefit in CHIP and through Early Periodic Screening, Diagnosis, and Treatment services in Medicaid for members under the age of 21; however, IOP is only offered as an in-lieu-of service for members over the age of 20.

BCBSTX is responsible for managing inpatient services for all members, including services providing in free standing psychiatric hospitals for children in STAR, CHIP and STAR Kids **1-877-560-8055** STAR/CHIP; **1-877-784-6802** – STAR Kids.

Member Access to Behavioral Health Services and Referrals

Behavioral health services are provided for the treatment of behavioral and mental health disorders, emotional disorders, and substance use disorders. Behavioral health services do not require a PCP referral. Members may self-refer to any Medicaid enrolled behavioral health provider from treatment. BCBSTX is responsible for authorizing, reviewing, and paying claims for medically necessary treatment, include inpatient hospital services. PCP's can reference BCBSTX website: **https://www.bcbstx.com/provider/medicaid/clinical-resources/behavioral**.

Referrals to Substance Use Treatment providers are not required from the PCP, members may self-refer or network Substance use Treatment Providers may submit a referral through Availity.

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

Attention Deficit Hyperactivity Disorder (ADHD)

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

The Role of a Behavioral Health Home

The term "behavioral health home" refers to a practice-based care team that takes collective responsibility for the patient's ongoing care. The behavioral health providers facilitate partnerships between patients, providers, behavioral staff, and families, which is but not limited to:

- Access to and coordination of care: The health home coordinates all care for a patient and provides or assists with access to specialty care.
- Adherence and compliance: The health home staff assists the patient in adhering to or complying with the recommendations of the provider. This includes a focus on ways to reduce complications for chronic illness and delay the advancement of the illness.
- Wellness: Many health problems are either caused or exacerbated by problematic lifestyle issues, such as poor diet and lack of exercise. The health home staff makes a special effort to encourage wellness activities.

Healthcare providers should contact BCBSTX at **1-877-560-8055** STAR/CHIP **1-877-784-6802** - STAR Kids.

Behavioral Health Referrals, Coordination, and Assessments

Members may self-refer without a referral from their primary care physician.

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

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

STAR, CHIP and STAR Kids members may self-refer to any BCBSTX network behavioral health services provider by calling **1-877-560-8055** STAR/CHIP **1-877-784-6802** STAR Kids.

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

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

Coordination Between Behavioral Health and Physical Health Services

PCPs and behavioral healthcare 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 healthcare 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

Court-ordered Commitments

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

Focus Studies and 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 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 there commendation of the BCBSTX Utilization Management Committee(UMC).The drill-down analyses may include data from specific provider and practice sites, including but not limited to:

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

BCBSTX Behavioral Health Claims Address

Attn: Claims
P.O. Box 650712
Dallas, TX 75265-0712

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

To help ensure continuity and coordination of care, BCBSTX takes specific actions to help CHIP members follow up with a behavioral health outpatient provider in a timely manner after discharge from an inpatient treatment facility. Medical records documentation and referral information must use the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) multi-axial classification.

Procedures for Follow-up On Missed Appointments

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

Follow-up After Hospitalization for Behavioral Health Services

BCBSTX requires that all members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/ or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Providers must contact members who have missed appointments within 24 hours to reschedule appointments. Members discharged from inpatient psychiatric facilities need to have follow-up within 7 days from the date of discharge.

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. In an emergency, 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.

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

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.

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.

Substance Use Disorder

BCBSTX uses the definition of substance use and dependence found in the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Treatments for substance use disorders, including opioid use disorder, drug, alcohol and tobacco misuse include the following services: screening, brief interventions, treatment referrals, outpatient substance use counseling, smoking cessation services, medication-assisted treatment and peer specialist services.

PCPs and behavioral healthcare providers are responsible for actively coordinating and communicating continuity of care.

Mental Health Rehabilitative Services and Targeted Case Management

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

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

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

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

- Medication training and support: Curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community
- Psychosocial rehabilitative services: Social, educational, vocational, behavioral, or cognitive interventions to improve the member's potential for social relationships, occupational or educational achievement, and living skills development

- Skills training and development: Skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers
- Crisis intervention: Intensive community-based one-to-one service provided to members who require services in Order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting

Targeted Case Management (TCM) Services include:

- Case Management for members who have severe emotional disturbance (child 3 through 17 years of age),
- Case Management for members who Serve and Persistent Mental Illness (adult 18 years of age of older)

Mental Health Rehabilitative Services and Targeted Case Management Services including any limitations to these services are described in the most current TPPM, including the Behavioral Health, Rehabilitation, and Case Management Services Handbook.

BCBSTX is not responsible for providing any services listed in the RRUMG that are not covered services.

Providers of MHR Services and TCM Services must use and be trained and certified to administer the Adult Needs and Strength Assessment (ANSA) for adult members ages 19 and 20 and the Child and Adolescent Needs and Strengths (CANS) for members between the ages 0-18; tools to assess a members need for services and recommend a level of care.

A provider entity must attest to BCBSTX that the organization can provide, either directly or through sub-contract, the full array of MHR and TCM services as outlined in the RRUMG.

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

Consent is required for disclosure of information between medical and behavioral health providers.

Section 9: CHIP Member Prescriptions

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

Cost Sharing for CHIP members only

CHIP members are responsible for the copayments listed on their ID card until they meet their cost sharing limit. Once the cost sharing limit is met, members should contact Maximus, the Administrative Services Contractor to obtain a new ID card. CHIP Perinatal, CHIP Perinatal Newborn members, and CHIP members who are Native Americans or Alaskan Natives do not have cost sharing. Additionally, for CHIP members there is no cost-sharing on benefits for well-baby and well-child services, preventive services or pregnancy-related assistance. CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug.

For more information regarding Cost Sharing, please reference Attachment G.

Section 10: Quality Management and Utilization Management

Quality Assessment and Performance Improvement Program

The BCBSTX Quality Improvement Program Description encompasses all clinical care and services provided to BCBSTX members inclusive of behavioral and long-term care services and supports. The scope of the quality improvement process includes a wide range of activities including process and outcomes of clinical care, behavioral health, ancillary services, pharmacy services, vendor services, member services and member / provider satisfaction, patient safety, and efficient use of resources. The program is comprehensive, ongoing, includes effective mechanisms to identify, monitor, evaluate, and resolve issues that may impact accessibility, availability, continuity, and seeks to serve the diversity of the population we serve. The program also recognizes that opportunities for improvement are unlimited.

As part of the BCBSTX program implementation, BCBSTX will focus on ensuring quality oversight for implementation of the Quality Assessment Performance Improvement (QAPI) program for all members. The intent is to facilitate quality care for members in accordance with the highest of standards as set forth by National Committee for Quality Assurance (NCQA), Texas Health and Human Services Commission (HHSC) principles and regulations, and BCBSTX values and goals.

BCBSTX is accredited by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to improving health-care quality. The NCQA seal is a widely recognized symbol of quality. NCQA health plan accreditation surveys include rigorous, on-site and off-site evaluations of over 70 standards and selected HEDIS measures. A national oversight committee of physicians analyzes the survey findings and assigns an accreditation level based on the performance level of each plan being evaluated to NCQA's standards. This recognition is the result of BCBSTX's long-standing dedication to provide quality health care service and programs to our members. BCBSTX requires all practitioners and providers to cooperate with all Quality Improvement (QI) activities, as well as allow BCBSTX to use practitioner and/or provider performance data to ensure success of the QAPI Program.

Goals:

- To improve population health and ensure member safety
- Improve member and provider satisfaction
- Assess cost efficiencies

In order to ensure quality of care provided to and for members the Quality Improvement team (QI) monitors various programs and services including but not limited to:

- Performance Improvement Projects across programs,

Distribution and monitoring of practice guidelines for diseases and conditions most likely to impact BCBSTX members, as well as pediatric and adult preventive health care guidelines

- Medical Records Review of primary care practices to promote the compliance with standards for appropriate medical record documentation, when necessary and,
- Monitoring and Investigation of potential quality of care complaints.

Quality Management

Consistent with National Committee for Quality Assurance (NCQA) standards, BCBSTX analyzes relevant utilization data compared against established thresholds to detect potential under- and over-utilization on an 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 analyses will occur based upon the recommendation of BCBSTX's Medicaid Quality Operations Committee (MQOC) and Medicaid Provider Advisory Committee (MPAC) to include:

- 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, and/ or
- Claims payment for covered services

Provider Profile Reporting

The Provider Profile report is generated annually by BCBSTX and delivered to providers either in face-to-face meetings or by mail with a follow-up call or visit to explain the findings. PCPs enrolled in Value Based Purchasing will receive profile reports.

Improving Performance of Profiled Providers

In order to promote continuous quality improvement, BCBSTX's Network Management, Quality Improvement and Medical Director(s) work directly with PCPs to interpret profile results in order to review opportunities, discuss medical guidelines, and promote collaborative partnerships to ensure population health, and improve the quality of care provided to our shared members.

Focus Studies and Reporting Requirements

BCBSTX performs focus studies to objectively and systematically monitor and evaluate the quality of care and services provided to members. The studies utilize topics and tools agreed upon by the Quality Operations Committee and include, but are not limited to, the following:

- Medical record review utilizing HEDIS® measures
- Provider surveys
- Member surveys
- Random audits of 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. **Practice Guidelines**

In order to achieve the best possible success, our Quality Operations Committee requires provider cooperation in the following areas:

- Upon request, submission of or 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

For more information on practice guidelines, please see Section 2: Provider Roles and Responsibilities.

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 evaluate quality of care and service in specific clinical and service areas.

HEDIS® Activities

Providers are asked to support and contribute to our efforts to improve HEDIS® measures.

HEDIS® Information for Office Staff

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

Annually BCBSTX providers HEDIS® training that 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
- Timelines and other pertinent information needed

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 allow access to medical records, provide medical records and ensure completion of records requested, to include copy services, for completion of medical records retrieval.

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 the time frame requested.

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.

Utilization Management Overview

Utilization Management (UM) collaborates with providers to promote and document the appropriate use of health care resources. UM reviews, analyzes and reports annually potential under and over utilization of health care services. Continuous improvement plans are implemented when measures fall below benchmarks.

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 (Attachment B).

To initiate a Utilization Management request for prior authorization, call

STAR and CHIP **1-877-560-8055**

Fax: **1-855-653-8129**

STAR Kids **1-877-784-6802**

Fax: **1-866-644-5456**

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 reference numbers below with questions and/or requests, including requests for urgent/expedited prior authorization and urgent concurrent/continued stay review.

STAR and CHIP **1-877-560-8055**

Fax: **1-855-653-8129**

STAR Kids **1-877-784-6802**

Fax: **1-866-644-5456**

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 for STAR and CHIP at **1-855-653-8129** and STAR Kids at **1-866-644-5456** with requests for urgent/expedited and non-urgent prior authorization and concurrent/continued stay review. Faxes are accepted during normal business hours as well as after hours. Faxes received after hours will be processed the next business day.

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

Providers who need to reach Utilization Management after hours should call:

STAR and CHIP **1-877-560-8055**

STAR Kids **1-877-784-6802**

An on-call nurse will provide assistance. For after-hours assistance, not available on the website, call the Customer Service for STAR and CHIP **1-877-560-8055** and STAR Kids **1-877-784-6802** for 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 Advocate or TTY numbers in the Provider Manual or Member Handbook.

Service Reviews

Utilization Management provides prior authorization, concurrent/continued stay and post-service reviews using clinical criteria based on sound clinical evidence. These criteria are available to members, physicians and other health care providers upon request by contacting Utilization Management for STAR and CHIP **1-877-560-8055** or via fax at **1-855-653-8129**. STAR Kids **1-877-784-6802** or via fax **1-866-644-5456**. Both numbers are toll-free.

Provider Notifications of Changes to Authorization Procedures

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

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. We inform providers of the results and plans for improvement through physicians' and other professional providers' bulletins, newsletters, meetings or training sessions.

Physicians and other Professional Providers Satisfaction Surveys

BCBSTX conducts provider surveys on an annual basis to monitor and measure Provider 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 improvement.

Third Party Validation: Appointment Availability and Accessibility

A third party 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.

Provider Mandatory Survey (aka Providers Challenge Survey)

The Provider Mandatory Survey Aka Provider Challenge Survey is used to verify provider information. The survey is sent periodically, but not less than bi-annually. Providers maybe surveyed during provider visits with their assigned provider representative. 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 Reviews

BCBSTX completes medical record reviews at select primary care sites and high-volume provider offices. The Medical Records Documentation Standards are outlined in Section 2, Provider Roles and Responsibilities. BCBSTX conducts medical record 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 survey tools are available upon request. The tools indicate which elements are reviewed.

Scheduling Medical Record Review

Quality Improvement staff will communicate with the physician's or professional provider's office to coordinate on-site or off-site medical record review within 30 days of notice to the provider. 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
- Upon completion of the medical record review the QI staff will 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, and if needed
- 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.

Sharing Besting 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 needs.

Facility Site Reviews

Facility Site Review

All primary care provider sites participating in BCBSTX must undergo an initial site inspection regardless of other accreditation or certification. A site review is completed as part of the initial credentialing process for new physicians and other professional providers if that site has not been previously reviewed and accepted as part of BCBSTX's credentialing process.

Obstetrics/gynecology (OB/GYN) specialty sites participating in BCBSTX (and not serving as PCPs) must undergo an initial site inspection.

A plan Quality Improvement associate will call the physician and other professional provider's office to schedule an appointment date and time before the facility site review due date. The associate will fax or send a confirmation letter with an explanation of the audit process and required documentation.

During the facility site review, our associate will:

- Lead a pre-review conference with the provider or office manager to review and discuss the process of facility review and answer any questions.
- Conduct a review of the facility, complete a facility site review and develop a corrective action plan, if applicable.

After the facility site review is completed, our associate will meet with the physician and other professional provider or office manager to:

- Review and discuss the results of the facility site review and explain any required corrective actions
- 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 compiles with the standards.

Out of Network and Single Case Agreements

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 accepts standard fees, the provider will be authorized to provide the care on an out-of-network basis. If the provider requires fee negotiation and has received an authorization, the provider will be asked to sign a Single Case Agreement and then will be provided with an authorization number.

Section 11: Provider Responsibilities

Provider General Responsiblities

General guide for network participation by all providers (excluding STAR Kids dual eligible):

- Provide BCBSTX's members with a professionally recognized level of care and efficacy consistent with community standards, compliant with BCBSTX's clinical and non-clinical guidelines and within the practice of your professional license.
- Abide by the terms of your BCBSTX Provider Participation Agreement and
- Comply with all BCBSTX's policies, procedures, rules and regulations, including those found in the Provider Manual.
- Facilitate inpatient and ambulatory care services at in-network facilities.
- Arrange referrals for care and service within BCBSTX's network.

- Verify member eligibility prior to requesting authorizations or providing services.
- Ensure member understands right to obtain medication from any network pharmacy.Maintain confidential medical records consistent with BCBSTX's medical records guidelines and applicable HIPAA regulations. Please note: Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through portals or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.
- Maintain a facility that promotes patient safety.
- Participate in BCBSTX's Quality Improvement program initiatives.
- Participate in provider orientations and continuing education.
- Follow Continuity of Care guidelines, see section Continuity of Care.
- Primary Care provider may provide behavioral health related services within the scope of its practice (STAR Kids Dual-Eligible Members excluded).
- Abide by the ethical principles of your profession.
- Notify BCBSTX if you are undergoing an investigation or agree to written orders by the state licensing agency.
- Notify BCBSTX if a member has a change in eligibility status by contacting Provider Services.
- Maintain professional liability insurance in the amounts that meet BCBSTX's credentialing requirements and/or state- mandated requirements.
- Notify BCBSTX if there is a change in your office address, tax ID number or any other demographic changes.
- Maintain enrollment status with Texas Medicaid. Please note: Texas Medicaid will deny claims for prescriptions, items and services ordered, referred or prescribed for any Medicaid, Children with Special Health Care Needs Services Program (CSHCN) or Healthy Women member when the provider who ordered, referred or prescribed the items or services is not enrolled in Texas Medicaid. This applies to both in state and out-of-state providers.
- Comply with the requirements of Texas Government Code §531.024161 regarding the submission of claims involving supervised providers.
- Maintain the Participating Provider Conflict of Interest and Health Care Entity Financial Interest Policy and Disclosure statements to reflect current status.
- Provide at no cost to the Texas Health and Human Services Commission (HHSC) or its delegates any requested records in accordance with the timelines, definitions, formats and instructions specified by HHSC.
- Find further details about the designees and types of request within the network provider contracts.
- Reminder: Providers can contact their local Provider Manager with any questions at **1-855-212-1615**. To find an Account Manager in your area, visit: **www.bcbstx.com/provider/medicaid/network_participation.html.**

Medical Home and Health Home

The PCP functions as the medical home or patient advocate and is responsible for member access to health care.

The health home, 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.

Appointment and Accessibility (Access Standards and Access to Care)

BCBSTX requires the hours of operation that providers offer to Medicaid and CHIP members be no less than those offered to commercial patients. BCBSTX's PCPs and specialty care providers must have adequate office hours to accommodate appointments for members using the following appointment access guide.

Accessibility 24/7

PCPs must be accessible to BCBSTX members 24 hours per day, 7 days per week. Members can call their primary care provider (PCP) with a request for medical assessment after PCP normal office hours. The provider must comply with the following after-hours telephone availability standards:

- Office phone is answered during normal business hours.
- After business hours, provider must have the following arrangements:

The office telephone is answered after-hours by an answering service that meets language requirements of the major population groups (English and Spanish) and can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.

The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served (English and Spanish), directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.

The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, or another designated medical provider, who can return the call within 30 minutes.

Examples of unacceptable after-hours coverage include:

- The office telephone is only answered during office hours.
- The office telephone is answered after-hours by a recording that tells patients to leave a message.
- Returning after-hours calls outside of 30 minutes.
- The answering machine is not bilingual (English and Spanish).
- The office telephone is answered after-hours by a recording that directs patients to go to an emergency room for any services needed.

Appointment Access Guide

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 21 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 60 days of enrollment for other eligible child members

- Preventive care visits: according to the American Academy of Pediatrics (AAP) periodicity schedule found within the Preventive Health Guidelines (PHG)

Services for Members 21 Years of Age and Older

- Preventive care visit within 90 days Prenatal and Postpartum Visits
- First and second trimesters: Within 14 days of request
- Third trimester: Within five days of request or immediately if an emergency
- High-risk pregnancy: Within five days of request or immediately if an emergency
- Postpartum: Between 21 and 56 days after delivery

Updates to Provider Contact Information

BCBSTX contracted providers must inform BCBSTX of any changes to the provider's address, telephone number, group affiliation, etc. Medicaid providers must also notify the Health and Human Services Commission (HHSC) Administrative Services Administrator and Texas Medicaid and Health Partnership (TMHP) of any changes in practice organization or demographic information. Find provider demographic changes, updates, and forms in the BCBSTX Secure Provider portal here: **www.bcbstx.com/forms/provider/update_info.html**.

Beginning Jan. 1, 2022, the federal Consolidated Appropriations Act (CAA) of 2021 requires that **certain provider directory information be verified every 90 days.**

This means that starting Jan. 1, 2022, you must:

- Verify your name, specialty, address, phone and digital contact information (website) for our provider directory every 90 days, and
- Update your data when it changes, including when you join or leave a network

Under CAA, **we're required to remove providers from displaying in our Provider Finder whose data we're unable to verify.**

Termination from BCBSTX

Providers may cease participating with BCBSTX for either mandatory or voluntary reasons. Mandatory disenrollment occurs when a provider becomes unavailable due to immediate, unforeseen reasons. Examples of this include death or loss of license. Members are assigned to another primary care provider to ensure continued access to our covered services as appropriate. BCBSTX will notify members of any termination of primary care providers or other providers from whom they receive ongoing care. BCBSTX will provide notice to affected members when a provider disenrolls for voluntary reasons, such as retirement. Providers must furnish written notice to us within the time frames specified in the Participating Provider Agreement. Members linked to a primary care provider who disenrolled for voluntary reasons will be notified to select a new primary care provider. By law, BCBSTX is responsible for submitting notification of all provider terminations to the Texas Health and Human Services Commission (HHSC).

Member Rights to Designate OB/GYN and Other Specialists as Primary PCP.

Members (STAR, STAR Kids, and CHIP only. STAR Kids Dual Eligible are excluded) have the right to designate an OB/GYN as their Primary Care Provider BCBSTX allows the member to pick any OB/GYN (within the BCBSTX Network), whether that doctor is in the same network as the member's Primary Care Provider or not. Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the member:

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

For members with disabilities, special health care needs and/or chronic or complex conditions, the member has the right to designate a specialist as their Primary Care Provider as long as the specialist agrees.

Non-Referral Eye Care

Members have the right to select and have access to, without a Primary Care Provider Referral, a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services other than surgery.

Member Pharmacy Rights

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

Advance Directives

BCBSTX adhere to the Patient Self-Determination Act and maintain written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to health care providers about treatment choices in certain circumstances.

There are two types of advance directives. A durable power of attorney for health care (durable power) allows the member to name a patient advocate to act on behalf of the member. A living will allows the member to state his or her wishes in writing but does not name a patient advocate.

BCBSTX encourage members to request education about advance directives and ask for an advance directive form from their primary care provider at their first appointment. Members over age 18 and emancipated minors are able to make an advance directive. His or her response is to be documented in the medical record. BCBSTX will not discriminate or retaliate based on whether a member has or has not executed an advance directive. While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual physician may conscientiously object to an advance directive.

BCBSTX will assist members with questions about advance directives. However, no associate of BCBSTX may serve as witness to an advance directive or as a member's designated agent or representative. BCBSTX notes the presence of advance directives in the medical records when conducting medical chart audits.

Referral to Network Facilities and Specialists

Providers have the responsibility for the complete care of their patients which includes referring members to the appropriate provider of care within BCBSTX network. Providers must ensure referrals for specialty care for members are made on a timely basis, based on the urgency of the member's medical, no later than 30 calendar days from the date the need is identified or requested. Please note referrals to specialist with health related services must include documentation of coordination of referrals and services provided between Primary Care Provider and Specialist. STAR Kids Dual-Eligible are excluded. Justification to BCBSTX regarding out-of-network referrals, including partners not contracted with BCBSTX is required.

Member 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 5 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/CHIP Enrollment Broker's toll-free telephone number at **1-800-964-2777**.

Second Opinions

A second opinion may be requested when there is a question concerning diagnosis, options for surgery, other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian or a social worker exercising a custodial responsibility.

Authorization for a second opinion shall be granted to a network provider or an out-of-network provider if there is not an in-network practitioner available. The second opinion will be provided at no cost to the member.

If the provider who will see the member for a second opinion is not in-network, an authorization is required. An authorization can be obtained by calling **1-877-560-8055** STAR and CHIP or via fax at **1-855-653-8129** or **1-877-784-6802** STAR Kids or via fax **1-866-644-5456**.

Specialty Care Provider Responsibilities

Specialty care providers are network providers who are specialized in a branch of medical practice that is focused on a defined group of patients, diseases, skills, or philosophy. Which includes but not limited to: pediatrics, oncology, pathology, and cardiology.

Specialty care providers contracted under BCBSTX must follow the same regulatory and mandatory guidelines referenced above including availability and accessibility standards.

All specialty care providers must give regular Specialists must give regular reports to the member's assigned PCP after the initial consultation and follow-up evaluations and must include the diagnosis, recommendations, and treatment plan. Members with Special Health Care Needs (SHCN) such as disabling conditions, chronic illnesses, pregnant women, or children with special health care needs, may request that their specialist also be their PCP. Medical Management must review the request for a specialist to be a PCP. Long Term Services and Supports (LTSS) Providers deliver a variety of care and assistance options including 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.

Healthy Texas Women

Healthy Texas Women is dedicated to offering women's health and family planning services at no cost to eligible women in Texas. This care helps women plan their families, whether they seek to achieve, postpone, or prevent pregnancy. It also can have a positive effect on future pregnancy planning and general health. Beginning Sept. 1, 2020, the Texas Health and Human Services Commission is implementing Healthy Texas Women Plus, an enhanced, cost-effective and limited postpartum services package for women enrolled in the Healthy Texas Women program. Healthy Texas Women Plus will be provided in the postpartum period for not more than 12 months after the enrollment date. Women in Healthy Texas Women Plus will have access to both Healthy Texas Women and Healthy Texas Women Plus Benefits.

Healthy Texas Women provides a variety of women's health and family planning services, including:

- Pregnancy testing
- Pelvic examinations
- Sexually transmitted infection services
- Breast and cervical cancer screenings
- Clinical breast examination
- Mammograms
- Screening and treatment for cholesterol, diabetes and high blood pressure
- HIV screening
- Long-acting reversible contraceptives
- Oral contraceptive pills
- Permanent sterilization
- Other contraceptive methods such as condoms, diaphragm, vaginal spermicide, and injections
- Screening and treatment for postpartum depression

Healthy Texas Women Plus

The HTW program now offers enrolled women an enhanced postpartum services package called HTW Plus. To qualify for HTW Plus benefits, HTW clients must have been pregnant within the last 12 months.

HTW Plus services focus on treating major health conditions that contribute to maternal morbidity and mortality in Texas, including:

- Postpartum depression and other mental health conditions (services include individual, family and group psychotherapy services and peer specialist services).
- Cardiovascular and coronary conditions (services include imaging studies; blood pressure monitoring; and anticoagulant, antiplatelet and antihypertensive medications).
- Substance use disorders, including drug, alcohol and tobacco misuse (services include screenings, brief interventions, treatment referrals, outpatient substance use disorder counseling, smoking cessation services, medication-assisted treatment and peer specialist services).

This program pays only for the services listed above. If a health condition such as cancer is found, you will be referred to a doctor or clinic that can treat you. If you are pregnant, you will be referred to a program such as Medicaid for Pregnant Women. You might have to pay for those extra services.

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/resources/forms?name=Sterilization&field_programs_target_id=All&field_topics_target_id=All&field_categories_target_id=All under the Legal heading.

Medical Record Standards

All participating primary care providers are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care. Participating practitioners are subject to Blue Cross and Blue Shield of Texas and State's periodic quality review of medical records to determine compliance to the following medical record keeping requirements. Medical records must reflect all aspects of patient care including ancillary services. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws. For more information about HIPPA Please refer to Section 21.

An office policy exists that addresses a process to respond to and provide medical records upon request of patients to include a provision to provide copies within 48 hours in urgent situations. Medical records are maintained in a current, detailed, organized and comprehensive manner.

Organization should include evidence of:

- Identifiable order to the chart assembly
- Papers are fastened in the chart
- Each patient has a separate medical record

Medical records are:

- Stored in a manner that helps ensure protection of confidentiality
- Released only to entities as designated consistent with federal requirements
- Kept in a secure area accessible only to authorized personnel
- Filed in a manner for easy retrieval
- Readily available to the treating practitioner where the member generally receives care
- Promptly sent to specialty providers upon patient request and within 48 hours in urgent situations

Critical Elements of Medical Records:

- Medical records are legible
- All entries are signed and dated
- Patient name/identification number is located on each page of the record
- Linguistic or cultural needs are documented as appropriate
- Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the patient's first language is something other than English
- Mechanism for monitoring and handling missed appointments is evident

- An executed advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information regarding advance directives.
- A problem list includes a list of all significant illnesses and active medical conditions
- A medication list includes prescribed and over-the-counter medications and is reviewed annually
- Documentation of the presence or absence of allergies or adverse reactions is clearly documented
- Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines
- Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)
- Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets.
- Treatment plans are consistent with evidence-based care and with findings/diagnosis

History:

- An initial history (for patients seen three or more times) and physical is present to include:
- Medical and surgical history*
- A family history that minimally includes pertinent medical history of parents and/or siblings
- A social history that minimally includes pertinent information such as occupation, living situations, education, smoking, ETOH, and/or substance use disorder/history beginning at age 11
- Current and history of immunizations of children, adolescents and adults

Screenings of/for:

- Recommended preventive health screenings/tests
- Depression
- High risk behaviors such as drug, alcohol and tobacco use; and if present, advise to quit
- Medicare patients for functional status assessment and pain
- Adolescents on depression, substance use disorder, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Non-Contracted Providers

To ensure member wellness and health BCBSTX partners with non-contracted providers to render required medical services when appropriate. Non-contracted providers must obtain an authorization from our utilization management team. A Single Case Agreement (SCA) will be issued when required.

How to Report Abuse, Neglect, and Exploitation (ANE)

Blue Cross and Blue Shield of Texas and providers must report any allegation or suspicion of ANE that occurs within the delivery of long- term services and supports to the appropriate entity. The managed care contracts include BCBSTX and provider responsibilities related to identification and reporting of ANE. Additional state laws related to BCBSTX and provider requirements continue to apply.

The Provider must provide the BCBSTX with a copy of the abuse, neglect, and exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services (DFPS). In addition, the provider is responsible for reporting individual remediation on confirmed allegations to BCBSTX.

Report to the Health and Human Services Commission (HHSC) 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 HHSC;
- Adult day care centers; or
- Licensed adult foster care providers.
- Contact HHSC at **1-800-458-9858**.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- For STAR and CHIP, an adult who is elderly or has a disability, receiving services from:
  - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to HHSC;
  - Unlicensed adult foster care provider with three or fewer beds

- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
  - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
  - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
  - a managed care organization;
  - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; 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**

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, HHSC, 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, HHSC, 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.

STAR Kids Long-Term Services and Supports (LTSS) Provider Responsibilities

The Long-Term Services and Supports (LTSS) provider serve certain members participating in the STAR Kids program. An LTSS provider assists a patient by providing a variety of non-medical services, such as adult day care, adult foster care, home delivered meals, personal attendant services, home modifications, respite services, etc. LTSS services require a prior authorization (Attachment A).

Long Term Services and Supports Provider Responsibilities

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/Medicare.
- Notifying BCBSTX of any change in member's physical condition or eligibility.

Community First Choice Provider

BCBSTX and its providers partner to identify and manage services for all members, including persons with disabilities, chronic or complex conditions and Members and Children with Special Health Care Needs (MSHCN/ CSHCN). This includes development of a plan of care to meet the needs of the member, which is updated at least annually. The plan of care is based on health needs, PCP and specialist(s) recommendations, periodic reassessment of the member's developmental and functional status and service delivery needs.

Community First Choice Provider Responsibilities

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 Home and Community-Based Services (HCS) or Texas Home Living (TxHmL) program provider must ensure that the rights of the members are protected (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 an Adult Protective Services investigation has begun through the completion of the investigation (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/Legally Authorized Representative (LAR) with information on how to report acts or suspected acts of abuse, neglect and exploitation and the Adult Protective Services hotline. (**1-800-252-5400**).
- 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 Personal Assistance Services (PAS) or habilitation (HAB) service providers is procured.
- 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 BCBSTX's 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.

Employment Assistance LTSS Providers:

Are responsible for developing and updated on a quarterly basis a plan for delivering employment assistance services to STAR Kids members.

Supported Employment LTSS Providers:

Providers must develop and update quarterly a plan for delivering supported employment services.

Additional Information:

LTSS providers are required to provide covered health services to members within the scope of their BCBSTX agreement and specialty license. BCBSTX offers LTSS providers access to necessary supports and resources, access to emergency services for their safety and protection, and a means to communicate grievances.

BCBSTX must require that LTSS providers submit periodic cost reports and supplemental reports to HHSC in accordance with 1 Tex. Admin. Code Chapter 355, including Subchapter A (Cost Determination Process) and 1 Tex. Admin. Code § 355.403 (Vendor Hold).

If an LTSS provider fails to comply with these requirements, HHSC will notify BCBSTX to hold payments to the LTSS provider until HHSC instructs BCBSTX to release the payments. HHSC will forward notices directly to LTSS providers about such costs reports and information that is required to be submitted.

In the event LTSS providers require assistance in the delivery of service, please contact the STAR Kids Provider Service Department **1-877-784-6802**

Providers may also:

1. Contact Provider Services, available Monday through Friday, 8:00 a.m. to 5:00 p.m. CST, except for state-approved holidays.
2. Contact the 24-hour Nurse Advice Line at **1-855-802-4614**, available 24 hours a day, 7 days a week to obtain medical guidance and support from a nurse.

Texas Health Steps

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

There is a THSteps Medical Inquiry Line available for providers. The THSteps Medical Inquiry Line at **1-800-757-5691** is available Monday through Friday, 7 a.m. to 7 p.m., Central Time, and is the main point of contact for information about THSteps medical services

Requirements for all Texas Health Steps claims:

- Use benefit code EP1 in field 11c of the CMS 1500 claim form
- Texas Health Steps medical checkup procedure code (all ages) with diagnosis code Z0000, Z0001, Z00110, Z00111, Z00121, or Z00129. Diagnosis code Z23 may also be included
- No requirement to bill other insurance coverage for Texas Health Steps claims

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

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

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

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

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

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

Preventive Medicine Services, New Patient

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

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

Preventive Medicine Services, Established Patient

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

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

Becoming a Texas Health Steps Provider

Providers performing Medical, Dental and Care Management services can become Texas Health Steps providers. You must be an enrolled Texas Health Steps provider in order to be reimbursed for Texas Health Steps services. Enrollment must be completed through Texas Medicaid and Healthcare Partnership (TMHP) at www.tmhp.com.

More About Texas Health Steps

Additional details regarding the Texas Health Steps and Comprehensive Care program services, including private duty nursing, prescribed pediatric extended care centers and therapies can be found in the Texas Medicaid Provider Procedures Manual, Volume 2:

Children's Services Handbook and in subsequent Medicaid bulletins at www.tmhp.com.

Refer provider to the Texas Medicaid Provider Procedures Manual (TMPPM) for information regarding Texas Health Steps medical and dental program, including Texas Health Steps environmental lead investigation (ELI) and Comprehensive Care Program services, including private duty nursing, prescribed pediatric extended care centers, and therapies.

Medical checkups must be performed in accordance with the Texas Health Steps medical checkups periodicity schedule that is based in part on the American Academy of Pediatrics (AAP) recommendations. Providers can find an updated Texas Health Steps periodicity schedule at www.dshs.state.tx.us.

BCBSTX is responsible for facilitating all covered services as described in the Texas Medicaid Provider Procedures Manual, per terms of BCBSTX's contract with the HHSC.

Exceptions to Periodicity Allowed

On occasion, a child may require a Texas Health Steps checkup that is outside of the recommended schedule. Such reasons for an exception to periodicity include:

- Medical necessity (developmental delay, suspected abuse).
- Environmental high risk (for example, sibling of child with elevated lead blood level).
- Required to meet state or federal exam requirements for Head Start, day care, foster care or pre-adoption.
- Required for dental services provided under general anesthesia.

Exceptions to periodicity must be billed on the CMS 1500 and should comply with the standard billing requirements as discussed in Section 18.

If a provider other than the PCP performs the exception to periodicity exam, the PCP must be provided with medical record information. In addition, all necessary follow up care and treatment must be referred to the PCP.

Environmental Lead Investigation (ELI) Lead Screening and Testing

In accordance with current federal regulations, Texas Health Steps requires blood lead screening at ages notated on the Texas Health Steps Periodicity Schedule and must be performed during the medical checkup.

Environmental lead risk assessments, as part of anticipatory guidance, should be completed at all check-ups through age 6 when testing is not mandated, and may be performed using the Lead Risk Questionnaire, Form Pb-110, which is provided in both English and Spanish at www.dshs.state.tx.us/THsteps/forms.shtm. Providers may also opt to use an equivalent form of their choice.

The initial lead testing may be performed using a venous or capillary specimen, and must either be sent to the DSHS Laboratory or performed in the provider's office using point-of-care testing. If the client has an elevated blood lead level of 5 mcg/dL or greater, the provider must perform a confirmatory test using a venous specimen. The confirmatory specimen may be sent to the DSHS Laboratory, or the client or specimen may be sent to a laboratory of the provider's choice.

All blood lead levels in clients who are 14 years of age or younger must be reported to DSHS. Reports should include all information as required on the Child Blood Lead Reporting, Form F09-11709 or the Point-of-Care Blood Lead Testing report Form Pb-111, which can be found at **www.dshs.state.tx.us/lead/providers.shtm** or by calling **1-800-588-1248**.

Information related to blood lead screening and reporting for clients who are 15 years of age or older is available on the DSHS Blood Lead Surveillance Group's website at **www.dshs.state.tx.us/lead/adult.shtm**

Initial blood lead testing using point-of-care testing (procedure code 83655 with modifier QW) may be reimbursed to Texas Health Steps medical providers when performed in the provider's office. Providers must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver.

Blood lead testing is part of the encounter rates for FQHCs and RHCs and is not reimbursed separately. Providers may obtain more information about the medical and environmental management of lead poisoned children from the DSHS Childhood Lead Poisoning Prevention Program by calling **1-800-588-1248** or visiting the web page at **www.dshs.state.tx.us/lead**.

Laboratory Testing

Laboratory specimen collection testing materials and necessary forms and supplies are made available free of charge to all Texas Health Steps providers. For forms and supplies, providers should contact the Laboratory Services Section at the phone number or website below:

DSHS – Laboratory Services Section
1100 West 49th Street
Austin, Texas 78756-3199

1-888-963-7111, ext. 7318

www.dshs.state.tx.us/lab/default.shtm

Providers may not bill for supplies and services provided by the DSHS laboratory. Tests for hemoglobin/hematocrit, chlamydia, gonorrhea and lead must be sent to the DSHS lab, with the exception of point-of-care testing in the provider's office for the initial lead specimen. All other tests may be sent to the lab of the provider's choice.

Immunizations

Children, adolescents and young adults must be immunized during medical checkups and, according to the Advisory Committee on Immunization Practices (ACIP) schedule, by age and immunizing agent. BCBSTX requires the immunizations be done unless medically contraindicated or against parental beliefs

Providers are required to submit immunization information to the Texas Immunization Registry (ImmTrac2) when an immunization is given. Written consent must be obtained by provider from parent or guardian before any information is included in the registry. The consent is valid until member becomes 18 years of age (those 18 and older may now consent for their records to be maintained in ImmTrac2 as well). Provider must verify consent before information is included in ImmTrac2. If provider is unable to verify consent, the provider will be notified by ImmTrac2 and given instructions for obtaining the consent and resubmitting the immunization to the registry. For more information, please see the ImmTrac2 website **www.dshs.texas.gov/immunize/immtrac/default.shtm**

Screenings

Screenings included but not limited to:

The Texas Health Steps Medical Checkups Periodicity Schedule. Providers should continue to check the periodicity schedule for updates.

- Anemia Screening Anemia screening by hemoglobin or hematocrit levels is required at ages as noted on the THSteps Periodicity Schedule and the specimen must be sent to the DSHS Laboratory. If there is an urgent need for test results, these tests may be completed in a provider's office or clinic, but they will not be reimbursed separately. These test results must be documented in the client's medical record
- Human Immunodeficiency Virus (HIV) screening: Addition of one mandatory screening for clients who are 16 through 18 years of age, regardless of risk. This is in addition to the current risk-based screening for clients who are 11 through 20 years of age.
- Dyslipidemia Screening (previously hyperlipidemia screening): Addition of one mandatory screening for clients who are nine through 11 years of age, and once again for clients who are 18 through 20 years of age, regardless of risk. These are in addition to the current risk-based screening for clients who are 24 months through 20 years of age.
- Providers must refer to the current version of the Texas Health Steps Medical Checkups Periodicity Schedule available on the Department of State Health Services (DSHS) website at **www.dshs.state.tx.us/**.

Vaccines for Children

The Department of State Health Services (DSHS) uses the Center for Disease Control and Prevention (CDC) federal contracts to purchase vaccines at federal contract prices for provision to providers enrolled in Medicaid. Vaccines not available on a federal contract will be purchased using a state contract price or using state purchasing procedures for vaccines not on a state contract. The vaccines purchased will be based on the most current recommended childhood immunization schedule of the ACIP.

DSHS will purchase, store and distribute vaccines purchased using the Texas Vaccines for Children program (TVFC). DSHS will monitor vaccine reports and track vaccine distribution to Medicaid providers to assure an adequate inventory of vaccines for Medicaid providers. Vaccines are ordered through regional and local health departments. A TVFC provider may not charge for the vaccine itself, but is permitted to charge an administration fee.

If you are not enrolled in the TVFC program, contact the DSHS TVFC division at **1-800-252-9152**. To enroll, a provider must: Fill out the Provider Enrollment and Provider Profile forms.

- Agree to screen for eligibility.
- Agree to maintain screening records.

More information is also available at **www.dshs.state.tx.us/.** Providers will not be reimbursed for a vaccine that is available through TVFC.

Dental Checkups

Patients are required to enroll in a Medicaid dental plan. Members must select a dental plan and main dentist. Patients should be encouraged to visit a Texas Health Steps dental provider from within their dental plan's network for routine dental checkups. Routine dental checkups do not require a referral.

If dental checkups result in treatment requiring a facility or anesthesia charge, the dentist must contact BCBSTX's Medical Management department to request authorization for facility services and dental procedures at

UM Phone:

STAR and CHIP **1-877-560-8055** / Fax # **1-855-653-8129**

STAR Kids **1-877-784-6802** / Fax #: **1-866-644-5456**

First Dental Home

First Dental Home (FDH) is a package of services aimed at improving the oral health of children six (6) through thirty-five (35) months of age. FDH is provided by enrolled Texas Health Steps pediatric and general dentists. In addition to a standard set of services, FDH provides simple, consistent messages to parents or caregivers of very young children about proper oral health.

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 5 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/CHIP Enrollment Broker's toll-free telephone number at **1-800-964-2777**.

Oral Evaluation and Fluoride Varnish

Oral Evaluation and Fluoride Varnish (OEFV) in the medical home offers limited oral health services provided by Texas Health Steps enrolled physicians, physician assistants and advance practice registered nurses. The service is provided in conjunction with the Texas Health Steps medical checkup and includes immediate oral evaluation, fluoride varnish application, dental anticipatory guidance and referral to a dental home.

Providers must attend the FDH training or OEFV training offered by the Department of State Health Services Oral Health program to be certified to bill for these services. For more information on both programs, go to **www.dshs.state.tx.us/**.

An OEFV visit is billed utilizing CPT code 99429 with U5 modifier. The service must be billed with one of the following medical checkup codes: 99381, 99382, 99391 or 99392. The provider must document all components of the OEFV on the appropriate documentation form and maintain record of the referral to a dental home. Federally Qualified Health Centers and Rural Health Centers do not receive additional reimbursement for these services.

Medicaid Non-Emergency Dental Services

BCBSTX is not responsible for paying for routine dental services provided to Medicaid members. The services are paid through Dental Managed Care Organizations.

BCBSTX is responsible for paying for treatment and devices for craniofacial anomalies, and for Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for members age six

(6) through thirty-five (35) months. Providers must attend the first dental home training or OEFV training offered by the Department of State Health Services Oral Health program to be certified to bill for these services. For more information on both programs, go to **www.dshs.state.tx.us/**

When providing OEFV benefits, please use the following guidelines:

- OEFV benefits include (during a visit) intermediate oral evaluation, fluoride varnish, 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 will pay for devices for craniofacial anomalies, hospital, physician and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth and removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Treatment craniofacial anomalies.

Comprehensive Care Program: Referrals for Necessary Services

The Comprehensive Care program (CCP) is an expansion of the Texas Health Steps program. CCP services are designed to treat and Improve specific physical and mental health problems of STAR and STAR Kids children discovered during the Texas Health Steps checkup. These services may include:

- Psychiatric hospitals.
- Private duty nurses.
- Occupational therapy.
- Speech therapy.
- Durable medical equipment.
- Medical supplies.
- Licensed professional counselors.
- Licensed social workers with at least a master's degree.
- Advanced clinical practitioners.
- Dieticians.

Children of Migrant Farmworkers

Families who travel for farm work encounter numerous barriers obtaining health care services for their children on a daily basis. High mobility, lack of transportation, language and cultural barriers, inaccessibility to health care services, socioeconomic status and lack of health insurance coverage are only a few obstacles faced by this population in accessing care. BCBSTX providers should cooperate with the state, outreach programs, Texas Health Steps regional program staff and BCBSTX staff to identify children of traveling farm workers and provide accelerated services to them.

Children of migrant farmworkers traveling farm 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. The flexibility of the "due" period for members over the age of three (3) years (extending to 364 days from their birthday) allows for children of traveling workers to be scheduled for checkups at their convenience.

If you become aware of a BCBSTX member who is a traveling farm worker or the child of a traveling farm worker, notify BCBSTX by calling **1-877-784-6802**. Refer the member to the same number.

This will allow BCBSTX to complete an assessment to better coordinate and accelerate services for that member.

Fraud, Waste and Abuse Prevention:

The Medicaid and CHIP programs include an important element of fraud, waste and abuse prevention, which requires the cooperation and participation of BCBSTX's contracted providers in prevention and reporting of potential fraud, waste or abuse. BCBSTX has a fraud, waste and abuse plan that complies with state and federal law, including Texas Government Code § 531.113, Texas Government Code § 533.012, 1 Tex. Admin. Code §§ 353.501- 353.505, and 1 Tex. Admin. Code §§ 370.501-370.505. It is your responsibility as a participating provider to report any member or provider suspected of potential fraud, waste or abuse. All reports will remain confidential.

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 fraud, waste, or abuse which is against the law. For example, tell us if you think someone is:

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

To report fraud, waste or abuse, you may file a report directly to the Texas Office of Inspector General (HHSC OIG), or you may report an issue to Blue Cross and Blue Shield of Texas.

To report fraud, waste or abuse:

- Call the OIG Hotline at **1-800-436-6184**.

Visit **oig.hhsc.state.tx.us/wafrep** / click "IG's Fraud Reporting Form" to complete the online form; or Contact BCBSTX's Special Investigative Department at:

BCBSTX
Special Investigations Department
1001 E Lookout Drive, Building A
Richardson, TX 75082

Toll-free Number: **1-800-543-0867**

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

When reporting a provider (doctor, dentist, therapist, pharmacist, etc.) include as much information as possible, such as:

- 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 (physician, therapist, pharmacist, etc.).
- Names and phone numbers of other witnesses who can aid in the investigation.
- Dates of events.
- Summary of what happened.

When reporting a member (a person who receives benefits), include:

- The person's name.
- The Medicaid or CHIP program in which the member is/was enrolled (STAR, STAR Kids and CHIP)
- The person's date of birth, social security number or case number if available.
- The city where the person resides.
- Specific details about the fraud, waste or abuse.

Section 12: Pharmacy Provider Responsibilities

General Responsibilities Pharmacy Providers

Texas Medicaid & Healthcare Participation Enrollment

Only STAR Kids members who are NOT covered by Medicare have access to unlimited prescriptions. This includes refills and prescriptions filled out-of-state. To ensure your patients, continue to receive their medications, please visit: **www.tmhp.com**

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, including Medicare Part D.

Pharmacy Providers Are Responsible for:

Emergency Prescriptions

A pharmacist may use his or her clinical judgment to dispense a 72-hour emergency supply of a medication if prior authorization is not available within 24 hours through the Prime Point-of-Sale System. If the medication is urgently needed and prior authorizations is not available within 24 hours of the request, a 72 hour supply may be provided upon request of member, physician or BCBSTX.

For questions or assistance with a 72-hour supply override, contact Prime's help desk, which is available 24 hours a day, 7 days a week at:

STAR: **1-855-457-0405**

CHIP: **1-855-457-0403**

STAR Kids: **1-855-457-0757** (Travis service area)

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

Processing Pharmacy Claims

BCBSTX shall adjudicate (finalize as paid or denied) within 18 days of point of sale process for clean electronic pharmacy claims and no later than 21 days for paper pharmacy claims. 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.

For a list of covered and preferred drugs, please visit:
www.txvendordrug.com/formulary/prior-authorization/preferred-drugs

Medicaid Members Now Have Access to Mail -Order Pharmacy

What's new: Blue Cross and Blue Shield of Texas (BCBSTX) Medicaid members now have access to a mail-order pharmacy through AllianceRx Walgreens Prime. Members can fill a 90-day supply of maintenance medications with free home delivery.

Action for Providers: Consider writing our Medicaid members' prescriptions for maintenance medications as a 90-day supply with refills. This will make it easier for members to choose the mail-order pharmacy. Patients who want to access the mail- order pharmacy and have an existing prescription may ask you to re-write their prescriptions as 90-day supplies.

How: Prescribers can e-prescribe prescriptions or fax them to AllianceRx mail-order pharmacy.

Questions: Visit the provider section of the AllianceRx website for frequently asked questions.
www.alliancerxwp.com/healthcare-providers

Coordination with Texas Department of Family and Protective Services

Providers are required to cooperate and coordinate with the Texas Department of Family and Protective Services (TDFPS) for the care of a child receiving services from or placed in the conservatorship of TDFPS. Provider cooperation and coordination are demonstrated by:

- Providing medical records to TDFPS
- Scheduling medical and behavioral health appointments within 14 days (unless requested earlier by TDFPS)
- Recognizing abuse and neglect and appropriately referring those cases to TDFPS

Providing all covered services defined in court orders or a TDFPS service plan until the member has been disenrolled from BCBSTX; reasons for disenrollment include loss of Medicaid managed care eligibility or enrollment in STAR Health (HHSC's managed care program for children in foster care).

Section 13: Routine, Urgent, and Emergency Services

General Overview

Medically necessary health services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided. Medically necessary health services must also be provided at the most appropriate level or supply of service which can safely be provided and could not be omitted without adversely affecting the member's physical health or the quality of life.

Except for emergency care in a true emergency, members are encouraged to contact the PCP prior to seeking care. In the case of a true emergency, members are encouraged to visit their nearest emergency department.

Definitions

The following are definitions for routine, urgent and emergency care:

- Routine care is health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.
- Urgent care is medical care provided for illnesses or injuries which require prompt attention but are typically not of such seriousness as to require the services of an emergency room.
- Emergency Care means a medical or behavioral health exam done in the Emergency Department of a Hospital and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Requirements for Scheduling Appointments

Members must have access to covered services within the timelines specified by the Health and Human Services Commission (HHSC) and Texas Department of Insurance (TDI). "Day" is defined as a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first. In coordination with the definitions above, this includes the following:

- Routine primary care and Behavioral Health appointments must be provided within 14 calendar days (unless requested earlier by DFPS).
- Routine specialty care referrals must be made on a timely basis, based on the urgency of the member's medical condition, but no later than five (5) calendar days.
- Initial outpatient behavioral health visits must be provided within 10 business days/14 calendar days or within 7 calendar days upon discharge from an inpatient psychiatric
- Urgent care, including urgent specialty care and Behavioral Health, must be provided within twenty-four (24) hours.
- Emergency services must be provided upon member presentation at the service delivery site, including at non-network and out-of-area facilities.

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: pharmacies may enter an '9' in field 461-EU (Prior Auth Type Code) and Code 801 in field 462-EV (Prior Auth Number Submitted), to override a 75/PA required rejection and submit a claim for a 72-hour emergency supply.

For more information about the 72-hour emergency prescription supply policy call:

STAR: **1-855-457-0405**

CHIP: **1-855-457-0403**

STAR Kids: **1-855-457-0757** (Travis service area) **1-855-457-0758** (MRSA Central service area)

Emergency Medical Transportation

BCBSTX considers emergency medical transportation as any event that puts the health and life of a Medicaid beneficiary at serious risk without immediate treatment. Real emergencies occur when the medical needs of a beneficiary are immediate and due to severe symptoms.

See Section regarding Non-Emergency Medical Transportation (NEMT) and Value-Added Services for Non-Emergency Transportation.

Urgent/Emergent Hospital-to-Hospital Ambulance Transportation

Blue Cross and Blue Shield of Texas is required to cover emergency and medically necessary non-emergency ambulance services. Urgent/ Emergency hospital-to-hospital transportation does not require prior authorization. Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition, as defined in 1 TAC §353.2, is not available at the first facility and BCBSTX has not included payment for such transports in the hospital reimbursement.

Emergency air transportation providers must notify BCBSTX within one (1) business day of providing emergency air transportation (hospital-to-hospital), when applicable.

Non-Emergent Ambulance Transportation

BCBSTX offers a non-emergency ambulance transportation service through ModivCare at no cost to our members, who have no other transportation options for non-emergency health care appointments. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. These trips do NOT include ambulance trips. To schedule a ride through ModivCare call **1-866-824-1565** between 8:00 am to 5:00 p.m. Central time, Monday through Friday. Emergency Dental Services

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

- The member's full name, current address, and phone number
- The member's BCBSTX member ID number
- The date and time of the appointment
- The name, address, and phone number of where you are going
- The type of appointment you are going to, and
- If you need a wheelchair van or some other kind of help during your trip.

Schedule NEMT Services as early as possible, and at least 48 hours before you need the NEMT service. In certain circumstances you may request the NEMT service with less than 48 hours' notice. Call ModivCare at it **1-866-824-1565**. These circumstances include being picked up after being discharged from a hospital; trips to the pharmacy to pick up medication or approved medical supplies; and trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours. You must notify BCBSTX prior to the approved and scheduled trip if your medical appointment is cancelled.

Extra Help Getting A Ride

If ModivCare cannot cover your ride through NEMT, you can ask for Extra Help Getting a Ride through the BCBSTX VAS program. BCBSTX STAR members may be eligible to use the VAS if the type of ride requested is not covered by the Texas Medicaid NEMT. This includes VAS services such as approved health classes, special member events and meetings, and transportation for covered services where the parent needs to bring more than one child. Out-of-area and out-of-state services require at least 48 hours notice and an OK from BCBSTX before you schedule a ride. You may also be able to get reimbursement for mileage for scheduled trips, but this must get an OK before the trip is taken. Please call ModivCare to schedule your ride.

Limitations: BCBSTX will decide what kind of transportation you will get based on the level of care that is medically necessary for you. Vehicles may include public transportation such as a bus or train or shared rides like a taxi, van or contracted car. ModivCare is an independent company that provides transportation services to Blue Cross and Blue Shield of Texas through a contractual agreement between BCBSTX and ModivCare. The relationship between BCSBTX and ModivCare is that of independent contractors.

Medicaid Emergency Dental Services:

BCBSTX is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- Treatment of oral abscess of tooth or gum origin
- Treatment and devices for correction of craniofacial anomalies and drugs

CHIP Emergency Dental Services:

BCBSTX is responsible for emergency dental services provided to CHIP Members and CHIP Perinatal Newborn Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- treatment of oral abscess of tooth or gum origin.

Non-Emergency Dental Services

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 aged 6 through 35 months.

OEFV benefit 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 Members' file.

BCBSTX is **responsible** for paying for treatment and devices for craniofacial anomalies.

CHIP Non-Emergency Dental Services:

BCBSTX is **not responsible** for paying for routine dental services provided to CHIP and CHIP Perinatal Members. These services are paid through Dental Managed Care Organizations.

BCBSTX is **responsible** for paying for treatment and devices for craniofacial anomalies.

Durable Medical Equipment and Other Products Normally Found in 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 (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 age 20), a pharmacy must be in the BCBSTX/Prime Therapeutics network. Pharmacies that wish to provide DME services and enrolled with the TMHP website (as DME providers), may complete a DME Provider Contract with BCBSTX to provide these services.

Call BCBSTX **1-855-212-1615** for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

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.

Please note that pharmacy providers have a separate manual. For information on how to access the BCBSTX STAR, CHIP and STAR Kids Pharmacy Manual, please visit **www.bcbstx.com** or contact your provider representative.

Section 14: Electronic Visit Verification (EVV)

General Information About EVV

1. **What is EVV?**

   EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV System documents the following:

   - Type of service provided (Service Authorization Data);
   - Name of the Member to whom the service is provided (Member Data);
   - Date and times the visit began and ended;
   - Service delivery location;
   - Name of the Service Provider or CDS Employee who provided the service (Service Provider Data); and
   - Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.

2. **Is there a law that requires the use of EVV?**

   Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. § 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Section 531.024172, requires HHSC to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law.

   To comply with these statutes, HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021.

   HHSC plans to require the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2024.

3. **Which services must a Service Provider or CDS Employee electronically document and verify using EVV?**

   The EVV required services that must be electronically documented and verified through EVV are listed on the HHSC EVV website. Refer to the Programs, Services and Service Delivery Options Required to Use Electronic Visit Verification on the HHSC EVV website.

Check the EVV Service Bill Codes Table on the HHSC EVV website for up-to- date information and specific HCPCS code(s) and modifiers for EVV-required services.
For additional information regarding HHSC EVV website for the EVV Service Bill Codes Table visit: www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification

4. **Who must use EVV?**

The following must use EVV:

- Provider: An entity that contracts with an MCO to provide an EVV service.
- Service Provider: A person who provides an EVV required service and who is employed or contracted by a Provider or a CDS Employer.
- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
- Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employer as described in Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, § 41.103(25), Consumer Directed Services Option.
- CDS Employer: A Member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a Service Provider who delivers a service.

EVV SYSTEMS

5. **Do Providers and FMSAs have a choice of EVV Systems?**

Yes. A Provider or FMSA must select one of the following two EVV Systems:

- EVV vendor system. An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV proprietary system.

Visit TMHP vendor page for additional information: www.tmhp.com/topics/evv/evv-vendors

- EVV proprietary system. An EVV proprietary system is an HHSC- approved EVV System that a Provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
  - Is purchased or developed by a Provider or an FMSA.
  - Is used to exchange EVV information with HHSC or an MCO; and
  - Complies with the requirements of Texas Government Code, Section 531.024172 or its successors

For additional information for the TMHP Proprietary System page:
www.tmhp.com/topics/evv/evv-proprietary-systems

6. **Does a CDS Employer have a choice of EVV Systems?**

No. A CDS Employer must use the EVV System selected by the CDS Employer's FMSA.

7. **What is the process for a Provider or FMSA to select an EVV System?**
   a. To select an EVV vendor, a Provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV vendor's website. www.tmhp.com/topics/evv/evv-vendors

b. To use an EVV proprietary system, a Provider or FMSA, signature authority, and the agency's appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV PSO Onboarding process and HHSC EVV Proprietary System approval process. TMHP's EVV website for more information about the EVV proprietary system onboarding process: www.tmhp.com/topics/evv/evv-proprietary-systems

8. **What requirements must a Provider or FMSA meet before using the selected EVV System?**

Before using a selected EVV System:

a. The Provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor via the TMHP website for state approved vendor information, www.tmhp.com/topics/evv/evv-vendors

b. Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:

i. An EVV Proprietary System Request Form

ii. EVV PSO Detailed Questionnaire (DQ)

iii. TMHP Interface Access Request

c. A Provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV proprietary system to comply with HHSC EVV requirements.

d. If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:

i. Complete all required EVV training as described in the answer in the EVV TRAINING section below; and

ii. Complete the EVV System onboarding activities:

1. Manually enter or electronically import identification data;
2. Enter or verify Member service authorizations;
3. Setup member schedules (if required); and
4. Create the CDS Employer profile for CDS Employer credentials to the EVV System.

9. **Does a Provider or FMSA pay to use the selected EVV System?**

- If a Provider or FMSA selects an EVV vendor system, the Provider or FMSA uses the system free of charge.
- If a Provider or FMSA elects to use an EVV proprietary system, the Provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

10. **Can a Provider or FMSA change EVV Systems?**

Yes. A Provider or FMSA may:

- Transfer from an EVV vendor to another EVV vendor approved by the state.
- Transfer from an EVV vendor to an EVV Proprietary System;
- Transfer from an EVV Proprietary System to an EVV vendor; or
- Transfer from one EVV Proprietary system to another EVV Proprietary system.

11. **What is the process to change from one EVV System to another EVV System?**

To change EVV Systems, a Provider or FMSA must request a transfer as follows:

- To request a transfer to an EVV vendor, a Provider or FMSA must submit an EVV Provider Onboarding Form to the new EVV vendor.

- To request a transfer to an EVV proprietary system, a Provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A Provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 days before the desired effective date of the transfer.
- If a Provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the Provider or FMSA and the newly selected EVV vendor agree on an earlier date.
- If a Provider or FMSA is transferring to an EVV proprietary system, the Provider or FMSA, TMHP, and HHSC will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.
- An FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
- A Provider or FMSA must complete all required EVV System training before using the new EVV System.
- A Provider or FMSA who transfers to a new EVV vendor or proprietary system:
  - Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement; and
  - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.
- After a Provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

12. Are the EVV Systems accessible for people with disabilities?

The EVV vendors provide accessible systems, but if a CDS Employer, Service Provider or CDS Employee needs an accommodation to use the EVV System, the vendor will determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.

If the Provider or FMSA is using a proprietary system, the Service Provider, CDS Employer or CDS Employee must contact the Provider or FMSA to determine accessibility features of the system and if an accommodation can be provided.

EVV SERVICE AUTHORIZATIONS

13. What responsibilities do Providers and FMSAs have regarding service authorizations issued by an MCO for an EVV required service?

A Provider and FMSA must do the following regarding service authorizations issued by an MCO for an EVV-required service:

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:
  - Name of the MCO;
  - Name of the Provider or FMSA;
  - Provider or FMSA Tax Identification Number;
  - National Provider Identifier (NPI) or Atypical Provider Identifier (API);
  - Member Medicaid ID;
  - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s);
  - Authorization start date; and
  - Authorization end date.

- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System; and
- Manually enter service authorization changes and updates into the EVV System as necessary.

EVV CLOCK IN AND CLOCK OUT METHODS

14. What are the approved methods a Service Provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?

A Service Provider or CDS Employee must use one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to end service delivery when providing services to a member in the home or in the community. A Service Provider or CDS Employee may use one method to clock in and a different method to clock out.

(1) Mobile method

- A Service Provider must use one of the following mobile devices to clock in and clock out:
  - the Service Provider's personal smart phone or tablet; or
  - a smart phone or tablet issued by the Provider.

- A Service Provider must not use a Member's smart phone or tablet to clock in and clock out.
- A CDS Employee must use one of the following mobile devices to clock in and clock out:
  - the CDS Employee's personal smart phone or tablet;
  - smart phone or tablet issued by the FMSA; or
  - the CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.

- To use a mobile method, a Service Provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the Service Provider or CDS Employee has downloaded to the smart phone or tablet.

- The mobile method is the only method that a Service Provider or CDS Employee may use to clock in and clock out when providing services in the community. Note, if a Service Provider or CDS Employee are unable to use a mobile method in the community, they must manually enter their clock in and/or clock out times in the EVV System.

(2) Home phone landline

- A Service Provider or CDS Employee may use the Member's home phone landline, if the Member agrees, to clock in and clock out of the EVV System.
- To use a home phone landline, a Service Provider or CDS Employee must call a toll-free number provided by the EVV vendor or the PSO to clock in and clock out.
- If a Member does not agree to a Service Provider's or CDS Employee's use of the home phone landline or if the Member's home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another approved clock in and clock out method.
- The Provider or FMSA must enter the Member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.

(3) Alternative device

- A Service Provider or CDS Employee may use an HHSC- approved alternative device to clock in and clock out when providing services in the Member's home.
- An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
- An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
- The alternative device codes are active for only seven days after the date of service and must be entered into the EVV system before the code expires.
- The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit.
- An alternative device must always remain in the Member's home even during an evacuation.

15. What actions must the Provider or FMSA take if a Service Provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?

- If a Service Provider does not clock in or clock out of the EVV System or an approved clock in or clock out method is not available, then the Provider must manually enter the visit in the EVV System.
- If a Service Provider makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the Provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to manually enter the clock in and clock out information and other service delivery information, if applicable.
- If a CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the
- FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to correct the inaccurate service delivery information in the EVV System.

- After the Visit Maintenance time frame has expired, the EVV System locks the EVV visit transaction and the Provider, FMSA or CDS Employer may only complete Visit Maintenance if the MCO approves a Visit Maintenance Unlock Request.
- The EVV Policy Handbook requires the Provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

EVV VISIT MAINTENANCE

16. Is there a timeframe in which Providers, FMSAs, and CDS Employers must perform Visit Maintenance?

In general, a Provider, FMSA, or CDS Employer must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in HHSC EVV Policy Handbook.

Note: the standard Visit Maintenance timeframe as set in EVV Policy Handbook may be changed by HHSC to accommodate Providers, FMSAs, or CDS Employers impacted by circumstances outside of their control.

17. Are Providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance?

Yes. Providers, FMSAs or CDS Employers must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing Visit Maintenance in the EVV System.

a. Reason Code Number(s) describe the purpose for completing Visit Maintenance on an EVV visit transaction.
b. Reason Code Description(s) describe the specific reason Visit Maintenance is necessary.
c. Free text is additional information the Provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.

BCBSTX refer their Providers, FMSAs, and CDS Employers to the Reason Code table on the HHSC EVV Website: www.hhs.texas.gov/providers/long-term-care-providers-long-term-care-provider-resources/electronic-visit-verification

EVV TRAINING

18. What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training:
  - EVV System training provided by the EVV vendor or EVV PSO;
  - EVV Portal training provided by TMHP; and
  - EVV Policy training provided by HHSC or the MCO.

- CDS Employers must complete training based on delegation of Visit Maintenance on Form 1722, CDS Employer's Selection for Electronic Visit

Verification Responsibilities:

- Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked In the EVV System;
  - EVV System training provided by the EVV vendor or EVV PSO;
  - Clock in and clock out methods; and
  - EVV Policy training provided by HHSC, the MCO or FMSA.

- Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
  - EVV System training provided by EVV vendor or EVV PSO; and
  - EVV Policy training provided by HHSC, the MCO or FMSA.

- Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
  - Overview of EVV Systems training provided by EVV vendor or EVV PSO; and
  - EVV policy training provided by HHSC, the MCO or FMSA.

- Providers and CDS Employers must train Service Providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.

EVV training requirements are located via website:
www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification

COMPLIANCE REVIEWS

19. What are EVV Compliance Reviews?

EVV Compliance Reviews are reviews conducted by the MCO to ensure Providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies. The MCO will conduct the following reviews and initiate contract or enforcement actions if Providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:

- EVV Usage Review – meet the minimum EVV Usage Score;
- EVV Required Free Text Review – document EVV required free text; and
- EVV Landline Phone Verification Review – ensure valid phone type is used.

For additional information regarding EVV Compliance Review visit:
www.hhs.texas.gov/handbooks/electronic-visit-verification-policy-handbook/10000-evv-compliance-reviews

EVV CLAIMS

20. **Are Providers and FMSAs required to use an EVV System to receive payment for EVV required services?**

    Yes. All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim to BCBSTX. BCBSTX may deny or recoup an EVV claim that does not match an accepted visit transaction.

21. **Where does a Provider or FMSA submit an EVV claim?**

    Providers and FMSAs must submit all EVV claims to the HHSC Claims Administrator in accordance with BCBSTX's submission requirements.

For more information on the claims' submission and the process for corrected or adjusted claims visit www.hhs.texas.gov/handbooks/electronic-visit-verification-policy-handbook/12000-evv-claims

22. **What happens if a Provider or FMSA submits an EVV claim to the BCBSTX instead of the HHSC Claims Administrator?**

    If a Provider or FMSA submits an EVV claim to BCBSTX instead of the HHSC Claims Administrator, BCBSTX will reject or deny the claim and require the Provider or FMSA to submit the claim to the HHSC Claims Administrator.

23. **What happens after the HHSC Claims Administrator receives an EVV claim from a Provider or FMSA?**

    The HHSC Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHSC Claims Administrator for further claims processing. After completing the EVV claims matching process, the HHSC Claims Administrator forwards the claim to BCBSTX for final processing.

24. **How does the automated EVV claims matching process work?**

    The claims matching process includes:

    - Receiving an EVV claim line item.
    - Matching data elements from each EVV claim line item to data elements from one or more accepted EVV transactions in the EVV Aggregator.
    - Forwarding an EVV claim match result code to the MCO once the claims matching process is complete.

    The following data elements from the claim line item and EVV transaction must match:

    - Medicaid ID;
    - Date of service;
    - National Provider Identifier (NPI) or Atypical Provider Identifier (API);
    - Healthcare Common Procedure Coding System (HCPCS) code;
    - HCPCS modifiers; and
    - Billed units to units on the visit transaction, if applicable.

Note: No unit match is performed on CDS EVV claims and unit match is not performed on visit transactions against the billed units on the claim line item for specific services. Refer to the EVV Service Bill Codes Table found on the HHSC EVV website for the specific services that bypass the units matching process.

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match codes viewable in the EVV Portal are:

- EVV01 – EVV Successful Match
- EVV02 – Medicaid ID Mismatch
- EVV03 – Visit Date Mismatch
- EVV04 – Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 – Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 – Units Mismatch
- EVV07 – Match Not Required
- EVV08 – Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. The MCO will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHSC implements a bypass of the claims matching process for disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- The MCO will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- The MCO may still deny an EVV claim if other claim requirements fail the claims adjudication process.
- If allowed by HHSC, the MCO may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

25. How can a Provider and FMSA see the results of the EVV claims matching process?

Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and the MCO system. The MCO's Provider Portal also provides claims status information, such as whether the MCO has paid or denied the claim. In addition, the MCO provides an Explanation of Payment (EOP) to Providers and FMSAs to inform them of whether the MCO paid or denied the claim, and if denied, the reason for denial. The TMHP EVV Training webpage: www.tmhp.com/topics/evv/evv-training

26. Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?

Yes. An MCO may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a Member's loss of program eligibility or the Provider's or FMSA's failure to obtain prior authorization for a service.

Section 15: Provider Complaints and Member Complaints

Provider Compliant Process for Medicaid (STAR and STAR Kids)

Provider complaints involving dissatisfaction or concerns about another provider, operation of BCBSTX and complaints not related to a claim determination or adverse determination

Complaints submitted to BCBSTX are tracked, trended, and resolved within an established time frame. Provider complaints may be submitted either by phone, fax, email or in writing, to:

Submit a complaint by phone:

STAR: **1-888-657-6061**

STAR KIDS: **1-877-688-1811**

TTY **711** (for members with hearing or speech loss)

Fax: **1-877-886-2593**

Email at TX_Medicaid_A&G_Complaints@bcbstx.com

Submit in writing to:

Blue Cross Blue Shield of Texas
Attn: Complaints
P.O. Box 660717
Dallas, TX 75266

A BCBSTX Complaints Representative receives and logs the provider's complaint and sends an acknowledgement letter to the provider within five business days of receipt of the complaint. The Complaint representative will investigate the provider complaint and respond to the provider in writing within 30 calendar days of receipt.

BCBSTX maintains all documentations (i.e., Fax Cover Pages, Emails, and Phone Communication) in reference to complaints. It is recommended that providers also maintain all communications to and from BCBSTX.

A provider has the right to file a complaint about BCBSTX with HHSC. Complaints to HHSC should be mailed to the following HHSC address:

Texas Health and Human Services Commission
Health Plan Operations,
H-320 Resolution Services
PO Box 85200
Austin, TX 78708-5200

Providers may also file a complaint with HHSC by email to: HPM_Complaints@hhsc.state.tx.us

Provider Complaint Process for CHIP

Providers will follow the same complaint process as Medicaid, when filing a complaint for CHIP.

Providers may also file a complaint with the Texas Department of Insurance (TDI). Filing a complaint with TDI only applies to CHIP. Providers may submit complaints to TDI at:

Mail to:

Texas Department of Insurance Consumer Protection (111-1A)
P.O. Box 149091
Austin, Texas 78714-9091

Phone: **1-512-463-6500** or **1-800-252-3439**

Fax: **1-512-475-1771**

Email: ConsumerProtection@tdi.state.tx.us

Member Compliant Process (STAR and STAR Kids)

A Member has the right to file a complaint to both BCBSTX and Texas Health and Human Services Commission (HHSC). In addition, BCBSTX member representative can assist the member with filing a complaint.

A member with a complaint may call or submit in writing to BCBSTX Complaint Department:

Submit a complaint by Phone:

STAR: **1-888-657-6061**

STAR KIDS: **1-877-688-1811**

TTY **711** (for members with hearing or speech loss)

Fax: **1-877-886-2593**

Submit a complaint by email GPDTXMedicaidAG@bcbsnm.com

Submit in writing to:
Blue Cross and Blue Shield of Texas
Attn: Complaints
P.O. Box 660717
Dallas, TX 75266

A member will receive an acknowledgement letter within five Business Days of receipt of the complaint. BCBSTX must resolve the complaint with 30 days. Member's will receive a resolution letter at the completion of the complaint investigation. If a member is not satisfied with BCBSTX resolution, they may file a complaint with HHSC.

Complaints to HHSC should be mailed to the following HHSC address:

Texas Health and Human Services Commission

Ombudsman Managed Care Assistance Team

P.O. Box 13247

Austin, Texas 78711-3247

If you can get on the Internet, you can submit your complaint at:

hhs.texas.gov/managed-care-help

Member Complaint Process (CHIP)

CHIP members have the right to file a complaint with BCBSTX. CHIP members filing a complaint with BCBSTX will follow the same process as Medicaid Member. In addition, BCBSTX CHIP Member Representative can assist the CHIP member with filing a complaint.

CHIP Members may contact BCBSTX toll-free number at:

CHIP: **1-888-657-6061**

TTY **711** (for members with hearing or speech loss)

CHIP Member may file a complaint in writing by sending to the following address:

Blue Cross and Blue Shield of Texas
Attn: Complaints
P.O. Box 660717
Dallas, TX 75266

A CHIP member will receive an acknowledgement letter within five Business Days of receipt of the complaint. BCBSTX must resolve the complaint within 30 days. CHIP Member's will receive a resolution letter at the completion of the complaint investigation.

If a CHIP member is not satisfied with the outcome of the complaint investigation, the CHIP member can file a complaint with Texas Department of Insurance (TDI):

Mail to:

Texas Department of Insurance Consumer Protection (111-1A)
P.O. Box 149091
Austin, Texas 78714-9091

Phone: **1-512-463-6500** or **1-800-252-3439**

Fax: **1-512-475-1771**

Email: ConsumerProtection@tdi.state.tx.us

Section 16 Provider Appeal and Member Appeal Process:

Provider Appeal Process for Medicaid (STAR and STAR Kids)

A provider may file an appeal with BCBSTX. To file an appeal, a provide may submit an appeal through BCBSTX Provider Portal (Availity). In addition, provider have the option to file an appeal orally or in writing to BCBSTX.

Provider may submit an appeal to the following address:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals
PO Box 660717
Dallas, TX 75266

Or by phone at:

STAR: **1-877-560-8055**

STAR Kids: **1-877-784-6802**

Or by fax at:

Fax: **1-877-886-2593**

Or by email at:

GPDTXMedicaidAG@bcbsnm.com

BCBSTX maintains all documentations (i.e., Fax Cover Pages, Emails, and Phone Communication) in reference to appeals. It is recommended that providers also maintain all communications to and from BCBSTX.

Provider Appeal Process for (CHIP)

A provider may file an appeal with BCBSTX. To file an appeal, a provide may submit an appeal through BCBSTX Provider Portal (Availity). In addition, providers have the option to file an appeal orally or in writing to BCBSTX.

If the provider is dissatisfied with the resolution of the appeal for a CHIP member service, and the provider has exhausted BCBSTX complaints and appeals process, the provider has the right to complain through TDI at:

Mail to:

Texas Department of Insurance Consumer Protection (111-1A)
P.O. Box 149091
Austin, Texas 78714-9091

Phone: **1-512-463-6500** or **1-800-252-3439**

Fax: **1-512-475-1771**

Email: ConsumerProtection@tdi.state.tx.us

Recoupment Appeal Process (STAR Kids)

Provider Appeal Process to HHSC (related to claim recoupment)

Upon notification of a claims payment recoupment, the first step is for the provider to recheck Member eligibility to determine if a Member eligibility change was made to Fee-for-Service or to a different managed care organization on the date of service.

1. Member eligibility changed to Fee-for-Service on the date of service

Provider may appeal claim payment 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. 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.

Note: Label the request "Expedited Review Request" at the top of the letter to ensure the appeal request is reviewed prior to eighteen (18) months from the date of service.

Mail Fee-for-Service related 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

Prepare a new paper claim for each claim that was recouped and insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing that the claims payment was recouped.

Submission of the new claims is not required before sending the administrative appeal letter. However, if a provider appeals prior to submitting the new claims, the provider must subsequently include the new claims with the administrative appeal.

HHSC Claims Administrator Contract Management only reviews appeals that are received within eighteen (18) months from the date-of-service. In accordance with 1 TAC § 354.1003, providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management and all claims must be finalized within 24 months from the date of service.

2. Member eligibility changed from one Managed Care Organization (MCO) to another on the Date-of-Service

Providers may appeal claims payment recoupments and denials of services by submitting the following information to the appropriate MCO to which the Member eligibility was changed on the date of service:

- 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. The EOB showing the recoupment and/or the MCO's "demand" letter for recoupment** must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- **Documentation must identify** the client name, identification number, DOS, and recoupment amount, and other claims information.

Note: Label the request **"Expedited Review Request"** at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

Submit appeals online at:

www.bcbstx.com/provider/medicaid/claims-and-eligibility/claims (under appeals)

Also submit appeals at:

Blue Cross and Blue Shield of Texas
Attn: Appeals Department
P.O. Box 660717
Dallas, TX 75266

Fax: **1-877-886-2593**

Email: GPDTXMedicaidAG@bcbsnm.com

Mail Fee-for-Service related appeals to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

Recoupment Appeal Process (STAR)

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 b y 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

Member Appeal Process for Medicaid (STAR and STAR Kids)

If a member's covered service is denied by BCBSTX or limits a Medicaid members request for covered services, the member has the right to file an appeal. In addition, A member has the right to request an appeal when there is a denial of payment for services in whole or in part. A member has the option of filing an appeal either orally or in writing, whichever is convenient for the member.

A member is notified if services are denied by letter.

Members must file a request for an appeal with BCBSTX within 60 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. BCBSTX must complete the entire standard appeal process within 30 days after the receipt of the initial written or oral request for an appeal. The deadline may be extended for up to 14 days at the request of a members or the if BCBSTX shows there is a need for additional information and how the delay is in the member's interest. Member must receive written notice of the delay.

Member's will be notified about the importance of ensuring continuity of current authorized services, the member must file the appeal on or before the later of 10 days following the BCBSTX mailing of the notice of action or the intended effective date of the proposed action.

Please note, the member may be required to pay the cost of services furnished while the appeal is pending the final decision and if the final decision is adverse to the member.

BCBSTX Member Representative can assist the member with filing an appeal by calling:

STAR: **1-888-657-6061**

STAR Kids: **1-877-688-1811**

Medicaid Members may also have the option to request an External Review and State Fair Hearing no later than 120 days after BCBSTX mails the appeal decision. In addition, a member has the right to a State Fair Hearing, and it must be no later than 120 days after BCBSTX mails the appeal decision or at any time during or after BCBSTX appeals process.

Member Appeal Process (CHIP)

If BCBSTX denies or limits a CHIP member's request for a Covered Service, the CHIP member has the right to file an appeal. A CHIP member will be notified by letter if a covered service has been denied in whole or part.

Members must file a request for an appeal with BCBSTX within 60 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. BCBSTX must complete the entire standard appeal process within 30 days after the receipt of the initial written or oral request for an appeal. The deadline may be extended for up to 14 days at the request of a members or the if BCBSTX shows there is a need for additional information and how the delay is in the member's interest. Member must receive written notice of the delay.

A BCBSTX member representative may assist CHIP member in filing an appeal. CHIP member appeals maybe accepted orally or in writing whichever is convenient for the CHIP member.

Member Expediated Appeal Process (STAR, STAR Kids and CHIP)

A member may request an expedited appeal in the same manner as a standard appeal but should include information informing BCBSTX of the need for the **expedited appeal process**. A BCBSTX Member Representative can assist members with filing an expedited appeal. Expedited appeals are accepted orally or in writing whichever the member finds convenient.
Members may call the Customer Advocate Department or write to BCBSTX to request an Expedited Appeal:

Request an expedited appeal by phone

Customer Advocate:

STAR and CHIP: **1-888-657-6061**

STAR Kids: **1-877-688-1811**

TTY **711**

Fax: **1-877-886-2593**

Request an expedited appeal by mail

Blue Cross and Blue Shield of Texas
Attn: Expedited Appeals
PO Box 660717
Dallas, TX 75266

BCBSTX will resolve an expedited appeals within three business days. A member will be notified with an acknowledgment letter or phone call that BCBSTX has received their expedited appeal. A resolution letter will be sent to the member. BCBSTX may also call the member to notify them of the decision.

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.

State Fair Hearing for (Medicaid)

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 State Fair Hearing. The Member may name someone to represent them by contacting the health plan and giving the name of the person the Member wants to represent him or her. A provider may be the Member's representative if the provider is named as the Member's authorized representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 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 State Fair Hearing within 120 days, the Member may lose his or her right to a State Fair Hearing. To ask for a State 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 660717
Dallas, TX 75266

Fax# **1-877-886-2593**

Or, call the Customer Advocate Department at:

STAR **1-888-657-6061**

STAR Kids **1-877-688-1811**

If the Member asks for a State 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, based on previously authorized services, at least until the final hearing decision is made. If the Member does not request a State Fair Hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

If the Member asks for a State Fair Hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most State 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.

HHSC will give the Member a final decision within 90 days from the date the Member asked for the hearing.

External Medical Review and State Fair Hearing

EXTERNAL MEDICAL REVIEW INFORMATION

- Can a Member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO 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 External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of BCBSTX Internal Appeal Decision letter and mail or fax it to BCBSTX by using the address or fax number at the top of the form:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeal Department
PO Box 660717, Dallas, TX 75266-0717
Fax: **1-877-886-2593**

Call the Customer Advocate Department at:
STAR and CHIPS **1-888-657-6061**
STAR Kids **1-877-688-1811**

You can also email us at: **GPDTXMedicaidAG@bcbsnm.com**

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The Member, the Member's authorized representative, or the Member's LAR may withdraw the Member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the Member's External Medical Review request. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. If the Member continues with the State Fair Hearing, the Member can also request the Independent Review Organization be present at the State Fair Hearing. The Member can make both of these requests by contacting the Member's MCO at BCBSTX or the HHSC Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, it is the State Fair Hearing decision that is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

- Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling BCBSTX. To qualify for an emergency External Medical Review and emergency State Fair Hearing, the Member must first complete BCBSTX's internal appeals process.

Independent Review Process (IRO) CHIP

CHIP members must complete the first level of the BCBSTX appeal process resulting in an adverse decision prior to filing a request for a review by an external Independent Review Organization (IRO) except in the case of a life-threatening condition.

An Independent Review Organization (IRO) is an organization that has no connection to BCBSTX or with health care providers that were previously in your treatment or decisions made by BCBSTX about services that have not been provided. Their decision is final.

Members or their authorized representative can file a request for a review by an Independent Review Organization within four months after getting the final appeal decision from BCBSTX.

To make a request, the member or their authorized representative must complete the HHS-Administered Federal External Review Request form and submit it to MAXIMUS.

There are three ways members can submit the form:

1. externalappeal.cms.gov/ferpportal/#/home
2. Fax: **1-888-866-6190**.
3. Mail: MAXIMUS Federal Services
   3750 Monroe Avenue, Suite 750
   Pittsford, NY 14534

If Members need help with the IRO process, they can call BCBSTX Member Services Toll Free Numbers:

CHIP: **1-866-657-6061**

Members must submit their request for an external medical review through the Independent Review Organization (IRO) within four (4) months of getting the final appeal decision from BCBSTX. MAXIMUS will notify BCBSTX immediately once the request is received. BCBSTX will send all information MAXIMUS needs within five (5) days a receiving notice of the IRO request. MAXIMUS will make a decision about the External Review as soon as possible, but no later than 45 days after receipt of the request for standard requests. For expedited requests, MAXIMUS will make a decision within 72 hours.

Section 17: Member Eligibility

Verifying Member Medicaid Eligibility

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:

- Use TexMedConnect on the TMHP website at **www.tmhp.com**.
- Log into your TMHP user account and accessing Medicaid Client Portal for providers.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at **1-800-925-9126** or **1-512-335-5986**.
- 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**1-800-252-8263**. Medicaid Members also can go online to order new cards or print temporary cards.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by patients. A copy is required during the appeal process if the patient's eligibility becomes an issue.

Important: Determination for eligibility is by HHSC.

Providers access to Medicaid medical and dental health information

Medicaid providers can log into their TMHP user account and access the Medicaid Client Portal for providers. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). This information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be.

The specific functions available are:

- Access to a Medicaid patient's medical and dental health information including medical diagnosis, procedures, prescription medicines and vaccines on the Medicaid Client Portal through My Account.
- Enhances eligibility verification available on any device, including desktops, laptops, tablets, and smart phones with print functionality.
- Texas Health Steps and benefit limitations information.
- A viewable and printable Medicaid Card.
- Display of the Tooth Code and Tooth Service Code for dental claims or encounters.
- Display of the Last Dental Anesthesia Procedure Date.

Additionally, an online portal is available to patients at **www.YourTexasBenefits.com** where they can:

- View, print, and order a Your Texas Benefits Medicaid card
- See their medical and dental plans
- See their benefit information
- See Texas Health Steps Alerts
- See broadcast alerts
- See diagnosis and treatments

- See vaccines
- See prescription medicines
- Choose whether to let Medicaid doctors and staff see their available medical and dental information

Note: The YourTexasBenefits.com Medicaid Client Portal displays information for active patients only. Legally Authorized Representatives can view anyone who is part of their case.

BCBSTX Provider Portal

Provider may also access the Availity website to determine member eligibility. Log on to the Availity website, an online tool for providers, by going online to **www.availity.com**. Registration is required to use this site.

Call BCBSTX Provider Services

STAR and CHIP: **1-877-560-8055**

STAR Kids: **1-877-784-6802**

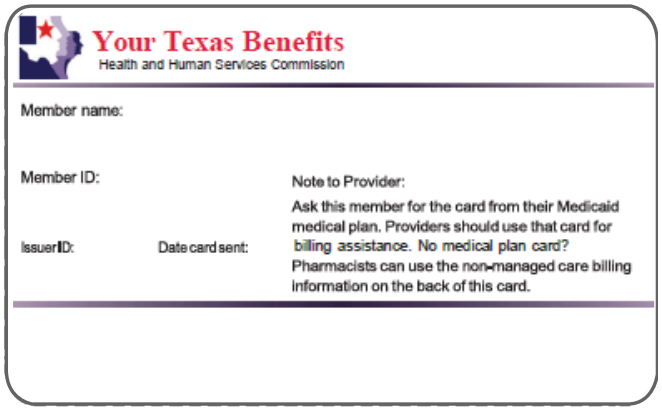
Sample Medicaid Insurance Cards and Helpful Tips

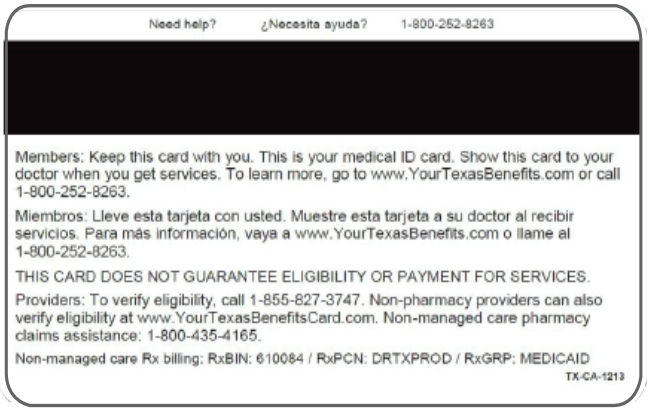
- Members can log into **www.yourtexasbenefits.com/Learn/Home** to show eligibility.
- View available health information such as: Vaccinations, Prescription drugs, Past Medicaid visits, and Health Events, including diagnosis and treatment Lab Results.
- Verify a Medicaid patient's eligibility and view patient program information.
- View Texas Health Steps Alerts.
- View Texas Benefit Cards
- Sample ID Card (s): STAR, CHIP, CHIP Perinatal, STAR KIDS, STAR Kids
- Temporary Id Form 1027-A

Dual Eligible (Medicare and Medicaid)

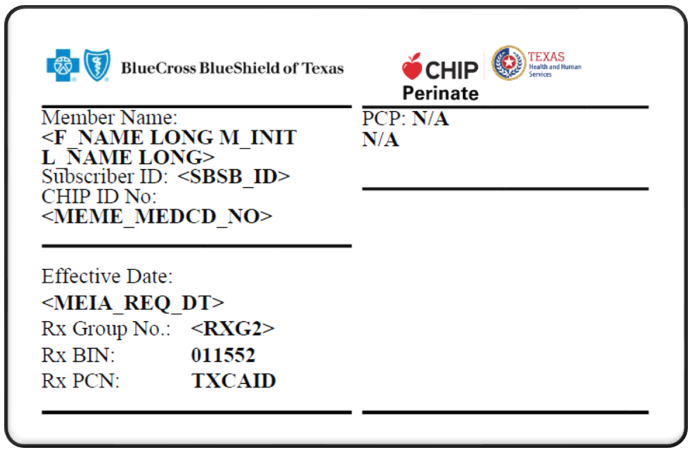
If the Member has Medicare, Medicare is responsible for most primary, acute, and behavioral health services; therefore, the Primary Care Provider's name, address, and telephone number are not listed on the Member's ID card. The Member receives long-term services and supports through BCBSTX.

Sample Your Texas Benefits Medicaid Card





CHIP Perinate Insurance Card 0%–198% FPL



BlueCross BlueShield of Texas

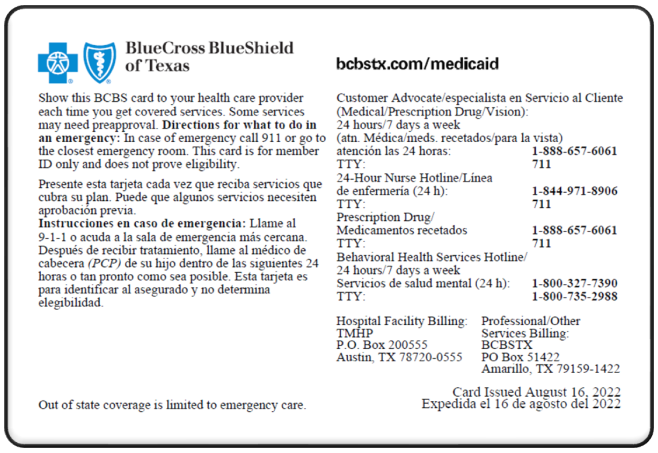
CHIP Perinate

TEXAS Health and Human Services

Member Name:
<F_NAME LONG M_INIT
L_NAME LONG>
Subscriber ID: <SBSB_ID>
CHIP ID No:
<MEME_MEDCD_NO>

Effective Date:
<MEIA_REQ_DT>
Rx Group No.: <RXG2>
Rx BIN: 011552
Rx PCN: TXCAID

PCP: N/A
N/A



BlueCross BlueShield of Texas

bcbstx.com/medicaid

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

Presente esta tarjeta cada vez que reciba servicios que cubra su plan. Puede que algunos servicios necesiten aprobación previa.
Instrucciones en caso de emergencia: Llame al 9-1-1 o acuda a la sala de emergencia más cercana. Después de recibir tratamiento, llame al médico de cabecera *(PCP)* de su hijo dentro de las siguientes 24 horas o tan pronto como sea posible. Esta tarjeta es para identificar al asegurado y no determina elegibilidad.

Customer Advocate/especialista en Servicio al Cliente (Medical/Prescription Drug/Vision):
24 hours/7 days a week
(atn. Médica/meds. recetados/para la vista)
atención las 24 horas: 1-888-657-6061
TTY: 711
24-Hour Nurse Hotline/Línea de enfermería (24 h): 1-844-971-8906
TTY: 711
Prescription Drug/ Medicamentos recetados 1-888-657-6061
TTY: 711
Behavioral Health Services Hotline/
24 hours/7 days a week
Servicios de salud mental (24 h): 1-800-327-7390
TTY: 1-800-735-2988

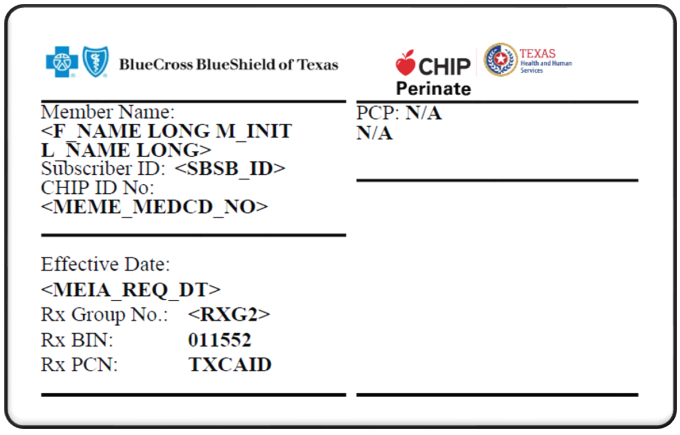
Hospital Facility Billing:
TMHP
P.O. Box 200555
Austin, TX 78720-0555

Professional/Other Services Billing:
BCBSTX
PO Box 51422
Amarillo, TX 79159-1422

Out of state coverage is limited to emergency care.

Card Issued August 16, 2022
Expedida el 16 de agosto del 2022

CHIP Perinate Insurance Card 198%–202% FPL



BlueCross BlueShield of Texas

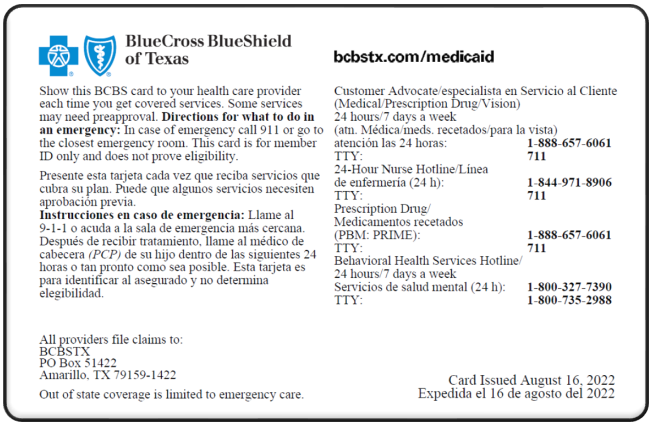
CHIP Perinate

TEXAS Health and Human Services

Member Name:
<F_NAME LONG M_INIT
L_NAME LONG>
Subscriber ID: <SBSB_ID>
CHIP ID No:
<MEME_MEDCD_NO>

Effective Date:
<MEIA_REQ_DT>
Rx Group No.: <RXG2>
Rx BIN: 011552
Rx PCN: TXCAID

PCP: N/A
N/A



BlueCross BlueShield of Texas

bcbstx.com/medicaid

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

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Instrucciones en caso de emergencia: Llame al 9-1-1 o acuda a la sala de emergencia más cercana. Después de recibir tratamiento, llame al médico de cabecera *(PCP)* de su hijo dentro de las siguientes 24 horas o tan pronto como sea posible. Esta tarjeta es para identificar al asegurado y no determina elegibilidad.

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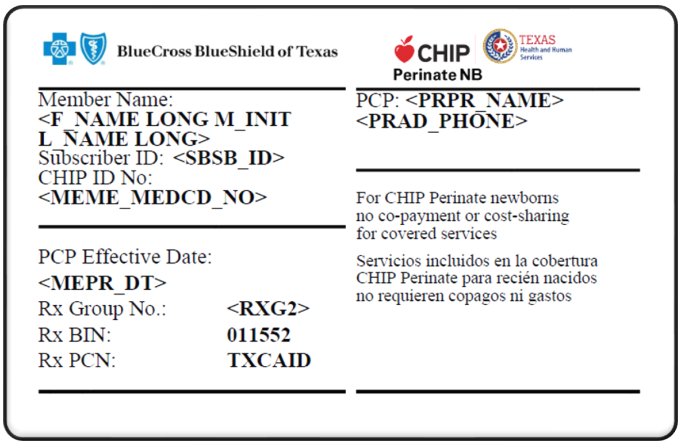
TTY: 711
24-Hour Nurse Hotline/Línea de enfermería (24 h): 1-844-971-8906
TTY: 711
Prescription Drug/ Medicamentos recetados
(PBM: PRIME): 1-888-657-6061
TTY: 711
Behavioral Health Services Hotline/
24 hours/7 days a week
Servicios de salud mental (24 h): 1-800-327-7390
TTY: 1-800-735-2988

All providers file claims to:
BCBSTX
PO Box 51422
Amarillo, TX 79159-1422

Out of state coverage is limited to emergency care.

Card Issued August 16, 2022
Expedida el 16 de agosto del 2022

CHIP Perinate Newborn Insurance Card



BlueCross BlueShield of Texas

CHIP Perinate NB

TEXAS Health and Human Services

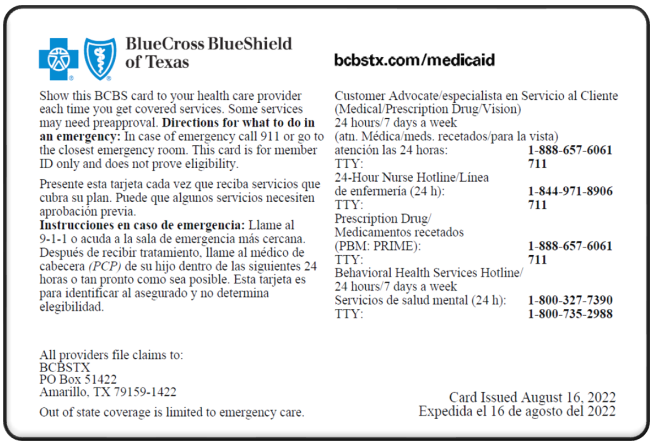
Member Name:
<F_NAME LONG M_INIT
L_NAME LONG>
Subscriber ID: <SBSB_ID>
CHIP ID No:
<MEME_MEDCD_NO>

PCP Effective Date:
<MEPR_DT>
Rx Group No.: <RXG2>
Rx BIN: 011552
Rx PCN: TXCAID

PCP: <PRPR_NAME>
<PRAD_PHONE>

For CHIP Perinate newborns
no co-payment or cost-sharing
for covered services

Servicios incluidos en la cobertura
CHIP Perinate para recién nacidos
no requieren copagos ni gastos



BlueCross BlueShield of Texas

bcbstx.com/medicaid

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

Presente esta tarjeta cada vez que reciba servicios que cubra su plan. Puede que algunos servicios necesiten aprobación previa.
Instrucciones en caso de emergencia: Llame al 9-1-1 o acuda a la sala de emergencia más cercana. Después de recibir tratamiento, llame al médico de cabecera *(PCP)* de su hijo dentro de las siguientes 24 horas o tan pronto como sea posible. Esta tarjeta es para identificar al asegurado y no determina elegibilidad.

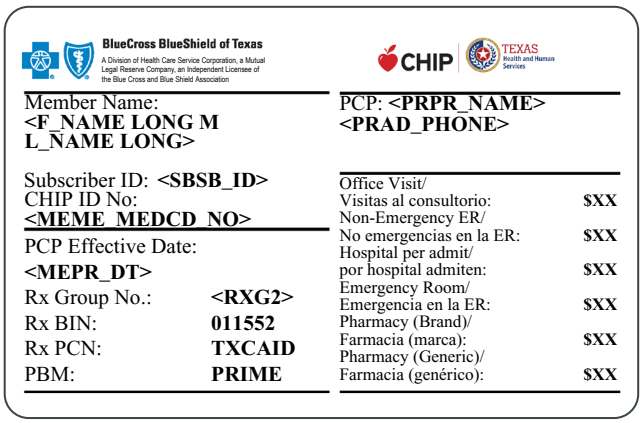
Customer Advocate/especialista en Servicio al Cliente (Medical/Prescription Drug/Vision)
24 hours/7 days a week
(atn. Médica/meds. recetados/para la vista)
atención las 24 horas: 1-888-657-6061
TTY: 711
24-Hour Nurse Hotline/Línea de enfermería (24 h): 1-844-971-8906
TTY: 711
Prescription Drug/ Medicamentos recetados
(PBM: PRIME): 1-888-657-6061
TTY: 711
Behavioral Health Services Hotline/
24 hours/7 days a week
Servicios de salud mental (24 h): 1-800-327-7390
TTY: 1-800-735-2988

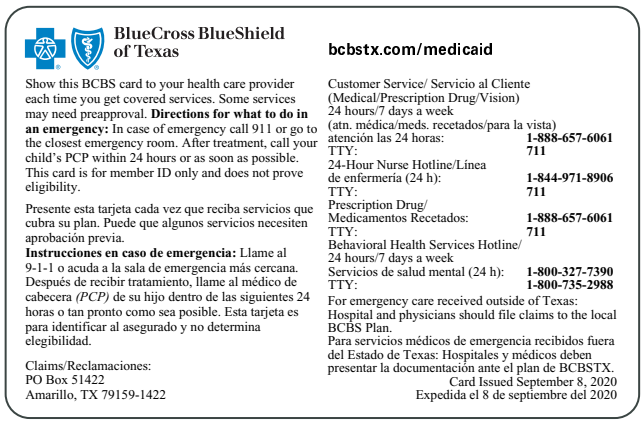
All providers file claims to:
BCBSTX
PO Box 51422
Amarillo, TX 79159-1422

Out of state coverage is limited to emergency care.

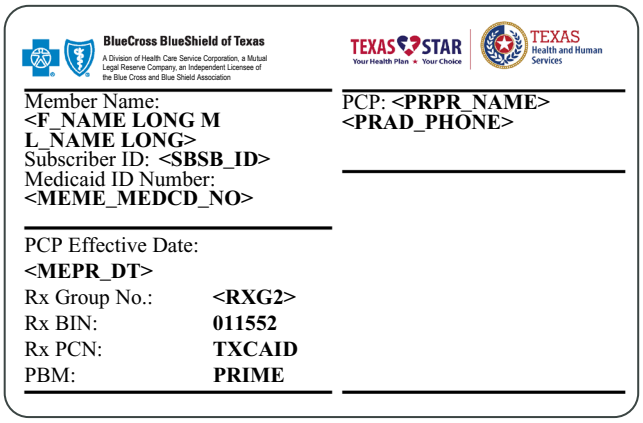
Card Issued August 16, 2022
Expedida el 16 de agosto del 2022

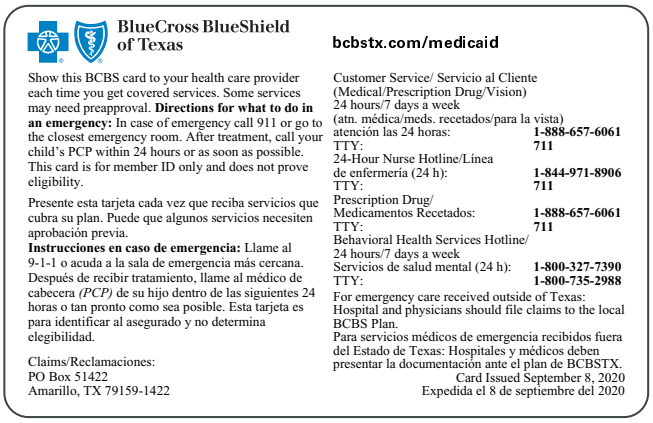
CHIP Insurance Card



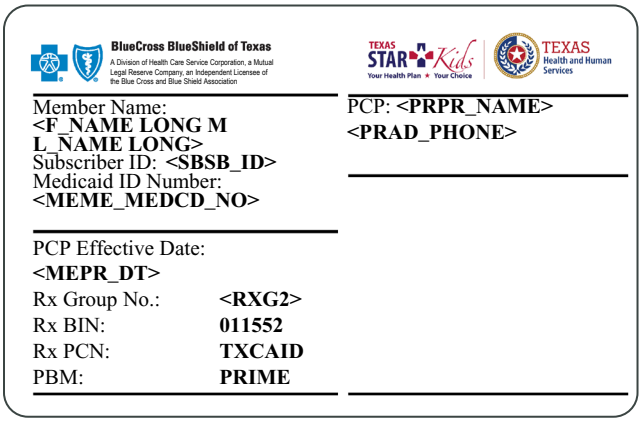


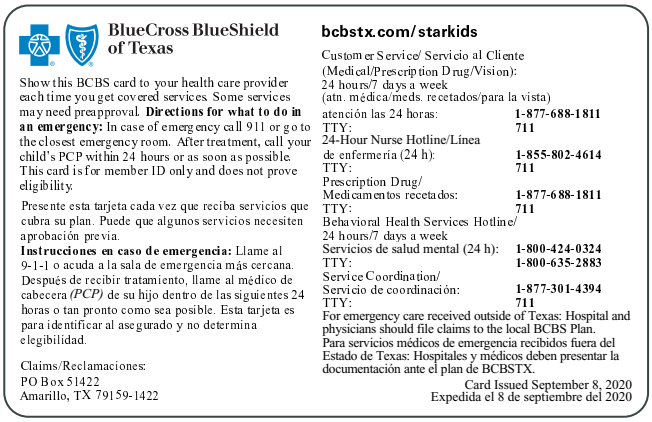
STAR Insurance Card



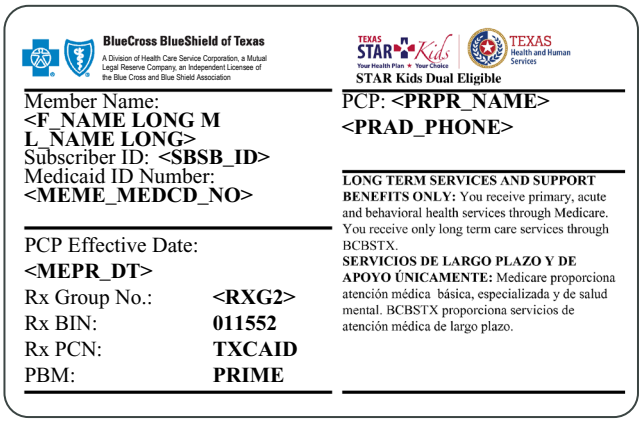


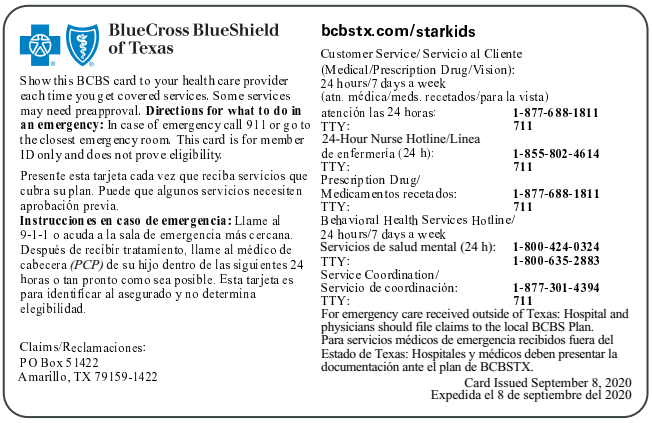
STAR Kids Insurance Card





STAR Kids Dual Eligible Insurance Card





Involuntary Disenrollment Due to Member Non-Compliance

There may be instances when a PCP feels that a member should be removed from his or her panel. BCBSTX requires notification of such requests so educational outreach can be arranged with the member. All notifications to remove a patient from a panel must:

- Be made in writing;
- Be directed to BCBSTX's Compliance Department.
- Contain detailed documentation; and Upon receipt of a request, BCBSTX may:
- Interview the provider or his or her staff requesting the disenrollment, as well as any additional providers who are relevant to the request;
- Interview the member; or
- Review any relevant medical records.

Examples of reasons a PCP may request to remove a member from his or her panel could include, but are not limited to:

- If a member is disruptive, unruly, threatening or uncooperative to the extent that the member seriously impairs the provider's ability to provide services to the member, or to other patients, and the member's behavior is not caused by a physical or behavioral condition.
- If a member refuses to comply with managed care guidelines, such as repeated emergency room use, combined with refusal to allow the provider to treat the underlying medical condition.

A PCP cannot request a member be disenrolled for any of the following reasons:

- Adverse change in the member's health status or utilization of services which are medically necessary for the treatment of a member's condition.
- On the basis of the member's race, color, national origin, sex, age, disability, political beliefs or religion.

Under no circumstances can a provider take retaliatory action against a member due to disenrollment from either the provider or a plan. HHSC will make the final decision.

Pregnant Teens

Network providers are required to notify us immediately upon identification of a pregnant CHIP member for Medicaid eligibility determinations. A CHIP member who is potentially eligible for Medicaid must apply for Medicaid. A pregnant CHIP member who is determined to be Medicaid-eligible will no longer be eligible for CHIP and will be disenrolled from the program. Medicaid coverage will be coordinated to avoid gaps in health care coverage. BCBSTX will follow Evidence of Care (EOC) and Certificate of Coverage (COC) requirement for these members identified.

Newly Enrolled Members

- After the initial 90-day period, or until the end of an authorization, continuity of care will no longer apply.
- If there is no participating provider who can perform the requested service within a 75-mile radius, BCBSTX may authorize or continue authorizing the service to a non-participating provider.
- Member will be automatically re-enrolled at BCBSTX, however, within a 180 day period, member can choose to switch plans.

CHIP Enrollment

CHIP program members are eligible for 12 months at a time.

Re-enrollment is necessary at that time.

A CHIP Perinatal (unborn child) who lives in a family with an income at or below Medicaid eligibility threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to MAXIMUS.

- CHIP members are allowed to make health plan changes under the following circumstances:
- For any reason within 90 days of enrollment in CHIP;
- For cause at any if the client moves to a different service delivery area; and
- During the annual re-enrollment period.

Newborn Enrollment – CHIP Perinatal

A CHIP Perinatal mother in a family with an income at or below Medicaid eligibility threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under Medicaid eligibility threshold receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to MAXIMUS. For a copy of the form and instructions, visit Texas Health and Human Services online at **www.hhs.texas.gov/regulations/forms/3000-3999/form-h3038-p-chip-perinatal-emergency-medical-services-certification.**

- CHIP Perinatal newborns are eligible for 12 months of continuous coverage, beginning with the month of enrollment to CHIP Perinatal. Services include mom's initial visit and up to 20 prenatal visits, prescriptions and prenatal vitamins
- Delivery and two doctor visits for the mother after the baby is born (coverage ends 30 days post-delivery)
- Well baby check-ups, immunizations and prescriptions

Please note that CHIP is an insurance program for children through age 19. CHIP Perinatal is for pregnant women age of 20 over. It is time-limited until through postpartum period.

Non-CHIP Perinatal members are enrolled for 12-month eligibility at a time.

A CHIP Perinatal baby will continue to receive coverage through the CHIP program as a "CHIP Perinatal Newborn" if born to a family with an income above Medicaid eligibility threshold, and the birth is reported to MAXIMUS.

A CHIP Perinatal Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinatal (month of enrollment as an unborn child plus 11 months). A CHIP Perinatal Newborn maintains coverage in their CHIP Perinatal health plan. Eligibility is determined by the administrative services contractor.

CHIP Perinatal Plan Changes

A CHIP Perinatal member who lives in a family with an income at or below Medicaid eligibility threshold (an unborn child who will qualify for Medicaid once born) is deemed eligible for Medicaid and receives 12 months of continuous Medicaid coverage (effective on the date of birth) after the birth is reported to MAXIMUS.

A CHIP Perinatal member in a family with an income at or below Medicaid eligibility threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Members under Medicaid eligibility threshold receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the physician at the time of birth and returned to MAXIMUS.

CHIP Perinatal members must select an MCO within 15 calendar days of receiving the enrollment packet or the CHIP Perinatal membership is defaulted into an MCO, and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.

When a member of a household enrolls in CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member's health plan if the plan is different.

All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal member's enrollment period, or (2) the end of the traditional CHIP members' enrollment period. In the 10th month of the CHIP Perinatal Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the

CHIP Perinatal Newborn's and the CHIP members' information. Once the child's CHIP Perinatal coverage expires, the child will be added to their siblings' existing CHIP case. CHIP Perinatal members may request to change health plans under the following circumstances:

- For any reason within 90 days of enrollment in CHIP Perinatal
- During the annual re-enrollment period
- If the member moves into a different service delivery area
- For cause at any time
- Pregnant Members

BCBSTX will allow pregnant member who is past the 24th week of pregnancy to remain under the care of her current OB/GYN, even if provide out-of-network. This remains in effect through the member's postpartum checkup.

In cases where the member wishes to change her OB/GYN to one who is in-network, the member will be allowed to do so as long as the provider agrees to accept her in the last trimester of pregnancy.

Community-Based Long-Term Care Services

At the time of new program implementation, BCBSTX will provide continued authorization for services prior authorized for a period not to exceed six (6) months or until a new assessment is completed and a new authorization is issued, whichever comes first. Please refer to Section 9 for details on how to request an out-of- network authorization.

Members Who Move Out of the Service Area

BCBSTX will continue to provide and coordinate services for members who move out of the service area until such time the member is disenrolled from BCBSTX.

Spell of Illness Limitations

In the traditional Medicaid and CHIP programs, the spell of illness limitation is defined as thirty (30) days of inpatient hospital care, which may accrue intermittently or consecutively. After thirty (30) days of an inpatient care admission, reimbursement for additional inpatient care is not considered until the patient has been out of an acute facility for sixty (60) consecutive days.

This limitation does not apply to BCBSTX STAR and STAR Kids members.

For STAR and STAR Kids members with BCBSTX, the $200,000 annual limit on inpatient services does not apply.

Automatic Enrollment

Members who temporarily lose Medicaid eligibility and become disenrolled are automatically enrolled to the same MCO if they regain eligibility status within six months. After automatic re- enrollment, members may choose to change MCOs. You can check the TMHP Automated Inquiry Services (AIS) line to verify member eligibility status at **1-800-925-9126**.

Disenrollment

A member's disenrollment request from BCBSTX will require medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment. Texas HHSC will make the final decision. Providers are strictly prohibited from taking any retaliatory action against a member for any reason, including reasons related to disenrollment.

Section 18: Member Rights and Responsibilities

STAR and STAR Kids Member Rights

Please note: Members have a right to make recommendations about the BCBSTX member rights and responsibilities policy.

MEMBER RIGHTS AND RESPONSIBILITIES

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.

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, External Medical Reviews and State 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. MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program.
    c. Get a timely answer to your complaint.
    d. Use the plan's appeal process and be told how to use it.
    e. Ask for a an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works*.
    f. Ask for a State Fair Hearing without an External Medical Reviewfrom the state Medicaid program and receive information about how that process works*.

* Applies to STAR Kids only.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    b. Get medical care in a timely manner.
    c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
    e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

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.

Additional Member Responsibilities while using ModivCare

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

It is recommended our members follow the care plans and instructions that you agreed on with your doctor or provider. If you think your child has been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at **1-800-368-1019**. You also can view information concerning the HHS Office of Civil Rights online at **www.hhs.gov/ocr**.

For a complete list of member rights and responsibilities, see the Member Handbook and Your Rights for Appeal of an Adverse Determination. The link for Your Rights for Appeal of an Adverse Determination: **www.bcbstx.com/starkids/pdf/rights-for-appeal.pdf**.

MDCP/DBMD Escalation Help Line

What is the MDCP/DBMD escalation help line?

The MDCP/DBMD escalation help line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf-Blind with Multiple Disabilities (DBMD) program. The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about External Medical Reviews, State Fair Hearings and continuing services during the appeal process.

When should Members call the escalation help line?

Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call **1-844-999-9543** and they will work to connect you with the right people.

Is the escalation help line the same as the HHS Office of the Ombudsman?

No. The MDCP/DBMD Escalation Help Line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at **1-866-566-8989** or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

Who can call the help line?

You, your authorized

representatives or your legal representative can call.

Can members call any time?

The escalation help line is available Monday through Friday from 8 a.m.–8 p.m. After these hours, please leave a message and one of our trained on-call staff will call you back.

STAR and STAR Kids Member Responsibilities

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.

You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:

d. Learn and follow your health plan's rules and Medicaid rules.

e. Choose your health plan and a primary care provider quickly.

f. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.

g. Keep your scheduled appointments.

h. Cancel appointments in advance when you cannot keep them.

i. Always contact your primary care provider first for your non-emergency medical needs.

j. Be sure you have approval from your primary care provider before going to a specialist.

k. Understand when you should and should not go to the emergency room.

You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:

l. Tell your primary care provider about your health.

m. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.

n. Help your providers get your medical records.

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:

o. Work as a team with your provider in deciding what health care is best for you.

p. Understand how the things you do can affect your health.

q. Do the best you can to stay healthy.

r. Treat providers and staff with respect.

s. Talk to your provider about all of your medications.

CHIP Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.

9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

CHIP Member Responsibilities

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

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.

7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. Talk to your child's provider about all of your child's medications.

CHIP Perinatal Members Rights

Member Rights:

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

CHIP Perinatal Member Responsibilities

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.

4. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.

Talk to your provider about all of your medications.

Members Rights to Designate an OB/GYN

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:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network

Section 19: 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. As a reminder there are no copayment for STAR Kids members.

Claims will be paid at the lesser of (1) billed charges for services and (2) the amount due on the claim per the provider's contract terms. In no event will claims be paid greater than provider's billed charges.

For services requiring prior authorizations and how to request a prior authorization please refer to Section 10 Utilization Management or Attachment B request for Prior Authorization Form. For complete list of Prior Authorization codes visit our website at: **www.bcbstx.com/provider/medicaid/claims-and-eligibility/um**. Services not requiring a prior authorization does not necessarily mean they are approved, for more information please contact BCBSTX UM Department. If any prior authorization form is returned with the language "PA Not Required" the requesting provider should verify if the service is a covered benefit and requires authorization using the prior authorization process.

For out-of-network claims prior authorization is required unless for emergency or urgent care services. Claims for continuity of care will provide continued authorization for services prior authorized for a period not to exceed six months or until a new assessment is completed and a new authorization is issued, whichever comes first. For claims questions and appeals see Section 16 Provider Appeals.

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.

Claims Editing

For Blue Cross and Blue Shield of Texas Medicaid-State of Texas Access Reform (STAR), Children's Health Insurance Program (CHIP) programs and State of Texas Access Reform (STAR Kids), BCBSTX uses claims editing software to incorporate editing rules that determine whether to pay, rejected or require manual processing for claims.

We periodically update claims editing software. BCBSTX will give providers advance notice of any new edits applied that we expect to result in material changes.

Claim Forms

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 in the link below:

www.bcbstx.com/provider/medicaid/education-and-reference/forms

Filing Limits

All claims must be submitted within 95 days from the render service date unless otherwise notated in your contractual agreement with BCBSTX. 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)
CMS – 1500 Claim Form	Physician and other professional services:	Within 95 days of date of service.
	Ancillary Services: Physical, Occupational, and Speech Therapy, Audiologist, Ambulance, Ambulatory Surgical Center, Dialysis, Durable Medical Equipment (DME), Diagnostic Imaging Centers, Hearing Aid Dispensers, Home Infusion, Hospice, Laboratories, Prosthetics, and Orthotics, Home Health Services Private Duty Nursing (PDN) Freestanding SNFs. Some ancillary providers may use CMS-1450 (UB-04) if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.	\Within 95 days of date of service.
CMS-1450 (UB-04) Claim Form	Hospitals, Institutions, Home Health Services (excluding Private Duty Nursing)	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	Timeframe
Third Party Liability (TPL) or Coordination of Benefits (COB)	If the claim has TPL or COB or requires submission to a third-party before submitting to BCBSTX, the filing limit starts from the date on the notice from the third party.	Within 95 days of date of service. From date of notice from third party: 95 days for CMS-1500 claims 95 days for CMS-1450 (UB-04) claims.
Checking Claim Status	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. Also, you can request your claims status by filing out the Claims Status Form, which can be found here: www.bcbstx.com/content/dam/hcsc/docs/provider/tx/provider-medicaid/claim-status-request-form.pdf	30 business days after BCBSTX's receipt of claim, contact Provider Customer Service at: STAR and CHIP: **1-877-560-8055** STARKids: **1-877-784-6802**

Action	Description	Timeframe
Provider Appeal	To request a claim appeal, please fill out the Claims Reconsideration Form, which can be found here: www.bcbstx.com/content/dam/hcsc/docs/provider/tx/provider-medicaid/claim-reconsideration-form.pdf	120 calendar days from the receipt of BCBSTX

BCBSTX accepts the following claims from non-contracted providers within the indicated time frames for STAR, CHIP, and STAR Kids:

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

Paper Claims and Correspondence Mailing Address

Blue Cross and Blue Shield of Texas
Attn: Claims
P.O. Box 650712
Dallas, TX 75265

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

Questions about claims

If you have questions about claims status or how to file a claim, including how to complete claims forms, please contact the Provider Customer Service at:

STAR and CHIP **1-877-560-8055**.

STAR Kids **1-877-784-6802**

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. TMHP Portal (STAR and STAR Kids)

Electronic Claims

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

Submit claims electronically through a plan-approved electronic billing system software vendor and/or clearinghouse. If you use EDI, you must include the following provider information:

- Provider name
- Rendering Provider NPI (National Provider Identifier)
- Group NPI (National Provider Identifier)
- 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 risks your claim being denied for timely filing if those claims are not successfully submitted.

After submitting electronic claims:

- Monitor claim status on Availity or through the BCBSTX Provider Customer Service Interactive Voice Response (IVR) for STAR and CHIP **1-877-560-8055** and for STAR Kids **1-877-784-6802**. Please note that the IVR accepts either your billing National Provider Identifier (NPI) or your Federal Tax Identification Number (TIN) for provider identification. Should the system not accept you're billing NPI or Federal TIN, the system will route your call to a Provider Customer Service representative who will help you with your query. For purposes of assisting you, we may ask you to provide 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 timely 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** to:

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

Paper Claims

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

- Use the correct form and be sure the form meets Centers for Medicare and Medicaid Services (CMS) standards
- Use black or blue ink; do not use red ink, as the scanner may not be able to read it
- Do not stamp or write over boxes on the claim form
- Send the original claim form to BCBSTX, and retain the copy for your records
- Do not staple original claims together. BCBSTX will consider the second claim as an attachment and process it later.
- Type information within the designated field. Be sure the type falls completely within the text space and is 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 or and Taxonomy Code
- The Federal Provider Tax Identification (ID) number
- National Provider Identifier (NPI)
- Medicare number (if applicable)

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
P.O. Box 650712
Dallas, TX 75265

Availity 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, call **1-800-AVAILITY (282-4548)**.

Submit claims electronically through the Availity web portal, a plan-approved electronic billing system software vendor and/or clearinghouse. Through the Availity 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:

BCBSTX
Attn: Claims
P.O. Box 650712
Dallas, TX 75265

Clinical Submissions Categories

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

- Claims involving precertification/prior authorization/predetermination (or some other form of utilization review) including but not limited to:
- Claims pending for lack of precertification or prior authorization
- Claims involving medical necessity or experimental/investigative determinations
- Claims involving drugs administered in a physician's office requiring prior authorization
- Claims requiring certain modifiers
- Claims involving unlisted codes
- Claims for which we cannot determine from the face of the claim whether it involves a covered service; thus, the benefit determination cannot be made without reviewing medical records (including but not limited to emergency service-prudent layperson reviews and specific benefit exclusions). A prudent layperson is someone who possesses an average knowledge of health and medicine.

- Claims that we have reason to believe involve inappropriate (including fraudulent) billing
- Claims that are the subject of an audit (internal or external), including high-dollar claims
- Claims for individuals involved in case management or disease management
- Claims that have been appealed (or that are otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated)

Other situations in which clinical information might routinely be requested:

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

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

National Provider Identifier

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

There are several advantages to using your NPI for claims and billing. NPI offers providers the opportunity to bill with only one number.

Providers may apply for an NPI individually online at the National Plan and Provider Enumeration System (NPPES) website at **https://nppes.cms.hhs.gov/** or by obtaining a paper application by calling the NPPES number at **1-800-465-3203**.

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 sho uld 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.

Unattested NPIs

BCBSTX will deny claims with an unattested NPI. Attestation is the process of registering and reporting your NPI with your state Medicaid agency. Providers serving STAR, CHIP, and 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**

Attesting makes processing and paying your claims more efficient and accurate. During attestation, you may also be assigned a benefit code to identify specific state programs as part of NPI-related data. You can verify your NPI assignment at the National Plan and Provider Enumeration System (NPPES) website at **nppes.cms.hhs.gov**.

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

Although a provider may not be currently bill to Medicaid or other publicly funded programs, a participating provider must still apply for an NPI with CMS.

Online Resources for NPI Information

The following websites offer additional NPI information:

National Plan and Provider Enumeration System (NPPES): **nppes.cms.hhs.gov/#/**

Workgroup for Electronic Data Interchange: **www.wedi.org/**

National Uniform Claims Committee: **www.nucc.org**

Texas Medicaid & Healthcare Partnership: **www.tmhp.com**

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 *) *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.

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

Benefit Code	Service
EP1*	Texas Health Steps
HA1	Hearing Aid
IM1	Immunization
MA1	Maternity
MH2	Behavioral/Mental Health Case Management
TB1	Tuberculosis (TB) Clinic
WC1	Women, Infants, and Children (WIC) Program
FP3	Family Planning Agencies
CA1	County Indigent Health Care Program

Family Planning Claims Submission

BCBSTX reimburses the following family planning procedure codes:

Family Planning Services									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
J7296	J7297	J7298	J7300	J7301	J7307				

Annual family planning examination must be submitted with modifier FP.

BCBSTX reimburses the following family planning diagnosis codes

Family Planning Diagnosis Codes							
Z30011	Z30013	Z30014	Z30018	Z3002	Z3009	Z302	Z3040
Z3041	Z3042	Z30430	Z30431	Z30432	Z30433	Z3049	Z308
Z309	Z9851	Z9852					

Procedure code 58300 must be submitted on the same claim as J7296, J7297, J7298, J7300 and J7301. Procedure code 58300 will process as informational only. Only the annual family planning examination requires modifier FP. All other family planning visits do not require the FP modifier. Claims filled incorrectly may be denied.

BILLING REQUIREMENTS FOR CHIP PERINATAL POSTPARTUM VISITS

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

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

If the claim was submitted with the incorrect code, the original delivery claim with the correct code may resubmitted within the 120-day claims reconsideration deadline.

A CHIP Perinatal mother in a family with an income at or below Medicaid eligibility threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under Medicaid eligibility threshold receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to MAXIMUS. For a copy of the form and instructions, visit Texas Health and Human Services online at **hhs.texas.gov**.

- CHIP Perinatal newborns are eligible for 12 months of continuous coverage, beginning with the month of enrollment to CHIP Perinatal. Services include mom's initial visit and up to 20 prenatal visits, prescriptions and prenatal vitamins
- Delivery and two doctor visits for the mother after the baby is born (coverage ends 30 days post- delivery)

Well baby check-ups, immunizations and prescriptions. Please note that CHIP is an insurance program for children through age 19. CHIP Perinatal is for pregnant women age of 20 over. It is time-limited until through postpartum period. Non-CHIP Perinatal members are enrolled for 12-month eligibility at a time. A CHIP Perinatal baby will continue to receive coverage through The CHIP program as a "CHIP Perinatal Newborn" if born to a family with an income above Medicaid eligibility threshold, and the birth is reported to MAXIMUS.

A CHIP Perinatal Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinatal (month of enrollment as an unborn child plus

11 months). A CHIP Perinatal Newborn maintains coverage in their CHIP Perinatal health plan. Eligibility is determined by the administrative services contractor.

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. Please refer to Section 12 Pharmacy Provider Responsibilities for list of covered and preferred drugs.

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.

Pharmacy Claims and Encounters:

Texas Medicaid requires all pharmacies to submit actual acquisition costs under the 340B program in the "ingredient cost" in field 409-D9, complete the "gross amount due" with appropriate dispensing fee in field 430-DU, and identify the claim/encounter by providing "8" in the "basis of cost" field 423-DN.

CHIP Provider Responsibility

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

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

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

EXCEPTIONS TO CHIP PROVIDER RESPONSIBILITY

1. Immunizations, Well-Child, Well-Baby

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

2. Native Americans and Alaskan Natives

Federal law prohibits charging copayments, deductibles or out-of-pocket costs to CHIP and CHIP Perinatal members who are Native Americans or Alaskan Natives. When we identify a member as a Native American or Alaskan native, we issue them a member Id card showing that the member has no cost-sharing obligations.

3. CHIP Perinatal

No copayments are applicable at any income level.

COORDINATION OF BENEFITS

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

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

- Third-party Provider Remittance Advice (PRA)
- Third-party letter explaining the denial of coverage or reimbursement
- Member Explanation of Benefits (EOB)

***COB information can be entered and submitted through electronic claims submission please contact your Availity representatives for more information.**

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

BCBSTX must receive Coordination of Benefit 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 pf the CMS-1500 claim form
- Electronic Loop for 1500

1500 Item Number	ANSI 837 Loop and Segment	Paper Claim Field Name	Electronic Claim Field/Element Name
9	2330A NM 103 2330A NM 104 2330A NM 105 2330A NM 107	Other Insured's Name (Last, First, Middle Initial	Insured Last Name Insured First Name Insured Middle Initial Insured Generation
9a	2320 SBR03 2330A NM 109	Others Insured's Policy or Group Number	Group Number Policy Number
9b	2320 DMG02 2320 DMG03	Other Insured's Date of Birth Sex	Other Insured's Date of Birth Sex
9c	No Mapping	Employer's Name or School Name	Insured Employment Status Insured Employer Name Insured Emplr Addr1 Insured Emplr Addr2 Insured Emplr City Insured Emplr State Insured Emplr Zip
9d	2320 SBR04	Insurance Plan Name or Program Name	Group Name

Boxes 58-62 of the CMS-1450 (UB-04) claim form

Electronic Loop 1450

1450 Item Number	ANSI 837 Loop and Segment	Paper Claim Field Name	Electronic Claim Field/Element Name
58	2330A NM 103 2320A NM 104	Insured's Name	Insured Last Name Insured First Name
59	2320 SBR02	Patient Relationship	Patient Relationship
60	2330A NM109	Insured Unique ID	Insured ID
61	2320 SBR04	Group Name	Group Name
62	2320 SBR03	IInsurance Group No.	Group Number

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 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 numbe

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 (some exceptions). Each claim is subjected to a comprehensive series of checkpoints called edits. These edits verify and validate all claim information to determine if the claim should be paid, denied or pended for manual review.

You are responsible for all claims submitted with your provider information, 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 not rendered by a health care provider are subject to Texas HHSC suspension.

Claim Returned for Correction/Additional Information

If the claim is not clean, it will be rejected and/or 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 PRA, BCBSTX processes your claim without denying it for failure to file within timely filing guidelines.

Claims Payment

BCBSTX claims received are reviewed for medical necessity and covered services.

BCBSTX will 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 generates a Provider Remittance Advice (PRA), either paper or electronic, summarizing services rendered and payer action taken. The appropriate payment amount is distributed to the appropriate provider entity.

Pharmacy Claims Payment

BCBSTX will adjudicate (finalize as paid or denied) a clean electronic pharmacy claim within 18 days from point of sale process, and paper pharmacy claims 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.

The electronic fund transfer (EFT) option allows claims payments to be deposited directly into a previously selected bank account.

Providers can choose to receive ERAs and will receive these advises through their clearinghouse. Enrollment is required.

Enroll or questions via phone contact EDI Services @ **1-800-746-4614** or online @ **www.bcbstx.com/provider/claims/era.html**.

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**.

Overpayments

When a claims overpayment is discovered, BCBSTX will notify the provider. If a provider is notified by BCBSTX of an overpayment, a check in the amount of the overpayment should be mailed to BCBSTX. If the provider would like the overpayment auto-recouped the provider should notify their Network Provider Representative. Checks should be mailed to BCBSTX with a copy of the overpayment notification and the Provider Refund Form (**www.bcbstx.com/content/dam/hcsc/docs/provider/tx/provider-medicaid/pvdr_refunddue-md.pdf**) to:

Blue Cross and Blue Shield of Texas
Claims Overpayment
Dept CH 14212
Palatine, IL 60055-1290

Courier Address:

Blue Cross and Blue Shield of Texas
Claims Overpayment
Box 14212
5505 North Cumberland Ave., Ste. 307
Chicago, IL 60656-1471

If provider believes that the overpayment was created in error, you should contact your Network Provider Representative.

If you are not sure who your Network Provider Representative is please contact **1-855-212-1615**.

For a claim reconsideration please contact our Provider Customer Service @ STAR and CHIP **1-877-560-8055** and STAR Kids **1-877-784-6802**, or complete the claims reconsideration form (**www.bcbstx.com/provider/pdf/claim-reconsideration-form.pdf**) and email.

Claim Status Inquiry and Follow-Up

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 Provider Remittance Advice (PRA).

Claim Status Online

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

Telephonic Claim Status

You can also confirm that BCBSTX received your claim by calling customer service:

STAR and CHIP **1-877-560-8055**

STAR Kids **1-877-784-6802**

Hours are Monday - Friday, 8 a.m. to 5 p.m. (Central Standard Time), except certain holidays.

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

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

Claim Status via Network Representative

You can also confirm status with your Network Provider Representative by completing the Claim Status Form (**www.bcbstx.com/provider/pdf/claim-status-request-form.pdf**).

Note: DME providers should complete the DME Claim Status Form (**www.bcbstx.com/provider/pdf/dme-claim-status-request-form.pdf**).

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)within the 120 days from the date of the Provider Remittance Advice (PRA) timely filing guidelines to prevent denials.

Claim Payment Reconsideration

Claims reconsideration is a request for a review of a previously submitted claim to BCBSTX for payment. Claims are either rejected at the EDI gateway, denied, or underpaid in the BCBSTX claim system.

Claim Reconsideration by Phone:

Contact Provider Customer Service

STAR and CHIP **1-877-560-8055**

STAR Kids **1-877-784-6802**

Claims Reconsideration via Network Representative

Complete the Claims Reconsideration Form (www.bcbstx.com/provider/pdf/claim-reconsideration-form.pdf) or contact by phone at **1-855-212-1615**

Note: Durable Medical Equipment (DME) providers please submit the DME Review Form (www.bcbstx.com/provider/pdf/dme-review-request-form.pdf)

Claim Payment Appeal Procedure

BCBSTX Claim Payment Appeals is defined as a request for review of an action or adverse determination, which is any denial, reduction, or termination of benefits in whole or in part Provider appeals include, but are not limited to:

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

To file a provider appeal please complete and submit the Provider Appeal Form (www.bcbstx.com/provider/pdf/provider-appeal-request-form.pdf) and return to BCBSTX within timely filing guidelines.

Note: Claims submitted on a BCBSTX Provider Appeal Form will be processed as an appeal and not Claims Reconsideration.

Provider appeals are not considered:

- Corrected claim
- General inquiry/question
- Claim denials needing additional information

Blue Cross and Blue Shield of Texas
Attn: Appeal Department
PO Box 660717
Dallas, TX 75266-0717

Fax: **1-877-886-2593**

Email: GPDTXMedicaidAG@bcbsnm.com

Providers may also submit provider appeals through the Availity online tool at www.availity.com. Claim payment appeal requests are resolved within 30 days of receipt of written request. After the review is complete, a resolution letter with the details of our decision will be sent to the provider.

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

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

If the above processes have been exhausted for a **STAR and 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
Complaints may also be emailed to:

HPM_complaints@hhsc.state.tx

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

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

Texas Department of Insurance
P.O. Box 149091
Austin, Texas 78714-9091

Phone: **1-512-463-6500** or **1-800-252-3439**

Email: **ConsumerProtection@tdi.state.tx.us**

Online form: **www.tdi.texas.gov/consumer/cpportal.html**

Complaints may also be emailed to: **ConsumerProtection@tdi.texas.gov**

Common Reasons for Rejected and Denied Claims

Many of the claims are rejected or denied for common billing errors.

Problem	Explanation	Resolution
Member's ID Number isIncomplete or incorrect	BCBSTX provides ID cards to the member in addition to the state ID card. The member's plan ID number is called the member number and is the same as their medical ID.	**Use the Member's ID number from the BCBSTX ID card or Texas Medicaid identification.** Inclusion of the alpha prefix at the beginning of the member's nine-digit BCBSTX ID number is encouraged for 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, utilize appropriate modifiers when necessary. Avoid spanning dates, except for inpatient billing. Make sure you read your Provider Remittance Advice (PRAs) Claim Denial Number (CDNs), and mail back forms for important claim determination information before resubmitting a claim. Additional information may be needed.
Authorization Number Missing/ Does Not Match Services	The authorization number is missing, or the approved services do not match the services described in the claim.	Confirm that the Authorization Number is provided on the claim form (CMS-1500 Box 24 and CMS-1450 (UB-04) Box 63) and that the approved services match the provided services.
Missing Codes for Required Service Categories	Current Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) manuals must be used because changes are made to the codes quarterly or annually. Manuals may be purchased at any technical bookstore, or through the American Medical Association or the Practice Management Information Corporation.	Make sure all services are coded with the correct codes). 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.

Problem	Explanation	Resolution
Unreasonable Numbers Submitted	Unreasonable numbers, such as '9999' may appear in the Service Units fields.	Make sure to check your claim for accuracy before submitting it.
Submitting Batches of Claims	Stapling claims together can make subsequent claims appear to be attachments, rather than individual claims.	Make sure each individual claim is clearly identified and not stapled to another claim.
Nursing Care	Nursing charges are included in the hospital and outpatient care charges. Nursing charges that are billed separately are considered unbundled charges and are not payable. In addition, BCBSTX will not pay claims using different room rates for the same type of room to adjust for nursing care.	Do not submit bills for nursing charges.

Acute Care, Professional, and Ancillary Billing Claims

After Hours Services

BCBSTX considers normal business hours for Primary Care Providers (PCP) as Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Time. BCBSTX will reimburse at after hour rates for services provided outside of the provider's normal business hours. Providers 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 BCBSTX. Submit all billing to:

BCBSTX

Attn: Claims
P.O. Box 650712
Dallas, TX 75265

BCBSTX Medicaid Provider Manual:
www.bcbstx.com/content/dam/hcsc/docs/provider/tx/provider-medicaid/education/2062277-medicaid-texas-star-chip-starkids-provider-manual.pdf

How to find a list of both covered and preferred drugs.

See section 12 Pharmacy Provider Responsibilities.

Clinician Administered Drugs (STAR Kids)

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 **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 **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 severity (including severe pain), such that a layperson possessing an average knowledge of health and medicine could reasonably expect that in the absence of immediate medical care could result in:

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

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

Providers must use procedure codes 99281, 99282, 99283, 99284, and 99285 when billing emergency department services. If an emergency department visit is billed by the same provider with the same date of service as an office visit, outpatient consultation, inpatient consultation, or subsequent nursing facility service, the emergency department visit may be reimbursed, and the other services will be denied.

If an emergency department visit is billed by the same provider with the same date of service as an initial nursing facility service, the initial nursing facility service may be reimbursed and the emergency department visit will be denied.

Emergency department visits are denied when billed with the same date of service as an observation service (procedure code 99217) by the same provider.

Reimbursement for physicians in the emergency department is based on Section 104 of TEFRA. TEFRA requires that Medicaid limit reimbursement for nonemergent and nonurgent physicians' services furnished in hospital outpatient settings that also are ordinarily furnished in physician offices. The emergency department procedure code that is submitted on the claim is used to determine the appropriate reimbursement for these services. The procedure code billed may include, but is not limited to, E/ M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered by the physician in the hospital's emergency department. The reimbursement for each service is determined by multiplying the base allowable fee by 60 percent.

Emergency Department Payment Reductions

Reimbursement for non-emergent and non-urgent services that are rendered by the facility during the emergency room visit will be limited to 125 percent of the adult, physician office visit fee for procedure code 99202. Reimbursement will not be reduced for those services that were rendered to address conditions that meet any of the following criteria:

- Problems of high severity
- Problems that require urgent evaluation by a physician
- Problems that pose immediate and significant threats to physical or mental function
- Critically ill or critically injured

Non-emergent and non-urgent services that are rendered by rural hospitals will be reimbursed at 65 percent of the allowed rates.

Non-rural hospitals will receive a flat rate which is limited to 125 percent of the adult, physician office visit fee for procedure code 99202. Diagnostic services, such as laboratory and radiology, will not be reduced by 40 percent.

The following services are excluded from the 60-percent limitation:

- Services furnished in rural health clinics (RHCs)
- Surgical services that are covered ASC/hospital-based ambulatory surgical center (HASC) services
- Anesthesiology and radiology services
- Prenatal services when billed with modifier TH and the appropriate E/M procedure code to the
- Highest level of specificity

Emergency services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in one of the following:

- Serious jeopardy to the client's health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Durable Medical Equipment

See the Ancillary Billing Requirements by Service Category section in the Ancillary Billing section for DME

Hospital Readmissions Policy

Readmissions are considered a continuous stay regardless of the original or readmission diagnosis. Admissions submitted inappropriately are identified and denied during the UR process and may result in intensified review.

Texas Health Steps Billing

THSteps medical checkups reflect the federal and state requirements for a preventive checkup.

Preventive care medical checkups are a benefit of the THSteps program if they are provided by enrolled THSteps providers and all of the required components are completed. An incomplete preventive medical checkup is not a benefit. The THSteps periodicity schedule specifies screening procedures required at each stage of the client's life to ensure that health screenings occur at age-appropriate points in a client's life.

Components of a medical checkup that have an available CPT code are not reimbursed separately on the same day as a medical checkup, with the exception of initial point-of-care blood lead testing, mental health screening for adolescents, postpartum depression screening, tuberculin skin test (TST), develop.

Newly enrolled members in STAR and 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.

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

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

Texas Health Step Billing

THSteps Medical providers are not required to bill other insurance before billing Medicaid. If a provider is aware of other insurance, the provider must choose whether or not to bill the other insurance. The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client's other insurance before submitting the claim to Medicaid.
- If the provider chooses to bill Medicaid and not the client's other insurance, the provider is indicating that he or she accepts the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.
- If the provider learns that a client has other insurance coverage after Medicaid has paid a claim, the provider must refund the payment to Medicaid before billing the other insurance.

Providers should bill their usual and customary fee except for vaccines obtained from TVFC. Providers may not charge Medicaid or clients for the vaccine received from TVFC. Providers may charge a usual and customary fee not to exceed $14.85 for vaccine administration when providing immunizations to a client eligible for TVFC. Providers are reimbursed the lesser of the billed amount or the maximum allowable fee.

Providers must record the following on the CMS-1500 claim form to receive reimbursement for a medical checkup, exception to periodicity checkup, or follow-up visit:

- The provider identifier and benefit code EP1 (exception: FQHC providers do not use benefit code EP1)
- The appropriate Texas Health Steps medical checkup procedure code (all ages) with diagnosis code Z0000, Z0001, Z00110, Z00111, Z00121, or Z00129. Diagnosis code Z23 may also be included.
- The condition indicator codes, which must be placed in 24C (ST, S2, or NU only to identify a checkup resulting in a referral)
- The provider type modifiers
- The exception-to-periodicity modifier, when applicable. For additional billing guidelines please visit tmhp.com

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

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 benefit code EP1
- Providers must use modifier 25 to describe circumstances in which an acute care visit was provided at the same time as a Texas Health Steps

Note: CHIP - A copay will apply for the acute care services.

Preventive Medicine Services, New Patient

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

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.

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.

Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on one claim form and file at the time of delivery. The filing deadline is applied to the date of delivery.
- Providers may itemize each service individually and submit claims as the services are rendered. The filing deadline is applied to each individual date of service. Providers who only provide prenatal care and choose to submit prenatal visit charges on one claim form have the filing deadline applied to the estimated date of confinement (EDC) that must be stated in Block 24D of the CMS-1500 claim form. Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately and claims must be received by TMHP within a days of the date of service. Medicaid may reimburse only one delivery or Cesarean section procedure code per client in a seven-month period; reimbursement includes multiple births. Delivering physicians who perform regional anesthesia or nerve block do not receive additional reimbursement because these charges are included in the reimbursement for the delivery except as outlined.

Claims for Obstetric Deliveries to Require a Modifier

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

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.
- 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.

Vaginal and Cesarean Claims

Medicaid and CHIP delivery charges should be billed with the appropriate CPT codes. Delivery charges should be billed with appropriate CPT codes.

Claims will deny if submitted for a delivery prior to 39 weeks of gestation and not medically necessary, or for a delivery service with no modifier.

Claims will deny or recoupment will occur for associated claims for deliveries that are performed prior to 39 weeks and are determined to be not medically necessary including:

- Claims for the provider performing the vaginal or Cesarean delivery
- Inpatient and outpatient hospital claims inclusive of the delivery, planned Cesarean section, induction with vaginal delivery or failed induction with subsequent Cesarean section
- Birthing center claims inclusive of induction with vaginal delivery
- Claims for medical or surgical admission, including ICU, due to the complications of the delivery for the mother Home deliveries must be billed with procedure code 59409 or 59410; including postpartum care. Licensed midwives will not be reimbursed for home deliveries.

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.

- 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 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.

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 contacting Provider Customer Service @ STAR/CHIP **1-877-560-8055** and STAR Kids **1-877-784-6802**.

Hospitals may bill claims for newborn delivery and other newborn services separately from the claims for services they provide for the mother. In all claim 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 5 p.m. by calling **1-888-657-6061** and requesting assistance with verifying member eligibility. BCBSTX Customer Service will

provide the pharmacy with the newborn's plan identification number. If the newborn requires a prescription after hours (including weekends and holidays) and before the state has issued the newborn's permanent ID, the pharmacy can contact the BCBSTX customer service number above and select the 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.

Newborn Enrollment Steps

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, CHIP and STAR Kids.

BCBSTX requires that you notify us of all deliveries within three days of delivery

Also, notify BCBSTX when you receive a newborn's permanent Medicaid ID number.

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

Circumcision charges should be billed with appropriate CPT codes.

Self-Referable Services

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

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

Sports and Camp Physicals

Sports physical examinations are not a benefit of Texas Medicaid. If the client is due for a THSteps medical checkup and a comprehensive medical checkup is completed, a THSteps medical checkup may be reimbursed and the provider may complete the documentation for the sports physical.

BCBSTX does allow Sports and Camp physicals annually.

Providers should submit the appropriate reimbursement form for Sports and Camp Physicals following the necessary steps.

1. The primary care provider (PCP) should verify the eligibility of assigned members and verify that the member has not already received a Sports and Camp Physical within one year of the last physical.
2. The provider will conduct a physical that meets the minimum requirements defined by a Sports or Camp Physical.

3. The provider must submit a Sports and Camp Physical Reimbursement Form (www.bcbstx.com/provider/pdf/SportsCampReimbursementForm.pdf) to BCBSTX within 95 days of the date of service.

Note: If the Sports and Camp Physical form is not attached with the request payment will be denied until submission

The reimbursement form should be sent to the following address:

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

4. BCBSTX will reimburse providers $25 for Sports and Camp Physicals services rendered.
5. Providers are not eligible for any additional payment for services from BCBSTX provided during a Sports or Camp Physical.

Family Planning Services

The following guidelines apply for all family planning services:

- Family planning services may be provided by a physician or under the direction of a physician, not necessarily personal supervision. A physician provides direction for family planning services through written standing delegation orders and medical protocols. The physician is not required to be on the premises for the provision of family planning services by a registered nurse (RN), physicians assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or certified nurse midwife (CNM).
- Services must be provided without regard to age, marital status, sex, race, ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference.
- Texas Medicaid clients, including limited care clients, are allowed to choose any enrolled family planning service provider.
- Family planning clients must be allowed freedom of choice in the selection of contraceptive methods as medically appropriate.
- Family planning clients must be allowed the freedom to accept or reject services without coercion.
- Only family planning clients may consent to the provision of family planning services. Counseling should be offered to adolescents that encourages them to discuss their family planning needs with a parent, an adult family member, or other trusted adult.
- Sterilization services cannot be provided to any person who is 20 years of age or younger. For more information, HHSC providers may refer to the HHSC website at www.healthytexaswomen.org

Texas Vaccines For Children

BCBSTX 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. Providers must follow the most current ACIP recommendations unless they conflict with guidelines from the Texas Vaccines for Children (TVFC) Program, in which case providers must follow TVFC guidelines. Providers must also provide the appropriate vaccine information statements (VISs) produced by the Centers for Disease Control and Prevention (CDC). VISs explain the benefits and risks of the vaccines and toxoids administered. 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.dshs.texas.gov/immunize/tvfc/. 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 along with U1 modifier and the appropriate administration procedure code on another line of Box 24D. For more information please contact the Texas Vaccines for Children program at **1-800-252-9152**.

Immunizations and Vaccines

Immunizations covered under the Texas Vaccines for Children program

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

Balance Billing

BCBSTX does not allow our STAR, CHIP, CHIP Perinatal, or STAR Kids members to billed, or payment requested for any remaining charges or services not covered for services rendered.

Note: Balancing billing is not allowed for CHIP members who are Native American or Alaskan Natives. CHIP members there is no cost-sharing on benefits for well-baby and well-child services, preventive services, or pregnancy-related assistance.

You may bill the member only if:

- A specific service or item is provided at the member's request, and
- You have obtained and keep a written Member Acknowledgment Statement signed by the member, or member representative under informed consent, that states:

English:

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

Billing may occur without obtaining a signed Member Acknowledgment Statement in the following circumstances:

- Any service that is not a benefit of Texas Medicaid (for example, cellular therapy).
- All services incurred on non-covered days because of eligibility or spell of illness limitation. Total member liability is determined by reviewing the itemized statement and identifying specific charges incurred on the non-covered days. Spell of illness limitations do not apply to medically necessary stays for Medicaid members who are 20 years of age and younger.

All services provided as a private pay patient. If you accept the member as a private pay patient, you must advise members they are accepted as private pay patients at the time the service is provided and are responsible for paying for all services received. In this situation, HHSC strongly encourages you to help ensure that the member signs written notification so there is no question how the member was accepted. Without written, signed documentation that the Texas Medicaid member has been properly notified of the private pay status, you cannot seek payment from an eligible Texas Medicaid member.

Note: A provider attempting to bill or recover money from a member in violation of the stated conditions may be subject to exclusion from Texas Medicaid.

Private Pay Agreement

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

All services provided as a private pay patient. If you accept the member as a private pay patient, you must advise members they are accepted as private pay patients at the time the service is provided and are responsible for paying for all services received. In this situation, HHSC strongly encourages you to help ensure that the member signs written notification so there is no question how the member was accepted. Without written, signed documentation that the Texas Medicaid member has been properly notified of the private pay status, you cannot seek payment from an eligible Texas Medicaid member.

Note: A provider attempting to bill or recover money from a member in violation of the stated conditions may be subject to exclusion from Texas Medicaid.

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.

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 consist of Current Procedural Terminology (CPT) codes maintained by the American Medical Association (AMA). CPT codes are represented by five numeric digits.

- Level II consists of other codes that identify products, supplies and services not included in the CPT codes, such as ambulance and durable medical equipment (DME). These are sometimes called the alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits.
- In some cases, two digit/character modifier codes should accompany the Level or Level II coding. To help ensure accurate handling and prompt payment of claims, use the following national guidelines when coding claims:

- Current Procedural Terminology (CPT) codes: Refer to the current edition of the physicians' CPT manual, published by the American Medical Association; to order, call 800-621-8335.
- Healthcare Common Procedure Coding System (HCPCS): Refer to the current edition of HCPCS published by the Centers for Medicare and Medicaid Services (CMS); to order, call 8 00-621-8335.

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

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

On-Call Services

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

Member ID Number

Use the member's STAR, STAR Kids, CHIP or CHIP Perinatal ID number from the BCBSTX ID card.

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.

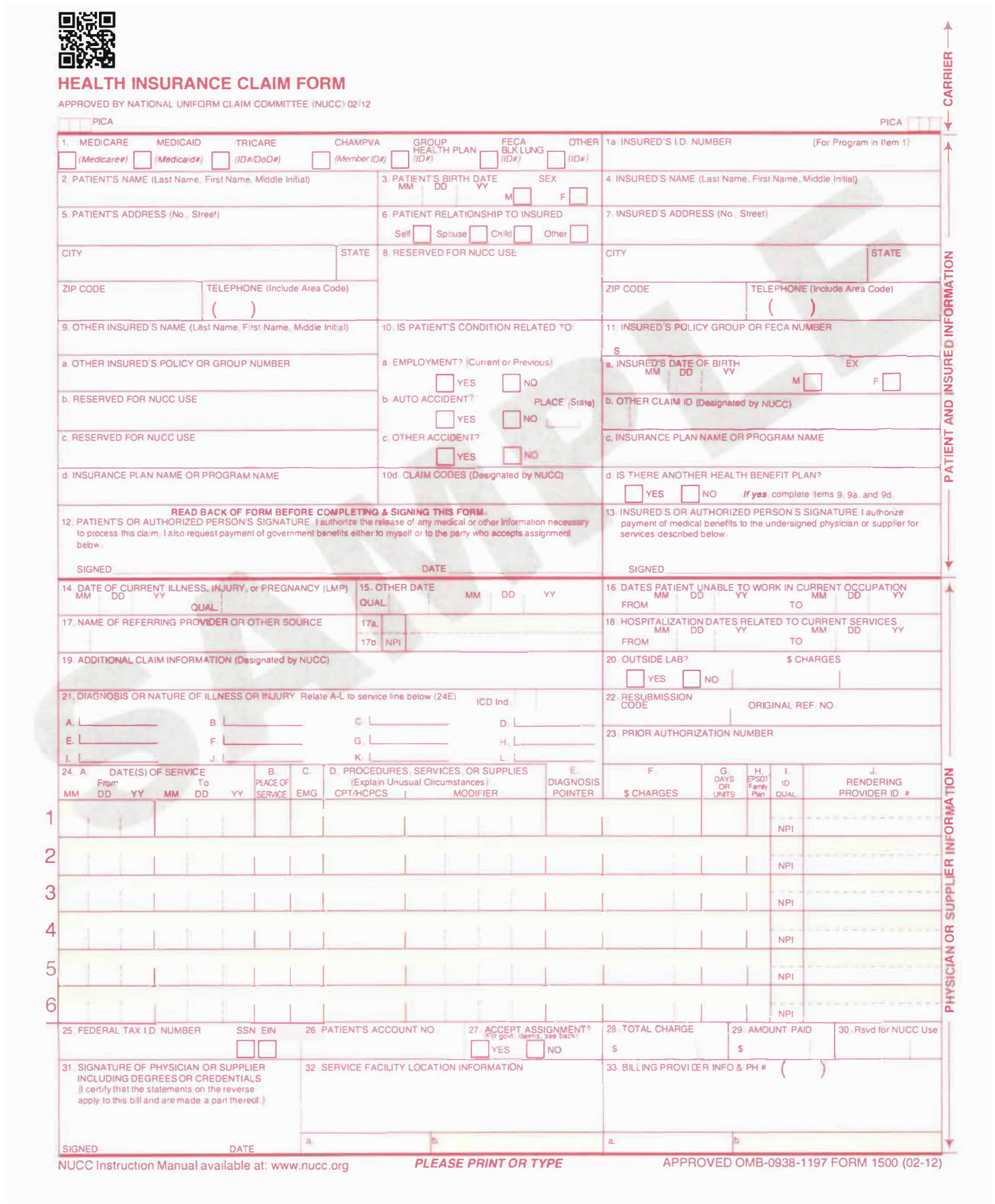
Mid-level practitioners must submit claims with their name and NPI number in Box 19 of the CMS-1500 and the supervising physician's NPI number in Box 24J of the CMS-1500 form. The following are defined as mid-level:

- 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.gov/**

SAMPLE SECTIONS FOR THE CMS-1500 CLAIM FORM

CMS 1500 Claim Form (Sample Only)



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Recommended Fields for CMS-1500

field. For additional information please refer to the TMHP website www.tmhp.com.

Field #	Title	Explanation
Field 1	Select Payer information. **Note:** This should always be MEDICAID.	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	Insured's ID Number	Use the member's STAR Kids, STAR, or CHIP identification number from the BCBSTX ID card with the billing prefix (prefix preferred but not required) at the beginning of the ID number. Or Enter the client's nine-digit patient number from the Medicaid identification form.
Field 2	Patient's Name	Enter the client's last name, first name, and middle initial as printed on the Medicaid identification form. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name. **Note:** Do not use nicknames.
Field 3	Patient's Birth of Date /Patient's Sex	Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the client's gender by checking the appropriate box. Only one box can be marked.
Field 4	Insured's Name	'Same' is acceptable if the insured is the patient.
Field 5	Patient's Address/Telephone	Enter the client's complete address as described (street, city, state, and ZIP code).
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 9	Other Insured's Name	For special situations, use this space to provide additional information such as: If the client is deceased, enter "DOD" in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.
Field 9a	Other Insured's Date of Birth	Name of the insurance with the group and policy number.
Field9b	Other Insured's Date of Birth	Date of birth format: MM/DD/YYYY.
Field 9c	Employer's or School Name	Name of other insured's employer or school.
Field9d	Insurance Plan Name or Program Name	Name of plan carrier.
Field 10a	Is Patient's Condition Related to: Related to Employment?	Check the appropriate box. If other insurance is available, enter appropriate information in blocks 11, 11a, and 11b

Field #	Title	Explanation
Field10b	Related to Auto Accident/Place?	Check the appropriate box. If other insurance is available, enter appropriate information in blocks 11, 11a, and 11b
Field 10c	Related to Other Accident?	Check the appropriate box. If other insurance is available, enter appropriate information in blocks 11, 11a, and 11b.
Field10d	Reserved for local use	If applicable, use for Member copayment.
Field 11	Insured's Policy Group or FECA Number Other health insurance coverage	If another insurance resource has made payment or denied a claim, enter the name of the insurance company. The other insurance EOB or denial letter must be attached to the claim form. If the client is enrolled in Medicare attach a copy of the MRAN to the claim form. For Workers Compensation and other property and casualty claims: (Required if known) Enter Workers' Compensation or property and casualty claim number assigned by the payer.
Field 11a	Insured's Date of Birth/Sex	Date of birth format: MM/DD/YYYY. Select Sex: M or F.
Field11b	Employer's Name or School Name	Name of organization from which the insured obtained the policy.
Field 11c	Insurance Plan Name or Program Name/ Texas Health Steps Benefit Code	Enter the benefit code, if applicable, for the billing or performing provider.
Field11d	Is There Another Health Benefit Plan?	Select Y or N. **Note:** If yes, items 9A-9Dmust be completed.
Field 12	Patient's or Authorized Person's Signature	
Field 13	Insured's or Authorized Person's Signature	Enter "Signature on File," "SOF," or legal signature. When legal signature is entered, enter the date signed in eight-digit format (MMDDYYYY). TMHP will process the claim without the signature of the patient.
Field 14	Date of Current Services	Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period. If the client has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for Physical Therapy and Occupational Therapy.
Field 15	First Date	Date of first consultation for the patient's condition. Date format: MM/DD/YYYY. If patient had same or similar illness give first date
Field 16	Dates Patient Unable to Work in Current Occupation (From– To)	Date format: MM/DD/YYYY.

Field #	Title	Explanation
Field 17	Name of Referring Physician or Other Source	Date format: MM/DD/YYYY. Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered, or supervised the service(s) or supplies on the claim. If multiple providers are involved, enter one provider using the following priority order: **1.** Referring Provider **2.** Ordering Provider **3.** Supervising Provider Do not use periods or commas within the name. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. DN = Referring Provider DK = Ordering Provider DQ = Supervising Provider Supervising Physician for Referring Physicians: If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19
Field 17a	Blank	ID Number of Referring Physician - Enter State Medical License number.
Field 17b	NPI	Enter the NPI number of the referring, ordering, or supervising provider.
Field 18	Hospitalization Dates Related to Current Services (From – To)	Hospitalization Dates Related to Current Services - Enter the date of hospital admission and discharge if the services billed are related to hospitalization. If the patient has not been discharged, leave the discharge date blank. Date format: MM/DD/YYYY.
Field 19	Additional claim information	**Ambulance transfers of multiple clients** If the claim is part of a multiple transfer, indicate the other client's complete name and Medicaid number. **Ambulance Hospital-to-Hospital Transfers** Indicate the services required from the second facility and unavailable at the first facility **Supervising Physician for Referring Physicians:** If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.
Field 20	Outside Lab? (Yes or No); $ Charge	Check the appropriate box. The information may be requested for retrospective review. If "yes," enter the provider identifier of the facility that performed the service in block 32.

Field #	Title	Explanation
Field 21	Diagnosis or Nature of Illness or Injury	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM Enter the patient's diagnosis and/or condition codes. List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.
Field 22	Medicaid Resubmission	Medicaid Resubmission Code
Field 23	Prior Authorization Number	Enter the Prior Authorization Number issued by Blue Cross and Blue Shield of Texas for service(s).
Field 24A	Date(s) of Service	Enter the date of service for each procedure provided in a MM/DD/YYYY format. If more than one date of service is for a single procedure, each date must be given on a separate line. **National Drug Code (NDC)** In the shaded area, enter the: • NDC qualifier of N4 (e.g., N4). • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). **Example:** N400409231231
Field 24B	Place of Service	Select the appropriate POS code for each service. Use current coding as indicated in the CPT manual.
Field 24C	EMG (Texas Health Steps medical checkup condition indicator)	Enter the appropriate condition indicator for Texas Health Steps medical checkups, if applicable.
Field 24D	Procedure, Services, or Supplies (Explain Unusual Circumstance)	Enter the appropriate procedure codes and modifier for all services billed. If a procedure code is not available, enter a concise description. **National Drug Code** In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit (e.g., 0.025).

Field #	Title	Explanation
Field 24E	Diagnosis Pointer	In 24 E, enter the diagnosis code reference letter (pointer) as shown in Form Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. Diagnosis codes must be entered in Form Field 21 only. Do not enter diagnosis codes in Form Field 24E.
Field24F	Charges	Indicate the usual and customary charges for each service listed. **Note:** Charges must not be higher than fees charged to private-pay clients.
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	ID Qualifier	Enter your ID Qualifier.
Field24J	Rendering Provider ID Number	Enter the provider identifier of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Enter the TPI in the shaded area of the field. Entered the NPI in the unshaded area of the field.
Field 25	Federal Tax ID Number	Nine-digit number listed on your W-9.
Field 26	Patient's Account Number	**Optional:** Enter the client identification number if it is different than the subscriber/insured's identification number. Used by provider's office to identify internal client account number.
Field 27	Accept Assignment	**Required** All providers of Texas Medicaid must accept assignment to receive payment by checking **Yes**.
Field 28	Total Charge	Enter the total charges. For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim.
Field 29	Amount Paid	Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.
Field 30	Balance Due	If appropriate, subtract block 29 from block 28 and enter the balance.

Field #	Title	Explanation
Field 31	Signature of Physician or Supplier Including Degrees or Credentials	The physician, supplier, or an authorized representative must sign and date the claim. Billing services may print "Signature on File" in place of the provider's signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.
Field 32	Service Facility Location Information	If services were provided in a place other than the client's home or the provider's facility, enter name, address, and ZIP code of the facility where the service was provided. This is a required field for services provided in a facility. The facility provider number, name, and address are not optional.
Field 32A	NPI	Enter the NPI of the service facility location.
Field 32B	Blank	
Field 33	Billing Provider Info & PH #	Enter the billing provider's name, street, city, state, ZIP+4 code, and telephone number.
Field 33A	NPI	Enter the NPI of the billing provider.
Field 33B	Other ID	Enter the Provider Taxonomy code including qualifier.

Acute Care Billing Institutional Claims (Special Billing)

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

Inpatient maternity care includes usual and customary care for all female clients.

Medicaid reimburses prenatal care, deliveries, and postpartum care as individual services. Providers may choose one of the following options for billing maternity services:

- Providers may itemize each service individually on one claim form and file at the time of delivery. The filing deadline is applied to the date of delivery.
- Providers may itemize each service individually and submit claims as the services are rendered. The filing deadline is applied to each individual date of service.

Providers who only provide prenatal care and choose to submit prenatal visit charges on one claim form have the filing deadline applied to the estimated date of confinement (EDC) that must be stated in Block 24D of the CMS-1500 claim form.

Laboratory (including pregnancy tests) and radiology services provided during pregnancy must be billed separately and claims must be received by BCBSTX within 95 days of the date of service.

Medicaid may reimburse only one delivery or Cesarean section procedure code per client in a seven-month period; reimbursement includes multiple births. Delivering physicians who perform regional anesthesia or nerve block do not receive additional reimbursement because these charges are included in the reimbursement for the delivery except as outlined.

Mother and Newborn Inpatient Stay

Circumstances that require the mother and newborn to remain in the hospital longer than two days for a routine vaginal delivery or four days for a cesarean section must be documented in the clients' medical records. Continuation of hospitalization is a benefit for the infant when the mother is required to remain hospitalized for medical reasons. The reason for the continuation of hospitalization must be documented in the client's medical record.

Note: CHIP Perinatal Services; For clients who are eligible for CHIP perinatal services as determined by HHSC, CHIP perinatal services include newborn services and inpatient hospital charges related to the delivery of the newborn. Preterm or false labor that does not result in a birth are not CHIP perinatal services. Inpatient services limited to labor with delivery for women with income at or below 202 percent of FPL will be covered under CHIP perinatal. Newborn services will also be covered under CHIP perinatal.

STAR Kids Payer Responsibility

	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 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

Hospital-based emergency departments are reimbursed for services based on a reasonable cost, based on the hospital's most recent tentative Medicaid cost report settlement. The reasonable cost is reduced by a percentage determined by the state. All claims that are submitted by outpatient hospital providers must include a procedure code with each revenue code for services that are rendered to Texas Medicaid clients. This procedure code must be listed on the same claim detail line as the emergency department revenue code.

The procedure code billed may include, but is not limited to, E/M, surgical or other procedure, or any other service rendered to the client in the emergency room. The procedure code must accurately reflect the services rendered in the hospital's emergency department. Emergency department ancillary services include, but are not limited to, the following:

- Laboratory services
- Radiology services

- Respiratory therapy services
- Diagnostic studies (including, but not limited to, ECGs, computed tomography (CT) scans, and supplies)

The administration of an injection may be reimbursed to the provider who administers the injection. The administration of the injection will not be reimbursed to outpatient hospital providers. An injection or infusion administered by a nurse is included in the emergency room charge and is not reimbursed separately to the outpatient facility.

Ancillary services must be submitted on the UB-04 CMS-1450 paper claim form using the appropriate procedure codes or revenue codes for rendered services.

If a client visits the emergency room more than once in one day, the times must be given for each visit.

If the client ultimately is admitted as an inpatient within 48 hours of treatment in the ER or clinic, the ER or clinic charges must be submitted on the inpatient hospital claim form as an ancillary charge. The date of inpatient admission is the date the client initially was seen in the ER or clinic.

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, compound medications and NEMT

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.

NEMT Provider Billing:

ModivCare
12234 N. Interstate 35
Bldg. B
Austin, TX 78753

1-877-564-9837–direct billing dept phone number

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.

Outpatient Laboratory, Radiology and Diagnostic Services

Texas Medicaid only covers professional and technical services that an independent laboratory is certified by CLIA to perform. Provider documentation must be maintained in the client's medical record and must delineate the medical need for administering the laboratory test.

The physician is responsible for providing to the performing laboratory the clinical diagnosis code that is associated with the individual test so that the performing laboratory may bill Texas Medicaid directly for the analysis of the specimen.

A physician may bill only one laboratory handling charge per client visit when the specimen is collected by drawing a blood sample through venipuncture or collecting a urine

specimen by catheterization, unless the specimen is divided and sent to different laboratories or there are different specimens collected and sent to different laboratories.

The claim must indicate the name and address of each laboratory where a specimen is sent for more than one laboratory handling charge to be paid.

An outpatient hospital may be reimbursed for a laboratory handling charge for

each independent laboratory to where it sends specimens when the laboratory handling charge is not being billed through other methods.

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

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:

- 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.

Infusion Therapy Visit

The outpatient infusion therapy visits 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.

Table of Present On Admission (POA) Codes

Medicaid present on admission (POA) reporting is required for all inpatient hospital claims.

All hospital providers are required to submit a POA value for each diagnosis on the claim form, and no hospital is exempt from this POA requirement. Medicare crossover hospital claims must also comply with the Medicaid requirement to include the POA values.

POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop

during an outpatient visit, including emergency department, observation, or outpatient surgery, are considered POA. The following table shows the POA values:

POA Value	Description	Payment
Y	Diagnosis was present at the time of admission	Payment will be made by Medicare when a hospital-acquired condition (HAC) is present
N	Diagnosis was not present at the time of admission	No payment will be made by Medicare when an HAC is present
U	Documentation was insufficient	No payment will be made by Medicaid when an HAC is present

Note: Texas Medicaid follows Medicare guidelines for payments referenced in this table

POA Value	Description	Payment
W	Clinically undetermined	Payment will be made by Medicaid when an (HAC) is present
(blank)	Exempt from POA reporting	Exempt from POA reporting

Note: Texas Medicaid follows Medicare guidelines for payments referenced in this table

Note: If a diagnosis code 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/resources/provider-manuals/tmppm.

CMS- 1450 (UB-04) CLAIM FORM

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

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

CMS-1450 (UB-04) Revenue Codes

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

Inpatient Coding — Institutional

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

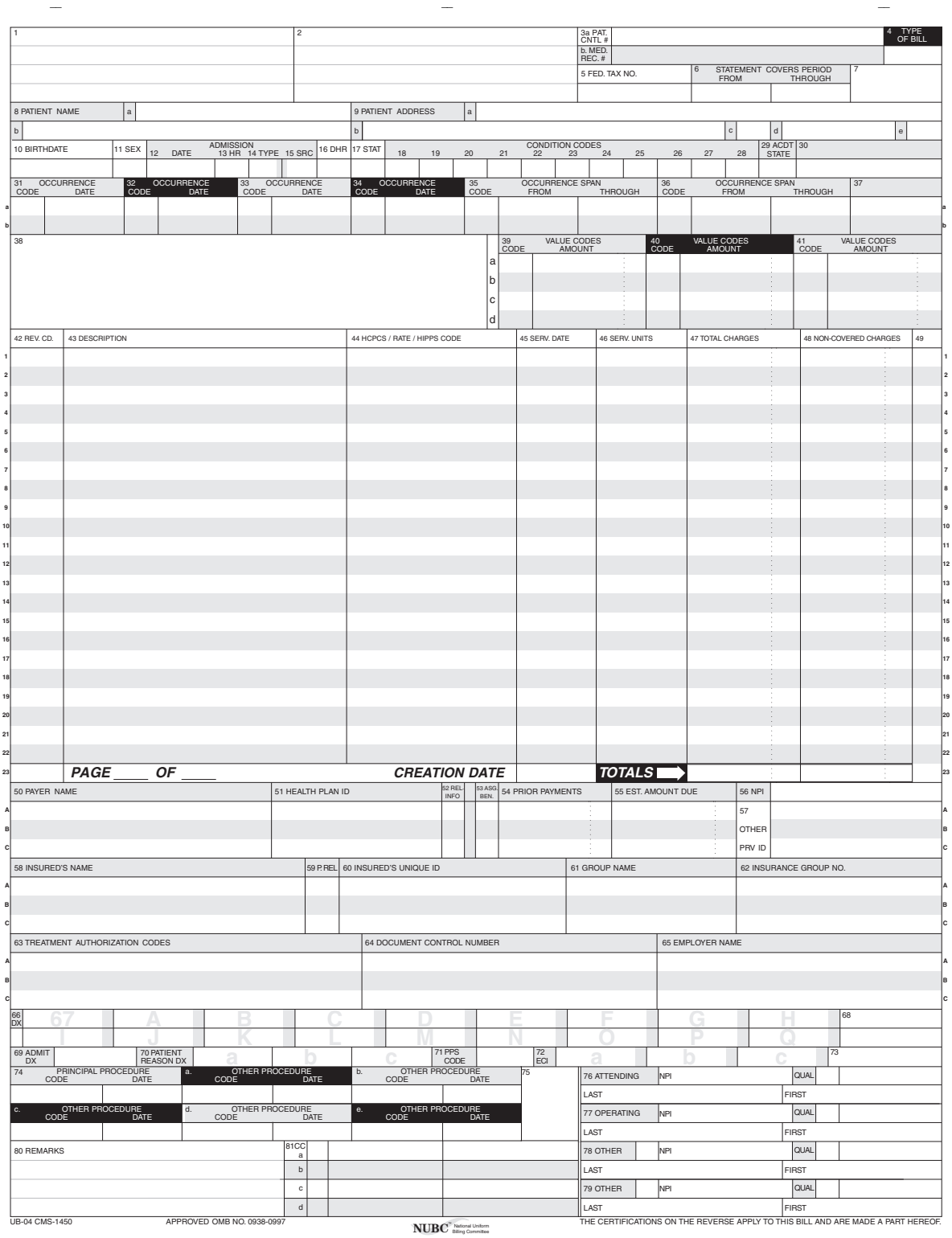
- Current ICD applicable and procedure codes must be in Boxes 74–74e of the CMS-1450 (UB-04) form when the claim indicates a procedure was performed.
- Modifier Codes: Use modifier codes when appropriate; refer to the current edition of the physicians' Current Procedural
- Terminology manual published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

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

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/resources/provider-manuals/tmppm



Field	Box Title	Description
Field 1	Blank	Enter the facility name, street, city, state, ZIP+4 Code, and telephone number.
Field 2	Blank	Pay-To Provider Name and Address - Enter the provider name, address and zip code and telephone number this section.
Field 3a	Patient Control (Pat Cntl#)	Enter the patient's medical record number (limited to ten digits) assigned by the hospital.
Field 3b	Medical Record (Med. Rec#)	Enter the patient's medical record number (limited to ten digits) assigned by the hospital.
Field 4	Type of Bill	Enter a TOB code. First Digit—Type of Facility: 1 Hospital 2 Skilled nursing 3 Home health agency 7 Clinic (rural health clinic [RHC], federally qualified health center [FQHC], and renal dialysis center [RDC]) 8 Special facility Second Digit—Bill Classification (except clinics and special facilities): 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) 7 Intermediate care Second Digit—Bill Classification (clinics only): 1 Rural health 2 Hospital-based or independent renal dialysis center 3 Free standing 5 CORFs Third Digit—Frequency: 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim-first claim 3 Interim-continuing claim 4 Interim-last claim 5 Late charges-only claim 6 Adjustment of prior claim 7 Replacement of prior claim

Field	Box Title	Description
Field 5	Federal Tax Number (Fed.Tax No.)	Enter the provider's Federal Tax Identification Number.
Field 6	Statement Covers Period	Enter the beginning and ending dates of service billed.
Field 7	Blank	Leave blank.
Field 8a	Patient Identifier	**Optional:** Enter the patient identification number if it is different than the subscriber/insured's identification number. Used by providers office to identify internal patient account number.
Field 8b	Patient Name	Enter the patient's last name, first name, and middle initial as printed on the Medicaid identification form.
Field 8b	Patient Name	Enter the patient's last name, first name, and middle initial as printed on the Medicaid identification form.
Field 9a–e	Patient Address	Starting in 9a, enter the patient's complete address as described (street, city, state, and ZIP+4 Code).
Field 10	Birthdate	Enter the member's date of birth in MM/DD/YYYY format.
Field 11	Sex	Indicate the patient's gender by entering an "M" or "F."
Field 12	Admission Date	Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or start of care (SOC) for home health claims. Providers that receive a transfer patient from another hospital must enter the actual dates the patient was admitted into each facility.
Field 13	Admission Hour	Use military time (00 to 23) for the time of admission for inpatient claims or time of treatment for outpatient claims.
Field 14	Admission Type	Providers can refer to the National Uniform Billing Code website at **www.nubc.org** for the current list of Priority (Type) of Admission or Visit codes.
Field 15	Admission Source	Providers can refer to the National Uniform Billing Code website at **www.nubc.org** for the current list of Priority (Type) of Admission or Visit codes.
Field 16	Discharge Hour (DHR)	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank.
Field 17	Status	Patient discharge status. Providers can refer to the National Uniform Billing Code website at **www.nubc.org** for the current list of Patient Discharge Status Codes.
Field 18–28	Condition Codes	Enter the two-digit condition code "05" to indicate that a legal claim was filed for recovery of funds potentially due to a patient.
Field 29	ACDT State	**Optional:** Accident state. Leave blank.
Field 30	Blank	Leave blank.

Field	Box Title	Description
Field 31–34	Occurrence Code and Date	For inpatient claims, enter code "71" if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay. Enter the dates in MM/DD/YYYY format.
Field 35–36	Occurrence Span (Code, From, & Through)	For inpatient claims, enter code "71" if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay. Enter the dates in MM/DD/YYYY format.
Field 37	Blank	**Optional:** Internal Control Number/Document Control Number.
Field 38	Blank	Responsible Party Name and Address - Enter the name and address of the party responsible for payment if different from name in box 50.
Field 39–41	Value Codes (Code & Amount)	Accident hour–For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6.
Field 42 – 43	Revenue Code and Description (Rev. Cd.)	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. **National Drug Code (NDC)** This block should include the following elements in the following order: • NDC qualifier of N4 (e.g., N4) • The 11-digit NDC number on the package or vial from which the medication was administered. Do not enter hyphens or spaces within this number (e.g., 00409231231). • The unit of measurement code. There are 5 allowed values: F2, GR, ML, UN, or ME (e.g., GR). • The unit quantity with a floating decimal for fractional units (limited to 3 digits, e.g., 0.025).

Field	Box Title	Description
Field 44	HCPCS/Rate/HIPPS Code	**Inpatient:** Enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. **Home Health Services** Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. **Outpatient:** Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Each service, except for medical/surgical and intravenous (IV)supplies and medication, must be itemized on the claim form or an attached statement. **Note:** The UB-04 CMS-1450 paper claim form is limited to 28 items per inpatient and outpatient claim. If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.
Field 45	Service Date (Serv. Date)	Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.
Field 46	Service Units (Serv. Units)	Units of Service -Enter the actual number of times a single procedure or item was performed or provided for the date of service.
Field 47	Total Charges	Enter the total charges for each service provided.
Field 48	Non-Covered Charges	If any of the total charges are noncovered, enter this amount.
Field 49	Blank	Leave blank.
Field 50	Payer Name	Enter the health plan name.
Field 51	Health Plan ID	Enter the health plan identification number.
Field 52	Rel. Info	Release of Information certification.
Field 53	Asg Ben.	Assignment of Benefit certification.

Field	Box Title	Description
Field 54	Prior Payments	Enter amounts paid by any TPR, and complete Blocks 32, 61, 62, and80 as required: • Block 32 - Occurrence code and date. • Block 61 - Insured group name • Block 62 - Insurance group number • Block 80 - Remarks. This section is used for requesting the 110-day rule for a third party insurance.
Field 55	Est. Amount Due	Estimated amount due.
Field 56	NPI	Enter the NPI of the billing provider.
Field 57	Other Prv Id	Enter the TPI number (non-NPI number) of the billing provider.
Field 58	Insured's Name	If other health insurance is involved, enter the insured's name.
Field 59	Patient Relationship (P. Rel)	Patient's Relation to Insured -Enter "03" (child) if billing for an infant using the mother's Identification Number
Field 60	Insured's Unique Id	Enter the insured's ID number on the member's ID card or enter the patient's nine-digit Medicaid identification number.
Field 61	Group Name	Enter the name and address of the other health insurance.
Field 62	Insurance Group No.	Enter the policy number or group number of the other health insurance.
Field 63	Treatment Authorization Codes	Enter the prior authorization number if one was issued.
Field 64	Document Control Number	The control number assigned to the original bill.
Field 65	Employer Name	Enter the name of the patient's employer if health care might be provided.
Field 66	Diagnosis/Procedure Code Qualifier (DX)	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 = ICD-9-CM 0 = ICD-10-CM
Field 67	blank	Enter the ICD-10-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available. Required: POA Indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.
Field 67a–q	blank	Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only. A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB "141").

Field	Box Title	Description
Field 68	blank	Other Diagnosis Codes - Enter all letters and/or numbers of the secondary ICD-9 CM code including fourth and fifth digits if present. Do not enter a decimal point when entering the code.
Field 69	Admit DX	Enter the ICD-10-CM diagnosis code indicating the cause of admission or include a narrative. **Note:** The admitting diagnosis is only for inpatient claims.
Field 70a–c (C)	Patient Reason DX	**Optional:** New block indicating the patient's reason for visit on unscheduled outpatient claims.
Field 71	Prospective Payment System (PPS) Code	**Optional:** The PPS code is assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
Field 72a – c	External Cause Of Injury (ECI) And POA Indication	Optional: Enter the ICD-10-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. **Required:** POA indicator—Enter the applicable POA indicator in the shaded area for inpatient claims.
Field 73	Blank	Leave blank.
Field 74	Principal Procedure (Code/Date)	Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
Field 74a–e (M)	Other Procedure (Code/ Date)	Enter the ICD-10-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.
Field 75	Blank	Leave blank.
Field 76	Attending	Enter the attending provider name and NPI. Outpatient claims require an attending provider.
Field 77	Operating	Enter operating provider's name (last name and first name) and NPI number of the operating provider.
Field 78–79	Other	Other provider's name (last name and first name) and NPI. NPI number of the referring and prescribing provider. Other operating physician—An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. Rendering provider—The health-care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure. **Important:** Qualifier 82 is required to identify the rendering provider for acute care inpatient and outpatient institutional services. **Note:** If the referring physician is a resident, Blocks 76 through 79 must identify the physician who is supervising the resident.

Field	Box Title	Description
Field 80	Remarks	This block is used to explain special situations such as the following: • The home health agency must document in writing the number of Medicare visits used in the nursing plan of care and also in this block. • If a patient stays beyond dismissal time, indicate the medical reason if additional charge is made. • If billing for a private room, the medical necessity must be indicated, signed, and dated by the physician. • If services are the result of an accident, the cause and location of the accident must be entered in this block. The time must be entered in Block 39. • If laboratory work is sent out, the name and address or the provider identifier of the facility where the work was forwarded must be entered in this block. • If the services resulted from a family planning provider's referral, write "family planning referral." • If services were provided at another facility, indicate the name and address of the facility where the services were rendered. • Request for 110-day rule for a third-party insurance.
Field 81a–d	Code Code (CC)	**Optional:** Area to capture additional information necessary to adjudicate the claims. required when, in the judgment of the provider, the information is needed to substantiate the medical treatment and is not support elsewhere on the claim data set.

Services That Must be Billed to the Texas 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)
- 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.

Durable Medical Equipment

Durable Medical Equipment (DME) is defined as medical equipment that is manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate the client's disability, condition, or illness.

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 STAR and CHIP @ **1-877-560-8055** and STAR Kids **1-877-784-6802**. Services that require prior authorization will be denied if approval is not obtained from the UM department.

Durable Medical Equipment Billing

Durable Medical Equipment (DME) providers should bill with the appropriate modifier to identify rentals versus purchases (new or used).

Modifier	Designation
NU	New Purchase
UE	Used Purchase
RR	Rental Monthly

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. After prior authorization is obtained for purchase, new equipment must be provided and the rental discontinued.

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.

DME Billing Request

Claim questions or status request about claim submissions can be obtained by contacting BCBSTX Provider Customer Service @ STAR and CHIP **1-877-560-8055** or STAR Kids **1-877-784-6802**. You can also contact your Network Provider Representative @ **1-855-212-1615**.

Electronic inquiries can be done by completing the DME Claim Status Request Form (**www.bcbstx.com/provider/pdf/dme-claim-status-request-form.pdf**) and returning via email.

Note: Electronic email request will be returned via email within 3 business days.

Claim questions about an adjudicated/paid claim can be obtained by contacting BCBSTX Provider Customer Service @ STAR and CHIP 1-877-560–8055 or STAR Kids (877) 784-6802. You can also contact your Network Provider Representative @ **1-855-212-1615**.

Electronic inquiries can be done by completing the DME Review Request Form (**www.bcbstx.com/provider/pdf/dme-review-request-form.pdf**) and returning via email.

Note: Electronic email request will be returned via email within 3 business days.

Other Service Types

LTSS Claims Filing:

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. Please refer to Attachment N for LTSS Billing Matrix.

Nursing Facility or Intermediate Care Facility:

For individuals with intellectual disabilities, claims should be sent to TMHP.

Minor Home Modification:

Homemodificationsareservicesthatprovideadjustmentsand/orimprovementstoamember'shomebasedon 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. Members have a minor home modification lifetime limit is $7,500

Ambulance:

Nonemergency ambulance services require prior authorization in circumstances not involving an emergency. Facilities and other providers must request and obtain prior authorization before contacting the ambulance provider for nonemergency ambulance services.

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**.

Anesthesia:

Anesthesia services are a benefit of Texas Medicaid with specific benefits and limitations to reimbursement. Medicaid may reimburse anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesiologist assistants (AAs) for administering anesthesia as defined within their individual scope

When billing for anesthesia and other services on the same claim, the anesthesia charge must appear in the first detail line for correct reimbursement. Any other services billed on the same day must be billed as subsequent line items. When billing for multiple anesthesia services performed on the same day or during the same operative session, use the procedure code with the higher RVU. For accurate reimbursement, apply the total minutes and dollars for all anesthesia services rendered on the higher RVU code. Multiple services reimbursement guidelines apply.

Ambulatory Surgical Centers

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

Inpatient admissions for surgical procedures listed as ambulatory surgical codes in the current fee schedule are denied if documentation does not support the need for the inpatient admission.

Freestanding ambulatory surgical centers must submit claims on the CMS-1500 claim form. The performing surgeon or referring physician name and number must be identified in Block 17. Identification of outpatient charges must be in Block 44 if submitting by HCPCS code. If appropriate, the revenue code must be indicated in Block 42. Texas Medicaid recommends the use of specific procedure codes for claim submission. Do not use the revenue code description in Block 43; the HCPCS narrative description must be identified in this block. For example, when submitting charges for physical therapy, do not use the description associated with revenue code 420. To receive reimbursement for physical therapy services, providers must identify the specific modality used (e.g., gait training).

Reimbursement of ASC and HASC procedures is based on the CMS-approved Ambulatory Surgical Code Groupings (1 through 9 per CMS and Group 10 per HHSC) payment schedule. Reimbursement is limited to the lesser of the amount reimbursed to an ASC for similar services, the hospital's actual charge, or the allowable cost determined by HHSC. When multiple surgical procedures are performed on the same day, only the procedure with the highest surgical code grouping is reimbursed. A complete list of approved ASC and HASC procedure codes with the assigned payment group can be found on the TMHP website at **www.tmhp.com**. Click on Resources and then Online Fee Lookup.

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

Dialysis

To enroll in Texas Medicaid, a renal dialysis facility must be Medicare-certified in the state where it is located. Facilities must also adhere to the appropriate rules, licensing, and regulations of the state where they operate. All dialysis care must be pre-authorized (except where Medicare is primary payer). Contact BCBSTX's Utilization Management department @ STAR and CHIP @ **1-877-560-8055** and STAR Kids **1-877-784-6802** for authorization prior to delivery of service.

Dialysis treatments are a benefit for clients in an inpatient or outpatient hospital or a renal dialysis facility according to the guidelines for outpatient maintenance dialysis approved through CMS. Dialysis treatments may also be a benefit in the client's home. Outpatient dialysis includes:

- Staff-assisted dialysis performed by the staff of the center or facility.
- Self-dialysis performed by a client with little or no professional assistance (the client must have completed an appropriate course of training).
- Home dialysis performed by an appropriately trained client (and the client's caregiver) at home.
- Dialysis furnished in a facility on an outpatient basis at an approved renal dialysis facility.

Physician reimbursement for supervision of ESRD clients on dialysis is based on a monthly capitation payment (MCP) that is calculated by Medicare. The MCP is a comprehensive payment that covers all of the physician services that are associated with the continuing medical management of a maintenance dialysis client for treatments received in the facility. An original onset date of dialysis treatment must be included on claims for all renal dialysis procedures in all places of service except inpatient hospital. Physician supervision of outpatient ESRD dialysis includes services that are rendered by the attending physician in the course of office visits during which any of the following occur:

- The routine monitoring of dialysis
- The treatment or follow-up of complications of dialysis, including:
- The evaluation of related diagnostic tests and procedures
- Services that are involved in the prescription of therapy for illnesses that are unrelated to renal

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

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

Home Health Care

Home health services include home health skilled nursing (SN), home health aide (HHA), physical therapy (PT) and occupational therapy (OT) services; DME; and expendable medical supplies that are provided to eligible Medicaid clients at their place of residence.

The benefit period for home health professional services is up to 60 days with a current plan of care (POC).

Home Health Agency providers should note the following:

- Claims are approved or denied according to eligibility, prior authorization status, and medicalappropriateness.
- Claims must represent a numerical quantity of one-month for medical supplies according to the billing requirements. File these services on a UB-04 CMS-1450 claim form.
- OT and PT are always billed as POS 2 (home) and may be prior authorized to be provided in thehome of the client or the home of the caregiver/guardian.

Note: Medical social services and speech-language pathology services are available to clients who are 20 years of age and younger and are not a home health services benefit. These services may be considered a benefit for clients who qualify for CCP.

Texas Medicaid does not reimburse separately for associated DME charges, including but not limited to battery disposal fees or state taxes. Reimbursement for any associated charges is included in the reimbursement for a specific piece of equipment.

The following items are a benefit of Home Health Services with prior authorization:

- Hospital bed
- Air-fluidized bed
- Pressure pads or a nonpowered pressure-reducing mattress overlay
- Nonpowered pressure-reducing mattress
- Powered pressure-reducing mattress overlay system
- Powered pressure-reducing mattress
- Advanced nonpowered pressure-reducing mattress overlay
- Powered pressure-reducing mattress overlay
- Advanced nonpowered pressure-reducing mattress
- Sheepskin and lamb's wool pads
- Decubitus care accessories

Note: For clients who are 20 years of age and younger and do not meet criteria through Title XIX Home Health Services, hospital beds and equipment may be considered through the Texas Health Steps—Comprehensive Care Program (THSteps-CCP).

Note: For clients who are 21 years of age or older, requests for hospital beds and equipment that do not meet the criteria through Title XIX Home Health Services may be considered under the Texas Medicaid Home Health—Durable Medical Equipment (DME) Exceptional Circumstances process.

All home health care must be pre-authorized. Contact Utilization Management STAR and CHIP at **1-877-560-8055** and STAR Kids **1-877-784-6802** for authorization prior to delivery of the service.

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

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**
- 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**.

Hospice

HHSC manages the Hospice Program through provider enrollment contracts with hospice agencies. These agencies must be licensed by the state and Medicare-certified as hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Hospice pays for services related to the treatment of the client's terminal illness and for certain physician services (not the treatments).

Texas Medicaid clients who are 21 years of age and older and who elect hospice coverage waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services that are unrelated to their terminal illness.

Texas Medicaid clients who are 20 years of age and younger and who elect hospice care are not required to waive their rights to concurrent hospice care and treatment of the terminal illness. They do not waive their rights to Medicaid services that are unrelated to their terminal illness.

Direct policy questions about the hospice program to HHSC at **1-512-438-3161**. Direct all other general questions related to the hospice program, such as billing, claims, rate key issues, and authorizations to HHSC at **1-512-438-2200**.

HHSC pays the provider for a variety of services under a per diem rate for any particular hospice day in one of the following categories:

- Routine home care
- Continuous home care
- Respite care
- Inpatient care

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

Occupational Therapy

The practice of occupational therapy includes:

- Evaluation and treatment of a person whose ability to perform the tasks of living is threatened or impaired by developmental deficits, sensory impairment, physical injury, or illness.
- Using therapeutic goal-directed activities to:
- Evaluate, prevent, or correct physical dysfunction.
- Maximize function in a person's life.
- Applying therapeutic goal-directed activities in treating patients on an individual basis, in groups, or through social systems, by means of direct or monitored treatment or consultation.

Texas Medicaid limits occupational therapy to the skilled treatment of clients whose ability to function in life roles is impaired. Occupational therapy may be provided by a physician or occupational therapist within their licensed scope of practice.

Occupational therapy uses purposeful activities to obtain or regain skills needed for activities of daily living (ADL) and/or functional skills needed for daily life lost through acute medical condition, acute exacerbation of a medical condition, or chronic medical condition related to injury, disease, or other medical causes. ADLs are basic self-care tasks such as feeding, bathing, dressing, toileting, grooming, and mobility.

All occupational therapy must be pre-authorized. Evaluations do not require pre-authorization. Contact Utilization Management STAR and CHIP at **1-877-560-8055** and STAR Kids **1-877-784-6802** 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 setting, or outpatient setting.
- Form CMS-1450 (UB-04): When providing services in a rehabilitation center.
- Form CMS-1450 (UB-04): for physical therapists affiliated with home health agencies and providing services in a patient's home.

Note: When billing therapy claims you must include the rendering provider's information.

Physical Therapy

The practice of physical therapy includes:

- Measurement or testing of the function of the musculoskeletal, or neurological, system.
- Rehabilitative treatment concerned with restoring function or preventing disability caused by illness, injury, or birth defect.
- Treatment, consultative, educational, or advisory services to reduce the incidence or severity of disability or pain to enable, train, or retrain a person to perform the independent skills and activities of daily living. Texas Medicaid limits physical therapy to the skilled treatment of clients who have acute or acute exacerbation of chronic disorders or chronic medical condition of the musculoskeletal and neuromuscular systems. Physical therapy may be provided by a physician or physical therapist within their licensed scope of practice.

All physical therapy must be pre-authorized. Evaluations do not require pre-authorization. Contact Utilization Management STAR and CHIP at **1-877-560-8055** and STAR Kids **1-877-784-6802** 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 CMS-1450 (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 STAR and CHIP at **1-877-560-8055** and STAR Kids **1-877-784-6802** for authorization prior to SNF admission.

Note: When billing therapy claims you must include the rendering provider's information.

Speech Therapy

Speech therapy is a benefit of Texas Medicaid for the treatment of chronic (for clients who are 20 years of age and younger), acute, or acute exacerbations of pathological or traumatic conditions of the head or neck, which affect speech production, speech communication and oral motor, feeding and swallowing disorders. Speech therapy may be provided by a physician or speech language pathologist within their licensed scope of practice.

Speech-language pathologists treat speech sound and motor speech disorders, stuttering, voice disorders, aphasia and other language impairments, cognitive disorders, social communication disorders and swallowing (dysphagia) deficits.

All speech therapy must be pre-authorized. Evaluations do not require pre-authorization. Contact Utilization Management STAR and CHIP at **1-877-560-8055** and STAR Kids **1-877-784-6802** 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 setting, or outpatient setting.
- Form CMS-1450 (UB-04): When providing services in a rehabilitation center.
- Form CMS-1450 (UB-04: for physical therapists affiliated with home health agencies and providing services in a patient's home.

Exclusions to Therapy

The following services are not a benefit of Texas Medicaid:

- Speech therapy provided in the home to adult clients who are 21 years of age and older
- Therapy services that are provided after the client has reached the maximum level of improvement or is now functioning within normal limits
- Massage therapy that is the sole therapy or is not part of a therapeutic plan of care to address an acute condition
- Separate reimbursement for VitalStim therapy for dysphagia. VitalStim must be a component of a comprehensive feeding treatment plan to be considered a benefit.
- Repetitive therapy services that are designed to maintain function once the maximum level of improvement has been reached, which no longer require the skills of a therapist to provide or oversee
- Therapy services related to activities for the general good and welfare of clients who are not considered medically necessary because they do not require the skills of a therapist, such as:
- General exercises to promote overall fitness and flexibility or improve athletic performance Activities to provide diversion or general motivation
- Supervised exercise for weight loss
- Treatment solely for the instruction of other agency or professional personnel in the client's physical, occupational or speech therapy program
- Emotional support, adjustment to extended hospitalization and/or disability, and behavioral readjustment
- Therapy prescribed primarily as an adjunct to psychotherapy
- Treatments not supported by medically peer-reviewed literature, including but not limited to investigational treatments such as sensory integration, vestibular rehabilitation for the treatment of attention deficit hyperactivity disorder, anodyne therapy, craniosacral therapy, interactive metronome therapy, cranial electro stimulation, low-energy neurofeedback, and the Wilbarger brushing protocol.
- Therapy not expected to result in practical functional improvements in the client's level of functioning

- Treatments that do not require the skills of a licensed therapist to perform in the absence of complicating factors (i.e., massage, general range of motion exercises, repetitive gait, activities and exercises that can be practiced by the client on their own or with a responsible adult's assistance)
- The therapy requested is for general conditioning or fitness, or for educational, recreational or work-related activities that do not require the skills of a therapist.
- Equipment and supplies used during therapy visits are not reimbursed separately; they are considered part of the therapy services provided.
- Therapy services provided by a licensed therapist who is the client's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage)

Auxiliary personnel (aide, orderly, student, or technician) may participate in physical therapy, occupational therapy, or speech therapy sessions when they are appropriately supervised according to each therapy discipline's scope of practice and provider licensure requirements. Providers may not bill Texas Medicaid for therapy services provided solely by auxiliary personnel.

Auxiliary personnel, a licensed therapy assistant, and a licensed speech-language pathology intern (Clinical Fellow) are not eligible to enroll as therapist providers in Texas Medicaid.

Section 20: Medicaid and CHIP Special Access Requirements

Interpretation/Translator Services

Emergency and Nonemergency Ambulance Transportation

BCBSTX members are covered for emergency and non emergency transportation for more information about these services please Section 13 Routine, Urgent and Emergency Services.

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: **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-HourNurse Hotline after hours.

Here are the phone numbers to call for telephone and face-to-face interpreter services:

STAR and CHIP (Customer Service): **1-877-560-8055**

24 Hour Nurse Advice Line TTY: (for speech or hearing impaired)..... **1-844-971-8906**

National TTY: **711**

STAR Kids (Customer Service) **1-877-784-6802**

24 Hour Nurse Advice Line:

24 Hour Nurse Advice Line TTY: (for speech or hearing impaired)..... **1-844-971-8906**

National TTY: **711**

Interpreter Services Texas Relay..... **1-800-735-2988**

Provider Interpretation Services (for STAR Kids)

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" 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 the Customer Advocate Department. 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 **www.bcbstx.com/provider/medicaid/index.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 the Customer Advocate Department three business days in advance to schedule an interpreter. To cancel an interpreter service, give 24 business hours' notice.

Physician and other Professional Provider Responsibilities

Physicians and other professional providers are responsible for ensuring that members know of available interpreter services by providing the following:

Please Note: Physicians and other professional providers must notify members of the availability of health plan interpreter services, at no cost to you or our members, and strongly discourage the use of minors, friends and family members who may act as interpreters.

After-Hours Linguistic Access

We encourage physicians and other professional providers to accommodate non-English proficient members by having multilingual messages on answering machines and by training their answering services and on-call personnel on how to access BCBSTX's free interpreter services. The 24-Hour Nurse Advice Line has access to interpreters after hours.

Please Note: Written communication, such as patient education pages, referrals and consent forms should be at a sixth grade reading level, in Spanish, Chinese or another translation, and in larger print.

Cultural Sensitivity

BCBSTX acknowledges the diversity of its membership and provider network. We appreciate the challenges providers may encounter integrating appropriate culturally diverse behaviors, values, norms, practices, attitudes and beliefs about the causes of disease, prevention and treatment into the delivery of health care, known as cultural competence. In addition, consideration of a member's health and reading literacy level may add to the complexity of the relationship.

Although medical advances and increased efforts regarding preventive medicine have contributed to increased life expectancies and improved general health for many Americans, health disparities are still very evident in the African American, Hispanic, Asian/Pacific Islander and Native American/Alaskan Native and other populations.

We are eager to assist your office with increasing your cultural competence and decreasing health disparities. We also recognize that such competence is a process that evolves over time, and that you and your office staff may be at various levels of awareness, knowledge and skills. We encourage you to increase your cultural sensitivity by using the cultural and linguistic resources included on our website: **www.bcbstx.com/provider/medicaid/education_reference.html**

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. Providers may want to consider any reading materials provided to members be written in simplest forms and not exceed 6th 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.

BCBSTX also provides ongoing provider training, which is conducted through webinars, quarterly and refresher trainings on an as-needed-basis, during routine on-site visits and upon request. In addition, your local, state and national provider organizations are likely to have information resources available as well. Providers may request information and resources by contacting their Provider Network Manager.

Special Health Care Needs

Members with special health care needs have direct access to specialists to a specialist, however appropriate to the member's condition and identified needs; to have in place a standing order for a specialty physician. For members with disabilities, special health care needs, and chronic or complex conditions, the right to designate a specialist as their PCP as long as the specialist agrees. A referral to specialists and

health-related services, including documentation of coordination of referrals and services provided between PCP and specialist. BCBSTX will assist members with provider coordination and other services needed to help the member achieve better health outcomes.

Value Added Services

STAR Value Added Services:

For an up-to-date list of these services go to www.bcbstx.com/provider/medicaid/education-and-reference/valueaddedservices/star. For more information about these or other extra services, please call **1-877-375-9097**.

- Free Rides: to Women, Infants and Children (WIC) visits, BCBSTX member events and meetings and approved health classes
- Toll- Free 24-Hour Nurse Advice Line: to talk in private with a nurse about your health
- One Free sports and camp Physicals: each year for members 18 years of age and under.
- Choice of an infant care seat or a pack-and-play playard when pregnant members complete a timely prenatal visit and register for our Special Beginning program
- $75 gift card for taking children birth through 15 months for Texas Health Steps checkups. Gift card awards are based on you sending claims to BCBSTX after the checkup is completed. Once you send BCBSTX the claim, it could take up to two months for members to get the gift card
- $25 gift card for members ages 11 to 21 when they get a yearly Texas Health Steps checkup. Gift card awards are based on you sending claims to BCBSTX after the checkup is completed. Once you send BCBSTX the claim, it could take up to two months for members to get the gift card.
- Upgraded eyewear up to a $150 value each year, after an eye exam, for children ages 18 and under
- BCBSTX prenatal class and a free diaper bag with baby items for pregnant members
- $50 reimbursement for completion of a health or wellness activity • Pregnant members can get a $25 gift card for timely completion of the first prenatal visit.
- Breastfeeding education through our Special Beginnings Program
- Earn a $25 gift card upon completing the postpartum visit 7 to 84 days after delivery.
- $50 of fresh fruits and vegetables delivered to the home for pregnant members
- Up to 14 meals delivered to the member's home after a hospital discharge for one incident per year
- Up to $250 in dental services per year for adult STAR members ages 21 and older
- Online Behavioral Health (BH) Resources
- Incentive gift card for getting follow-up care after a BH inpatient discharge
- Access to Findhelp online health and wellness resources
- Access to the Blue365® Discount Program

Value-Added Services may have limitations or restrictions.

STAR Kids Value Added Services:

For an up-to-date list of these services, go to www.bcbstx.com/provider/medicaid/education-and-reference/valueaddedservices/starkids. For more information about these or other extra services, please call **1-877-688-1811**.

BCBSTX STAR Kids members also have access to other services in addition to Medicaid-covered benefits and services. These extra benefits are offered at no cost to the member. BCBSTX offers these benefits at no cost to the member. We refer to this coverage as Value-Added Services (VAS). VAS may have restrictions and limitations. Some of those extra services include:

- Free rides for BCBSTX member meetings and events, approved health classes and more
- Up to eight hours of extra respite care for STAR Kids members in the Medically Dependent Children Program (MDCP)
- $75 gift card for taking children birth through 15 months for a yearly Texas Health Steps checkup
- $25 gift card for members ages 11 to 21 when they get a yearly well checkup
- Upgraded eyewear up to a $150 value each year, after an eye exam
- One free sports and camp physical each year
- Members can get up to 14 meals delivered to their home after a hospital discharge for one incident per year
- Hippotherapy or therapeutic riding services include one evaluation and up to 10 therapy sessions per year
- $25 gift card, up to four times a year, for Parents/Legally Authorized Representatives (LARs) who attend a Member Resource Meeting
- Reimbursement for Summer Recreational Activity up to $100
- Choice of an infant car seat or a pack-and-play playard when pregnant members complete a timely prenatal visit and register for our Special Beginnings® program

Case-by-Case Services: BCBSTX offers 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.

Value-Added Services may have limitations or restrictions.

CHIP Value Added Services

For an up-to-date list of these services, go to **www.bcbstx.com/provider/medicaid/education-and-reference/valueaddedservices/chip**. For more information about these or other extra services, please call **1-877-375-9097**.

- Free rides: Get free rides to non-emergency doctor visits, therapy, pharmacy, WIC visits, BCBSTX member events and meetings, and approved health classes.
- 24-Hour Nurse Advice Line: Talk in private with a nurse about your health. Call toll-free 24 hours day, seven days a week.
- Well Child Incentive: Get a $75 gift card for taking children from birth through age 15 months to their yearly Well Child checkup.
- Adolescent Checkup Incentive: Adolescent CHIP members ages 11 to 18 can earn a $25 gift card when they get a yearly well checkup.
- Human papillomavirus (HPV) Vaccine Incentive: CHIP members ages 9-13 can earn a $25 gift card when they get all their age-required doses of the Human Papillomavirus (HPV) vaccine.
- Enhanced Eyewear: Children ages 18 and under can get one upgrade per year to eyewear, such as one pair of stylish frames or contact lenses up to a $150 value.
- Sports and Camp Physicals:Members 18 years of age or younger can get a free sports and camp physical each year.
- Receive up to $50 for health and wellness activity.

- Prenatal Care Incentive: Pregnant members can choose an infant car seat or a pack-and-play playard when they complete a timely prenatal visit and register for our Special Beginnings® program.
- Prenatal Class with Incentive Diaper Bag: Pregnant members can take a prenatal class at no cost, in-person or online, and earn a free diaper bag with baby care items.
- New Mom Welcome Kit:Members who deliver a newborn while on our plan can get a New Mom Welcome Home Kit with baby care items.
- Breastfeeding Education with a Breastfeeding Support Kit:Members who deliver a newborn while on our plan can get a free breastfeeding support kit and breastfeeding education.
- Fresh and Healthy Produce Delivery for Pregnant Members: Pregnant members are eligible to get up to $50 of fresh fruits and vegetables per year delivered to their home.
- In-Home Delivery Meal Service:Members who qualify can receive up to 14 meals delivered to their home after a hospital discharge for one incident per year.
- Dental Services for Adult Members: CHIP Perinate members age 19 and older can get up to $250 per year in dental services.
- Online Behavioral Health Resources
- Incentive Gift Card for getting follow-up care after a behavioral health inpatient discharge.
- Access to Findhelp (formerly Aunt Bertha) online health and wellness resource.
- Get access to Blue365® Discount Pharmacy Program

Provider Coordination with BCBSTX

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. The number for training is **1-855-212-1615** and the number for coordination is the Customer Advocate Department at **1-877-688-1811**. BCBSTX will make training and coordination of services available to providers to help ensure that the needs of members are met.

Section 21: Health Insurance Portability and Accountability Act

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, includes administrative simplification provisions that require national standards for electronic health care transactions and code sets, unique health identifiers and security, as well as federal privacy protections for individually identifiable health information.

The Office for Civil Rights administers and enforces the Privacy Rule and the Security Rule.

Other HIPAA Administrative Simplification Rules are administered and enforced by the Centers for Medicare and Medicaid Services (CMS), and include:

- Transactions and code sets standards.
- Employer identifier standard.
- National provider identifier standard.
- Security Rule.
- Enforcement Rule.

The Enforcement Rule provides standards for the enforcement of all the Administrative Simplification Rules. A summary of the HIPAA Administrative Simplification Rules can be found at

www.cms.gov/regulations-and-guidance/administrative-simplification/hipaa-aca

Privacy Rule

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health-care clearinghouses, and those health-care providers that conduct certain health-care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

The Privacy Rule is located at 45 CFR Part 160 and Subparts A and E of Part 164.

In compliance with the privacy regulations, BCBSTX has provided each member with a privacy notice, which describes how BCBSTX can use or share a member's health records and how the member can get access to the information. In addition, the member privacy notice in forms the member of their health care privacy rights and explains how these rights can be exercised.

As a provider, if you have any questions about BCBSTX's privacy practices, contact BCBSTX's compliance officer by emailing **BCBSTX.Compliance@BCBSTXHealthPlan.com**.

Members should be directed to BCBSTX's Member Services Department with any questions about the privacy regulations. Provider Services can be reached at the following phone numbers:

STAR and CHIP **1-877-560-8055**

STAR Kids **1-877-784-6802**

Security Rule

The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by BCBSTX. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity and security of electronic protected health information.

The Security Rule is located at 45 CFR Part 160, and Subparts A and C of Part 164.

Breach Notification Rule

The HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414, requires HIPAA covered entities and their business associates to provide notification following a breach of unsecured protected health information. Similar breach notification provisions implemented and enforced by the Federal Trade Commission (FTC), apply to vendors of personal health records and their third-party service providers, pursuant to section 13407 of the HITECH Act.

Definition of Breach

A breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information. An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment of at least the following factors:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification.
- The unauthorized person who used the protected health information or to whom the disclosure was made.
- Whether the protected health information was or viewed.
- The extent to which the risk to the protected health information has been mitigated.

Breach Notification Requirements

Following a breach of unsecured protected health information, covered entities must provide notification of the breach to affected individuals, the Secretary, and, in certain circumstances, to the media. In addition, business associates must notify covered entities if a breach occurs at or by the business associate.

Transactions and Code Sets Regulations Adopted Standards and Operating Rules

HIPAA required HHS to establish national standards for electronic transactions to improve the efficiency and effectiveness of the nation's health care system.

These standards apply to all HIPAA-covered entities:

- Health plans.
- Health-care clearinghouses.
- Health-care providers who conduct electronic transactions, not just those who accept Medicare or Medicaid.
- Any provider who accepts payment from any health plan or other insurance company must comply with HIPAA if they conduct the adopted transactions electronically.

Adopted Standard Code Sets

The HIPAA Code Sets regulation requires that all codes utilized in electronic transactions are standardized, utilizing national standard coding.

Adopted Standard Code Sets include:

1. Outpatient procedure and physician services coding - Current Procedure Terminology (CPT) codes - The CPT codes are used to describe medical procedures, and this code set is maintained by the American Medical Association. For more information on the CPT codes, please contact the American Medical Association (AMA) at **1-800-621-8335**.

    - Supplies/not included in CPT - Health Care Common Procedure Coding System (HCPCS) - This code set, established by the CMS, primarily represents items and supplies and non-physician services not covered by the American Medical Association CPT-4 codes, which can be purchased from the American Medical Association (AMA) at **1-800-621-8335**.

2. Diagnosis Coding - ICD-10-CM—International Classification of Diseases, 10th edition, Clinical Modification.
3. Hospital inpatient procedure coding - ICD-10-PCS—International Classification of Diseases, 10th edition, Procedure Coding System.

In addition, National Drug codes are required for submission on applicable claims to identify clinician administered drugs (CAD). Reimbursable CAD are found on the Texas Vendor Drug website, see: www.TXVendorDrug.com/formulary/clinician-administered-drugs.

Section 22: Credentialing and Re-Credentialing Process

Credentialing Process

BCBSTX has established rigorous standards for Credentialing in compliance with and standards of approved accrediting bodies.

All credentialing and recredentialing questions should be directed to BCBSTX's Network Representative at **1-855-212-1615** or TexasMedicaidNetworkDepartment@bcbstx.com.

Physicians or Other Professional Providers

The BCBSTX credentialing process is consistent with NCQA guidelines and the State of Texas requirements to practice.

BCBSTX requires full credentialing of the following office-based physicians and other professional providers for participation in the STAR, CHIP and 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)

Behavioral health professionals and physicians must contact BCBSTX for questions regarding the credentialing or recredentialing process for STAR, CHIP: **1-877-560-8055** and STAR Kids: **1-877-784-6802** or website: **ww.bcbstx.com/provider/medicaid**.

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 fully completed the CAQH ProView 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, CHIP and STAR Kids network.

Credentialing is a very involved process. Please allow an enough 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®) ProView for initial credentialing and recredentialing.

ProView, 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 ProView online credentialing application process supports our administrative streamlining and paper reduction efforts. Providers will be able to utilize ProView 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	
• Medical Doctor (MD)	• Doctor of Podiatric Medicine (DPM)

CAQH Approved Provider Types List	
• Doctor of Dental Surgery (DDS)	• Doctor of Chiropractic (DC)
• Doctor of Dental Medicine (DMD)	• Doctor of Osteopathy (DO)
• Audiologist (AUD)	• Nurse Midwife (NMW)
• Biofeedback Technician (BT)	• Nurse Practitioner (NP)
• Christian Science Practitioner (CSP)	• Nutritionist (LN)
• Clinical Nurse Specialist (CNS)	• Occupational Therapist (OT)
• Licensed Practical Nurse (LPN)	• Registered Nurse (RN)
• Massage Therapist (MT)	• Certified Registered Nurse Anesthetist (CRNA)
• Naturopath (ND)	• Registered Nurse First Assistant (RNFA)
• Neuropsychologist (NEU)	• Respiratory Therapist (RT)
• Midwife (MW)	• Speech Pathologist (SLP)
• Anesthesia Assistant (AA)	• Applied Behavioral Analyst (ABA)
• Acupuncturist (ACU)	• Alcohol/Drug Counselor (ADC)
• Advanced Practice Nurse (APN)	• Athletic Trainers (AT)
• Clinical Psychologist (CP)	• Clinical Social Worker (CSW)
• Dietitian (DT)	• Genetic Counselor (GC)
• Hospitalist (HOS)	• Nurse Midwife (NMW)
• Optometrist (OD)	• Optician (OPT)
• Physician Assistant (PA)	• Professional Counselor (PC)
• Pharmacist (PHA)	• Physical Therapist (PT)
• Registered Dental Hygienist (RDH)	• Surgical Assistant (SA)

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)
- 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)

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 PROVIEW Registration with CAQH

Blue Cross and Blue Shield of Texas STAR, CHIP and STAR Kids participating physicians and other professional providers must have a CAQH 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 send you access and registration instructions, along with your personal CAQH Provider ID, allowing you to obtain immediate access to the CAQH ProView database via the Internet. When you receive your CAQH Provider ID:

- Go to the CAQH website to register, or
- Physicians and other professional providers that do not have Internet access may submit their application via fax to CAQH by first contacting the CAQH Help Desk at 1- 888-599-1771
- After successfully authenticating key information, you will be able to create your own username and unique password to begin using CAQH ProView.

Note: Registration and completion of the online application is free.

Completing the Application Process

The ProView 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 ProView is maintained by CAQH in a secure, state-of-the-art data center.

Referring to these materials will be helpful while completing the ProView online application:

- Previously completed credentialing application
- List of previous and current practice locations
- Various identification numbers (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
- 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 ProView with your username and password.

After completing the online credentialing application, you will also be asked to:

- Authorize access to your information you may select 'global authorization' or wait until we add you to our CAQH roster and you will be able to authorize BCBSTX. CAQH will email you if authorization is required. CAQH cannot release your information without authorization.
- Verify your data entry or attest – Review the summary of your data for accuracy and completeness, and make any necessary changes
- Upload supporting documents. All supporting documents will be reviewed in 3-5 business days. If a document is rejected, CAQH will email you with the reason. Your application is not complete until all required documents are received and approved.
- 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)
- 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 ProView, 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 ProView.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 ProView online application through your participation with another health plan, CAQH will email you, if you have not selected "Global Authorization" to authorize BCBSTX. Log into ProView 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 **proview.caqh.org/Login?Type=PR**
- 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 ProView and the application process. Or you can view the CAQH Provider Credentialing Application now.

Additional CAQH Resources

CAQH Contact Information Help Desk **888-599-1771**

Phone Hours: Monday – Thursday: 7 am. – 9 pm. (EST) Friday: 7 am. – 7 pm. (EST)

CAQH Provider Help Desk:

Chat: **proview.caqh.org/PR** Chat

Hours: Monday – Friday: 8:30 AM to 6:30 PM (EST)

Credentialing Process for Hospital or Facility-Based Providers

For your convenience, we have outlined the steps necessary for hospital or facility-based providers to submit a request for contracting/participating in the STAR, CHIP and STAR Kids networks.

Eligible hospital-based specialties include, but are not limited to:

- Anesthesia
- Emergency Medicine
- Radiology
- Pathology
- Neonatology
- Hospitalist

The Facility-based Application (located below) only applies to providers who practice exclusively in a facility, either a hospital OR a freestanding outpatient facility.

Hospital or Facility- Based Providers must have the following:

Hospital privileges

Type 1 NPI#

Texas Medical Board License (temporary permit is acceptable) or appropriate Texas licensure applicable to provider type.

Certificate/ AANA# (applicable to CRNA providers only)

Note: Obtaining a BCBSTX Provider Record ID does not automatically activate the STAR, CHIP and STAR Kids networks. Claims will be processed out-of-network until the provider has applied for network participation and has been approved and activated in the STAR, CHIP and STAR Kids networks.

If the Provider is:	Then:
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, CHIP and Star Kids networks and does not currently have a Medicaid Agreement.	Please follow the steps below: **4.** Complete the STAR, CHIP and STAR Kids 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: **1-800-336-5696**. **5.** 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 **1-512-349-4853** or mail to: Blue Cross and Blue Shield of Texas 9442 Capital of Texas Highway N Suite 500, Arboretum Plaza II Austin, TX 78759-6839 **6.** Complete the STAR, CHIP and Star Kids Facility-based Provider Application (located below) and return to your local Network Management office in Austin by fax to **1-512-349-4853** or by mailing to: Blue Cross and Blue Shield of Texas 9442 Capital of Texas Highway N Suite 500, Arboretum Plaza II Austin, TX 78759-6839
A medical group that has a Group Medicaid Agreement and is adding a provider to the group as a facility-based provider with the Medicaid (STAR), CHIP and STAR Kids networks.	Complete the Medicaid (STAR), CHIP and STAR Kids Facility-based Provider Application (a sample on the next page) and fax the completed application to your local Network Management office in Austin. Fax: **1-512-349-4853**

Facility Based Provider Application for Network Participation (Attachment I).

Credentialing Updates

Keeping your information current with CAQH and BCBSTX is your responsibility.

CAQH ProView

CAQH will send you automatic reminders to review and attest to the accuracy of your data. Use ProView to report any changes to your practice.

Note: You must enter your changes into ProView for BCBSTX to access during the credentialing and recredentialing process. Only health plans that participate in ProView 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.

Recredentialing Process

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 recredentialing, BCBSTX will send your name, via its roster, to CAQH to determine if you have already completed the ProView application and authorized BCBSTX or selected 'global authorization'. If so, BCBSTX will be able to obtain current information from ProView and complete the recredentialing process without having to contact you.

If your credentialing application (for recredentialing) is not available to BCBSTX through CAQH because:

1. You have not completed the ProView process - CAQH will send you a welcome kit that includes access and registration instructions, along with your personal CAQH Provider ID, allowing you to obtain immediate access to ProView 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)
- 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 healthcare 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 ProView?

The CAQH ProView 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 ProView 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, ProView 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 ProView at no cost.

Q4. Are Accrediting Bodies in support of the CAQH application?

Yes. The CAQH application (ProView 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 ProView is a proven solution for simplifying administrative burdens placed on providers during the credentialing or recredentialing 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.

Q6. Am I required by BCBSTX to use the CAQH database?

Yes. All Providers required to submit a credentialing or recredentialing application must use the CAQH database. Exception: Texas physicians and other professional providers who do not have a provider type listed in the 'CAQH Approved Provider Types' list below must go to the TDI website to access and complete a Texas Standardized Credentialing Application, and fax or mail the completed application along with the required supporting documents referenced below to BCBSTX:

CAQH Approved Provider Types List	
Standard Provider Types	Medical Doctor (MD), Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatric Medicine (DPM) Doctor of Chiropractic (DC), Doctor of Osteopathy (DO)
Allied Provider Types	Audiologist (AUD), Biofeedback Technician (BT), Christian Science Practitioner (CSP), Clinical Nurse Specialist (CNS), Licensed Practical Nurse (LPN), Massage Therapist(MT),Naturopath(ND),Neuropsychologist (NEU), Midwife (MW), Nurse Midwife (NMW), Nurse Practitioner(NP),Nutritionist(LN),Occupational Therapist (OT), Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Registered Nurse First Assistant (RNFA), Respiratory Therapist (RT), Speech Pathologist (SLP)

Note: Behavioral health professionals and physicians for the STAR, CHIP, and STAR Kids network, contact BCBSTX at **1-877-560-8055** STAR/CHIP, **1-877-784-6802** STAR Kids or **www.bcbstx.com/provider/medicaid** for questions regarding the credentialing or recredentialing for the STAR, CHIP:**1-877-560-8055** and STAR Kids: **1-877-784-6802** and website: **https://www.bcbstx.com/provider/medicaid**.

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)
- 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. When will CAQH send my registration information after I have been 'rostered' by BCBSTX?

CAQH will typically send registration information within 24 hours of receiving a provider on a roster.

Q8. 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 recredentialing due date. If you do not have a CAQH ID number, CAQH will send you a registration notification with your ID.

Q9. **How can I access the CAQH database?**

To access CAQH database for BCBSTX, 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.

1. You have the right to speak for your unborn child in all treatment choices.
2. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
3. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
4. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
5. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

Attachment A: LTSS Authorization Forms

LTSS Authorization Request
Phone: 1-877-301-4394
Fax: 1-866-644-5456

Date Request Submitted:			
Member Name:			
Address:		City	
State:	ZIP Code:	Phone:	
Person completing Form:		Phone:	Fax:

Service Type: ☐ Agency ☐ CDS ☐ SRO

	New Request?	Current Service?	
☐ Personal Care Services	☐	☐	Hours/Week:_____
☐ Private Duty Nursing	☐	☐	Hours/Week:_____
☐ PAS/Habilitation	☐	☐	Hours/Week:_____
☐ Day Activity and Health Services (DAHS)	☐	☐	Hours/Week:_____
☐ PPECC	☐	☐	Hours/Week:_____
☐ Respite	☐	☐	Hours/Week:_____
☐ Supported Employment	☐	☐	Hours/Week:_____
☐ Employment Assistance	☐	☐	Hours/Week:_____
☐ Flexible Family Support Service	☐	☐	Hours/Week:_____
☐ ERS	☐	☐	Months: ____
☐ Adaptive Aids	☐	☐	$_____
☐ Minor Home Mods	☐	☐	$_____
☐ Transition Assistance Service	☐	☐	$_____

Date of Service: Begin Date:_____ End Date: _____

Provider NPI/API: _____ **Agency Name**:_____

Justification for Request (Diagnosis Code Required):_____

Certain request for services require specific clinical information for us to authorize requested services. Always include this information with the Request for LTSS Authorization Form. If there's no form available for the service you are requesting authorization for, please submit information from your own files that would support the request. Thank you.

Health Plan Use Only

Status

Approved: _____ Expires: _____ Authorization Number: _____

Comments: _____

Representative Name Nurse Reviewer: _____

This authorization is based on medical necessity only and will be contingent upon eligibility and benefits. This is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. Please call the number at the top of this form if this member has any additional medical or behavioral health needs.

SKP-9018-16v2

Attachment B: Request for Authorization

Request for Prior Authorization

Medicaid (STAR) and CHIP: 1-877-560-8055 **STAR Kids: 1-877-784-6802**

Medicaid (STAR) and CHIP Fax: 855-653-8129 **STAR Kids Fax: 1-866-644-5456**

THIS FORM IS TO BE USED FOR ACUTE CARE SERVICE REQUESTS SUBJECT TO PRIOR AUTHORIZATION AND IS NOT TO BE USED FOR LTSS SERVICE REQUESTS*

Date Request Submitted: _____

Member Name: _____ Date of Birth: _____ Age: _____

Subscriber ID: _____ Sex: ☐ Male ☐ Female

Address: _____ City _____

State: ZIP Code: Phone:

Requesting Physician Name: _____ NPI: _____

Address: _____ City: _____

State: _____ ZIP Code: Phone: _____

Person completing Form: Phone: Fax:

Check One: ☐ Medical ☐ Surgical Check One: ☐ Inpatient ☐ Outpatient

Date of Service, if known: _____

Diagnosis: _____ ICD-10: _____

Procedure: _____ CPT/HCPCS: _____

Facility:

Service Provider: _____ Tax ID/Medicare ID: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Phone Number: _____

Provider NPI:

In Network: Yes ☐ No ☐

History/Treatment Provided by Referring Physician:

Certain request for services require specific clinical information for us to authorize requested services. Always include this information with the Request for Preservice Review form. If there's no form available for the clinical service you are requesting authorization for, please submit clinical information from your own files that would support the request. Thank you.

TXW2341

SKSCP-9104-17

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 or the designated services below may result in a denial for reimbursement.

Availity Authorization & Referrals, 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 Availity Authorization & Referrals, including how to register, visit the Provider Tools page on our Provider website at **www.bcbstx.com/provider/tools/availity-authorizations.html**. BCBSTX offers a variety of forms to obtain authorization prior to rendering services. Services not listed on Prior Authorization Grid do not require Prior Authorization. For more information regarding which services require Prior Authorization, please visit: **www.bcbstx.com/provider/medicaid/claims-and-eligibility/um**. Services not requiring a prior authorization does not necessarily mean they are approved, for more information please contact BCBSTX UM Department.

You will find this toolkit on the Provider Resources webpage under Prior Authorization Requirements at: **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
- Selected durable medical equipment (DME)
- Formula
- Home healthcare
- Sensory integration therapy
- All infusion therapies
- Physical, Occupational and Speech therapy (initial evaluations do not require PA)
- Radiology Services-PET/SPEC scans, CTAs and MRIs
- Cosmetic procedures
- Experimental and investigational therapies
- Cardiac and pulmonary rehabilitation
- Transplants
- Hospice
- Skilled Nursing Facilities (SNFs)
- Out-of-network specialist referrals
- Out-of-network services, except family planning, emergency services, chiropractic services and dialysis

For instructions regarding Prior authorization, see Services Requiring Prior Authorization in Section 10: Medical Management/ Utilization Management.

FORMULARY AND PRIOR AUTHORIZATION (PA)

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

To obtain a STAR and CHIP PA form and a list of drugs that require prior authorization, go to bcbstx.com/provider/medicaid/rx_prior_auth.html or

for STAR Kids go to: bcbstx.com/provider/medicaid/star_kids_prior_auth.html

Or please call Prime Therapeutics' Prior Authorization department at

STAR and CHIP PA: **1-855-457-0407**

STAR Kids PA: **1-855-457-1200**

STAR Helpdesk:**1-855-457-0405**

CHIP Helpdesk: **1-855-457-0403**

STAR Kids Helpdesk Travis: **1-855-457-0757**

STAR Kids Helpdesk MRSA Central: **1-855-457-0758**

Fax: Please fax our PA forms to **1-877-243-6930**. To expedite request and review time, an online PA may be submitted via **account.covermymeds.com/**.

Private Pay Agreement

I understand that _____ is accepting me as a private pay patient for the period of _____, and I will be responsible for paying for any services that I receive. The provider will not file a claim to Medicaid for the services that are provided to me.

Signed: _____

Date: _____

Attachment D: Provider Refund Form

BlueCross BlueShield of Texas

Please submit refunds to:
Claims Refund for Medicaid
Blue Cross and Blue Shield of Texas
Claims Overpayments
Dept. CH 14212
Palatine, IL 60055-4212

Please submit refunds to:
Courier Address (signature required)
Blue Cross and Blue Shield of Texas
Claims Overpayments
Box 14212
5505 North Cumberland Ave., Ste 307
Chicago, IL 60656-1471

Provider Refund Form

Provider Information:	
Name:	
Address:	
Contact Name:	
Phone Number:	
NPI Number:	

Refund Information:

1	Member Number	Claim/DCN (Document Control Number) #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		
2	Member Number	Claim/DCN #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		
3	Member Number	Claim/DCN #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		
4	Member Number	Claim/DCN #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		
5	Member Number	Claim/DCN #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		
6	Member Number	Claim/DCN #	
	Patient's Name	Patient Account #	Refund Amount:
	Reason/Remarks		

Signature	Date	Check Number	Check Date

753690.0720

Attachment E: Breast Pump Coverage

ATTACHMENT F

Breast Pump Coverage in Medicaid and CHIP

Texas Medicaid and CHIP cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother's Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's Medicaid client number.

Coverage in prenatal period	**Coverage at delivery**	**Coverage for newborn**	**Breast pump coverage & billing**
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	
STAR Health	STAR Health	STAR Health	
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

*CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an Emergency Medicaid application 30

Attachment F: Facility Based Provider Application for Network Participation

BlueCross BlueShield of Texas

Facility Based Provider Application for Network Participation

*This application is used for providers who practice **exclusively** in an inpatient or freestanding facility. Eligible specialties include, but are not limited to, Anesthesia, Emergency Medicine, Radiology, Pathology, Neonatology & Hospitalist.*

Please complete all blanks below and include appropriate required attachments as indicated.

NOTE: Incomplete or inaccurate applications will be returned resulting in processing delays.

BCBSTX Agreements: ☐ Group agreement(s) on file ☐ Individual Agreement(s) attached		
Group Name:		**Organizational Type 2 NPI #:**
Provider Name:		**Professional Provider Type 1 NPI #:**
Degree:	**Maiden Name**, *if applicable:*	
Social Security #:	**Date of Birth:**	**Gender:** ☐ **Male** ☐ **Female**
Tax Identification # Used for Billing:	**Start Date With Group:**	
Practice Location – Physical Address/City/State/Zip:		
Billing Address/City/State/Zip:		
Billing Phone #:	**Fax #:**	
Correspondence Address/City/State/Zip:		
Name of Primary Hospital/Facility:		**City of Primary Facility:**
Practicing Specialty:		☐ **Board Certified** ☐ **Board Eligible**
Practicing Sub-Specialty:		☐ **Board Certified** ☐ **Board Eligible**
Texas License Number *(if temporary, attach copy)*:		**License Effective Date:**
Anesthesia Assistants & CRNAs Only – Certificate or AANA# *(**MUST** attach copy of certificate)*		**Date Certified:**
Does applicant have professional liability insurance limits of at least $200,000/600,000? ☐ **Yes** ☐ **No**		
Is the applicant active military? ☐ **Yes** ☐ **No**	**Is applicant a Medicare Participant?** ☐ **Yes** ☐ **No**	
Is applicant currently in Residency Program? ☐ **Yes** ☐ **No**	**Is applicant currently in Fellowship Program?** ☐ **Yes** ☐ **No**	
Add Provider to: ☐ **Medicaid Star** ☐ **Star Kids** ☐ **CHIP** **If yes, please indicate TPI numbers below:**		
Group TPI:	**Individual TPI:**	
Application Submitted By:	***Title:***	***Date:***
Email Address:	***Phone #:***	***Fax #:***

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

Attachment G: CHIP Cost Sharing

Cost Sharing Table effective 1/1/14 Added by Version 2.0

CHIP Cost-Sharing	
Enrollment Fees (for 12-month enrollment period):	
	Charge
At or below 151% of FPL*	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-Pays (per visit):	
At or below 151% FPL	**Charge**
Office Visit (non-preventative)	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Co-pay, Inpatient (per admission)	$35
Cost-sharing Cap	5% (of family's income)**
Above 151% up to and including 186% FPL	**Charge**
Office Visit (non-preventative)	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$35
Facility Co-pay, Inpatient (per admission)	$75
Cost-sharing Cap	5% (of family's income)**
Above 186% up to and including 201% FPL	CHARGE
Office Visit (non-preventative)	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$35
Facility Co-pay, Inpatient (per admission)	$125
Cost-sharing Cap	5% (of family's income)**

** Federal Poverty Level (FPL) – The Federal Poverty level refers to income guidelines established each year by the federal government.

**Per 12-month term of coverage CHIP members who are Native American or Alaskan Native are exempt from all cost-sharing obligations, including enrollment fees and copayments.

If the member's card shows a copay requirement and the member is Native American or Alaskan Native, the member should call the Customer Advocate Department at **1-888-657-6061**. Members with hearing or speech loss can call the TTY Line at **711** to have this corrected.

All CHIP Members are exempt from co-pays on benefits for well-baby and well-child services, preventive services, or pregnancy-related assistance.

Members receiving the CHIP Perinatal benefit are exempt from all cost- sharing obligations, including enrollment fees and copays.

Attachment H: Provider Appeal Process to HHSC for STAR Kids

Provider Appeal Process to HHSC (related to claim recoupment)

Upon notification of a claims payment recoupment, the first step is for the provider to recheck Member eligibility to determine if a Member eligibility change was made to Fee- for-Service or to a different managed care organization on the date of service.

1. Member eligibility changed to Fee-for-Service on the date of service Provider may appeal claim payment 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. 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.

Note: Label the request "Expediated Review Request" at the top of the letter to ensure the appeal request is reviewed prior to eighteen (18) months from the date of service.

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

Prepare a new paper claim for each claim that was recouped, and insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing that the claims payment was recouped.

Submission of the new claims is not required before sending the administrative appeal letter. However, if a provider appeals prior to submitting the new claims, the provider must subsequently include the new claims with the administrative appeal.

HHSC Claims Administrator Contract Management only reviews appeals that are received within eighteen (18) months from the date-of-service. In accordance with 1TAC § 354.1003, providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management and all claims must be finalized within 24 months from the date of service.

2. Member eligibility changed from one Managed Care Organization (MCO) to another on the Date-of-Service

Providers may appeal claims payment recoupments and denials of services by submitting the following information to BCBSTX to which the Member eligibility was changed on the date of service:

- 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. The EOB showing the recoupment and/or BCBSTX "demand" letter for recoupment must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- Documentation must identify the client name, identification number, DOS,and recoupment amount, and other claims information.

Note: Label the request "Expedited Review Request" at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

Submit appeals online at:

Blue Cross and Blue Shield of Texas
Attn: Complaint and Appeal Department
P.O. Box 660717 Dallas, TX 75266

Fax: **1-877-886-2593**

Email: GPDTXMedicaidAG@bcbsnm.com

Mail Fee-for-Service related appeals to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

Attachment I: STAR Covered Services

Physical Health Covered Services

Covered Benefit	Description of Services
Ambulance Services	Covered when the member has an emergency medical condition. An emergency medical condition is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance abuse) such that a prudent layperson with an average knowledge of health and medicine. Could reasonably expect the absence of immediate attention to result in one of the following: • Placing the member's health (or with pregnant member, health of the member or the unborn child) in serious jeopardy • Serious impairment to bodily functions • Serious dysfunction of any bodily organ or part Logistical problems may also define an emergency: • Facility-to-facility transport may be considered an emergency if emergency treatment is not available at the first facility and the member requires emergency care • Air ambulance transport services may be covered only if one of the following conditions exists: • The medical condition requires immediate and rapid ambulance transportation that could not have been provided by standard automotive ground ambulance • The point of member pick up is inaccessible by standard automotive ground vehicle • Great distances or other obstacles are involved in transporting the client to the nearest appropriate facility • Please note: Prior authorization is required for non-emergency ambulance transport services.
Audiology Services	Audiology services, including hearing aids, for adults and children
Chiropractic Services	Limited to an acute condition or an acute exacerbation of chronic condition for a maximum of 12 visits in a consecutive 12-month period, and a maximum Limited to an acute condition or an acute exacerbation of chronic condition for a maximum of 12 visits in a consecutive 12-month period, and a maximum of one visit per day. If the condition persists more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. of one visit per day.

Covered Benefit	Description of Services
Dental Services, Primary and Preventive	Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth and removal of cysts. For more information about primary and preventive STAR dental benefits, please contact: **Denta Quest Provider Services** **1-800-516-0165** Monday– Friday 8a.m.– p.m., Saturday 8 a.m.–Noon Central Time www.dentaquest.com MCNA Dental Provider Services **1-800-494-6262**, Monday–Friday8a.m.–4p.m., Central Time (excludes holidays) www.mcna.net United Dental **1-800-822-5353**
Dialysis	Inpatient and outpatient services require prior authorization.
Direct Birthing Services	• Provided by a physician or advanced practice nurse in a licensed birthing center. • Provided by a licensed birthing center.
Division for the Blind Services	The Division for the Blind Services (DBS) of the Texas Department of Assistive and Rehabilitative Services (DARS) assists blind or visually impaired individuals and their families. DBS staff work in partnership with Texans who are blind or visually impaired to get high-quality jobs, live independently, or help a child receive the training needed to be successful in school and beyond. For more information, call the Division for the Blind Services at **1-800-628-5115**.
Durable Medical Equipment and Supplies	• Most DME needs prior authorization • Covered when medically necessary • Given for use in home when medically necessary • Not covered if: • Used for exercise • The equipment is experimental or used for research • More than one piece of equipment serves the same use

Covered Benefit	Description of Services
Early Childhood Intervention Case Management and Service Coordination **See also Texas Health Steps Case Management for Children and Pregnant Women later in this chapter**	Early Childhood Intervention (ECI) is a statewide program for families with children, age 0 to 3 years, with disabilities or developmental delays. ECI supports families to help children reach their developmental potential. All health care providers are required to identify and refer children up to 35 months of age suspected of having a developmental disability or delay, or of being at risk of delay, to ECI for screening and assessment as soon as possible but no longer than seven days after identification. Families and professionals work together to develop an Individual Family Service Plan (IFSP) for appropriate services based on the unique needs of the child. The IFSP describes the member's disability or delay, services required, and the individual accountable for service delivery. It becomes a permanent part of the member's medical record. The local ECI program implements and coordinates ongoing case management. Appropriate services are provided in collaboration with an interdisciplinary team, including the PCP, member, family, ECI case manager, plan staff and any other Team professional. BCBSTX may not limit services recommended in the IFSP. Educational materials are approved by the Texas Interagency Council on Early Childhood Intervention. Services by non-network providers are permitted when no in-network provider is available. Call **1-877-787-8999**; TYY: **1-866-581-9328** or visit the ECI website at www.hhs.texas.gov/services/disability/early-childhoodintervention-services to learn more.
Emergency Services	Covered services include, but are not limited to: • Emergency services based on prudent lays person's definition of emergency health condition • Hospital emergency room, ancillary services and physician services 24 hours a day/seven days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated level I and Level II Trauma Centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air, and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth and removed of cysts

Covered Benefit	Description of Services
Family Planning Services	Services, supplies or medications provided to Members of childbearing age in order to temporarily or permanently prevent or delay pregnancy. The following are not considered family planning services: • Therapeutic abortion services • Routine infertility studies or procedures to promote fertility • Hysterectomy for sterilization purposes only • Transportation*, parking or childcare For the latest information on Family Planning Services (Texas Healthy Women), go to: **www.healthytexaswomen.org/**
Home Healthcare Services	Requires prior authorization. Medically necessary services include: • Home health aide services • Physical therapy visits • Occupational visits • Speech therapy visits • Durable Medical Equipment (DME) • Medical supplies
Hospice Services Provided by the Department of Aging and Disability Services (DADS)	Medicaid Hospice provides palliative care to all Medicaid-eligible members (no age restriction) who sign statements electing hospice services and are certified by physicians to have six months or fewer to live if their terminal illness runs its normal course. The following are part of hospice services: • Hospice care includes medical and support services designed to keep members comfortable and without pain during the last weeks and months before death. • When members elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness. • Medicare and Medicaid members must elect both the Medicare and Medicaid Hospice programs. Individuals who elect hospice care are issued Medicaid Identification with 'HOSPICE' printed on it. Members may cancel their election at any time. • All members are disenrolled from BCBSTX upon enrollment into a hospice program. To learn more, call Department of Aging and Disability Services (DADS) at **1-800-458-9858**.
Hospital Services	Includes inpatient and outpatient.
Laboratory and Radiology	Laboratory (including pregnancy tests) and radiology services that are rendered during pregnancy must be billed separately from prenatal care visits.

Covered Benefit	Description of Services
Mastectomy, Breast Reconstruction, and Related Follow-up Procedures	Inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate. Physician and professional services provided in an office, inpatient, or outpatient setting for: • All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed. • Surgery and reconstruction on the other breast to produce symmetrical appearance. • Treatment of physical complications from the mastectomy and treatment of lymphedemas • Prophylactic mastectomy to prevent the development of breast cancer • External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
Medical Checkups and Comprehensive Care Program (CCP) **See Texas Health Steps later in this chapter**	Services for children under age 21 through the Texas Health Step program.
Podiatry	Covered services include: • Medical problems of the feet • Medical or surgical treatment of disease, injury or defects of the feet • The following are not covered: • Routine foot care • Treating the feet when the bones are not in line and surgery is not required • Cutting or removing corns, warts or calluses • Experimental procedures
Prenatal Care	Limited a combined total of 20 outpatient prenatal care visits and one postpartum care visit per pregnancy. • Normal pregnancies usually require 11 visits per pregnancy. • High-risk pregnancies usually require 20 visits per pregnancy.

Covered Benefit	Description of Services
Prescription Drugs (Outpatient Only)	STAR members' pharmacy benefits are administered by Prime Therapeutics LLC for BCBSTX. These benefits, based on medical necessity, cover outpatient prescription drugs obtained through any in-network pharmacy. Members may obtain medication from any network pharmacy. The formulary is a comprehensive list of drugs compiled and governed by Vendor Drug Program (VDP) available to STAR members. The goal of the formulary is to ensure that members receive therapeutically appropriate and cost-effective drug therapy. 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: **www.txvendordrug.com.** Prime Therapeutics offers e-prescribing through Sure Scripts, which allows providers to: • Submit prescriptions electronically Verify client eligibility • Review medication history • Review formulary and PDL information

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

Covered Benefit	Description of Services
Prescription Drugs (Outpatient Only) (Continued)	The formulary is also available for mobile devices on **www.epocrates.com.** Additional outpatient prescription drug information: • No copay is required for prescriptions. • Prior authorization is required for certain drugs. • We do not reimburse cl aims for diet aids, cosmetic or hair-growth drugs, erectile dysfunction drugs, or infertility drugs. • We limit over-the-counter drugs to those on the Medicaid formulary. • We have limited home health supplies available under the pharmacy benefit. All other medical supplies and equipment are available under the medical benefit. • We do not reimburse cl aims for nutritional products (enteral or parenteral) under the pharmacy benefit. Medical prior authorization is required. • We offer free prescription delivery from those Texas VDP approved delivery pharmacies in our pharmacy provider service area network. We will coordinate or provider rides to the pharmacy if no other transportation is available. **Quantity Supply** All medications will be limited to a one-month supply with a maximum 34-day supply at all retail pharmacies. If a medical condition warrants a greater quantity supply than the defined one-month supply of medication, prior authorization is available. Some over-the-counter supplies are available from pharmacies that are designated to provide Comprehensive Care Program (CCP) items for STAR children. **Limited Home Health Supplies** Limited home health supplies such as needles, syringes, test strips, monitors and aerosol holding chambers are covered under the pharmacy benefit. Claims for these supplies should be submitted as a pharmacy cl aim to Prime Therapeutics: STAR: **1-855-457-0405** CHIP: **1-855-457-0403** For more information about Limited Home Health Supplies, please refer to the Durable Medical Equipment section later in this chapter. **340B Billing Requirements** Pharmacies billing claims for drugs purchased under the 340B Drug Discount Program should identify these claims using National Council for Prescription Drug Program values as applicable. For more information on **340B Billing Requirements,** please see Section 10: Claims and Billing

Covered Benefit	Description of Services
Prescription Drugs – Specialty Medications	Specialty medications are high-cost injectable drugs that generally require close supervision and monitoring of the patient's drug therapy. These drugs often require special handling such as temperature-controlled packaging and overnight delivery and are often unavailable at retail pharmacy stores. Self-injectable medications will be covered under the pharmacy benefit program. Self-injectable medications will be limited up to a 34-day supply per fill. Office-based injectables are covered under the member's medical benefit. For questions about specialty drugs contact Prime: STAR: **1-855-457-0405** CHIP: **1-855-457-0403**
Prescription Drugs 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 prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List (PDL) 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. The PDL is available online at **www.txvendordrug.com/about/news/2022/january-2022-preferred-drug-list-now-available** 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-houremergency prescription supply, pharmacies may enter an '8' in field 461-EU (Prior Authorization Type Code) and code 801 in field 462-EV (Prior Auth Number Submitted), to override a 75/PA required rejection and submit a claim for a 72-hour emergency supply. Providers may call the Prime Help Desk for more information about the 72- hour emergency prescription supply policy: STAR: **855-457-0405**CHIP: **855-457-0403.**
Prior Authorization	Prior authorization (PA) is required for all non-preferred and non-formulary medications that appear on the Texas Medicaid Formulary. PA is not available for drugs that are not covered or not included in this benefit. PA may be obtained by phone or by fax: STAR: **855-457-0405** Fax**: 1-877-560-8055** CHIP: **855-457-0403** Fax**: 1-855-879-7180**

Covered Benefit	Description of Services
Public Health Services **Essential Public Health Services and Resources**	BCBSTX must provide the following Covered Services or refer to Public Health Entities: • Testing for Sexually Transmitted Diseases (STDs) • Confidential HIV testing • Immunizations • Tuberculosis (TB) care • Family Planning services • Texas Health Steps medical checkups • Prenatal services • Texas Vaccines for Children (TVFC) Program **Please Note:** These services may be provided without referral and members may self-refer. BCBSTX may contract with public health entities as well as physicians or other professional providers in private practice to supply these services. BCBSTX must coordinate with public health entities in each service area to provide essential public health care services. In addition to the requirements listed above or otherwise required under state law or this contract, the HMO must meet the following requirements: • Report to public health entities regarding communicable diseases and/or diseases that are preventable by immunization as defined by state law • Notify the local public health entity, as defined by state law, of communicable disease outbreaks involving members • Educate members and providers regarding Women, Infants and Children (WIC) services available to members • Coordinate with local public health entities that have a child lead program, or with DSHS regional staff when the local public health entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure
Radiology, Imaging and X-rays	Some services require prior authorization. Radiology services include: • X-rays and noninvasive diagnostic testing • Mammograms for women 40 years of age and older • CTs and MRIs if medically necessary

Covered Benefit	Description of Services
School Health and Related Services (SHARS)	School Health and Related Services (SHARS) is a Medicaid financing program and is a joint program of the Texas Education Agency and the Texas Health and Human Services Commission (HHSC). Primary care providers should educate eligible members about SHARS. SHARS allows local school districts/shared services arrangements (SSAs) to obtain Medicaid reimbursement for certain health-related services provided to students in special education. School districts/SSAs receive federal Medicaid money for SHARS services provided to students who meet all three of the following requirements: • Be Medicaid eligible, • Meet eligibility requirements for Special Education described in the Individuals with Disabilities Education Act (IDEA), and • Have individual Educational Plans (IEPs) that prescribe the needed services Services include: • Assessment • Audiology • Counseling • School health services • Medical services • Occupational therapy • Physical therapy • Psychological services • Speech therapy • Special transportation • To learn more about SHARS, visit **www.tmhp.com**. BCBSTX is not responsible to pay for SHARS. SHARS claims are submitted to HHSC.

Covered Benefit	Description of Services
Texas Health Steps **Texas Health Steps is also known as Early Periodic Screening and Diagnostic Tool (EPSDT)** **Case Management for Children and Pregnant Women**	To be eligible for Children and Pregnant Women (CPW) case management services, a member must: Be eligible for Medicaid: • Be a pregnant member with a high-risk condition, or a child (birth through 20 years of age) with a health condition or health risk. • Be in need of services to prevent illnesses or medical conditions to maintain function or slow further deterioration. • Agree to receive case management services. Pregnant women with high-risk conditions are defined as having one or more medical and/or personal/psychosocial conditions. Children with certain high-risk health conditions are defined as being at risk of having a medical condition, illness, injury or disability that results in a limitation of function, activities or social roles as compared to healthy same-age peers in the general areas of physical, cognitive, emotional or social growth and development. To refer members to CPW services, contact the Texas Health Steps program at **1-877-847-8377** or visit the CPW provider list at: www.dshs.state.tx.us/caseman/providerRegion.shtm A referral for CPW services can be received from any source. A Case Management provider will contact the family to offer a choice of providers and to obtain information necessary to request prior authorization for case management services.
Therapies	• Physical • Occupational • Speech
Transplants	Requires prior authorization. The following are considered medically needed transplants: • Heart • Lungs • Combined heart and lung • Liver • Kidney • Cornea • Stem cell The first transplant is covered, but only one future re-transplant because of rejection is allowed.
Transportation Modivcare	Rides to and from their scheduled appointments with scheduled appointments with their In-Network Provider. Appointments must be pre-authorized by BCBSTX with their primary care physician (PCP), a specialist, physical therapist, behavioral health therapist, dentist, or eye care specialist, BCBSTX Medicaid members may use the benefit as often as necessary. One attendant may accompany a child age 14 or youngers who is visually impaired, hearing impaired or mentally challenged while the child receives medical service

Covered Benefit	Description of Services
Tuberculosis Services	Plan providers screen, diagnose and treat tuberculosis (TB). All confirmed or suspected cases are reported immediately (within 24 hours) to the Local Tuberculosis Control Health Authority (LTCHA). All Health and Human Services Commission (HHSC) reporting procedures are to be followed. A contact investigation and Directly Observed Therapy (DOT) referral is initiated. Upon request, LTCHA, HHSC and Department of Health Services (DHS) are given access to the medical records of members with suspected or confirmed TB. Any member who is noncompliant, drug-resistant or presents a public threat must be reported to the LTCHA. Additionally, network physicians and care coordinators will work closely with the Texas Department of State Health Services (DSHS) South Texas Hospital and Texas Center for Infectious Disease for voluntary and court-ordered admissions of members with drug resistant TB. Following treatment from a local TB program or inpatient hospital treatment, network physician and care coordinators will participate with post-discharge planning and safe re-entry into the community.
Vision	Annual routine eye health examination inclusive of refraction and dilation (when professionally indicated) at no cost. Prescription eyewear (if applicable) as follows: • Spectacle lenses every year (cl ear plastic single vision, bifocal, or trifocal lenses [any Rx] at no cost) • A large assortment of frames are available every year (see benefit guide for more information) at no cost • Enhanced eye wear for children offer as a Value-Added Service. • To arrange for a routine eye examination and fulfillment of glasses, contact Davis Vision: Member Services: **1-888-588-4825**; TTY: **1-800-523-2847** Provider Services: **1-800-77DAVIS (800-773-2847)**; TTY: **1-800-523-2847** Website: **www.davisvision.com**

Behavioral Health Covered Services

Covered Benefit	Description of Services
Inpatient Mental Health Services	• Inpatient psychiatric services for adults and children in acute care hospitals, • Inpatient psychiatric services for children under age 21 in a free-standing psychiatric facility.
Outpatient Mental Health Services	• Medically necessary services for the treatment of mental health disorders, such as: • Psychiatric diagnostic evaluation • Psychotherapy (including individual, family, or group) • Psychological and neuropsychological testing, • Electroconvulsive therapy (ECT). • Pharmacological management • Targeted Case Management and Mental Health Rehabilitation
Inpatient and Residential Substance Use Disorder Services	• Inpatient and residential withdrawal management treatment services • Residential treatment services which provide a structured therapeutic environment where persons reside with staff support and deliver comprehensive SUD treatment with attention to co-occurring conditions as appropriate.
Outpatient Substance Use Disorder Services	• Substance use disorder (SUD) treatment services are age appropriate medical and psychotherapeutic services designed to treat a member's substance disorder and restore function such as: – Individual therapy – Group therapy – Outpatient withdrawal management services – Medication Assisted Treatment
Case Management and Care Coordination Services	These services include outreach education, case management, care coordination and community referral.

Attachment J: CHIP Covered Services

Physical Health Covered Services

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation.	Not a covered benefit.
Delivery and Post-Partum Care	Covered Services include: • Child's benefit begins at birth and ends on last day of 12-month continuous eligibility period. • Birth-related services only for pregnant member, and coverage ends on last day of month in which they give birth.	**Exception:** Member receives two (2) post- partum visits even if it is beyond last day of birth month.
Durable Medical Equipment	$20,000, 12-monthperiodlimitfor DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. Advance Practice Registered Nurses (APRNs) and Physician Assistants (Pas) are prohibited. from prescribing any durable medical equipment (including limited home health supplies) and outpatient schedule 11controlled substance for Medicaid clients. This includes any product dispensed through the pharmacy.	Not a covered benefit.

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Emergency Services, including Emergency Hospitals, Physicians and Ambulance Services	Authorization is not required as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day/ seven day a week, both by in-network and • out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level I and Level II Trauma Centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin.	BCBSTX cannot require authorization as a condition for payment or emergency conditions related to labor with delivery. • Covered services are limited to • those emergency services that • are directly related to the delivery • of the unborn child until birth • Emergency services based on • prudent lay person definition of • emergency health condition • Medical screening examination • to determine emergency when • directly related to the delivery of the covered unborn child • Stabilization services related to the labor with delivery of the covered unborn child Emergency ground, air and water transportation for labor and threatened labor is a covered benefit. Emergency ground, air and water transportation for an emergency associated with: **a.** Miscarriage or **b.** A non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. **Benefit limits**: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinatal are covered.

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies • Services are not intended to replace the child's caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services	Not a covered benefit.
Hospice Care Services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness • Up to a maximum of 120 days with a 6-month life expectancy • Patients electing hospice services may cancel this election at anytime • Services apply to the hospice diagnosis	Not a covered benefit.

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Hospital Services – Inpatient Inpatient General Acute and Inpatient Rehabilitation Hospital Service	Services include, but are not limited to: • Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints	For CHIP Perinatals in families with incomes at or below 186% of the Federal Poverty Level, the facility charges are not a covered benefit, however, professional services charges associated with labor with delivery are a covered benefit. Hospitals bill TMHP under the Emergency Medicaid Program. For CHIP Perinatals in families with income above 186% to 201% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or non-viable pregnancy. Services include: • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component)
Hospital Services – Inpatient Inpatient General Acute and Inpatient Rehabilitation Hospital Service (continued)	Drugs, medications and biologicals • Blood or blood products that are not provided free-of- charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs and so on) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to Department of State Health Services • (DSHS)-designated Level III perinatal centers or hospitals meeting equivalent levels of care	Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to (a) miscarriage or(b)non- viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with (a) miscarriage or(b)a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) area covered benefit Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: • Dilation and curettage (D&C) procedures • Appropriate provider-administered medications • Ultrasounds • Histological examination of tissue samples

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Hospital Services – Inpatient Inpatient General Acute and Inpatient Rehabilitation Hospital Service (continued)	Inpatient services for a mastectomy and breast reconstruction include: • All stages of reconstruction on the affected breast • External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s)have been performed • Surgery and reconstruction on the other breast to produce symmetrical appearance; and • Treatment of physical complications from the mastectomy and treatment of lymphedemas Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit. Pre-surgical or post-surgical orthodontic services for anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: • Cleft lip and/or palate • Severe traumatic skeletal and/or congenital craniofacial deviations • Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment	

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Hospital Services - Outpatient Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center), and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory healthcare setting: • X-ray, imaging and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free- of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility	Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory healthcare setting: • X-ray, imaging and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs • Outpatient services associated with (a) a miscarriage or(b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired inutero • Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: • Dilation and curettage (D&C) procedures • Appropriate provider-administered medications • Ultrasounds • Histological examination of tissue samples

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Hospital Services - Outpatient Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center), and Ambulatory Health Care Center (continued)	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory healthcare setting: • Radiation and chemotherapy • Blood or blood products that are not provided free- of-charge to the patient and the administration of these products Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) Outpatient services associated with miscarriage or non- viable pregnancy include, but are not limited to: • Dilation and curettage (D&C) procedures; • Appropriate provider-administered medications; • Ultrasounds, and • Histological examination of tissue samples. • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility • Surgical implants • Other artificial aids including surgical implants	Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: 1. Laboratory and radiological services that directly relate to antepartum care and/or the delivery of the covered CHIP Perinatal until birth. 2. Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, intellectual and developmentally disabled,, gestational age confirmation or miscarriage or non-viable pregnancy. 3. Amniocentesis, cordocentesis, fetal intrauterine transfusion (FIUT)and ultrasonic guidance for cordocentesis, FIUT are covered benefits with an appropriate diagnosis.

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Hospital Services - Outpatient Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center), and Ambulatory Health Care Center (continued)	Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: • All stages of reconstruction on the affected breast • External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s)have been performed • Surgery and reconstruction on the other breast to produce symmetrical appearance • Treatment of physical complications from the mastectomy and treatment of lymphedemas • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: • Cleft lip and/or palate • Severe traumatic skeletal and/or congenital craniofacial deviations • Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth orits treatment	**4.** Laboratory tests are limited to: non- stress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client **5.** Surgical services associated with(a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Physician/ Physician Extender Professional Services	Services include, but are not limited to: • American Academy of Pediatrics • recommended well-child exams and • preventive health services (including, but • not limited to, vision and hearing screenings • and immunizations), and screening for • behavioral health problems and behavioral • health disorders • Physician office visits, inpatient and • outpatient services • Laboratory, X-rays, imaging and pathology • services, including technical component and/ • or professional interpretation • Medications, biologicals and materials • administered in physician's office • Allergy testing, serum and injections • Professional component (in/outpatient) of • surgical services, including: – Surgeons and assistant surgeons – for surgical procedures including appropriate follow-up care – Administration of anesthesia by physician (other than surgeon) or Certified Registered Nurse Anesthetist (CRNA) – Second surgical opinions – Same-day surgery performed in a – hospital without an overnight stay – Invasive diagnostic procedures such – as endoscopic examinations – Hospital-based physician services, – including physician-performed technical and interpretive components	Services include, but are not limited to the following: • Medically necessary physician • services for prenatal and • post partum care and/or the • delivery of the covered unborn • child until birth • Physician office visits, inpatient • and outpatient services • Laboratory, X-rays, imaging and • pathology services including • technical component and /or • professional interpretation • Medically necessary medications, • biologicals and materials • administered in physician's office • Professional component • (in/outpatient) of surgical • services, including: – Surgeons and assistant surgeons for surgical procedures directly related to the labor – with delivery of the covered unborn child until birth. – Administration of anesthesia by a physician (other than – surgeon) or CRNA – invasive diagnostic – procedures directly related to the labor with delivery of the unborn child

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Physician/ Physician Extender Professional Services (continued)	Physician and professional services for a mastectomy and breast reconstruction include: • All stages of reconstruction on the • affected breast; • External breast prosthesis for the breast(s) • on which medically necessary mastectomy • procedure(s)have been performed • Surgery and reconstruction on the • other breast to produce symmetrical • appearance; and • Treatment of physical complications from the • mastectomy and treatment of lymphedemas. • In-network and out-of-network physician • services for a mother and her newborn(s) • for a minimum of 48 hours following an • uncomplicated vaginal delivery and 96 hours • following an uncomplicated delivery by • caesarian section. • Physician services associated with (a) • miscarriage or • (b)a non-viable pregnancy (molar pregnancy, • ectopic pregnancy, or a fetus that • expired in utero).	Professional component of inpatient/outpatient surgical services (continued): • Surgical services associated with • (a) miscarriage or(b) a nonviable • pregnancy (molar pregnancy, • ectopic pregnancy, or a fetus that • expired in utero.) • Hospital-based physician • services (including Physician • performed technical and • interpretive components). • Professional component of the • ultra sound of the pregnant • uterus when medically indicated • for suspected genetic defects, • high-risk pregnancy, intellectual and developmentally disabled or gestational age • confirmation. • Professional component of • amniocentesis, cordocentesis, • Fetal Intrauterine Transfusion • (FIUT) and ultrasonic • guidance for amniocentesis, • cordocentesis, and FIUT.

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities Related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services. Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.	Services are limited to an initial visit and subsequent prenatal(antepartum)care visits that include: • One visit every four weeks for the first 28 weeks of pregnancy; • One visit every two to three weeksfrom28to 36 weeks of pregnancy; and • One visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary. Benefits are limited to 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review.

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Prenatal Care and Pre-Pregnancy Family Services and Supplies (continued)	Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities Related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services. Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.	Services are limited to an initial visit and subsequent prenatal(antepartum)care visits that include: • One visit every four weeks for the first 28 weeks of pregnancy; • One visit every two to three weeksfrom28to 36 weeks of pregnancy; and • One visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary. Benefits are limited to 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high- risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review.

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Prenatal Care and Pre-Pregnancy Family Services and Supplies (continued)		Visits after the initial visit must include: • Interim history (problems, marital • status, fetal status); • Physical examination (weight, • blood pressure, fundal height, • fetal position and size, fetal heart • rate, extremities), and • Laboratory tests (urinalysis • for protein and glucose every • visit; hematocrit or hemoglobin • repeated once a trimester and • at 32-36 weeks of pregnancy; • multiple marker screen for fetal • abnormalities offered at 16-20 • weeks of pregnancy; repeat • antibody screen for Rh negative • Women at 28 weeks followed • by Rho immune globulin • administration if indicated; screen • for gestational diabetes at 24-28 • weeks of pregnancy; and other • lab tests as indicated by medical • condition of client)

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Prescription Drug Benefits	CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to a 90-day supply of a drug. Services include, but are not limited to: • Outpatient drugs and biologicals; • including pharmacy- dispensed and • provider-administered outpatient drugs • and biologicals • Drugs and biologicals provided in an • inpatient setting Federal Poverty Level (FPL) / Generic / Brand At or below100% / $0 / $3 Up to and including 151% FLP / $0 / $5 Above 151% through 186% / $10 / $35 Above 186% through 201% / $10 / $35 Prime Therapeutics offers e-prescribing administered through Prime Therapeutics, which allows providers to: • • Submit prescriptions electronically, • • Verify client eligibility, • • Review medication history, and • • Review formulary information. For additional information visit the website www.txvendordrug.com. The formulary is also available for mobile devices on www.epocrates.com. vel (FPL)	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; • including pharmacy-dispensed • and provider-administered • outpatient drugs and biologicals • Drugs and biologicals provided in • an inpatient setting • CHIP Perinatal has no copayments • for this benefit. • BCBSTX offers e-prescribing • abilities through Prime • Therapeutics for providers to: • Submit prescriptions • electronically, • Verify client eligibility, • Review medication history, and • Review formulary information. For additional information visit the website www.txvendordrug.com. The formulary is also available for mobile devices on www.epocrates.com.
Prescription Drug Benefits - Continued	**Limited Home Health Supplies** Limited home health supplies such as needles, syringes, test strips, monitors and aerosol holding chambers are covered under the pharmacy benefit. Claims for these supplies should be submitted as a pharmacy claim to **Prime Therapeutics:** CHIP: **1-855-457-0403**	**Limited Home Health Supplies** Limited home health supplies such as needles, syringes, test strips, monitors and aerosol holding chambers are covered under the pharmacy benefit. Claims for these supplies should be submitted as a pharmacy claim to **Prime Therapeutics:** CHIP: **1-855-457-0403**

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Prescription Drugs (Outpatient Only)	Prime Therapeutics LLC administers the BCBSTX pharmacy benefit for CHIP Members. These benefits cover outpatient prescription drugs obtained through any in-network pharmacy based on medical necessity. Members may obtain medication from any network pharmacy. The formulary is used to administer pharmacy benefits for BCBSTX CHIP members. The goal of the formulary is to ensure that members receive therapeutically appropriate and cost-effective drug therapy. Since the formulary promotes rational, scientific care based on consideration of published clinical studies, Food and Drug Administration (FDA) data, community standards, and cost-benefit evaluations, the formulary serves as a primary reference in the selection of medications for CHIP members. The formulary is reviewed and, as necessary, updated once per quarter. Providers should always refer to the website for accurate formulary lists. Please refer to the formulary for a list of covered drugs. To view the formulary and for additional information, go to **www.txvendordrug.com**. The formulary is also available for mobile devices on **www.epocrates.com**. BCBSTX offers e-prescribing abilities through Prime Therapeutics for Providers to: • Verify client eligibility, • Review medication history, and • Review formulary and PDL information. • Above 100% through 151% FPL: Generic $0; Brand $5 • Above 151% through 186% FPL: Generic $10, Brand $35 • Above 186% through 201% FPL: Generic $10; Brand $35 • Prior authorization is required for certain drugs • Over the counter medications are not covered in the CHIP prescription benefit	

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
	We do not cover diet aids, cosmetic or hair-growth drugs, erectile dysfunction drugs, or drugs for infertility • We do not reimburse claims for nutritional products (enteral or parenteral), medical supplies or equipment under the pharmacy benefit • We offer free prescription delivery from those Texas VDP approved delivery pharmacies in our Pharmacy Provider Service Area network. **Quantity Supply:** All medications will be limited to a one-month supply with a maximum 34-day supply at all retail pharmacies. If a medical condition warrants a greater quantity supply than the defined one-month supply of medication, then prior authorization (PA) is available	
Prior Authorization	Prior authorization (PA)is required for all non-formulary medications that appear on the Texas Medicaid Formulary. PA is not available for drugs that are not covered or not included in this benefit. PA may be obtained by phone or by fax. **Prime Therapeutics** BIN 0 11552 PCN; TXCAID **TX CHIP Pharmacy Help Desk:** **1-855-457-0403** **TX STAR Pharmacy Help Desk:** **1-855-457-0405**	
Specialty Medications	Specialty medications are high-cost injectable drugs that generally require close supervision and monitoring of the patient's drug therapy. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at retail pharmacy stores. Self-injectable medications will be covered under the pharmacy benefit program, limited up to a 34-day supply per fill. Office-based injectables are covered under the medical benefit.	

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
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), such as those that 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. The 72-hour emergency supply is not applicable if the three prescription limit has been reached.	
Rehabilitation Services	Services include, but are not limited to: • Habilitation (the process of supplying a child • with the means to reach age-appropriate • developmental milestones through therapy • or treatment) and rehabilitation services • including, but not limited to physical, • occupational and speech therapy. • Developmental assessment.	Not a covered benefit.
Skilled Nursing Facilities (SNFs) (includes rehabilitation hospitals	Services include, but are not limited to: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	Not a covered benefit.
Transplants	Services include, but are not limited to, the following: Using up-to-date FDA guidelines, all nonexperimental human organ and tissue transplants and all forms of non- experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	Not a covered benefit.

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Vision Benefit (through Davis Vision)	Annual routine eye health examination inclusive of refraction and dilation (when professionally indicated) at no cost. Prescription eyewear (if applicable) as follows: • Spectacle lenses every year (cl ear plastic single vision, bifocal, or trifocal lenses [any Rx] at no cost) • A large assortment of frames are available every year (see benefit guide for more information) at no cost • Free one year breakage warrantee on Davis Visio supplied material • Medically necessary contacts paid in full with prior approval.	

Behavioral Health Covered Services

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Inpatient Mental Health Services	• Inpatient psychiatric services for adults and children in acute care hospitals, • Inpatient psychiatric services for children under age 21 in a free-standing psychiatric facility.	Not a covered benefit.
Outpatient Mental Health Services	Medically necessary services for the treatment of mental health disorders, such as: • Psychiatric diagnostic evaluation • Psychotherapy (including individual, family, or group) • Psychological and neuropsychological testing, • Electroconvulsive therapy (ECT). • Pharmacological management Targeted Case Management and Mental Health Rehabilitation	Not a covered benefit.
Case Management and Care Coordination Services	These services include outreach education, case management, care coordination and community referral.	Not a covered benefit.
Inpatient and Residential Substance Use Disorder Services	Services include, but are not limited to: Inpatient and residential substance abuse treatment services including inpatient and residential withdrawal management treatment services, crisis stabilization, and 24-hour residential rehabilitation programs.	Not a covered benefit.

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Inpatient and Residential Substance Use Disorder Services	• Inpatient and residential withdrawal management treatment services • Residential treatment services which provide a structured therapeutic environment where persons reside with staff support and deliver comprehensive SUD treatment with attention to co-occurring conditions as appropriate.	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12-month limit for a plan-approved program. May be subject to formulary requirements.	Not a covered benefit.

Attachment K: STAR Kids Covered Services

Physical Health Covered Services

Covered Benefit	Description of Services
Adaptive Aids	Not limited to MDCP
Audiology services, including hearing aids	The Texas Health Steps program gives audiology services and hearing aids for ages 0 through 20.
Birthing Services	Provided by a physician and CNM in a licensed birthing center Provided by a licensed birthing center
Cancer screening, diagnostic, and treatment service	• 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 • CT, MRI, MRA, PET and SPECT need an OK from us
Chiropractic services	Covers services that help keep the spine and other body structures straight You do not need an OK from us to see a chiropractor in your network. (Maximum visit limits may apply)
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 **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 radio pharmaceuticals. 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 **www.txvendordrug.com.**
Day Activity and Health Services	Day Activity and Health Services (DAHS) (only for Members 18 of age and older) 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 of adult day services.

Covered Benefit	Description of Services
Dialysis	Covered as inpatient and outpatient hospital service.
Drugs and biologicals provided in an inpatient setting	Outpatient drugs and biologicals; including pharmacy-dispensed and clinician-administered outpatient drugs and biologicals.
Durable medical Equipment and supplies	These items are: • Covered when medically necessary. • Covered within the limits of what is covered by Medicaid. DME and supplies are not covered if: • They are used for exercise. • They are still being tested or research equipment. • More than one piece of equipment serves the same purpose • They are used only for making the room or home comfortable, such as: – Air conditioning – Air filters* – Air purifiers* – Exercise equipment – Spas – Swimming pools – Elevators – Supplies for hygiene or looks *On a case-by-case basis, these my be approved
Early Childhood Intervention (ECI) services	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
Emergency and Non-Emergency Ambulance Services	• Emergency room • Ambulance services
Family planning services	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.
Financial Management Services	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: • Managing payroll • Preparing and filing required tax forms and reports • Paying allowable expenses incurred by the employer • Providing status reports concerning the individual's budget, expenditures and compliance with the CDS option requirements

Covered Benefit	Description of Services
Flexible Family Support Services	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: • Assist a child to participate in childcare • Assist a person to participate in post-secondary education • Increase a person's independence • 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. • For MDCP members only.
Health Home Services	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 healthcare 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.
Home Health	Services such as nursing care or therapies provided in the home.
Hospital services, inpatient and outpatient	Inpatient: Hospital room with two or more beds • Nursing care • Operating room • Surgery • Anesthesia Outpatient • Dialysis • Giving you someone else's blood
Laboratory	All authorized lab services.
Program (EPSDT) Texas Health Steps	Medical checkups and Comprehensive Care Program (CCP) Services through the Texas Health Steps Program (EPSDT)

Covered Benefit	Description of Services
Mastectomy, breast reconstruction, and related follow -up procedures, including:	• 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: – All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed; – Surgery and reconstruction on the other breast to produce symmetrical appearance; – Treatment of physical complications from the mastectomy and treatment of lymphedemas; and – Prophylactic mastectomy to prevent the development of breast cancer. • External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
Medical checkup and Comprehensive Care Program (CCP) Services through the Texas Health Steps	CCP provides medically necessary, federally allowable treatment for Medicaid/ THSteps clients who are20 years of age and younger. Some medical services that usually would not be covered under Medicaid may be available to CCP-eligible clients.
Minor Home Modifications	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.
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	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.
Optometry, glasses, and contact lenses, if medically necessary	

Covered Benefit	Description of Services
Outpatient drugs and biologicals	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. 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. 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 **www.txvendordrug.com**. Prime Therapeutics offers e-prescribing through Sure Scripts, which allows providers to: • Submit prescriptions electronically • Verify client eligibility • Review medication history • Review formulary and PDL information The formulary is also available for mobile devices on **www.epocrates.com**. Additional outpatient prescription drug information: • No copay is required for prescriptions. • Prior authorization is required for certain drugs. • We do not reimburse claims for diet aids, cosmetic or hair-growth drugs, erectile dysfunction drugs, or infertility drugs. • We limit over-the-counter drugs to those on the Medicaid formulary. • We have limited home health supplies available under the pharmacy benefit. All other medical supplies and equipment are available under the medical benefit. • We do not reimburse claims for nutritional products (enteral or parenteral) under the pharmacy benefit. Medical prior authorization is required. • We offer free prescription delivery from those Texas VDP approved delivery pharmacies in our pharmacy provider service area network. • We will coordinate or provide rides to the pharmacy if no other transportation is available.
Personal Care Services (PCS)	All qualified members may receive medically and functionally necessary Personal Assistance Services under CFC.
Podiatry	Covered services include: • Medical problems of the feet. • Medical or surgical treatment of disease, injury or defects of the feet.
Prenatal Care	Provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center.

Covered Benefit	Description of Services
Prescribed pediatric extended care center (PPECC) services	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.
Prescription Drugs-Specialty Medications	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.
Private Duty Nursing (PDN) services	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.
Radiology, imaging, and X-rays	• 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 • CT, MRI, MRA, PET and SPECT need an OK from BCBSTX
Respite Care	Respite Care is the direct care of a member in order to provide their caregiver temporary relief from caregiving activities.
Telehealth	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.
Telemedicine	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.
Tele-monitoring	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.
Therapies – Physical, occupational, and speech	• Developmental assessments • Physical, occupational or speech therapy
Transition Assistance Services	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.
Transplantation of organs and tissues	• Human organ and tissue transplants that are not still being tested • All corneal, bone marrow and peripheral stem cell transplants that are not still being tested
Vision services	An eye exam every 12 months

Behavioral Health Covered Services

Covered Benefit	Description of Services
Inpatient Mental Health Services	• Inpatient mental health services in any facility type are a covered benefit for individuals under age 21 enrolled in STAR Kids. Inpatient mental health services provided in settings other than acute inpatient settings are available for up to 15 calendar days per month. BCBSTX provides these services in a free-standing psychiatric hospital and acute care inpatient hospital setting.
Outpatient Mental Health Services	• Medically necessary services for the treatment of mental health disorders, such as: – Psychiatric diagnostic evaluation – Psychotherapy (including individual, family, or group) – Psychological and neuropsychological testing, – Electroconvulsive therapy (ECT). – Pharmacological management – Targeted Case Management and Mental Health Rehabilitation
Inpatient and Residential Substance Use Disorder Services	• Inpatient and residential withdrawal management treatment services • Residential treatment services which provide a structured therapeutic environment where persons reside with staff support and deliver comprehensive SUD treatment with attention to co-occurring conditions as appropriate.
Outpatient Substance Use Disorder Services	• Substance use disorder (SUD) treatment services are age appropriate medical and psychotherapeutic services designed to treat a member's substance disorder and restore function such as: – Individual therapy – Group therapy – Outpatient withdrawal management services – Medication Assisted Treatment
Case Management and Care Coordination Services	These services include outreach education, case management, care coordination and community referral.

Disclaimers

BlueCross BlueShield of Texas

TEXAS Health and Human Services | CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS STAR Kids Your Health Plan ★ Your Choice

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