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

WELCOME PROVIDERS

This provider manual explains the policies and procedures of the:

Blue Cross and Blue Shield of Texas
Medicaid STAR, CHIP, and STAR Kids

bcbstx.com/provider/medicaid/

June 2026



STAR/CHIP: Travis Service Area
Provider Customer Service **877-560-8055**
SKSCP-9032-0626

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

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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How to Navigate This Manual

We developed this manual to make it easy for you as a participating provider to find information that will help you understand our STAR, CHIP and STAR Kids plans and to help you serve our members.

A few tips in navigating the manual:

- You can click on the blue header on any section to move directly to that section.
- You can navigate to different sections of the manual by clicking on any of the blue tabs along the lower right side of each page.
- You can also click on highlighted links throughout the manual. Those links will take you to other sections of the manual that relate to the topic you're reading about or will take you to relevant information online information from BCBSTX, Medicaid or other sources.
- You can find information related only to the STAR Kids plan in bold and with an asterisk.

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Section 1: Introduction

Background

Blue Cross and Blue Shield of Texas 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 providers and 500 hospitals to serve more than 5 million members in all 254 Texas counties.

BCBSTX has been around for more than 90 years and is 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 Texans as possible. We collaborate and innovate to deliver efficient, high-quality care. We contract with the Texas Health and Human Services Commission to provide services to enrollees of Texas Medicaid, Children's Health Insurance Program and STAR Kids and several STAR Kids programs.

Here are details of BCBSTX programs and service areas in Texas:

PROGRAM	SERVICE AREA
Children's Health Insurance Program and CHIP Perinatal	Travis Service Area: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson counties.
State of Texas Access Reform	Travis Service Area: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson counties.
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

The BCBSTX STAR program is a Medicaid-managed care program that provides acute medical care to children, pregnant women, and low-income families. (Acute care is preventive care, primary care and other medical care provided under the direction of a provider for a condition having a relatively short duration.) BCBSTX provides delivery of acute care to members who are not served by, or eligible for, other state-assisted health insurance programs.

The BCBSTX STAR program emphasizes early intervention and promotes improved access to quality health care with a special focus on prenatal care and regular medical checkups for children through the Texas Health Steps program.

The objectives 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.
- Promote provider and member satisfaction.

CHILDREN'S HEALTH INSURANCE PROGRAM

The Children's Health Insurance Program provides health coverage for children who are age 18 and younger in families that earn too much to qualify for Medicaid but cannot afford private health care coverage. A child in the program must be 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 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 the CHIP Perinatal program 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 Texas residents aged 20 and younger who get Supplemental Security Income (SSI) Medicaid or Home and Community-Based Waiver services under Medicaid will receive some or all 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 are to:

- Provide Medicaid benefits customized to meet the health care needs of recipients through a defined system of care
- Better coordinate care for recipients
- Improve health outcomes
- Improve access to health services
- Achieve cost containment and cost efficiency
- Reduce administrative complexity
- Reduce potentially preventable events through out-of-home residential care and provision of care management and appropriate services.

Quick Reference Guide

Program Area	STAR and CHIP	STAR Kids	Other/General Info
Provider Customer Service	**1-877-560-8055**	**1-877-784-6802** TTY: 711	Availity®: 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	**1-877-560-8055**	**1-877-784-6802**	Automated Inquiry System (AIS) **1-800-925-9126** www.availity.com www.tmhp.com
Utilization Management			
Prior Authorization and Referrals	**1-877-560-8055**	**1-877-784-6802**	Fax: **1-855-653-8129** www.availity.com Forms: www.bcbstx.com/provider/medicaid/claims-and-eligibility/um
Long-term Services and Supports (LTSS)			Phone: **1-855-212-1615** Fax: **1-512-349-4860**
Service Coordination Referrals	**1-877-214-5630**	**1-877-301-4394** Fax: **1-866-644-5456**	Email: TX_Medicaid_HC@bcbstx.com
Electronic Visits Verification (EVV)			**1-877-784-6802** Email: BCBSTX_EVV_Questions@bcbstx.com Web: www.bcbstx.com/provider/medicaid/education-and-reference/evv
Interpreter Services	**1-877-560-8055**	**1-877-784-6802**	
Claims and Payment			
Claims Phone Number and Address	**1-877-560-8055**	**1-877-784-6802** TTY: 711	www.availity.com/ (Payor ID: 66002) Mailing Address: Blue Cross and Blue Shield of Texas PO BOX 650712 Dallas, TX 79159-1422
Refunds and Overpayments			Mailing Address: Blue Cross and Blue Shield of Texas Claims Overpayment Dept. 14212 Palatine, IL 60055-4212
Complaints and Appeals			
Provider Complaints	**1-877-560-8055**	**1-877-784-6802**	Fax: **1-877-886-2593** Email: GPDTXMedicaidAG@bcbsnm.com Mailing Address: Blue Cross and Blue Shield of Texas Complaints and Appeals PO Box 660717 Dallas, TX 75226

Provider Appeals	**1-877-560-8055**	**1-877-784-6802**	Appeal Form: www.bcbstx.com/docs/provider/tx/provider-medicaid/provider-appeal-request-form.pdf (Please see website for instructions on filing an appeal) Fax: **1-877-886-2593** Email: GPDTXMedicaidAG@bcbsnm.com Mailing Address: Blue Cross and Blue Shield of Texas Complaints and Appeals PO Box 660717 Dallas, TX 75226
Fraud, Waste and Abuse			**1-800-543-0867** TTY: 711
Texas Medicaid & Healthcare Partnership Billing			www.tmhp.com
Supporting Vendors			
DentaQuest (Dental Services)			**1-800-516-0165** or www.dentaquest.com
MCNA Dental (Dental Services)			**1-800-494-6262** or www.mcna.net/
Prime Therapeutics Specialty Pharmacy™	Customer Service: STAR **1-855-457-0405** CHIP **1-855-457-0403** Prior Authorization: **1-855-457-0407**	Customer Service: STAR Kids (Travis Service Area) **1-855-457-0757** STAR Kids (MRSA Central Service Area) **1-855-457-0758** Prior Authorization: **1-855-457-1200**	Prior Authorization: Fax: **1-877-243-6930**
24/7 Nurseline	**1-844-971-8906**	**1-855-802-4614**	
ModivCare (Transportation Services)	**1-866-824-1565** (TTY: 711)	**1-855-933-6993**	**1-877-564-9835** Monday – Friday 8 a.m. – 5 p.m. (Central Time)
Davis Vision℠ (Vision Services)			Provider: **1-800-773-2847** Member: **1-888-657-6061** www.davisvision.com

Frequently Asked Questions

HOW CAN I VERIFY A PATIENT'S ELIGIBILITY AND BENEFITS UNDER THE HEALTH PLAN?

You can verify a patient's eligibility and benefits through the Availity tool. You can also call **1-877-560-8055** for STAR and CHIP and **1-877-784-6802** for STAR Kids.

WHAT IS THE PROCESS FOR SUBMITTING A CLAIM AND RECEIVING REIMBURSEMENT?

You can submit a claim electronically, through the Availity tool. You can also file a paper claim through the mail. See the Claims and Payment section of the Quick Reference Guide and Section 9: Claims and Billing for more info.

HOW DO I OBTAIN OR VERIFY PRIOR AUTHORIZATION?

You can use the Availity portals to submit a prior authorization request. You can also call 1-877-560-8055 for STAR and CHIP and 1-877-784-6802 for STAR Kids for prior authorization information. Staff there can help you with prior authorizations or questions. Also see Section 8: Quality Management and Utilization Management for more information. You can also find lists of services and procedure codes that may require prior authorization. You can download prior authorizations forms Request for Prior Authorization Acute Form or Request for Prior Authorization LTSS Form.

HOW DO I CHECK ON THE STATUS OF A CLAIM?

You can check on Availity or contact **1-877-560-8055** for more information about a STAR or CHIP claim or **1-877-784-6802** for a STAR Kids claim. You can also see Section 9: Claims and Billing for more information.

HOW CAN I UNDERSTAND WHY A CLAIM WAS DENIED?

You can check on the Availity portal, which helps providers with claims, prior authorizations and other processes. You can also contact Provider Customer Service at **1-877-560-8055** (for STAR and CHIP) and **1-877-784-6802** (for STAR Kids).

HOW CAN I FIND IN-NETWORK PROVIDERS?

You can find in-network providers here.

Section 2: Definitions for STAR Kids programs

Below are important STAR Kids definitions and details on STAR Kids programs:

1915(I) HOME AND COMMUNITY BASED SERVICES-ADULT MENTAL HEALTH

Home and Community Based Services-Adult Mental Health is a statewide 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 them 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 WAIVER PROGRAM

The Community Living Assistance and Support Services 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. 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 WAIVER PROGRAM

The Deaf Blind with Multiple Disabilities 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 condition. 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 are called dual-eligible.

HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

The Home and Community-based Services 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 means assistance with daily health care and living needs for individuals with a long-lasting illness or disability.

MEDICALLY DEPENDENT CHILDREN PROGRAM WAIVER PROGRAM

The Medically Dependent Children Program 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 WAIVER PROGRAM

The Texas Home Living 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 WAIVER PROGRAM

The Youth Empowerment Services 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 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. The waiver is intended to provide hope to families by offering services aimed at keeping children and youth in their homes and communities.

Section 3: Provider Roles and Responsibilities

Provider Roles

ROLE OF A PRIMARY CARE PROVIDER

A primary care provider is a physician who has agreed with BCBSTX to provide initial and routine care to members, to provide referrals for care and to maintain the continuity of care for patients. The PCP is the foundation of BCBSTX health care.

STAR, STAR Kids and CHIP members are required to have a PCP; STAR Kids Dual Eligible members are not required to have a PCP.

The STAR, CHIP and STAR Kids PCP networks include:

- General/Family Practice
- Internal Medicine
- OB/GYN
- Pediatrician
- Advanced Nurse Practitioner
- Physician Assistant

ROLE OF A MEDICAL HEALTH HOME

The term “medical health home” refers to a practice-based care team that takes collective responsibility for a member’s ongoing care. The PCP facilitates partnerships between members, families, clinicians, and medical staff.

ROLE OF A SPECIALTY CARE PROVIDER

A specialty care provider (SCP) is a physician or other health care provider who has education, training, and qualifications in a specialty other than primary care. Specialty care means advanced and medically necessary care for specific physical, mental, or behavioral health conditions. An SCP preferably works in coordination with a PCP.

ROLE OF AN LTSS CARE PROVIDER

Long Term Services and Supports care providers deliver a continuum of care and assistance. These services can be in-home, or community based. The services are for members of all ages, including the elderly and people with disabilities who need assistance in maintaining their independence.

ROLE OF A SERVICE COORDINATOR

The service coordinator develops and implements a person-centered care plan for each member. The service coordinator will work directly with the member or their legally authorized representative (LAR), or both, to coordinate the member’s clinical and non-clinical support.

ROLE OF A CHIP PERINATAL PROVIDER

CHIP Perinatal providers provide obstetrics and gynecology services to CHIP Perinatal members/mothers during the pregnancy and postpartum period. They also provide medically necessary services for the unborn child. Once born, the child will receive Medicaid or CHIP benefits, depending on the family’s income.

THE ROLE OF A BCBSTX TRANSITION SPECIALIST

A BCBSTX transition specialist works with adolescent and young adult STAR Kids members and their legally authorized representative to prepare the member for a successful transfer out of the 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. That plan will continue until the member has successfully transitioned out of the STAR Kids program after the member’s 21st birthday.

ROLE OF A 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 through arrangements with Prime Therapeutics LLC, the pharmacy benefits manager. You can find more information in “Pharmacy Provider Responsibilities” in this section.

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 they do not choose one in a timely manner. Whether chosen or assigned, each member who is six months or older must have a designated Main Dental Home.

A Main Dental Home serves as a 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

All BCBSTX Medicaid providers must follow local, state, and federal regulations, including those issued by the Texas Health and Human Services Commission to BCBSTX. Providers must also adhere to rules outlined in the Uniform Managed Care Manual (UMCM) Chapter 8.1, specifically the "Provider Standard Contract Provision," which can be found in the UMCM or Attachment I of the Blue Cross and Blue Shield of Texas Medicaid Provider Manual. Regular review of the "Provider Standard Contract Provision" is crucial for compliance.

BCBSTX works to ensure that members can access appropriate medical services within the participating provider network. BCBSTX will determine if medical services can be provided in-network. If BCBSTX determines only a non-participating provider can furnish needed services, we will authorize those services. BCBSTX will attempt to contract with non-participating providers to enhance our provider network.

Credentialing and Re-Credentialing Process

CREDENTIALING PROCESS

BCBSTX has established rigorous standards for credentialing in compliance with the standards of approved accrediting bodies.

All credentialing and recredentialing questions should be directed to your BCBSTX Network Representative at **1-855-212-1615** or TexasMedicaidNetworkDepartment@bcbstx.com.

Physicians or Other Professional Providers

The BCBSTX credentialing process is consistent with guidelines of the National Committee for Quality Assurance and Texas requirements to practice.

BCBSTX requires full credentialing of the following office-based physicians and other appropriate 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 Doctor (MD)
- Doctor of Chiropractic (DC)
- Doctor of Dental Surgery (DDS)
- Doctor of Dental Medicine (DMD)
- Doctor of Osteopathy (DO)
- Doctor of Podiatric Medicine (DPM)
- Occupational Therapist (OT)
- Licensed Physical Therapist (LPT)
- Physician Assistant (PA)
- Registered Dietician (RD)
- Speech and Language Pathologist (SLP)

Behavioral health providers can contact Provider Customer Service at **1-877-560-8055** (for STAR and CHIP) and **1-877-784-6802** (for STAR Kids) with any questions regarding the credentialing or recredentialing process.

Expedited Credentialing Process

BCBSTX will provide an expedited credentialing process that allows for a “provisional network participation” status if the provider applicant:

- Has enrolled as a Medicaid provider with the Texas Medicaid and Health Partnership for STAR, CHIP or 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 Council for Affordable Quality Healthcare (CAQH®) Provider Data Portal database (see details below) online application with “global” or “plan specific” authorization to BCBSTX or has submitted a completed Texas Department of Insurance application, as appropriate
- Has a current, valid license in good standing with the Texas licensing board applicable to their provider type

If the applicant does not meet the provisional network participation requirements above, the applicant must be fully credentialed and approved prior to becoming part of the STAR, CHIP and STAR Kids networks.

Credentialing is a very involved process. Please allow enough time for the full credentialing process to be completed before calling BCBSTX for a status update.

Initial Credentialing and Re-Credentialing Process

BCBSTX requires that providers use the CAQH Provider Data Portal for initial credentialing and recredentialing.

The CAQH Provider Data Portal, a free online service, allows providers to complete one application to meet the credentialing data needs of multiple organizations. The Provider Data Portal online credentialing application process supports our administrative streamlining and paper reduction efforts.

RECREDENTIALING PROCESS

If you are an existing user of CAQH, you are required to review and attest to basic information about you and your practice once every four 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 Provider Data Portal application and authorized BCBSTX to receive the information or selected "global authorization." If so, BCBSTX will be able to obtain current information from the Provider Data Portal and complete the recredentialing process without having to contact you.

If your credentialing application (for recredentialing) is not available to BCBSTX through CAQH because you have not completed the Provider Data Portal registration process, CAQH will send you a welcome kit that includes access and registration instructions. It will also send you your personal CAQH Provider ID. This will allow you to obtain immediate access to the Provider Data Portal to complete and submit your application.

If your provider type is not included in the CAQH Approved Provider Types' list, you must go to the TDI website to access and complete a Texas Standardized Credentialing Application. See the "Exceptions to Required Use of CAQH Database" subsection above for information on how to complete and submit that application.

Keeping Your Provider Info Updated

- Updating CAQH

CAQH will send you automatic reminders to review and attest to the accuracy of your data. Use the Provider Data Portal to report any changes to your practice.

You must enter any changes into the Provider Data Portal for BCBSTX to access during the credentialing and recredentialing process. Only health plans that participate in the Provider Data Portal and that you have given authorization to access will receive these changes.

- Updating Your BCBSTX Provider File

BCBSTX members rely on the accuracy of the provider information in our directories and our online Provider Finder®. (Scroll to the bottom of the directories page to find Provider Finders for each plan.) 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.

CAQH — FREQUENTLY ASKED QUESTIONS

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 staff. CAQH's participating organizations provide health care coverage for more than 165 million Americans.

What is the CAQH Provider Data Portal?

The CAQH Provider Data Portal 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 Provider Data Portal service. Providers in all 50 states and the District of Columbia can enter their information free of charge through an interview-style process.

Through its streamlined, electronic data collection process, the Provider Data Portal is helping to reduce unnecessary paperwork while saving millions of dollars in annual administrative costs for more than 800,000 health care providers, as well as more than 550 participating health plans, hospitals and health care organizations.

Is there a charge for providers to use CAQH?

No. Providers use The CAQH Provider Data Portal at no cost.

Are accrediting bodies in support of the CAQH application?

Yes. The CAQH application (Provider Data Portal form) meets the data collection requirements of the Utilization Review Accreditation Commission, the National Committee for Quality Assurance and the Joint Commission 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.

Why did BCBSTX choose to work with CAQH?

BCBSTX chose to work with CAQH because the Provider Data Portal 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.

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. The exceptions: Providers whose type is not listed in the "CAQH Approved Provider Types" list must go to the TDI website to access and complete a Texas Standardized Credentialing Application. See details in the "CAQH Approved Provider Types List" subsection above.

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.

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.

How can I access the CAQH database?

To access CAQH database for BCBSTX, you will use a personal ID and password. You may submit your completed application online and fax supporting documents to **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.**

Getting Started with the CAQH

CAQH will accept only providers from among the following approved provider types:

CAQH Approved Provider Types List

CAQH Approved Provider Types List	
• Medical Doctor (MD)	• Doctor of Podiatric Medicine (DPM)
• 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

Providers whose type is not listed in the CAQH Approved Provider Types 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 or licenses applicable to your provider type
- Current federal Drug Enforcement Administration Certificate, if applicable
- Current Controlled and Dangerous Substances Certificate, if applicable
- Current malpractice insurance face sheet (declaration of coverage)
- Summary of any pending or settled malpractice cases, if within the past 10 years
- Curriculum Vitae
- Current signed attestation, attesting to the accuracy of information
- Hospital coverage letter (this is required from providers without admitting privileges at a participating network hospital)

Providers send their completed application packet to BCBSTX via:

- Fax: **1-512-349-4853** (preferred method) or
- Mail:
  Blue Cross and Blue Shield of Texas
  9442 II Capital Texas Highway North, Suite 500 Arboretum Plaza II
  Austin, TX 78759

Activating your Provider Data Portal Registration with CAQH

Participating providers must have a CAQH ID to register and begin the credentialing process.

- First Time Users (if not yet 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 Provider Data Portal database via the Internet. When you receive your CAQH Provider ID, you can register by either:

- Using the CAQH website, or
- Submitting your 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 the CAQH Provider Data Portal.

Completing the Application Process

The Provider Data Portal standardized application is a single, standard online form that meets the needs of all participating health care organizations. When completing the application, you will need to indicate which participating health plans and health care organizations you authorize to access your application data. All provider data you submit through the Provider Data Portal is maintained by CAQH in a secure, state-of-the-art data center.

Referring to the following materials will be helpful while completing the Provider Data Portal online application:

- Previously completed credentialing application
- List of previous and current practice locations
- Various identification numbers (National Provider Identifier, or NPI, Medicare, Medicaid, etc.)

When you are ready to begin entering your data, log in to the Provider Data Portal with your username and password. After completing the online credentialing application, you will 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 and attest; you will review the summary of your data for accuracy and completeness and make any needed changes.
- Upload supporting documents. All supporting documents will be reviewed in three to five 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. Required supporting documents include:
  - State licenses applicable to your provider type
  - Current federal Drug Enforcement Administration Certificate, if applicable
  - Current Controlled and Dangerous Substances Certificate, if applicable
  - Current malpractice insurance face sheet
  - Summary of any pending or settled malpractice case — if within the past 10 years
  - Curriculum Vitae
  - Current signed attestation
  - Hospital coverage letter (this is required from providers without admitting privileges at a participating network hospital)

If you have any questions about accessing the Provider Data Portal, you may contact the CAQH Help Desk at 1-888-599-1771.

BCBSTX may contact you to supplement, clarify or confirm certain responses on your application. We may require you to submit additional documentation in some situations, in addition to the information you submit through the Provider Data Portal.

You will forward additional documentation to BCBSTX through:

- Fax: **1-512-349-4853** (preferred method) or
- Mail:
  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 Provider Data Portal online application through your participation with another health plan and have not selected "global authorization," CAQH will email you to authorize BCBSTX. Log in to the Provider Data Portal and add BCBSTX as one of the health plans that can access your information.

To authorize BCBSTX to access your data follow these four steps:

- Go to the Provider Data Portal homepage.
- 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.

Providers can visit the CAQH Provider Data Portal webpage for more information about the Provider Data Portal and the application process.

Additional CAQH Resources

CAQH Contact Information Help Desk:

- **1-888-599-1771**

Phone Hours:

- Monday – Thursday: 7 am. – 9 pm. EST
- Friday: 7 am. – 7 pm. EST

Credentialing Process for Hospital or Facility-Based Providers

Below are the necessary steps for hospital or facility-based providers to submit a request for contracting and 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 applies only 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)

Requirements Beyond Provider Record ID

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.

Council for Affordable Quality Healthcare — Frequently Asked Questions

IF THE PROVIDER IS:	THEN:
A solo practitioner or medical group that is currently contracted with the BCBSTX and is interested in contracting as a facility-based provider with the STAR, CHIP and Star Kids networks and does not currently have a contract to participate as a Medicaid network provider.	Please follow the steps below: • 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**. • 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 • Complete the STAR, CHIP and Star Kids Facility- based Provider Application 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 STAR, CHIP or STAR Kids networks.	Complete the STAR, CHIP and STAR Kids Facility-based Provider Application and fax the completed application to your local Network Management office in Austin. Fax: **1-512-349-4853**

Provider Responsibilities

PROVIDER GENERAL RESPONSIBILITIES

General guide for network participation for all providers (excluding for STAR Kids Dual Eligible members):

- 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 Professional Provider Agreement.
- Comply with all BCBSTX 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 members understand the right to obtain medication from any network pharmacy.
- Maintain confidential medical records consistent with BCBSTX's medical records guidelines and applicable Health Insurance Portability and Accountability Act regulations. (Please note: As a provider, you agree 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 details in "Continuity of Care" subsection within Section 3: Covered Services.)
- 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 state-mandated requirements.
- Notify BCBSTX if there is a change in your office address, tax ID number or any other demographic changes relating to you or your office.
- Maintain enrollment status with Texas Medicaid. (Please note: Texas Medicaid will deny claims for prescriptions, items and services ordered when the provider who ordered, referred, or prescribed the prescriptions, items or services is not enrolled in Texas Medicaid. This applies to care for any member enrolled in Medicaid, Children with Special Health Care Needs Services Program or Healthy Women programs. This also 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.
- Provide at no cost to the Texas Health and Human Services Commission or its delegates any requested records in accordance with the timelines, definitions, formats, and instructions specified by Texas HHSC.
- Providers are encouraged to review and become familiar with the contract standard provisions available on the UMCM website or in Attachment I. Provisions are subject to change; refer to the UMCM website for the most current version.

Reminder: Providers can contact your local Provider Representative with any questions about provider responsibilities at **1-855-212-1615**. To find a Provider Representative in your area, visit the Provider Customer Service Numbers webpage.

Medical Home and Health Home

The PCP functions as a member's "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 or provider teams. Its goal is to provide comprehensive and continuous medical and behavioral care to patients to obtain the best possible 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 SCPs 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 and seven days per week. Members must be able to call their PCP with a request for medical assessment outside of PCP normal office hours. The provider must comply with the following telephone availability standards:

- The office telephone is answered during normal business hours.
- After business hours, provider must have one of the following arrangements:
  - The office telephone is answered outside of normal business 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 outside 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 answered only during office hours.
  - The office telephone is answered after-hours by a recording that tells patients to leave a message.
  - Member calls made outside normal business hours are returned outside of 30 minutes.
  - The answering machine is not bilingual (English and Spanish).
  - The office telephone is answered outside of normal business hours by a recording directing patients to go to an emergency room for any services needed.

Appointment Access Guide

Here are requirements for general appointment scheduling:

- Emergency examinations: immediate access during office hours
- Urgent examinations: within 24 hours of request
- Non-urgent, routine, and 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 Age 21

Here are services for members under age 21:

- Well-child check with assigned PCP:
  - Within 14 days of enrollment for newborns
  - Within 60 days of enrollment for other eligible child and young adult members
- Preventive care visits:
  - CHIP members should receive preventive care in accordance with the American Academy of Pediatrics (AAP) periodicity schedule.
  - Medicaid members should receive preventive care in accordance with the Texas Health Steps periodicity schedule.
  - We encourage new members under age 21 to receive a Texas Health Steps checkup within 90 days of enrollment.

Services for Members Aged 21 Years and Older

Here are services for members aged 21 and older:

- Preventive care visits within 90 days of request
- 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 Texas HHSC Administrative Services Administrator and Texas Medicaid and Health Partnership of any changes in practice organization or demographic information. You can find forms to provide updates in the BCBSTX Secure Provider portal.

Federal law requires certain provider information be verified every 90 days. That means you must:

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

Under federal law, we are required to remove providers from displaying in our Provider Finder whose data we are unable to verify.

PROVIDER TERMINATION FROM BCBSTX

Providers may cease participating with BCBSTX for mandatory or voluntary reasons. Mandatory disenrollment occurs when a provider becomes unavailable due to immediate and unforeseen reasons. Examples of this include death or loss of license.

Providers must give written notice to us within the time frames specified in the Participating Provider Agreement of their voluntary end to participation with BCBSTX. Members linked to a PCP who disenrolled for voluntary reasons will be notified to select a new PCP. By law, BCBSTX must submit notification of all provider terminations to the Texas HHSC.

When this happens with a PCP, we assign members to another PCP to ensure continued access to our covered services. BCBSTX will notify members of any termination of PCPs or other providers from whom they receive care. BCBSTX will provide notice to affected members when a provider disenrolls for voluntary reasons, such as retirement.

MEMBER RIGHTS TO DESIGNATE OB/GYN AND OTHER SPECIALISTS AS PCP

Members have the right to designate an OB/GYN as their PCP. (This right is for STAR, STAR Kids, and CHIP members only— STAR Kids Dual Eligible members are excluded.) 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 provider within the network

For members with disabilities, special health care needs or chronic or complex conditions, the member has the right to designate a specialist provider as their PCP if the specialist agrees.

NON-REFERRAL EYE CARE

Members have the right to select and have access to, without a PCP referral, a network ophthalmologist or therapeutic optometrist to provide eye health care services other than surgery.

ADVANCE DIRECTIVES

BCBSTX adheres to the federal Patient Self-Determination Act and maintains written policies and procedures regarding advance directives for patients. An advance directive is a statement, signed by the member, that indicates, in advance, the member's choices for medical treatment if the member becomes incapacitated or otherwise unable to make treatment decisions.

There are two types of advance directives:

- A durable power of attorney for health care allows the member to name a patient advocate to act on behalf of the member.
- A living will allow the member to state his or her wishes in writing but does not name a patient advocate.

BCBSTX encourages members to request education about advance directives and ask for an advance directive form from their PCP at their first appointment. Members over age 18 and emancipated minors can make an advance directive. A member's choice on completing an advance directive should be documented in their 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 limits, 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 are responsible for the complete care of their patients. That includes referring members to the appropriate provider of care within BCBSTX network.

BCBSTX does not require a referral from a PCP for a member to see an SCP. SCPs, however, may require a referral from a PCP before they see a member. In any case, providers must ensure any referrals for specialty care for members are made on a timely basis, based on the urgency of the member's medical condition. Those referrals should happen no later than 30 days from the date the need is identified or requested.

Referrals to specialists must include documentation of the coordination of referrals and services provided between the PCP and specialist. This requirement does not apply to STAR Kids Dual Eligible members. PCPs must provide justification to BCBSTX when making a referral to an out-of-network specialist.

MEMBER DENTAL CARE

The Dental Plan Member ID card lists the name and telephone number of a member's Main Dental Home provider. The member can contact the dental plan to select a different Main Dental Home provider at any time. If the member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan's system, and the member is mailed a new ID card within five business days.

Note: 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 at **1-800-964-2777**.

A PCP CAN PROVIDE BEHAVIORAL HEALTH SERVICES

A PCP may provide behavioral health related services within the scope of the PCP's practice — except for STAR Kids Dual Eligible members. A PCP should refer those members to a behavioral health provider.

SECOND OPINIONS

A member may get a second opinion when they have 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. That includes a parent 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**, or via fax at **1-855-653-8129** (for STAR and CHIP members), or **1-877-784-6802** or via fax at 1-866-644-5456 (for STAR Kids members).

SPECIALTY CARE PROVIDER RESPONSIBILITIES

Specialty care providers are network providers who specialize in a branch of medicine focused on a defined group of patients, diseases, skills, or philosophy. Specialty care areas include pediatrics, oncology, pathology, cardiology, and other specialties.

SCPs contracted under BCBSTX must follow the same regulatory and mandatory guidelines referenced above for PCPs, including availability and accessibility standards.

All SCPs must give regular reports to the member's assigned PCP after the initial consultation and any follow-up evaluations. These reports must include the diagnosis, recommendations, and a treatment plan.

Some members may be determined to have "special health care needs." This would include members with disabling conditions, chronic illnesses, some pregnant women, and children with special health care needs. Members with these special needs may request that their SCP also be their PCP. Our Medical Management department must review the request for an SCP to be a PCP.

Long Term Services and Supports (LTSS) providers deliver a variety of care and assistance options. Those include in-home and community-based services for children and youth who get additional services through the Medically Dependent Children Program.

VERIFYING MEMBER ELIGIBILITY

Providers or their staff must verify member eligibility prior to providing services or requesting authorizations.

MEDICAL RECORD STANDARDS

All providers are required to maintain medical records in a complete and orderly fashion that promotes efficient and quality patient care. Participating practitioners are subject to periodic quality review of medical records by BCBSTX and Texas to check whether they are complying with medical record-keeping requirements.

Medical records must reflect all aspects of patient care, including ancillary services that may be part of diagnosis and treatment. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act and other federal and state laws. (You can learn more about HIPAA in Section 13.)

Providers must have a policy in how they respond to requests and provide medical records of patients. That policy must include a provision for providing copies within 48 hours in urgent situations. Medical records must be maintained in a current, detailed, organized and comprehensive manner.

If a provider uses paper medical records, those records should have:

- An identifiable order in the patient chart assembly
- Papers fastened in the chart

Medical records must be:

- Stored in a manner that helps ensure 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 provider who generally furnishes care to the member.
- Promptly sent to SCPs upon patient request and within 48 hours in urgent situations.

Important elements in each patient's medical record:

- The records are legible.
- All physician entries are signed and dated.
- The patient's name/identification number is located on each page of the record.
- Linguistic or cultural needs are documented as appropriate.
- The records contain demographic data that include name, identification numbers, date of birth, gender, address, telephone number(s), employer, contact information, marital status and an indication whether the patient's first language is something other than English.
- The records include important parts of a patient's medical history, including:
    - An initial history (for patients seen three or more times)
    - 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, alcohol and/or substance use/history beginning at age 11
    - History of immunizations of children, adolescents, and adults
- Notes on how any missed appointments were monitored and handled.
- Any executed advance directive is in a prominent part of the 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.
- Include a list of all significant illnesses and active medical conditions.
- A medication list that includes prescribed and over-the-counter medications and is reviewed annually.
- The presence or absence of allergies or adverse reactions is clearly documented.
- Information on tracking of age and gender appropriate preventive health services — and referrals to other providers for those services when appropriate — consistent with BCBSTX's Preventive Care Guidelines
- Documentation of all elements of periodic screening, diagnosis, and treatment for those under 21 years through the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit

- Clinical decisions and safety support tools are in place to ensure evidence-based care.
- Treatment plans that are consistent with evidence-based care and with findings/diagnosis
- The medical record should also show that the provider has periodically screened the patient for:
  - 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

NON-CONTRACTED PROVIDERS

BCBSTX ensures that members can access appropriate medical services within the participating provider network.

If we determine that services can be provided only by a non-participating provider, we will approve those services for coverage. We 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.

Non-contracted providers must obtain an authorization from our Utilization Management department. In some cases, we will issue something called a “Single Case Agreement.” This will allow the non-contracted provider to provide covered treatment to the member for a specified period.

All non-contracted providers still must be attested with Medicaid – approved as Medicaid providers.

HOW TO REPORT ABUSE, NEGLECT AND EXPLOITATION

BCBSTX and participating providers must report to the appropriate organization any allegation or suspicion of abuse, neglect and exploitation that occurs within the delivery of long-term services and care. BCBSTX’s managed care contracts outline BCBSTX and provider responsibilities relating to identifying and reporting abuse, neglect and exploitation. State laws also apply to the reporting of these issues.

In some cases, the Texas Department of Family and Protective Services may investigate a report of ANE and give a written report on its findings to a health care provider. In those cases, the provider must give BCBSTX a copy of the report within one business day of receiving it.

In addition, the provider must report to BCBSTX individual remediation measures relating to confirmed allegations against the provider or any of their staff.

Providers should report any suspicions of ANE to Texas HHSC if the victim — child or adult — resides in or receives services from:

- Nursing facilities
- Assisted living facilities
- Adult day care centers
- Licensed adult foster care providers
- Home and Community Support Services Agencies (With HCSSAs, providers should report to both HHSC and DFPS.)

Providers can contact HHSC at **1-800-458-9858**. They can contact DFPS at **1-800-252-5400** or, in non-emergency situations, online at www.txabusehotline.org.

Providers should report any suspicions of ANE to DFPS if the victim is any of the following:

- For STAR or CHIP programs, an adult who is elderly or has a disability and is receiving services from:
  - An unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from any of the following providers or their contractors:
  - A local intellectual and developmental disability authority, local mental health authority, community center, or mental health facility operated by the Texas 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
  - Through Consumer Directed Services option (Consumer Directed Services allows people receiving services from HHSC to hire and manage people who provide those services.)
  - If a provider is unable to identify state agency jurisdiction but suspects an instance of ANE occurred, they should report their suspicions to local law enforcement. (They should also report to DFPS.)

Failure to Report or False Reporting

Everyone has an obligation to report to DFPS any suspected ANE against a child, an elderly adult, or an adult with a disability to DFPS. This includes ANE committed by a family member, a DFPS-licensed foster parent or accredited child-placing agency foster home, DFPS-licensed general residential operation, or a childcare center.

It is a crime 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 also a crime to knowingly 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.)

COORDINATION WITH TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

Providers are required to cooperate and coordinate with foster parents and the Texas DFPS for the care of a child receiving services from or placed in the conservatorship of Texas DFPS.

Providers demonstrate their cooperation and coordination by:

- Providing medical records to Texas DFPS
- Scheduling medical and behavioral health appointments within 14 days (unless requested earlier by Texas DFPS)
- Recognizing abuse and neglect and appropriately referring those cases to Texas DFPS
- Providing all covered services defined in court orders or a Texas DFPS 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 (Texas HHSC's managed care program for children in foster care)

Continuity of Care

CONTINUED OB/GYN CARE FOR PREGNANT MEMBERS

BCBSTX will allow pregnant members who are past the 24th week of pregnancy to remain under the care of their current OB/GYN through the member's postpartum checkup — even if the provider is out-of-network. If a member wants to change their OB/GYN to a provider who is part of the network, they must be allowed to do so if the provider agrees to accept the members during the last trimester of pregnancy.

MEMBERS WHO MOVE OUT OF THE SERVICE AREA

If a member moves out of the BCBSTX service area, BCBSTX will provide or pay out-of-network providers in the new service area who provide medically necessary covered services to the member. This will happen through the end of the period for which BCBSTX receives a capitation payment for the member. (A capitation payment is a fixed amount of money a managed care organization receives in advance to care for a patient during a defined period.)

OUT-OF-NETWORK CONTINUITY OF CARE

In some situations, BCBSTX may approve services out-of-network. To ensure the continuity of care for a member, BCBSTX may authorize out-of-network services if a specialty care provider has helped treat a member's health conditions. We may also authorize out-of-network services if a member's health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

In these cases, BCBSTX may authorize a non-contracted provider to provide medically necessary services until the transition to a network provider may be completed. BCBSTX will not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to the member.

BCBSTX helps ensure continued access to care for members with qualifying conditions when:

- Members are newly enrolled
- Members move out of the service area
- Services are not available within the network
- The provider's contract terminates.
- Members disenroll to another health plan
- Members receive Home and Community-Based Services
- There is an existing prior authorization from a previous managed care organization
- Any STAR Kids member receiving any other services on the STAR Kids operational start date

A qualifying condition is a medical condition that may qualify a member for continued access to care. Qualifying conditions include:

- Pregnancy
- 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)

Some of the above qualifying conditions still require prior authorizations.

If a member is new to one of our health plans and is already receiving care from an out-of-network provider, BCBSTX allows continuation of services with that out-of-network provider for 90 days.

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

Long Term Services and Supports Provider Responsibilities

STAR KIDS LONG-TERM SERVICES AND SUPPORTS PROVIDER RESPONSIBILITIES

Long-Term Services and Supports providers serve certain members participating in the STAR Kids program. An LTSS provider helps a patient by furnishing a variety of non-medical services. Those services include adult day care, adult foster care, home-delivered meals, personal attendant services, home modifications and respite services. LTSS services require a prior authorization. You can download a form here.

Long-Term Services and Supports Provider Responsibilities

LTSS providers deliver a continuum of care and assistance to children and youth who get additional services through the Medically Dependent Children Program.

LTSS providers have certain responsibilities for the STAR Kids program and the members they serve. These include:

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

COMMUNITY FIRST CHOICE PROVIDERS

Community First Choice enables Texas Medicaid to provide the most cost-effective approach to helping members with basic attendant and habilitation needs. The CFC program helps eligible clients who require assistance with activities of daily living and instrumental activities of daily living because of limitations related to their disability or chronic health condition. The limitations might be physical, cognitive, or behavioral.

The program also helps with habilitation — teaching a person how to do everyday tasks without help.

Community First Choice Provider Responsibilities

Here are the responsibilities of a CFC provider:

- The provider must deliver CFC services in accordance with the member's service plan.
- The provider must maintain current documentation, including the member's service plan and their intellectual disability/related condition assessment, if applicable. They must also maintain 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 provider must ensure that they train and continually have available qualified service providers who can help with the needs of the member they are serving. That means a service provider should be available to help with nursing tasks, dietary needs, behavioral needs, mobility needs, allergies and any other needs the member has. The goal is to ensure the member's health, safety and welfare. The program provider must maintain documentation in the member's record of this training of service providers.

- The provider must ensure that staff members have been trained to recognize and report acts or suspected acts of abuse, neglect and exploitation (ANE). The provider must also show documentation regarding required actions that they must take when an Adult Protective Services investigation begins. Those actions are required from the beginning through the completion of the investigation. They include, for example, providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc. The provider must also give the member or the member's legally authorized representative (LAR) information on how to report acts or suspected acts of abuse, neglect and exploitation, including information about the Adult Protective Services hotline (**1-800-252-5400**).
- The provider must address any complaints received about the provider or staff from a member or the member's LAR and have documentation showing the attempts at resolution of the complaint. The provider must give the member or the member's LAR the appropriate contact information for filing a complaint.
- The provider must not retaliate against anyone 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 of a member. That includes any staff member, service provider, member, someone acting on behalf of a member or any other person filing a complaint or providing information.
- The provider must ensure that service providers meet all personnel requirements (minimum age, high school diploma/GED or competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting and checks on criminal history, employee misconduct registry, nurse aide registry and exclusion list of the U.S. Health and Human Services Office of Inspector General). For emergency response services that are part of CFC, the provider must ensure that the provider of the emergency response services has the appropriate licensure.
- The provider must ensure that any additional training requested by the member or the member's LAR for CFC Personal Assistance Services, or habilitation service providers is procured for those providers.
- The use of seclusion in treating a member is prohibited. Providers must maintain documentation regarding the appropriate use of restrictive intervention practices, including restraints. That documentation must include information on any necessary behavior support plans.
- The provider must adhere to BCBSTX's financial accountability standards.
- The provider must prevent conflicts of interest between the provider, any staff member, or a service provider and a member. That includes the acceptance of payment for goods or services from which the provider, staff member or service provider could financially benefit.
- The provider must prevent any financial impropriety relating to a member. That includes unauthorized disclosure of information related to a member's finances and using the member's funds to purchase of goods that a member cannot use.

EMPLOYMENT ASSISTANCE BY LTSS PROVIDERS

LTSS providers must develop and update quarterly a plan for delivering employment assistance services to STAR Kids members. Employment assistance is provided to members receiving Medically Dependent Children Program services. The assistance helps members find paid employment in the community.

SUPPORTED EMPLOYMENT BY LTSS PROVIDERS

LTSS providers must develop and update quarterly a plan for delivering supported employment services. Supported employment services are provided to members receiving MDCP services; they are intended to help members sustain employment or self-employment.

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 helpful support and resources. We also provide access to emergency services for LTSS providers' safety and protection, and a means to communicate grievances.
- BCBSTX also requires that LTSS providers submit periodic cost reports and supplemental reports to Texas 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, Texas HHSC will notify BCBSTX to hold payments to the LTSS provider until Texas HHSC instructs BCBSTX to release the payments. Texas HHSC will forward notices directly to LTSS providers about such cost reports and information that they must submit.

- If LTSS providers need any assistance in serving members, they can contact:
  - The STAR Kids Provider Service Department at **1-877-784-6802**. Staff is available there Monday through Friday, 8 a.m. to 5 p.m. CT, except for state-approved holidays.
  - The 24-hour Nurse Advice Line at **1-855-802-4614**, available 24 hours per day, seven days per week

Pharmacy Provider Responsibilities

GENERAL RESPONSIBILITIES OF PHARMACY PROVIDERS

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
- 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 also responsible for emergency prescriptions. A pharmacist may use their clinical judgment to dispense a 72-hour emergency supply of a medication if prior authorization is not available within 24 hours through the Prime Therapeutics point-of-sale system. (Prime Therapeutics LLC administers pharmacy benefits for BCBSTX.)

For questions or assistance in properly submitting a 72-hour supply claim, contact Prime Therapeutic's help desk, which is available 24 hours per day, seven days per week. Those numbers are:

- For STAR — **1-855-457-0405**
- For CHIP — **1-855-457-0403**
- For STAR Kids
- Travis service area — **1-855-457-0757**
- MRSA Central service area — **1-855-457-0758**

PROCESSING PHARMACY CLAIMS

BCBSTX will adjudicate (finalize as paid or denied) pharmacy claims within 18 days of the point-of-sale process for clean electronic pharmacy claims. It will adjudicate paper pharmacy claims within 21 days.

BCBSTX will pay pharmacy providers interest at a rate of 18 percent per year, calculated daily on clean claims for pharmacy claims that we do not adjudicate within those time frames.

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

For a list of covered and preferred drugs, please visit the formulary and preferred drug list.

FRAUD, WASTE AND ABUSE PREVENTION

The STAR, CHIP and STAR Kids programs include an important element of fraud, waste and abuse prevention. That requires the cooperation and participation of BCBSTX's providers in preventing and reporting 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.

How To Report Fraud, Waste or Abuse?

Providers should let us know if they think a doctor, dentist, pharmacist, other health-care provider or a person getting benefits is potentially taking part in fraud, waste, fraud or abuse. Let us know 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 card
- Using someone else's Medicaid or CHIP ID card
- Not telling the truth about the amount of money or resources they must get benefits.

To report fraud, waste or abuse, you may file a report directly to the Texas Office of Inspector General, or you may report an issue to BCBSTX.

To report fraud, waste or abuse, you can do any of the following:

- Call the OIG Hotline at **1-800-436-6184**.
- Visit the Office of Inspector General's to complete the online form
- Contact BCBSTX's Special Investigative Department at:
  Blue Cross and Blue Shield of Texas
  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 or 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

Pharmacy Information for Members

MEDICAID MEMBERS NOW HAVE ACCESS TO MAIL-ORDER PHARMACY

BCBSTX Medicaid members now have access to mail-order pharmacy through Walgreens Mail Service. Members can fill up to a 90-day supply of maintenance medications with free home delivery.

Patients who want to access the mail-order pharmacy and have an existing prescription may ask their provider to rewrite their prescriptions as 90-day supplies.

For Providers:

- Consider writing our 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.
- Prescribers can e-prescribe prescriptions or fax them to Walgreens Mail Service.
- If sending via fax, call Walgreens Mail Service at **1-877-357-7463** for the fax number.

MEMBER PHARMACY RIGHTS

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

Section 4: Electronic Visit Verification

Electronic Visit Verification is a digital system that providers use for certain Medicaid visits. EVV helps prevent fraud, waste and abuse, while ensuring Medicaid recipients receive care that is authorized for them.

Here are some frequently asked questions and answers about EVV and how providers should use it.

General Information About EVV

WHAT IS EVV?

Electronic Visit Verification (EVV) is a computer-based system that electronically documents and verifies a visit by a service provider or Consumer Directed Services (CDS) employee, as defined in Chapter 8.7.1 of the Uniform Managed Care Manual, 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).
- Other information that the Texas Health and Human Services Commission determines necessary to ensure the accurate adjudication of Medicaid claims.

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 Texas HHSC to implement an EVV system to electronically verify certain Medicaid services in accordance with federal law.

To comply with these statutes, Texas HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. Texas HHSC required the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2024.

WHICH SERVICES MUST A SERVICE PROVIDER OR CDS EMPLOYEE ELECTRONICALLY DOCUMENT AND VERIFY USING EVV?

Services that must be electronically documented and verified through EVV are listed on the HHSC EVV webpage. Refer also to the "Programs, Services and Delivery Options Required to Use Electronic Visit Verification" PDF.

Providers should also check the EVV Service Bill Codes Table (which can also be found under "Resources" on the EVV webpage) for up-to-date information and specific codes and modifiers for EVV-required services.

WHO MUST USE EVV?

The following people or entities must use EVV:

- Provider: An entity that contracts with a managed care organization 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 legally authorized representative who chooses to participate in the CDS option and is responsible for hiring and retaining a service provider who delivers a service.

EVV Systems

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 Texas HHSC claims administrator, on behalf of Texas HHSC. A provider or FMSA may opt to use this system instead of an EVV proprietary system.

Visit the Texas Medicaid & Healthcare Partnership EVV Vendor webpage for additional information.

- EVV proprietary system: An EVV proprietary system is a Texas 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 Texas HHSC or an MCO
  - Complies with the requirements of Texas Government Code, Section 531.024172 or its successors

You can find additional information on the TMHP EVV Proprietary Systems webpage.

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.

WHAT IS THE PROCESS FOR A PROVIDER OR FMSA TO SELECT AN EVV SYSTEM?

- To select an EVV vendor, a provider or FMSA must complete, sign and date the EVV Provider Onboarding Form located on the EVV vendor's website. (You can find more info on the TMHP EVV Vendor webpage.)
- To use an EVV proprietary system, a provider or FMSA must visit the TMHP Proprietary Systems webpage and review the onboarding process for the EVV proprietary system operator and the approval process for the EVV proprietary system.

WHAT REQUIREMENTS MUST A PROVIDER OR FMSA MEET BEFORE USING THE SELECTED EVV SYSTEM?

Before using a selected EVV system:

- The provider or FMSA must submit an accurate and completed onboarding form directly to the selected EVV vendor. (You can find more info on the TMHP EVV Vendor webpage.)
- The provider or FMSA must submit the PSO request packet to enter the EVV PSO onboarding process. (You can learn more about that process at the TMHP EVV Proprietary System webpage.) That process includes:
  - An EVV Proprietary System Request Form
  - EVV PSO Detailed Questionnaire
  - TMHP Interface Access Request
- The provider or FMSA must complete the EVV PSO onboarding process and receive written approval from Texas HHSC to use an EVV proprietary system to comply with Texas HHSC EVV requirements.
- If selecting either an EVV vendor or an EVV proprietary system, a provider or FMSA must:
  - Complete all required EVV training as described in the answer in the "EVV Training" section below
  - Complete the EVV system onboarding activities, which include:
    - Manually entering or electronically importing member identification data
    - Entering or verifying member service authorizations
    - Setting up member schedules (if required)
    - Creating the CDS employer profile for CDS employer credentials in the EVV system

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.

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
- Transfer from one EVV proprietary system to another EVV proprietary system

WHAT IS THE PROCESS TO CHANGE FROM ONE EVV SYSTEM TO ANOTHER?

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 scheduled 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 Texas HHSC will establish an effective date of transfer for the proprietary system that may be different than the previously scheduled 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.
  - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV aggregator — a centralized database that stores EVV visit data.
- After a provider or FMSA begins using a new EVV system, the provider or FMSA must return any alternative devices supplied by the previous EVV vendor to the previous EVV vendor.

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. The vendor is not required to provide the accommodation if it determines the accommodation is not required.

If the provider or the FMSA is using a proprietary system, the service provider, CDS employer or CDS employee must contact the provider or the FMSA to determine accessibility features of the system and if an accommodation can be provided.

EVV Service Authorizations

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 modifiers
  - Authorization start date
  - Authorization end date
- Perform “visit maintenance” if the most current service authorization is not entered into the EVV system (Visit maintenance is the process a provider or FMSA uses to refine or correct an EVV visit transaction in the EVV system to accurately reflect the delivery of service.)
- Manually enter service authorization changes and updates into the EVV system as needed.

EVV Clock In and Clock Out Methods

WHAT ARE THE APPROVED METHODS A SERVICE PROVIDER OR CDS EMPLOYEE MAY USE TO CLOCK IN AND CLOCK OUT TO BEGIN AND END SERVICE DELIVERY WHEN PROVIDING SERVICES TO A MEMBER IN THE HOME OR 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 the community — outside of a member’s home. A service provider or CDS employee may use one method to clock in and a different method to clock out.

- 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.
    - A smart phone or tablet issued by the provide.

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.
- A smart phone or tablet issued by the FMSA.
- The CDS employer’s smart phone or tablet if the CDS employer authorized the CDS employee to use the 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 appropriate 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. If a service provider or CDS employee is unable to use a mobile method in the community, they must later manually enter their clock-in and clock-out times in the EVV system.

- Home phone landline
- With permission from the member, a service provider or CDS employee may use a member’s home phone landline to clock in and clock out of the EVV system.
- To use a home phone landline to clock in and clock out, a service provider or CDS employee must call a toll-free number provided by the EVV vendor.
- 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. The system will not allow clock in and clock out inputs from a landline not registered in the system.
- Alternative device
- A service provider or CDS employee may use a Texas HHSC-approved alternative device to clock in and clock out when providing services in a member's home.
- An alternative device is a Texas 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 due to a power outage or natural disasters.

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, 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 - CDS Employer's Selection for Electronic Visit Verification Responsibilities. (You can access the form at the forms page of the EVV Policy Handbook.) To do that, they will 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. They will 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. The provider, FMSA or CDS employer may then complete visit maintenance only 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

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 and prior to the end of the visit maintenance timeframe as set in the EVV Policy Handbook. (Note: Texas HHSC may adjust the standard visit maintenance timeframe set in the EVV Policy Handbook to accommodate providers, FMSAs or CDS employers impacted by circumstances outside of their control.)

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) and Reason Code Description(s) and must enter any required "free text" when completing visit maintenance in the EVV system.

- Reason Code Number(s) describe the purpose for completing visit maintenance on an EVV visit transaction.
- Reason Code Description(s) describe the specific reason visit maintenance is necessary.
- Free text is additional information the provider, FMSA or CDS employer enters to further describe the need for visit maintenance.

Providers can get access to Reason Code tables and see more information about Reason Codes at the Texas HHSC EVV webpage. (Scroll toward the middle of the page.)

EVV Training

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
  - EVV policy training provided by Texas HHSC or the MCO
- CDS employers must complete training based on how they've assigned responsibility for visit maintenance on Form 1722:
- **Option 1:** The CDS employer agrees to complete all visit maintenance and approve their employee's time worked in the EVV system. In this case:
  - EVV system training is provided by the EVV vendor or EVV PSO.
  - The CDS employer trains their employees on the clock in and clock out methods.
  - EVV policy training are provided by Texas HHSC, the MCO or the FMSA.
- **Option 2:** The CDS employer elects to have their FMSA complete all visit maintenance on their behalf; however, the CDS employer will approve their employees' time worked in the system. In this case:
  - EVV system training is provided by the EVV vendor or the EVV PSO.
  - EVV policy training is provided by Texas HHSC, the MCO or the FMSA.
- **Option 3:** The CDS employer elects to have their FMSA complete all visit maintenance on their behalf. In this case:
  - Training that includes an overview of EVV systems is provided by EVV vendor or EVV PSO.
  - EVV policy training is provided by Texas HHSC, the MCO or the 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.
- Providers can see an EVV training checklist here. They can learn more about EVV training requirements and access EVV training resources at the EVV Training Resources webpage.

Compliance Reviews

WHAT ARE EVV COMPLIANCE REVIEWS?

The MCO conducts EVV compliance reviews 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 each of the following EVV compliance requirements:

- EVV Usage Review: Required to meet the minimum EVV usage score.
- EVV Landline Phone Verification Review: Ensures valid phone type is used.

You can find additional information regarding EVV compliance reviews in the EVV Compliance Reviews section of the EVV Policy Handbook.

EVV Claims

ARE PROVIDERS AND FMSAS REQUIRED TO USE AN EVV SYSTEM TO RECEIVE PAYMENT FOR EVV REQUIRED SERVICES?

Yes. An MCO will reimburse an EVV claim required to use EVV services only when the EVV claim matches an accepted EVV visit transaction in the EVV aggregator. The MCO may deny or recoup an EVV claim that does not match an accepted visit transaction.

WHERE DOES A PROVIDER OR FMSA SUBMIT AN EVV CLAIM?

Providers and FMSAs must submit all EVV claims to the Texas HHSC claims administrator in accordance with the MCO's submission requirements.

You can find more information on the process for submitting, correcting or adjusting claims at the EVV Claims webpage.

WHAT HAPPENS IF A PROVIDER OR FMSA SUBMITS AN EVV CLAIM TO THE MCO INSTEAD OF THE TEXAS HHSC CLAIMS ADMINISTRATOR?

If a provider or FMSA submits an EVV claim to the MCO instead of the Texas HHSC claims administrator, the MCO will reject or deny the claim and require the provider or FMSA to submit the claim to the Texas HHSC claims administrator.

WHAT HAPPENS AFTER THE TEXAS HHSC CLAIMS ADMINISTRATOR RECEIVES AN EVV CLAIM FROM A PROVIDER OR FMSA?

The Texas 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 Texas HHSC claims administrator for further claims processing. After completing the EVV claims matching process, the Texas HHSC claims administrator will forward the claim to the MCO for final processing.

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 or Atypical Provider Identifier
- Healthcare Common Procedure Coding System code
- HCPCS modifiers
- Billed units to the units on the visit transaction, if applicable

Note: Providers can refer to the EVV "Service Bill Codes Table" found on the Texas HHSC EVV webpage for the specific services that bypass the units matching process. (Scroll down to "Service Bill Codes Table" on the lower part of the page.)

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:

Code	Code Meaning
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 an EVV claim match result code 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 Texas HHSC implements a bypass of the claims matching process for disaster or other temporary circumstances:

- 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.
- The MCO may still deny an EVV claim if other claim requirements fail the claims adjudication process.
- If allowed by Texas 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.

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 to providers and FMSAs to inform them of whether the MCO paid or denied the claim, and if denied, the reason for denial.

Providers can learn more about the EVV portal at the EVV Training webpage. (Scroll down to "EVV Portal Job Aids.")

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. Possible reasons for denial include a member's loss of program eligibility or the provider's or the FMSA's failure to obtain prior authorization for a service.

Section 5: Member Eligibility

Verifying 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. You can:

- Use TexMedConnect on the Texas Medicaid & Healthcare Partnership (TMHP) website.
- Log into your TMHP user account at tmhp.com and access 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 a Texas HHSC benefits office for a paper form. Members can request a new card by calling 1-800-252-8263. Medicaid members also can go to YourTexasBenefits.com 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 appeals process if the patient's eligibility becomes an issue.

Important: Texas HHSC determines member eligibility.

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 — whether the plan is fee-for-service or managed care. This information is collected and displayed in a consolidated form (Health Summary) that allows providers to view additional details if needed.

The specific functions available are:

- Access to a Medicaid patient's medical and dental health information, including medical diagnosis, procedures, prescription medicines and vaccines by clicking on "My Account."
- Eligibility verification available through any device, including desktop computers, laptops, tablets and smart phones with print functionality.
- Information on Texas Health Steps and benefit limitations.
- 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 YourTexasBenefits.com. The portal allows patients to:

- 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 general information about diagnoses and treatments.
- See general information about vaccines.
- See general information about 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 information for any patient they represent.

BCBSTX Provider Portal

Providers may also access the Availity website, an online tool for providers, to determine member eligibility. Providers must register to use the site.

For more information, providers can call BCBSTX Provider Services:

- STAR and CHIP — **1-877-560-8055**
- STAR Kids — **1-877-784-6802**

Electronic Eligibility Verification (E1) for Pharmacies

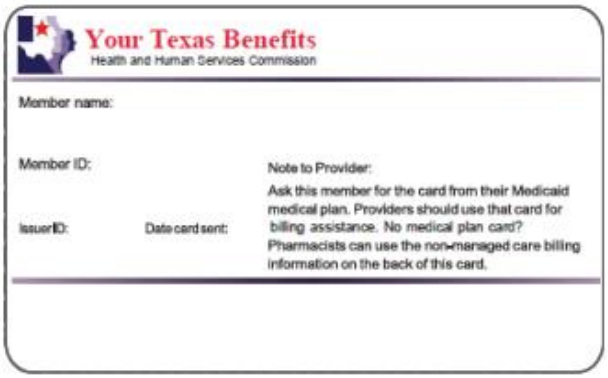
Electronic eligibility verification (for example, an NCPDP E1 Transaction) is available to check eligibility when filling a prescription.

SAMPLE MEDICAID INSURANCE CARDS

Members can log into www.yourtexasbenefits.com to show eligibility.
Providers can also verify a member's eligibility and view patient program information.
Providers and members can also:
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

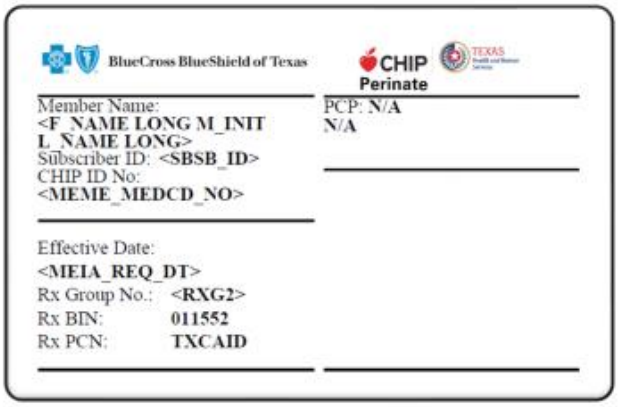
Here are samples of insurance cards for various BCBSTX Medicaid and other programs:

- Your Texas Benefits Medicaid Card



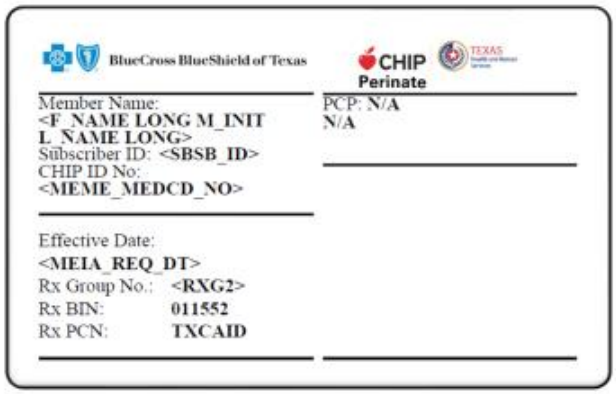


- CHIP Perinate Insurance Card 0%–198% FPL





- CHIP Perinate Insurance Card 198%–202% FPL


BlueCross BlueShield of Texas

CHIP Perinate

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.

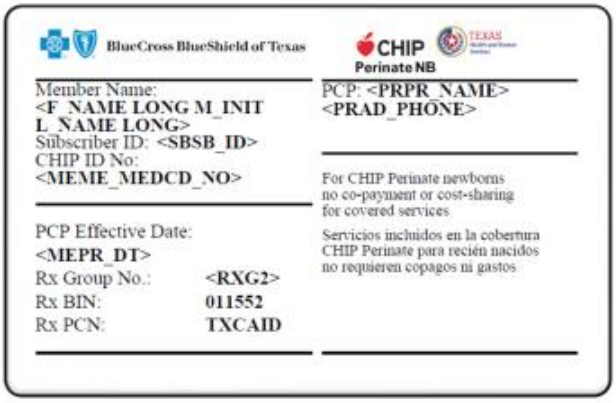
Presente esta tarjeta cada vez que reciba servicios que cubra su plan. Puede que algunos servicios necesiten aprobación previa.
Instrucciones en caso de emergencia: Llame al 9-1-1 o acuda a la sala de emergencia más cercana. Después de recibir tratamiento, llame al médico de cabecera *(PCP)* de su hijo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

All providers file claims to:
BCBSTX
PO Box 51422
Amarillo, TX 79159-1422
Out of state coverage is limited to emergency care.

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

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

- CHIP Perinate Newborn Insurance Card


BlueCross BlueShield of Texas

CHIP Perinate NB

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.

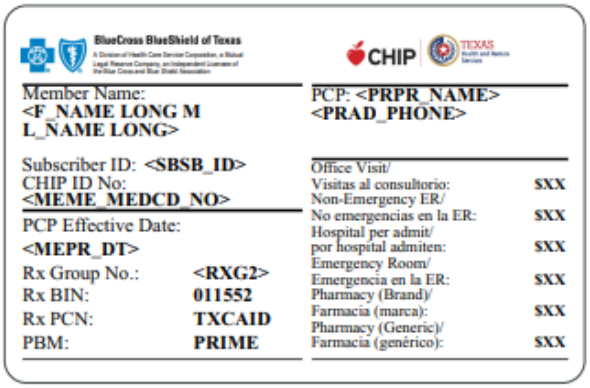
Presente esta tarjeta cada vez que reciba servicios que cubra su plan. Puede que algunos servicios necesiten aprobación previa.
Instrucciones en caso de emergencia: Llame al 9-1-1 o acuda a la sala de emergencia más cercana. Después de recibir tratamiento, llame al médico de cabecera *(PCP)* de su hijo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

All providers file claims to:
BCBSTX
PO Box 51422
Amarillo, TX 79159-1422
Out of state coverage is limited to emergency care.

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

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

- CHIP Insurance Card


BlueCross BlueShield of Texas

CHIP

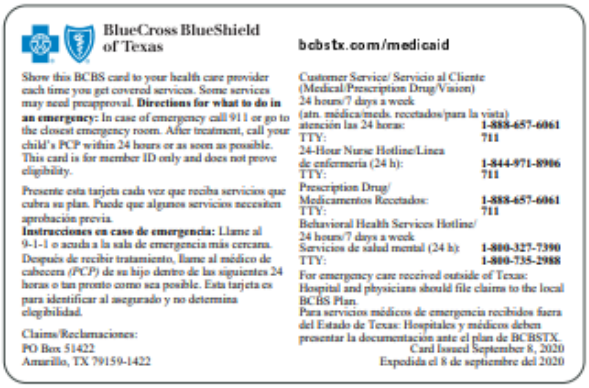
Member Name:
<F_NAME LONG M
L_NAME LONG>

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
PBM: PRIME

PCP: <PRPR_NAME>
<PRAD_PHONE>

Office Visit/ Visitas al consultorio:	$XX
Non-Emergency ER/ No emergencias en la ER:	$XX
Hospital per admit/ por hospital admiten:	$XX
Emergency Room/ Emergencia en la ER:	$XX
Pharmacy (Brand)/ Farmacia (marca):	$XX
Pharmacy (Generic)/ Farmacia (genérico):	$XX


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. After treatment, call your child's PCP within 24 hours or as soon as possible. This card is for member ID only and does not prove eligibility.

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.

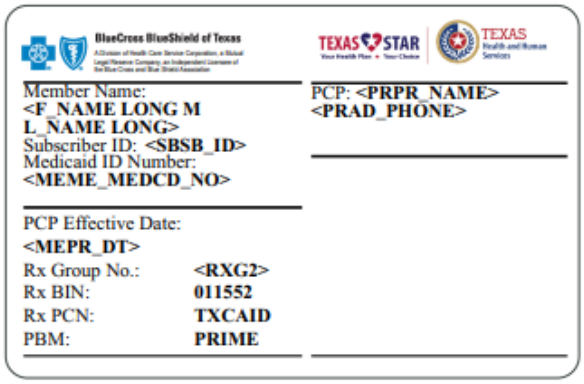
Claims/Reclamaciones:
PO Box 51422
Amarillo, TX 79159-1422

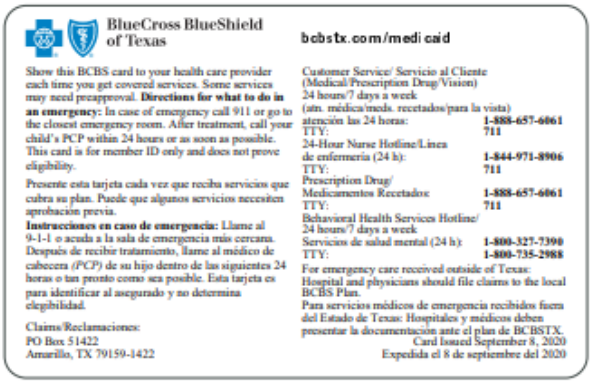
Customer Service/ Servicio al Cliente (Medical/Prescription Drug/Vision)
24 hours/7 days a week
(atn. médica/meds. recetados/para la vista)
atención las 24 horas: 1-888-657-6061
TTY: 711
24-Hour Nurse Hotline/Línea de enfermería (24 h): 1-844-971-8906
TTY: 711
Prescription Drug/ Medicamentos Recetados: 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

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

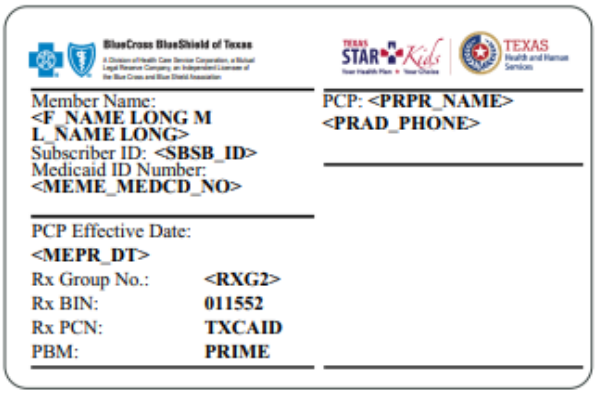
Card Issued September 8, 2020
Expedida el 8 de septiembre del 2020

- STAR Insurance Card



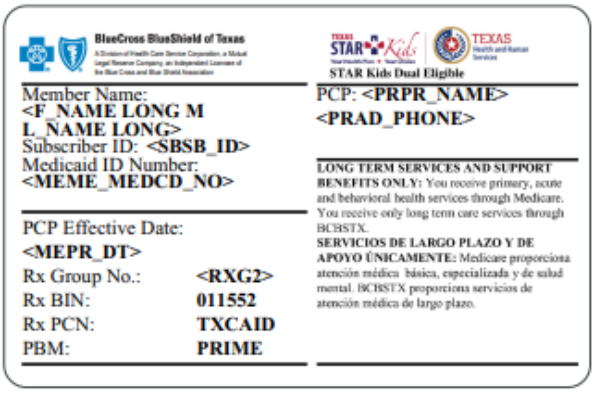


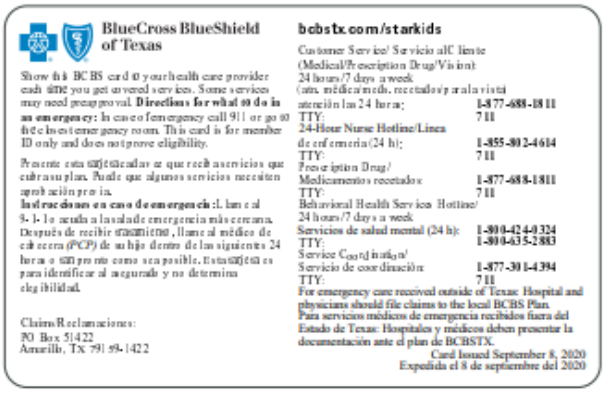
- STAR Kids Insurance Card





- STAR Kids Dual Eligible Insurance Card





DUAL ELIGIBLE (MEDICARE AND MEDICAID)

If a member is eligible for Medicare, Medicare is responsible for most of their primary, acute and behavioral health services. The name, address and telephone number of the Medicaid primary care provider is not listed on the member's ID card. The member receives long-term services and support through the STAR and STAR Kids plans.

Added Benefits

SPELL OF ILLNESS LIMITATIONS

In the traditional Medicaid and CHIP programs, the “spell of illness” limitation is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 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 60 consecutive days. This limitation does not apply to STAR Kids, CHIP and CHIP Perinatal members.

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

CHIP Eligibility

CHIP PERINATAL PLAN

The CHIP Perinatal plan is for pregnant women aged 20 and older and their newborn children. Mothers are eligible for CHIP Perinatal through the postpartum period. Newborns are eligible for 12 months of continuous coverage, starting from their birth month.

CHIP Perinatal covers:

- The mother’s initial prenatal visit and up to 20 prenatal visits, along with 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.

A CHIP Perinatal mother in a family that qualifies for Medicaid may be eligible to have the costs of the birth covered through Emergency Medicaid. Families who qualify for Medicaid receive Form H3038 from Texas HHSC with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to Maximus, the state Medicaid program’s enrollment broker.

A child whose family has been part of the CHIP Perinatal program and whose family qualifies for Medicaid will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage beginning on the date of birth. The birth must be reported to Maximus.

A baby whose family has been part of CHIP Perinatal will continue to receive coverage through the CHIP program as a “CHIP Perinatal Newborn” if born to a family with an income above the Medicaid eligibility threshold. The birth must be reported to Maximus.

CHIP Perinatal mothers must select a managed care organization within 15 days of receiving the enrollment packet or an MCO is automatically chosen for them. We will then notify the mother of the plan choice. When this occurs, the mother has 90 days to select another MCO.

BCBSTX will allow a pregnant member who is past the 24th week of pregnancy to remain under the care of their current OB/GYN, even if the provider is out-of-network. This will remain 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 if the provider agrees to accept her in the last trimester of pregnancy.

When a member of a household enrolls in CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current CHIP plan and enrolled in the CHIP Perinatal member’s health plan. All members of the household must remain in the same health plan until the later of:

- the end of the CHIP Perinatal member’s enrollment period
- the end of the traditional CHIP members’ enrollment period.

When the newborn’s CHIP Perinatal coverage expires, the child will be added to their siblings’ existing CHIP plan. If there is no active CHIP plan, then 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 information of the CHIP Perinatal newborn and the other family members.

MAKING CHANGES FROM CHIP PERINATAL PLAN

CHIP Perinatal members may request to change health plans under the following circumstances:

- For any reason within 90 days of enrollment in CHIP Perinatal.
- For cause at any time.
- If the member moves into a different service delivery area.

CHIP PLAN CHANGES

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 time.
- If the client moves to a different service delivery area.
- During the annual re-enrollment period.

PREGNANT TEENS

Providers must notify us immediately when they identify a pregnant CHIP member who might be eligible for Medicaid. A CHIP member who is potentially eligible for Medicaid must apply for Medicaid. A pregnant CHIP member who is Medicaid-eligible will no longer be eligible for CHIP and will be disenrolled from the program.

COST SHARING FOR CHIP MEMBERS

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 state Medicaid program's enrollment broker, to obtain a new ID card.

CHIP Perinatal, CHIP Perinatal Newborn and CHIP members who are Native Americans or Alaskan Natives do not have cost sharing. Also, there is no cost-sharing for CHIP members for well-baby and well-child services, preventive services or pregnancy-related help.

You can find a table with more information about CHIP cost sharing in this Texas HHSC manual.

Enrollment and Disenrollment

AUTOMATIC ENROLLMENT

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

INVOLUNTARY DISENROLLMENT DUE TO MEMBER NON-COMPLIANCE

There may be instances when a PCP feels that a member should be removed from their panel. Reasons might 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 furnish services to the member or other patients. This reason for possible removal applies if 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.

BCBSTX requires that a PCP notify us of such intentions before the PCP contacts the member. That will allow us to provide educational outreach to the member. Those notifications from the PCP to BCBSTX recommending removal or disenrollment of a patient must:

- Be made in writing.
- Be directed to BCBSTX's Compliance Department.
- Contain detailed documentation for the removal request. (A disenrollment request will require medical and other documentation that indicates sufficiently compelling circumstances that merit disenrollment).

Upon receipt of such a request, BCBSTX may:

- Interview the provider or their staff requesting the disenrollment, as well as any additional providers who are relevant to the request.
- Interview the member.
- Review any relevant medical records.

A PCP cannot request a member be disenrolled:

- Because of an adverse change in the member's health or their using services that are medically necessary for the treatment of the member's condition
- Based on the member's race, color, national origin, sex, age, disability, political beliefs or religion

Texas HHSC will make the final decisions on any possible disenrollment. Providers are strictly prohibited from taking any retaliatory action against a member for any reason, including reasons related to disenrollment.

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 the member is disenrolled from BCBSTX.

Section 6: Covered Services

As a reminder abortion and Gender Transitioning/ Gender Reassignment Procedures and Treatment are not covered by Texas Medicaid.

STAR, CHIP and STAR Kids benefits are governed by BCBSTX's contract with the Texas HHSC and include medical, vision, behavioral health, and pharmacy benefits. Covered services also include Long-Term Services and Supports for STAR Kids members.

In addition, we cover Medically Dependent Children's Program services for those who qualify.

Texas Health Steps

Texas Health Steps is health care for children birth through age 20 who have Medicaid. Texas Health Steps gives children and young adults free medical checkups starting at birth, and free dental checkups starting at six months of age. Checkups can help find health problems before they get worse and harder to treat.

Texas Health Steps also provides a range of comprehensive care for eligible members.

Providers can find details about Texas Health Steps, including private duty nursing, prescribed pediatric extended care centers and therapies, in the Texas Medicaid Provider Procedures Manual, Volume 2: Children's Services Handbook. Providers can also learn more in new Medicaid bulletins at www.tmhp.com and on the Texas Health Steps website.

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 to be reimbursed for Texas Health Steps services. Enrollment must be completed through the Texas Medicaid and Healthcare Partnership at www.tmhp.com/

TEXAS HEALTH STEPS - PROVIDER BASICS

Newly enrolled members in STAR, CHIP and STAR Kids must be seen within 90 days of joining the plan for a Texas Health Steps visit. BCBSTX gives providers a list of their assigned members with their enrollment date. Providers should contact these members to schedule an appointment for a Texas Health Steps checkup.

Providers must perform medical checkups in accordance with the Texas Health Steps medical checkups periodicity schedule that is based in part on American Academy of Pediatrics recommendations. Providers can visit this Texas HHSC webpage to find the most recent Texas Health Steps periodicity schedule.

A checkup for an existing member from birth through 35 months of age is considered 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 aged three years and older is due annually beginning on the child's birthday. It is considered timely if it occurs no later than 364 days after the child's birthday.

Providers can call the Texas Health Steps Medical Inquiry Line for more information about the program, or for any questions. The line is at **1-800-757-5691**. Representatives are available from 7 a.m. to 7 p.m. CT, Monday through Friday. The line is the main point of contact for information about Texas Health Steps.

DOCUMENTATION OF COMPLETED TEXAS HEALTH STEPS COMPONENTS AND ELEMENTS

Texas Health Steps and its periodicity schedule for children recommend six components to help providers keep children healthy. These components are described in the Texas Medicaid Provider Procedures Manual (TMPPM). Providers should complete these six components and document that they have done that in the child's medical record.

Providers should note in the patient's medical record any component — or any element that is part of a component — that was not completed. They should also note 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 tuberculosis, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record.

Texas Health Steps checkups are subject to retrospective review and recoupment of fees if the medical record does not include all required documentation.

The six components are:

1. Comprehensive health and developmental history, including nutrition screening, developmental and mental health screening and tuberculosis screening.
    - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. Completion of 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. A comprehensive, unclothed physical examination that includes measurements of height or length, weight, fronto-occipital circumference, body mass index, 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 recommended by the federal Advisory Committee on Immunization Practices, based on age and health history.
    - 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 schedule. Exceptions to this requirement are if the immunization is medically contraindicated, or because of parental reasons of conscience, including religious beliefs.
    - The screening provider is responsible for administration of the immunization and should not refer children to other immunizers, including local health departments, to receive immunizations.
    - Providers should note parental consent on a federal Vaccine Information Statement, which gives parents information about vaccines and asks for their consent.
    - Providers may enroll as providers in the Texas Vaccines for Children Program.
4. Laboratory tests, as appropriate, including newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia.
    - Newborn Screening: Providers should send all Texas Health Steps newborn screens to the Texas Department of State Health Services Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn members and each 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 at 18 to20 years of age
    - HIV screening at 16 to 18 years of age
    - Risk-based screenings include:
    - dyslipidemia, diabetes and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia
5. Health education (including something called "anticipatory guidance") is a federally mandated component of the medical checkup. Anticipatory guidance from providers helps parents, caregivers and patients understand what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices and prevention of lead poisoning, accidents and disease.
6. Dental referrals every six months until the parent or caregiver reports a dental home is established.
    - Clients must be referred to establish a dental home beginning at six 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 Texas Health Steps Child Health Record forms can help with performing and documenting checkups completely. That includes laboratory screening and immunization components. Use of the forms is optional but recommended.

Each checkup form includes all checkup components, screenings required at the checkup and suggested age-appropriate health guidance topics. You can access forms through the Texas Health Steps forms webpage.

EXCEPTIONS TO PERIODICITY ALLOWED

On occasion, a child may require a Texas Health Steps checkup 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 form. Providers should comply with the standard billing requirements as discussed in Section 9. You can learn more about the CMS-1500 form in Section 9.

If a provider other than the primary care provider 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.

BILLING FOR TEXAS HEALTH STEPS

Providers can learn details about proper billing for Texas Health Steps services in Section 9: Claims and Billing.

ENVIRONMENTAL LEAD INVESTIGATION LEAD SCREENING AND TESTING

In accordance with current federal regulations, Texas Health Steps requires blood lead screening at ages noted in the Texas Health Steps periodicity schedule. They must be performed during the medical checkup. Providers can visit this Texas HHSC webpage to find the most recent Texas Health Steps periodicity schedule.

Environmental lead risk assessments should be completed at all checkups through age 6 — even when testing is not mandated. Providers may perform the assessments using the Lead Risk Questionnaire, Form Pb-110, which is provided in both English and Spanish. Providers may also use an equivalent form of their choice.

Providers may perform the initial lead testing using a venous or capillary specimen. They must either use point-of-care testing or send the specimen to the DSHS laboratory. If the client has an elevated blood lead level of 5 mcg/dL or higher, the provider must perform a confirmatory test using a venous specimen. The provider may send the confirmatory specimen to the DSHS laboratory, or the provider can send the client or specimen to another laboratory that the provider chooses.

Providers must report all blood lead levels in clients who are 14 years of age or younger to DSHS. Reports should include all information as required on the Child Blood Lead Report, Forms F09-11709 or the Point-of-Care Blood Lead Testing Report, Form Pb-111. Providers can also find other forms on a Blood Lead Surveillance Program webpage.

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 webpage.

Texas Health Steps medical providers can get reimbursement for using point-of-care testing in their office by using procedure code 83655 with modifier QW. Providers must have a Clinical Laboratory Improvement Amendments of 1988 Certificate of Waiver.

Blood lead testing is part of the encounter rates for Federally Qualified Health Centers and Rural Health Centers and is not reimbursed separately.

Note: You can also learn much more about the medical and environmental management of lead poisoning through the **DSHS Childhood Lead Poisoning Prevention Program.** And you can learn more about blood lead screening at **this webpage**. You can also learn more by calling 1-800-588-1248.

LABORATORY TESTING

Testing materials and necessary forms and supplies for laboratory specimen collection are made available free of charge to all Texas Health Steps providers. For forms and supplies, providers should contact the DSHS 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, except point-of-care testing in the provider's office for the initial lead specimen. All other tests may be sent to a lab the provider chooses.

SCREENINGS

Providers should give health screenings to Texas Health Steps patients according to the Texas Health Steps medical checkups periodicity schedule. Providers can visit this Texas HHSC webpage to find the most recent periodicity schedule. Providers should continue to check the schedule for any updates.

Required screenings include:

- Anemia screening by hemoglobin or hematocrit levels at 12 months and then the ages noted in the periodicity schedule. Providers must send the specimen 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. Required screenings include one risk-based screening for clients 11 through 20 years old, and a screening for clients 16 to 18 years old, regardless of risk.
- Dyslipidemia screening (previously hyperlipidemia screening): One risk-based screening for clients who are 24 months through 20 years of age. Then an additional mandatory screening for clients who are nine through 11 years of age, and another for clients who are 18 through 20 years of age, regardless of risk.

DENTAL CARE

Dental Checkups

Texas Health Steps patients are required to enroll in a Medicaid dental plan. Members must select a dental plan and main dentist. Patients should 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 Utilization Management department to request authorization for facility services and dental procedures. Providers can call:

- **1-877-560-8055 for** STAR and CHIP — Fax: **1-855-653-8129**
- **1-877-784-680**2 for STAR Kids — Fax: **1-866-644-5456**

First Dental Home

First Dental Home is a package of services aimed at improving the oral health of children aged six months through 35 months. Enrolled Texas Health Steps pediatric and general dentists provide FDH services. 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. (A Main Dental Home serves as the member's main dentist for all aspects of oral health care.) The member can contact the dental plan to select a different Main Dental Home provider at any time. If the member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan's system, and the member is mailed a new ID card within five business days.

Note: 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

Texas Health Steps physicians, physician assistants and advance practice registered nurses provide oral health services through the Oral Evaluation and Fluoride Varnish program. The services are provided as part of a Texas Health Steps medical checkup for children six months through 35 months old. Services include immediate oral evaluation, fluoride varnish application, guidance to parents about dental care and referral to a dental home.

Providers must attend the FDH training or OEFV training offered by the DSHS Oral Health program to be certified to bill for these services. Providers can learn more information about each program at the DSHS website. You can learn more about billing for these services in Section 9.

Medicaid Non-Emergency Dental Services

BCBSTX is not responsible for paying for routine dental services provided to Medicaid members. Dental managed care organizations pay for these services.

BCBSTX is responsible for paying for treatment and devices for craniofacial anomalies, and for OEFV services provided as part of a Texas Health Steps medical checkup for members aged six months through 35 months.

Texas Health Steps providers must help members establish a Main Dental Home and document the member's Main Dental Home choice in the member's file.

BCBSTX will pay for treatment of and devices for craniofacial anomalies, along with hospital, physician and related medical services (e.g., anesthesia and drugs) for:

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

COMPREHENSIVE CARE PROGRAM: REFERRALS FOR NECESSARY SERVICES

The Comprehensive Care program 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 child members 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 getting health care services for their children. 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 health services to them.

Children of migrant farmworkers due for a Texas Health Steps medical checkup can receive their checkup on an accelerated basis prior to their leaving the area where their family is temporarily living. A checkup performed under these circumstances 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 age three years (extending to 364 days after 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.

STAR and CHIP Covered Services

COVERED SERVICES FOR ACUTE CARE

Star and CHIP members can receive preventive care, diagnostics and medical treatments called acute care services. Acute care services may include:

- 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 STAR and CHIP cover dental services for children and youth. You can see comprehensive lists of STAR and CHIP covered services in Attachment B (for STAR) and Attachment C (for CHIP and CHIP Perinatal) in this manual. More details on services covered under the Medicaid program, including fee-for-service benefits, limitations and exclusions are available in the Texas Medicaid Provider Procedures Manual (TMPPM).

(*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 CHIP covered services including CHIP Perinate members will receive evidence of coverage or certificate of coverage. Coverage limitations, exclusions can be found in the TMPPM.

SUBMITTING IMMUNIZATION INFORMATION

As noted above, children, adolescents and young adults must be immunized during medical checkups according to the ACIP schedule.

Providers are required to submit immunization information to the Texas Immunization Registry (ImmTrac2) when an immunization is given — if they get written consent from a parent or guardian for any immunizations given to a child. That consent is valid until the member becomes 18 years of age. (Those 18 and older must consent for their records to be maintained in ImmTrac2 as well).

Providers must verify consent before information is included in ImmTrac2. If a 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. Providers can find more information on this Texas immunization webpage.

VACCINES FOR CHILDREN

DSHS contracts with the federal Centers for Disease Control and Prevention to purchase vaccines at federal contract prices to give to providers enrolled in Medicaid. Vaccines not available on a federal contract will be purchased using a state contract price or by 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 by ACIP.

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

Providers will not be reimbursed for a vaccine that is available through TVFC.

Providers who are not enrolled in the TVFC program can contact the DSHS TVFC division at 1-800-252-9152. To enroll, a provider must:

- Complete the provider enrollment and provider profile forms.
- Agree to screen for eligibility.
- Agree to maintain screening records.

More information is available on the DSHS website.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

ADHD is one of the most common childhood neurobehavioral disorders. ADHD affects the cognitive, academic, emotional, and social well-being of individuals. We support early identification of ADHD to ensure members are connected to needed services. Our plans cover evaluation for and ongoing treatment of children diagnosed with ADHD. Coverage includes medication therapy for children prescribed ADHD medication, and behavior therapy to help children learn positive actions and limit problems behaviors. These services are considered outpatient mental health services.

HEALTHY TEXAS WOMEN

The Healthy Texas Women program 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.

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

Healthy Texas Women Plus is an enhanced, cost-effective and limited postpartum services package for women enrolled in the Healthy Texas Women program. To qualify for Health Texas Women Plus benefits, Healthy Texas Women clients must have been pregnant within the past 12 months.

Healthy Texas Women Plus will be provided in the postpartum period for not more than 12 months after their enrollment date in Healthy Texas Women. Women in Healthy Texas Women Plus will have access to both Healthy Texas Women and Healthy Texas Women Plus benefits.

Healthy Texas Women 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 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.

PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS AND PRIVATE DUTY NURSING

A Member has a choice of PDN, 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. Per 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.

BREAST PUMP COVERAGE IN STAR AND CHIP

STAR 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 STAR or CHIP client number. However, if a mother is no longer eligible for STAR or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's STAR or CHIP client number. You can see comprehensive information about breast pump coverage in Attachment A at the end of this manual.

CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN

What is Case Management?

Case Management for Children and Pregnant Women is a Medicaid benefit that provides health-related case management services to children and young adults with a health condition — from birth through age 20 — 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?

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

Social workers with a Licensed Baccalaureate Social Worker license or a Licensed Master Social Worker license who plan to provide case management services independently or contract with an agency must either:

- Have the Independent Practice Recognition license or
- Be under a board approved IPR or Licensed Clinical Social Worker 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 services for durable medical equipment, home health nursing or occupation, physical or speech therapy
- Assisting with the special education process or school issues
- Helping with transition planning
- Addressing issues such as substance abuse, homelessness or domestic violence
- Finding help with other needs, such as respite care

How to become a Case Management Provider?

For more information on how to become a case management provider for the Children and Pregnant Women program, please email TexasMedicaidNetworkDepartment@BCBSTX.com.

NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES

ModivCare

ModivCare provides transportation to covered health care services for STAR, STAR Kids and CHIP 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.

ModivCare services include:

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- 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 for a completed and verified trip to a covered health care service. The ITP can be the member or a family member, friend or neighbor of the member.
- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain a 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 before a trip to cover authorized NEMT services.

If a member needs assistance while traveling to and from their appointment with a provider, ModivCare will cover the costs of an attendant. The provider may be asked to furnish medical necessity documentation for the attendant's transportation 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 during the travel 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.

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 per day and seven days per week at **1-866-824-1565 (TTY: 711)** for members to cancel or make changes to a reservation, get a ride to urgent care or ask questions about a ride that has already been scheduled.

Members should schedule NEMT Services as early as possible, and – most of the time – at least 48 hours before they need the service.

In certain circumstances, members may request the NEMT service with less than 48 hours' notice. These circumstances include:

- Pickups after member is discharged from a hospital
- Trips to the pharmacy to pick up medication or approved medical supplies
- Trips for urgent conditions*

Out-of-area and out-of-state services require at least 48 hours' notice and approval from BCBSTX before a member schedules a ride. A member may also be able to get reimbursement for mileage for scheduled trips, but this must get BCBSTX approval before the trip is taken.

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 member is going
- The type of appointment member is going to
- If member needs a wheelchair van or some other kind of help during their trip.

Limitations: BCBSTX will decide what kind of transportation members will get based on the level of care that is medically necessary. 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 BCBSTX through a contractual agreement between BCBSTX and ModivCare.

Members should first call the NEMT program for a possible ride to covered services. If ModivCare is unable to schedule the ride, members can ask for a ride using the BCBSTX transportation value added service. The transportation VAS is available for STAR, CHIP and STAR Kids members. More information about the transportation VAS is available at **1-855-933-6993 (TTY:711).**

(*An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours. A member must notify BCBSTX prior to the approved and scheduled trip if their medical appointment is cancelled.)

STAR Kids Covered Services

STAR Kids covered services include medical, vision, behavioral health, pharmacy and Long-Term Services and Supports (LTSS). Members enrolled in the Medically Dependent Children's Program (MDCP) will receive their acute needs through the BCBSTX STAR Kids program. There are no co-payments for STAR Kids members.

Attachment D at the end of this manual has more information about covered services in the STAR Kids program. For more information on limitations and exclusions, see the **Texas Medicaid Provider Procedures Manual (TMPPM).**

STAR KIDS COVERED LTSS SERVICES

Adaptive Aids

Adaptive aids are specialized medical equipment, including devices, controls or appliances specified in the plan of care. They 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 to provide individuals a safe alternative to nursing facility placement. Items that do not provide 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 nursing facility placement.
- Provide nursing facility residents an opportunity to return to the community.

COMMUNITY FIRST CHOICE

Community First Choice services include the following:

- Emergency response services (emergency call button).
- Habilitation services (acquisition, maintenance, and enhancement of skills training): These enable members to accomplish activities of daily living, instrumental activities of daily living and other health-related tasks. ("Activities of daily living" are fundamental tasks required for people to care for themselves, including things like walking, dressing, toileting, and bathing. "Instrumental activities of daily living" are things like meal preparation, using the phone and light housework.)
- Personal attendant services: These help members perform the activities of daily living and instrumental activities of daily living that are needed to maintain the home in a clean, sanitary, and safe environment. Services are available to members based on medical and functional need and provided to members living in their own home and in community settings. Personal attendant services include:
    - Helping with the activities of daily living.
    - Helping with personal maintenance (for example, grooming, bathing, dressing and routine care of hair and skin).
    - Helping 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).
    - Providing protective supervision.
    - Providing extension of therapy services.
    - Providing ambulation and exercise.
    - Helping with medications that are normally self-administered.
    - Performing nursing tasks delegated by registered nurses.
    - Escorting the member on trips to obtain medical diagnosis, treatment or both.
- Support management: This is voluntary training that members can get on how to select, manage and dismiss attendants.

DAY ACTIVITY AND HEALTH SERVICES

All members aged 18 and older may receive medically and functionally needed Day Activity and Health Services. DAHS includes services in nursing and personal care, physical rehabilitation, nutrition, transportation and other supportive services. These services are provided at facilities licensed or certified by the Department of Health and Human Services.

Employment Assistance

We provide employment assistance to members to help them find paid employment in the community. Employment assistance includes:

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

Financial Management Services

Financial management services are the help we provide to members who participate in the Consumer Directed Services option to manage funds associated with services they receive. (Consumer Directed Services allows people who receive services from the Texas Health and Human Services Commission to hire and manage the people who provide their services).

A financial management services agency provides these financial management services. The services include 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, a legally authorized representative or a designated representative) would benefit from additional support with employer responsibilities. Support consultation services must not duplicate or replace services delivered by a case manager, a service coordinator, the FMSA or other sources. A support advisor provides skills-specific training, help and support to the employer or the employer's designated representative to meet responsibilities of the CDS option.

A support advisor may help with training related to recruiting and screening applicants for employment and verifying employment eligibility. The advisor might help with developing job descriptions, coaching on problem-solving and coordinating employee management activities. The advisor may also provide training on developing and implementing service backup and corrective action plans and provide coaching on handling other employer responsibilities.

Flexible Family Support Services

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

- Childcare
- Independent living
- Post-secondary education

Flexible family support services include personal care help with basic ADLs and IADLs. The services also help with skilled tasks and certain "delegated skilled tasks" — delegated by a nurse. 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

Minor home modifications are physical adaptations to a member's home that can help prevent institutionalization or support de-institutionalization. They are modifications needed 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 and widening of doorways. They also may include modification of bathroom facilities or installation of specialized electric and plumbing systems needed 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. That would include carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are also 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

Personal care services are support services furnished to a member who has physical, cognitive or behavioral limitations related to their disability or certain chronic health conditions. The chronic health conditions would be those that limit a member's ability to accomplish ADLs, 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 Center and Private Duty Nursing

A client has a choice of Private Duty Nursing, a Prescribed Pediatric Extended Care Center, or a combination of both for ongoing skilled nursing needs. PDN and PPECC are considered equivalent services and must be coordinated to prevent duplication. A client may receive both in the same day, but not simultaneously (For example, PDN may be provided before or after PPECC services are provided.)

The combined total hours between PDN and PPECC services should not increase unless there is a change in the client's medical condition, or the authorized hours are not commensurate with the client'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.

RESPITE CARE

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

SUPPORTED EMPLOYMENT

Supported employment is assistance provided to help a member maintain paid employment. This help is for members who, because of a disability, require intensive and 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

Transition assistance services pay for nonrecurring, set-up expenses for members 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 needed to enable the member to establish a basic household. Expenses 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 a 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. These services could include pest eradication, allergen control or a one-time cleaning before occupancy.

Members who are part of the Medically Dependent Children Program and 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 member has lost a residence because of moving into the nursing facility, or conditions in the previous residence are so inadequate that the member cannot return.

Routine, Urgent and Emergency Services

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 cannot 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 their PCP prior to seeking care. In the case of a true emergency, members are encouraged to visit their nearest emergency department.

DEFINITIONS

Here are definitions for routine, urgent and emergency care:

- **Routine care** is medically necessary health care for non-emergent or non-urgent conditions.
- **Urgent care** is medical care provided for illnesses or injuries that require prompt attention but typically are not serious enough 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.

PROVIDER REQUIREMENTS FOR SCHEDULING APPOINTMENTS

Members must have access to covered services within the timelines specified by Texas HHSC and the Texas Department of Insurance. The time periods are measured from the date of a patient request for service. The requirements are:

- 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 within no more than five calendar days.
- Initial outpatient behavioral health visits must be provided within 10 business days/14 calendar days, or within seven calendar days upon discharge from an inpatient psychiatric facility.
- Urgent care, including urgent specialty care and behavioral health urgent care, must be provided within 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 is not available. This applies to all drugs requiring a prior authorization, either because they are non-preferred drugs on the preferred drug list or because they are subject to clinical edits — requirements like clinical prior authorizations or quantity limits.

The 72-hour emergency supply should be dispensed any time a prior authorization 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 prior authorization, 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 (for example, 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: Enter a '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) or **1-855-457-0758** (MRSA Central service area)

EMERGENCY MEDICAL TRANSPORTATION

BCBSTX considers emergency medical transportation as appropriate in any event that puts the health and life of a Medicaid beneficiary at serious risk without immediate treatment.

For information about medical transportation in less urgent cases, see subsection above on Non-Emergency Medical Transportation (NEMT) Services, or transportation information in the "Value-Added Services" subsection below.

URGENT/EMERGENT HOSPITAL-TO-HOSPITAL AMBULANCE TRANSPORTATION

BCBSTX covers 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 business day of providing emergency air transportation (hospital-to-hospital), when applicable.

MEDICAID EMERGENCY DENTAL SERVICES

STAR Kids and CHIP 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 (anesthesia and drugs, for example) for:

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

NON-EMERGENCY DENTAL SERVICES

BCBSTX *is not responsible* for paying for routine dental services provided to STAR, CHIP and STAR Kids members. These services are paid through dental managed care organizations.

BCBSTX *is responsible* for paying for treatment and devices for craniofacial anomalies. It is also responsible for paying for Oral Evaluation and Fluoride Varnish (OEFV) benefits provided as part of a Texas Health Steps medical checkup for members aged six months through 35 months.

OEFV benefits include (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance and assistance with a Main Dental Home choice.

Here are some provider details relating to OEFV and a Main Dental Home:

- Texas Health Steps providers must bill for OEFV on the same day as the Texas Health Steps medical checkup.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist members with establishing a Main Dental Home and document a member's Main Dental Home choice in the members' file.

Providers can learn more about billing OEFV services in Section 9.

DURABLE MEDICAL EQUIPMENT AND OTHER PRODUCTS NORMALLY FOUND IN PHARMACY

BCBSTX reimburses for covered durable medical equipment and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans, and other supplies and equipment. For children and young adults (birth through age 20), BCBSTX also reimburses for items typically covered under the Texas Health Steps Program. That includes 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 and young adults (birth through age 20), a pharmacy must be in the BCBSTX/Prime Therapeutics network. Pharmacies that wish to provide DME services and are enrolled with the Texas Medicaid & Healthcare Partnership (TMHP) website as DME providers may complete a DME provider contract with BCBSTX to provide these services.

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

Providers can contact a provider representative at **1-855-212-1615** to get DME Provider Contract information.

Once a pharmacy is contracted as a DME provider, it may submit claims with the billing National Provider Identifier (NPI) number and rendering NPI (as appropriate) on the CMS 1500 claim form. Providers can call **1-877-688-1811** for information about DME and other covered products commonly found in a pharmacy for children and young adults (birth through age 20). Claims for limited home health supplies may be submitted to Prime Therapeutics.

BCBSTX pharmacy providers have a separate provider manual. For information on how to access the STAR, CHIP and STAR Kids Pharmacy Manual, please contact your provider representative.

Value-Added Services

BCBSTX members also have access to services in addition to Medicaid-covered benefits and services. BCBSTX offers these benefits at no cost to the member. We refer to this coverage as value-added services. Value-added services have restrictions and limitations.

You can learn more about value-added services in the STAR program. You can also call **1-877-375-9097** for more info.

You can learn more about value-added services in the STAR Kids program. You can also call **1-877-688-1811** for more info.

You can learn more about value-added services in the CHIP program. You can also call **1-877-375-9097** for more info.

Here are details on value-added services in each program:

Value Added Service	STAR	STAR KIDS	CHIP
TRANSPORTATION			
Free rides for non-emergency doctor visits, therapy, pharmacy, WIC visits, BCBSTX member events and meetings, and approved health classes	X	X	X
PREGNANCY/NEWBORNS			
$50 of fresh fruits and vegetables delivered to the home for pregnant members	X	X	X
Choice of an infant car seat or a playard when pregnant members complete a timely prenatal visit and register for our Special Beginnings® program.	X	X	X
Pregnant members can get a $50 gift card for timely completion of the first prenatal visit.	X	X	X
BCBSTX prenatal class and a free diaper bag with baby items for pregnant members	X	X	X
Breastfeeding education through our Special Beginnings program.	X	X	X
$120 gift card for taking children birth through 15 months for Texas Health Steps checkups.	X	X	X
A $25 gift card upon completing the postpartum visit 7 to 84 days after delivery	X	X	X
ONGOING CARE/CHECKUPS			
$25 gift card for members ages 2 to18when they get a yearly Texas Health Steps checkup.	X	X	X
Human papillomavirus (HPV) vaccine incentive: STAR and CHIP members ages 9-13 can earn a $25 gift card when they get all their age-required doses of the HPV.	X		X

Value Added Service	STAR	STAR KIDS	CHIP
BEHAVIORAL HEALTH			
$50 Incentive gift card for getting follow-up care after a behavioral health inpatient discharge.	X	X	X
OTHER/GENERAL			
Up to eight hours of extra respite care for STAR Kids members in the Medically Dependent Children Program (MDCP)		X	
Toll-free 24/7 Nurseline: to talk in private with a nurse about your health.	X		X
One free sports and camp physical each year for members 18 years of age and under.	X	X	X
Reimbursement for Summer Recreational Activity up to $100		X	
Upgraded eyewear up to a $150 value each year, after an eye exam, for children ages 18 and under	X	X	X
Value Added Service	**STAR**	**STAR KIDS**	**CHIP**
$25 gift card for members who fill an asthma prescription for four consecutive months.	X	X	X
$50 reimbursement for completion of a health or wellness activity	X		X
Up to 14 meals delivered to the member's home after a hospital discharge for one incident per year.	X	X	X
Up to $250 in dental services per year for adult STAR members 21 and older, and CHIP Perinatal members 19 and older.	X		X
Access to online health and wellness resources	X	X	X
Access to the Blue365® Discount Program	X	X	X

Case-by-Case Services:

BCBSTX offers case-by-case services, based on availability and members' needs, which are non-Medicaid covered benefits. These services can include pregnancy-related services and other programs above the standard Medicaid benefit. These added services may have limitations or restrictions.

Non-Medicaid Coordination

NON-MEDICAID MANAGED CARE COVERED SERVICES

Coordination of Services

Other services are available outside of the BCBSTX provider network. These services are known as “Non-Medicaid” Managed Care Covered Services. Below is a listing of those services. These services are subject to change.

- Texas Health Steps Environmental Lead Investigations.
- Early Childhood Intervention case management/service coordination and specialized skills training targeted case management and developmental rehabilitative services.
- Texas HHSC-contracted providers of case coordination or service coordination for individuals who have intellectual or developmental disabilities.
- Texas Department of State Health Services mental health rehabilitation services and targeted case Management.
- Texas Health Steps dental services — including orthodontia for STAR and STAR Kids. (Note: STAR and STAR Kids members 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).
- Texas Health Steps medical case management - Medicaid only.
- Texas School Health and Related Services - Medicaid only.
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation).
- Texas HHSC hospice care.
- Texas HHSC or Texas DSHS Home and Community-Based Services waiver programs, including Deaf Blind with Multiple Disabilities, Texas Home Living, Community Living Assistance and Supports Services and Youth Empowerment Services.
- Department of Assistive and Rehabilitative Services blind children’s vocational discovery and development program.
- Court-ordered commitments to inpatient mental health facilities as a condition of probation.

For STAR only

- Texas Health Steps Personal Care Services for members birth through age 20.

For STAR Kids only

- Preadmission Screening and Resident Review screenings, evaluations and specialized services for STAR Kids members in a nursing facility.
- Texas HHSC-contracted providers of Long-Term Services and Supports), for individuals who have intellectual or developmental disabilities.

COORDINATION WITH NON-CHIP COVERED SERVICES

There are other services also available outside of the CHIP network and plan. They include:

- Texas agency administered programs and case management services.
- Essential public health services.

Service Coordination Services

ROLE OF SERVICE COORDINATOR

The service coordinator’s role is to develop and implement a person-centered plan for the STAR, CHIP or STAR Kids member. The service coordinator will work directly with the member or their legally authorized representative, or both, to coordinate the member’s clinical and non-clinical support.

STAR and CHIP providers can access Service Coordination by calling **1-877-214-5630**. STAR Kids providers can access Service Coordination by calling **1-877-301-4394**.

A component of the STAR Kids program uses the STAR Kids Screens and Assessment Instrument. This instrument helps BCBSTX determine each child’s health and independent living needs.

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

For all members, the service coordinator will provide:

General Support

- Clinical and Non-Clinical Support.
- Identify member's needs.
- Help with 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 face-to-face contacts.
- Coordinate services with other entities to ensure integration of care (Early Childhood Intervention; Special Supplemental Nutrition Program for Women, Infants, and Children; Durable Medical Equipment; Non-Emergency Medical Transportation, etc).

Direct Support

- Coordinate care for members with special healthcare needs.
- Conduct asthma and diabetes disease management.
- Conduct complex care management.
- Help coordinate 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.
- Coordinate discharge planning.
- Help with adult transition planning.
- Continuity of Care transition planning.
- Ensure 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 practices/evidence-based services.
- Ensure compliance with Psychotropic Medications on utilization standards.
- Identify and report potential abuse/neglect.

LEVELS OF SERVICE COORDINATION FOR STAR KIDS

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 at risk for institutionalization
- 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 or severe and persistent mental illness*

*We define SED as psychiatric disorders in children and adolescents that 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 either of the following:

- Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping or employment) due to the disorder.
- Impaired emotional or behavioral functioning that interferes with the member's capacity to remain in the community without supportive treatment or services.

All Level 1 members must receive a minimum of four face-to-face service coordination contacts yearly, in addition to monthly phone calls, unless otherwise requested by the member or the member's LAR.

Level 2

- Members who do not meet the requirements for Level 1 classification but receive Personal Care Services or Community First Choice.
- Members that BCBSTX believes would benefit from a higher level of service coordination based on results from the STAR Kids SAI and additional BCBSTX findings.
- Members with a history of substance use disorder (multiple outpatient visits, hospitalization, or institutionalization within the past year).
- 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 face-to-face service coordination contacts and six service coordination phone calls yearly, 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 face-to-face service coordination contact and at least three service coordination phone calls yearly.

Individual Service Plans

The ISP is a regularly updated document. Members, their providers, their LARs and other caretakers develop the ISP by working together in a person-centered, culturally competent manner. The ISP's purpose is to articulate assessment findings, goals, service needs and member preferences, and to measure outcomes over time.

The ISP helps the member's team to develop a plan of care to address the needs of the member, making updates as required by the member's health needs.

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 the STAR Kids screening and assessment process.
- Covered services currently receiving.
- Covered services not currently receiving, 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.
- A description of member-related 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 other third-party resources, and the providers of those services.
- Plans specifically related to transitioning to adulthood for members aged 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

ADULT TRANSITION PLANNING

BCBSTX will ensure that teens and young adult STAR Kids members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday.

BCBSTX will conduct ongoing transition planning, starting when a member turns 15 years old. BCBSTX will provide transition planning services as a team approach through the named service coordinator, if applicable, and with a transition specialist within the Customer Advocate department. Transition specialists must be BCBSTX employees and wholly dedicated to counseling and educating members and others in their support network about considerations and resources for transitioning members 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 members in the transition process. Transition planning must include the following activities:

- 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.
- Prior to the member turning 10 years old, BCBSTX will inform the member and the member's LAR about LTSS programs offered through HHS. If applicable, BCBSTX will help the member provide the information needed to apply. LTSS programs through HHS include Home and Community-Based Services, CLASS, DBMD and TxHmL.
- Beginning when the member reaches age 15, BCBSTX must regularly update the ISP with transition goals.
- Coordination with DARS to help identify future employment and employment training opportunities.
- If desired by the member or the member's LAR, coordination with the member's school and Individual Education Plan to ensure consistency of goals.
- Health and wellness education to assist the member with self-management.
- Identification of other resources to help 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.
- Help in applying for community services and other supports under the STAR+PLUS program after the member's 21st birthday.
- Help in identifying adult healthcare providers.

Providers with questions about adult transition planning can contact a STAR Kids service coordinator at **1-877-301-4394**.

Section 7: Behavioral Health Services

Behavioral Health Essentials

BCBSTX covers behavioral health services for the treatment of mental, emotional or substance use disorders. This includes treatment for acute and chronic psychiatric disorders. BCBSTX behavioral health network providers include psychiatrists, nurse practitioners, psychologists, social workers, licensed professional counselors, hospitals, federally qualified health centers and local mental health authority facilities.

Behavioral health services we cover include:

- Assessment and treatment planning
- Psychiatric services
- Medication management
- Inpatient services
- Partial hospitalization*
- Intensive outpatient services*
- Case management services
- Outpatient therapy
- Substance use services

(*Partial hospitalization and Intensive Outpatient programs are available benefits to CHIP members and through Early Periodic Screening, Diagnosis and Treatment services for members under age 21 enrolled in the STAR and STAR Kids programs. Request for members age 21 and older will be reviewed on a case-by-case basis.)

BCBSTX provides inpatient mental health services to all members in any facility type. Services provided in freestanding facilities are available to members under age 21 as long as medically appropriate. The services are allowable for up to 15 days per month for members age 21-64, in lieu of acute hospital care.

Providers and members can learn more details about behavioral health benefits, and covered services at this BCBSTX Behavioral Health webpage.

Behavioral Health Services

MEMBER ACCESS TO BEHAVIORAL HEALTH SERVICES AND REFERRALS

Behavioral health services are provided for the treatment of mental, emotional or substance use disorders. Behavioral health services do not require a referral from a primary care provider (PCP). Members may self-refer to any network Medicaid-enrolled behavioral health provider for treatment. Members need a prior authorization to see an out-of-network provider.

A PCP may refer a patient to a behavioral health provider for assessment or for treatment of a mental, emotional or substance use disorder. The PCP may work closely with a service coordinator to ensure the member is receiving appropriate behavioral health services. PCPs may also provide behavioral health services that are within the scope of their practices.

Members may self-refer to any BCBSTX network behavioral health provider by calling Customer Advocate Department at **1-888-657-6061** (for STAR and CHIP) and **1-877-688-1811** (for STAR Kids). Providers may refer members for services by calling Provider Customer Service at **1-877-560-8055** (for STAR and CHIP) and **1-877-784-6802** (for STAR Kids).

BCBSTX is responsible for authorizing, reviewing and paying claims for medically necessary treatment, including inpatient hospital services.

THE ROLE OF A BEHAVIORAL HEALTH HOME

The term “behavioral health home” refers to a practice-based care team that takes collective responsibility for a patient’s ongoing care. The behavioral health providers facilitate partnerships among patients, providers, behavioral health staff and families. This teamwork helps with:

- **Access to and coordination of care:** The health home coordinates all care for a patient and provides or helps with access to specialty care.
- **Adherence and compliance:** The health home staff helps the patient in adhering to the recommendations of the provider. This includes helping patients 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.

BEHAVIORAL HEALTH ASSESSMENTS

BCBSTX requires that all providers have procedures to screen and evaluate their patients for behavioral health problems and disorders. The screenings and evaluations should help detect issues and allow for the provider to make referrals when needed.

COORDINATION BETWEEN BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES

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

BCBSTX also requires that behavioral health providers send initial and regular summary reports of a member’s behavioral health status to the PCP, with the consent of the member or the member’s legal guardian.

PCPs and behavioral health care providers are responsible for actively coordinating and communicating continuity of care. Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. The exchange of information helps improve both behavioral and medical health care. Our care continuity and coordination guidelines for PCPs and behavioral health providers include:

- Both the PCP and behavioral health provider should coordinate medical and behavioral health services with the Local Mental Health Authority and state psychiatric facilities regarding admission and discharge planning for members with Serious Emotional Disorders and Serious Mental Illness, if applicable.
- Both the PCP and behavioral health provider should complete and send the member’s consent for information release to the collaborating provider.
- Both the PCP and behavioral health provider should share information — per conditions of the patient release — to help coordinate care for the member.
- Both the PCP and behavioral health provider should note contacts and collaboration in the member’s chart.
- Both the PCP and behavioral health provider should respond to requests for collaboration within one week, or immediately if an emergency is indicated.
- The behavioral health provider should send a completed coordination of care/treatment summary form to the member’s PCP when they have seen a member.
- The behavioral health provider should send to the member’s PCP an initial and quarterly (or more frequently, if clinically indicated) summary reports of a member’s behavioral health status.
- The behavioral health provider should contact the PCP when making a change in the behavioral health treatment plan.
- The PCP should contact the behavioral health provider when the PCP determines the member’s medical condition could be expected to affect the member’s mental health treatment planning or outcome. The PCP should document the information on the coordination of care/treatment summary.

To support PCPs as they identify and manage a member’s mental health and behavioral health needs, BCBSTX provides a variety of behavioral health tips and hosts behavioral health education webinars. More information is on our website.

BCBSTX also encourages providers to use the Child Psychiatry Access Network and the Perinatal Psychiatry Access Network. The networks offer real-time access to a multidisciplinary network of mental health experts, including child psychiatrists, for peer-to-peer consults by phone. They also provide referrals to local resources.

Child Psychiatry Access Network
Phone: **1-888-901-2723**
Website: tcmhcc.utsystem.edu/child-psychiatry-access-network-cpan/

Perinatal Psychiatry Access Network
Phone: **1-888-901-2726**
Website: tcmhcc.utsystem.edu/perinatal-psychiatry-access-network-peripan/

COURT-ORDERED COMMITMENTS

BCBSTX covers services that are court ordered, including substance use disorder treatment and inpatient/outpatient psychiatric services. Court-ordered services will not be clinically reviewed, reduced, limited or denied in any way that would controvert those court orders.

BCBSTX requests notification of admission to court-ordered care to ensure that claims will be paid appropriately, and proper coordination of care occurs. Providers may submit notification of admission and court order documents through fax or our provider portal.

FOCUS STUDIES AND UTILIZATION MANAGEMENT REPORTING REQUIREMENTS

Consistent with 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. The drill-down analyses may include data from specific provider and practice sites, including:

- 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 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 must contact within 24 hours members who have missed appointments to reschedule the appointments, per requirements from HHSC.

FOLLOW-UP AFTER HOSPITALIZATION FOR BEHAVIORAL HEALTH SERVICES

BCBSTX requires that all members who receive 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.

VALUE-ADDED SERVICES FOR BEHAVIORAL HEALTH

Providers can see the value-added services that BCBSTX offers members for behavioral health in Section 6: Covered Services.

EMERGENCY BEHAVIORAL HEALTH SERVICES

An emergency behavioral health condition means any condition that, in the opinion of a prudent layperson possessing an average knowledge of health and medicine, requires immediate intervention or medical attention. This is without regard to the nature or cause of the condition.

A behavioral health emergency exists when, without immediate intervention or medical attention, the member would present an immediate danger to themselves or others, or would be rendered incapable of controlling, knowing or understanding the consequences of their actions.

With a behavioral health emergency, the safety of the member and others is paramount. Providers should tell the member 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. BCBSTX does not require prior authorization for emergency services, including the 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 their activities of daily living
- Showing signs of severe withdrawal from alcohol or substance use.

Urgent Behavioral Health Services

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

SUBSTANCE USE DISORDERS

BCBSTX uses the definition of substance use and dependence found in the American Psychiatric Association's current Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). Treatments for substance use disorders include for opioid use disorder and drug, alcohol and tobacco misuse. Care could include the following services: screenings, brief interventions, treatment referrals, outpatient substance use counseling, smoking cessation services, medication-assisted treatment, inpatient and residential substance use treatment services.

PCPs and behavioral health care providers are responsible for actively coordinating and communicating continuity of care regarding all substance use treatment and services.

MHR and TCM Services

MENTAL HEALTH REHABILITATIVE SERVICES AND TARGETED CASE MANAGEMENT

Mental Health Rehabilitative Services and Targeted Case Management are available to eligible members with Severe and Persistent Mental Illness or Serious Emotional Disturbance.

SPMI is a condition of an adult 18 years of age or older. It is a diagnosable mental, behavioral or emotional disorder that meets the criteria outlined in the DSM-5 and has resulted in functional impairment that substantially interferes with or limits one or more major life activities.

SED is a condition of a child up to age 18. It is a diagnosable mental, behavioral or emotional disorder of enough duration to meet diagnostic criteria specified within the DSM-5. To be considered an SED, the disorder must also have resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

Mental Health Rehabilitative Services include training and services that help the member maintain independence in the home and community. Services include:

- Medication training and support: Curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of their mental illness or emotional disturbance and the role of medications in ensuring symptom reduction and 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 functioning effectively with family, peers and teachers.
- Crisis intervention: Intensive, community-based, one-to-one service provided to members who require services to control acute symptoms. These symptoms would otherwise place the member at immediate risk of hospitalization, incarceration or placement in a more restrictive treatment setting.

Targeted Case Management includes:

- Case management for members who have an SED (children age 3 through 17), which includes routine and intensive case management services.
- Case management for members who have SPMI (adults age 18 and older)

MHR and TCM services — including any limitations to these services — are described in the Texas Medicaid Provider Procedures Manual, and in the Behavioral Health, Rehabilitation, and Case Management Services Handbook). BCBSTX is not responsible for providing any services listed in those guidelines that are not covered services.

Providers of MHR and TCM services must use and be trained and certified to administer the Adult Needs and Strengths Assessment for adult members age 19 and 20, and the Child and Adolescent Needs and Strengths for members 18 and younger. Both are tools that can help assess a member's need for services and can recommend a level of care.

A provider entity must attest to BCBSTX that they or their organization could provide, either directly or through sub-contract, the full array of MHR and TCM services as outlined in the Texas Department of State Health Services Resiliency and Recovery Utilization Management Guidelines.

Texas HHSC has established qualifications and supervisory protocols for providers of MHR and TCM services. These requirements are located in Chapter 15.1 of the HHSC Uniform Managed Care Manual.

In Lieu of Services

In-lieu-of services are services offered by MCOs that substitute for Medicaid state plan services or settings, as allowed by 42 Code of Federal Regulations (CFR) § 438.3(e)(2).

As allowed by 42 C.F.R § 438.6(e) and 42 C.F.R. § 438.3(e)(2), we provide services in the following Texas Health and Human Services Commission -approved settings in lieu of an acute care inpatient hospital setting:

Inpatient Services in an Institution of Mental Disease: Services include hospitalization at an IMD in lieu of an acute care inpatient hospital setting. Inpatient services in an IMD are to treat acute psychiatric conditions and are allowed for up to 15 calendar days per month for members aged 21-64 only.

Partial Hospitalization Services: Partial hospitalization services provide a structured day program of outpatient behavioral health services. Partial Hospitalization Programs may provide services for mental health, substance use disorders, or both. These services resemble highly structured, short-term hospital inpatient programs. The treatment level is more intense than outpatient day treatment or psychosocial rehabilitation.

Intensive Outpatient Services: Intensive outpatient services, also referred to as IOP services are used to treat behavioral health issues that do not require detoxification or 24-hour supervision. IOPs are generally less intensive than PHPs. They may be delivered for mental health, SUD, or both. IOP services are organized non-residential services providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per Day.

PROVIDER QUALIFICATIONS

Intensive Outpatient Program for Mental Health:

BCBSTX will authorize medically necessary IOP services for mental health when rendered in hospital outpatient departments and clinic/group practices offered under the direction of a clinical director responsible for programming requirements. Rendering providers must be enrolled in Medicaid and may include those outlined in Section 4 of the Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks) of the TMPPM for outpatient mental health services, which are: Physicians, physician assistants (PAs), advanced practice registered nurses (APRNs), licensed clinical social workers (LCSWs), licensed marriage and family therapists (LMFTs), licensed professional counselors (LPCs), psychologists, licensed psychological associates (LPAs), provisionally licensed psychologists (PLPs), post-doctoral fellows, and pre-doctoral psychology interns.

Intensive Outpatient Program for Substance Use Disorder:

BCBSTX will authorize medically necessary IOP SUD treatment services when rendered by and delivered in a licensed Chemical Dependency Treatment Facility enrolled in Medicaid.

Partial Hospitalization Mental Health

BCBSTX will authorize medically necessary PHP services in hospital outpatient departments and clinic/group practices enrolled in Medicaid for members who are discharged from an inpatient hospital treatment program, and the PHP is in-lieu-of continued inpatient treatment; or for members, who in the absence of partial hospitalization services, would be at reasonable risk of requiring inpatient hospitalization.

When partial hospitalization is used to shorten an inpatient stay and transition the patient to a less intense LOC, there must be evidence of the need for the acute, intense, structured combination of services provided by a PHP. Recertification of services must address the continuing serious nature of the Member's psychiatric condition requiring active treatment in a PHP.

Partial Hospitalization Substance Use Disorder

BCBSTX will authorize medically necessary PHP SUD services when delivered in a licensed CDTF. Partial hospitalization for SUD delivered in CDTFs licensed by the Texas Department of Insurance to provide SUD services may be provided for Members who require care or support or both in a hospital or chemical dependency treatment center for at least 20 hours per week but who do not require 24-hour supervision.

SERVICE REQUIREMENTS:

Partial Hospitalization Services

Partial hospitalization services provide a structured day program of outpatient behavioral health services. Partial Hospitalization Programs may provide services for mental health, SUD, or both. These services resemble highly structured, short-term hospital inpatient programs. The treatment level is more intense than outpatient day treatment or psychosocial rehabilitation.

Items and services that may be included as part of PHPs are:

- Psychotherapy (individual, family, and group);
- Providers of psychotherapy must meet requirements in Section 4 (Outpatient Mental Health Services) of the Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks) of the TMPPM SUD Counseling (individual and group);
- SUD Counseling (individual and group)
    - Providers of SUD counseling must meet requirements in Section 9 (SUD Services) of the Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks) of the TMPPM.
- Medication- Assisted Treatment as described in the TMPPM;
- Occupational therapy requiring the skills of a qualified occupational therapist.
    - Occupational therapy may be provided by a physician or occupational therapist within their licensed scope of practice.
    - Occupational therapists must meet the requirements in Section 4 (Therapy Services Overview) and Section 5 (Children's Therapy Services Clients birth through 20 years of age) of the Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook of the TMPPM.
- Services of other staff (social workers, psychiatric nurses, and others) trained to work with persons with psychiatric conditions.
- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes as described in the TMPPM;
- Individualized activity therapies that are not primarily recreational or diversionary.
    - These activities must be individualized and essential for the treatment of the person's diagnosed condition and for progress toward treatment goals.
- Training and education, to the extent the training and educational activities are closely and clearly related to the person's care and treatment of their diagnosed psychiatric condition; and
- Medically necessary diagnostic services related to mental health and/or SUD treatment.

Services that may not be covered as part of a PHP include:

- Meals and transportation
- Room and board
- Services to Members receiving inpatient services, including IMDs

Intensive Outpatient Program Services

Intensive outpatient program services are used to treat behavioral health issues that do not require detoxification or 24-hour supervision. IOPs are generally less intensive than PHPs. They may be delivered for mental health, SUD, or both.

Intensive outpatient services are organized non-residential services providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day.

As required in Section 9 (SUD Services) of the Behavioral Health and Case Management Services Handbook (Vol. 2, Provider Handbooks) of the TMPPM, LOC and specific services provided must adhere to current evidence-based industry standards and guidelines for SUD treatment, such as those outlined in the current edition of ASAM's Treatment Criteria for Addictive Substance-Related and Co-Occurring Conditions.

Services that may not be covered as part of a IOP services include:

- Meals and transportation
- Room and board
- Services to Members receiving inpatient services, including IMDs

Duplication of Services and Payment for In-Lieu-Of Services

BCBSTX will not reimburse in-lieu-of services and a Medicaid state plan covered service that is a component of the in-lieu-of service per diem on the same date of service. Additionally, partial hospitalization services and IOP services, provided as in-lieu-of services, may not be reimbursed on the same day as each other.

To prevent duplication of services and payments Claims System duplicate logic will detect a duplicate within the patient's history using data elements, date of service, services rendered and the Providers identification number.

MEMBER ELIGIBILITY:

All members are eligible except for the following circumstances:

- Inpatient services in an Inpatient Services in an Institution of Mental Disease are for members aged 21-64 only.

Member Cost Sharing Responsibility

Only CHIP members have cost sharing responsibilities, "**IF"**, it's stated on their member ID card.

Member's Choice

Member's must agree to receive in-lieu-of services before any service is authorized.

PROVIDER RESPONSIBILITY

Providers are strongly encouraged to notify and educate members regarding their eligibility for in-lieu of services. Providers have the responsibility to note in the member record the member's choice to receive of the in-lieu-of-services.

Prior Authorization:

Prior Authorization is required for inpatient services in an IMD, partial hospitalization and intensive outpatient program.

BCBSTX will follow the service authorization notice requirements described in UMCM 3.21 and will provide written notice to both the provider and the member when in-lieu-of services are authorized, reduced, or denied. All in-lieu-of services require prior authorization and requests may be submitted by phone, fax, or through the Availity portal.

All requests for inpatient services in an IMD, partial hospitalization and intensive outpatient services will be reviewed for medical necessity. For Mental Health MCG Guidelines 28th Edition will be utilized. For Substance Use, ASAM 3rd Edition will be utilized.

For more information about the prior authorization process please refer to Section 8 Quality Management and Utilization Management of the provider manual.

Submission of Claims

Authorization will be required for claims payment for both PHP and IOP. If an urgent need for BH services, Providers will not be penalized for obtaining authorization after initiation of services.

Claims Codes and Modifiers

- BCBSTX chosen procedure and modifier code combinations will be unique to each in-lieu-of service. Intensive Outpatient Program (IOP) Psychiatric - S9480
- Intensive Outpatient Program (IOP) Alcohol and/or drug services - H0015
- Partial Hospital Services (PHP) Psychiatric-H0035
- Partial Hospital Services (PHP) Alcohol and/or drug services – S0201
- For questions regarding ILOS please contact our service coordination team:
- STAR and CHIP: **1-877-214-5630**
- STAR Kids: **1-877-301-4394**

Section 8: Quality Management and Utilization Management

Quality Assessment and Performance Improvement Program

The BCBSTX Quality Assessment and Performance Improvement Program encompasses all clinical care, behavioral services and long-term services and supports that we provide to members. The program looks at:

- The process and outcomes of clinical care
- Behavioral health services
- Ancillary services
- Pharmacy services
- Vendor services
- Member services and member/provider satisfaction
- Patient safety
- Efficient use of resources

The program is comprehensive and ongoing. It includes effective mechanisms to identify, monitor, evaluate and resolve issues that may impact health care accessibility, availability and continuity. It seeks to help the diverse population we serve. And it recognizes we can always improve.

The program's overall goals are to:

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

The program's intent is to foster quality care for members. It does that in accordance with the highest standards set forth by the National Committee for Quality Assurance, with the principles and regulations of the Texas Health and Human Services Commission, and with BCBSTX's own values and goals.

The NCQA, an independent, not-for-profit organization dedicated to improving health-care quality, has accredited BCBSTX. 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 measures of the Healthcare Effectiveness Data and Information Sets (HEDIS®). More than 90 percent of U.S. health plans use HEDIS to measure performance on health care and service.

A national oversight committee of physicians analyzes the NCQA survey findings and assigns an accreditation level based on performance. This recognition for BCBSTX is the result of our long-standing dedication to providing quality health care service and programs to our members.

BCBSTX requires all providers to cooperate with all quality improvement activities. We also require providers to allow BCBSTX to use provider performance data to ensure success of the QAPI Program.

To ensure quality of care provided to members, the Quality Improvement department monitors various programs and services, including:

- Performance improvement projects across programs.
- Distribution and monitoring of practice guidelines for diseases and conditions most likely to affect BCBSTX members, as well as pediatric and adult preventive health care guidelines.
- Medical records reviews of primary care practices to promote compliance with standards for appropriate medical record documentation.
- Monitoring and investigation of quality-of-care complaints.

Primary Care Quality Incentive Program

Blue Cross and Blue Shield of Texas is committed to supporting providers in delivering high-quality, cost-effective care to our Medicaid STAR, CHIP, and STAR Kids members. The Primary Care Quality Incentive Program is designed to reward participating providers for achieving or exceeding specific quality and performance benchmarks. The program aligns with state and federal quality initiatives and aims to improve health outcomes, patient experience, and the overall value of healthcare services. For more information see Attachment J.

Quality Management

Each year, BCBSTX analyzes how members are using health care services and checks that against certain standards. We check for whether members are under-using some services, or whether some services are at or beyond capacity. We do all this consistent with NCQA standards.

If we find that the use of certain services falls outside acceptable ranges and could adversely affect members, we will do further analysis. To do that, we may gather further information, including:

- Case management services as needed for members
- Retrospective reviews of any services provided without authorization
- Investigation and resolution of member and provider complaints and appeals that were filed within established time frames
- Coordination with physicians, other professional providers and agencies
- Claims payment for covered services

Provider Profile Reporting

Primary care providers enrolled in the Value Based Purchasing program will receive profile reports. The Provider Profile report is generated every year 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.

Improving Performance of Profiled Providers

To promote continuous quality improvement, directors of BCBSTX's Network Management and Quality Improvement departments and its Medical Director work directly with PCPs to help interpret profile results. This allows BCBSTX and PCPs to review opportunities, discuss medical guidelines and promote collaborative partnerships to ensure population health and improve the quality of care for our members.

Focus Studies and Reporting Requirements

BCBSTX performs focus studies to monitor and evaluate the quality of care and services provided to members objectively and systematically. The studies look at areas and use tools that BCBSTX's Medicaid Quality Operations Committee has agreed on.

Those tools include:

- Medical record reviews using HEDIS measures
- Provider surveys
- Member surveys
- Random audits of medical records
- Review of claims and encounter data

Providers are notified of medical records audits (if medical records review is necessary) at least two weeks prior to the review visit. BCBSTX submits findings from these focus studies to providers.

Practice Guidelines

To do the best job in improving care, the MQOC requires provider cooperation in the following ways:

- Upon request, providers should submit or give access to medical records of a member or members
- Providers should respond promptly to all communications from BCBSTX regarding quality improvement or management issues
- Providers should maintain the confidentiality of all BCBSTX member information

For more information on practice guidelines and provider responsibilities, please see Section 3: Provider Roles and Responsibilities.

Quality Improvement Studies and Projects

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 (HEDIS Hybrid uses medical records and administrative data for analysis.)
- Internal quality improvement projects. These include focused studies that evaluate quality of care and service in specific clinical and service areas.

Help to Improve HEDIS

We ask providers 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. Providers can request a consultation by calling Provider Relations at **1-855 -212-1615**.

Each year, BCBSTX provides 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

Access to Medical Records for HEDIS Audits

BCBSTX's Quality Improvement department will contact the provider's office to arrange for a review or to copy any medical records required for quality improvement studies. Providers' office staff must cooperate in giving access to or delivering the records BCBSTX requests.

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 goal of eliminating them.

Physicians and health care systems are responsible for the continuous monitoring, implementation and enforcement of all standards to ensure good health care. We will work with network providers and hospitals to identify adverse events that are measurable and preventable to improve patient care.

Preventable adverse events should not occur. We believe that a health plan and patients should not pay for services that resulted from a preventable adverse event. We are committed to working collaboratively with providers and hospitals to ensure that they 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.

Health Insurance Portability and Accountability Act regulations specify that Protected Health Information can be disclosed for health care operations in relation to quality assessment and improvement activities.

The information that providers share with us is also 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 adverse events from federal, state and private payers, including "Serious Reportable Events." Serious Reportable Events — defined by the National Quality Forum, a not-for-profit organization working to improve healthcare — are adverse events that are serious but largely preventable. They are of concern to both the public and to health care providers. Medicaid is prohibited from paying for certain health care acquired conditions (HCACs) — which are preventable conditions acquired in a health care setting.

Utilization Management Overview

The role of the BCBSTX Utilization Management department is to help providers give members the right care, at the right time, in the appropriate setting.

The UM department collaborates with providers to promote and document the appropriate use of health care resources. The UM program reflects the most current UM standards from the NCQA.

Authorization for health care services 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, except Texas Health Steps services for children from birth through age 20. For these Texas Health Steps services, medical necessity is based on the clinical documentation the provider sends to the Utilization Management department when requesting a prior authorization. You can learn more about prior authorizations at online.

Providers can verify member eligibility and access information on benefits and prior authorizations at www.availity.com.

Providers may also use the phone numbers below for questions or prior authorization requests. Representatives are available 24 hours per day and seven days per week at these numbers. After normal business hours, an on-call nurse can help callers with urgent requests.

STAR and CHIP
Phone: **1-877-560-8055**
Fax: 1**-855-653-8129**

Behavioral Health Fax: **1-888-530-9809**

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

Behavioral Health Fax: **1-888-530-9809**

Faxes received after hours will be processed the next business day.

BCBSTX offers TTY services for deaf and hearing- and speech-impaired members. Language assistance is available at no cost to members and providers to discuss utilization management issues. For interpreters and other help, providers and members can call the Customer Advocate or TTY numbers in Section 12 of this manual.

Service Reviews

Our Utilization Management department provides prior authorization, concurrent/continued stay and post-service reviews using clinical criteria based on sound clinical evidence. These criteria are available to members and providers upon request. You can learn more by contacting **1-877-560-8055** for STAR and CHIP (or via fax at **1-855-653-8129**) or **1-877-784-6802** for STAR Kids (or via fax **1-866-644-5456**).

Provider Notifications of Changes to Authorization Procedures

We provide a 30-day notice to providers of changes to authorization procedures via provider bulletins. Provider bulletins are distributed to all network providers and then posted on the Prior Authorizations page of the BCBSTX website. We then update the provider manual with changes during its next scheduled revision.

Member and Provider Surveys

MEMBER SATISFACTION SURVEYS

Member satisfaction with our services is measured every year. The Texas External Quality Review Organization conducts the Consumer Assessment of Healthcare Providers and Systems of our members annually. The survey measures satisfaction with the service and care provided by BCBSTX and its providers.

The survey measures access to care, member satisfaction with BCBSTX, satisfaction with providers and their communications, and office staff performance. We inform providers of the survey results, along with plans for improvement. We do that through providers' bulletins, newsletters, meetings or training sessions.

Provider Satisfaction Surveys

BCBSTX conducts provider surveys every year to monitor and measure provider satisfaction with BCBSTX's services and with member access to care. The surveys help us identify areas for improvement. We inform providers of the results and plans for improvement through providers' bulletins, newsletters, meetings or training sessions. We highly encourage providers' participation in the surveys. Your feedback is very important to help us 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, and details are sent in advance. 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.

Provider Mandatory Survey (Provider Challenge Survey)

The mandatory Provider Challenge Survey is used to verify provider information. We send the survey periodically, but not less than twice per year. A provider's assigned representative may survey them during provider visits. The information validated includes provider demographics, appointment wait times, preventive care wait times and acceptance of new patients. We will send details about the survey in advance. Providers should not wait for the survey to update their information. A form for updating information is on the BCBSTX provider website.

MEDICAL RECORD REVIEWS

The BCBSTX Quality Improvement department completes medical record reviews at random primary care sites and high-volume provider offices. The required standards for how providers keep medical records are outlined in Section 3: Provider Roles and Responsibilities.

BCBSTX conducts medical record reviews to:

- Determine providers' ongoing compliance with standards for provision and documentation of health care services, and compliance with processes that maintain safety standards and practices.
- Confirm provider involvement in the continuity and coordination of care for our members.

Texas HHSC and BCBSTX representatives 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.

Scheduling Medical Record Reviews

Quality Improvement department staff will communicate with providers' offices to coordinate on-site or off-site medical record review with 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 provider.
- Upon completion of the medical record review, provide a copy of the medical record review results to the office manager or provider, sending a final copy within 10 days of the review.
- If needed, schedule follow-up reviews for any corrective actions required.

Providers must attain a score of 80 percent or greater to pass the medical record review. Quality Improvement staff will provide educational help to providers who do not pass the review.

Sharing Best Practice Methods

BCBSTX Network Management representatives share healthcare and healthcare administration best practice methods with providers during scheduled provider visits. BCBSTX also offers educational toolkits to help guide improvements. Toolkits may include examples of best practices from other provider offices. They will include BCBSTX policies and procedures and resources for improving compliance with preventive health services. And they will also include clinical practice guidelines and recommendations on quality care for members with special or chronic care needs.

FACILITY SITE REVIEWS

All PCP 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 providers if that site has not been previously reviewed and accepted as part of BCBSTX's credentialing process.

All obstetrics/gynecology specialty sites participating in BCBSTX (whether serving as a PCP or not) must also undergo an initial site inspection.

A BCBSTX Quality Improvement department representative will call the provider's office to schedule an appointment date and time before performing a facility site review. The representative will fax or send a confirmation letter with an explanation of what BCBSTX representatives will be looking for during the site review.

During the facility site review, the Quality Improvement representative will:

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

After the facility site review is completed, the Quality Improvement representative will meet with the provider or the 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 provider or office manager or send a copy within 10 days of the review.
- Schedule a follow-up review for any corrective actions identified.
- Educate the provider and office staff about BCBSTX standards and policies.

Facility Site Review Follow-ups

Providers are expected to take any corrective actions the site review identifies. Follow-up site visits will occur every six months until the site complies with the BCBSTX standards.

Section 9: Claims and Billing

Introduction and General Claims Guidelines

We need providers' 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 copayments for STAR Kids members.

To learn about services requiring prior authorizations — and how to request a prior authorization — please refer to Section 8: Quality Management and Utilization Management. You can also find a Request for Prior Authorization Form online. For a complete list of prior authorization codes, visit our Prior Authorization webpage.

Services that don't require a prior authorization are not necessarily approved as covered services. For more information, please contact the BCBSTX Utilization Management Department at **1-877-560-8055** (for STAR and CHIP) or **1-877-784-6802** (for STAR Kids). If any prior authorization form is returned with the language "PA Not Required," the requesting provider should verify that the service is a covered benefit.

Prior authorization is required for all out-of-network claims unless the claim involves emergency or urgent care services. For continuity of care services that have been prior authorized, BCBSTX will provide continued authorization for no longer than six months. That authorization will be for either six months or when a new assessment of the member is completed, whichever comes first. For claims questions and appeals, see Section 10: Complaints and Appeals.

Claims will be paid at the lesser of (1) billed charges for services or (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. Reimbursement for all services will be determined according to the Provider Agreement. All covered benefits are as outlined in the Texas Medicaid Provider Procedures Manual.

Submitting a Claim

Notice: Beginning September 1, 2025, per Rider 32, providers will now bill BCBSTX directly for Medicaid wrap-around services for their dually eligible members which are all covered Medicaid services that are not covered by Medicare.

There are four methods for submitting a claim:

- Availity portal
- Electronic Data Interchange (EDI) (preferred)
- Paper or hard copy
- Texas Medicaid & Healthcare Partnership (TMHP) Portal (STAR and STAR Kids)

Availity Provider Portal

The Availity portal optimizes the flow of information between health care professionals, health plans and other health care stakeholders 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 or call **1-800-AVAILITY (282-4548)**.

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

Other 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
- National Provider Identifier (NPI) for rendering provider (see more information about NPI in "National Provider Identifier" subsection below.)
- Group NPI
- Referring or ordering provider NPI

- The provider's federal Tax Identification Number (TIN)
- BCBSTX's Payer Identification number 66002. (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 system for STAR and CHIP (**1- 877-560-8055**) and for STAR Kids (**1-877-784-6802**). Please note that the IVR system accepts either your billing NPI or your federal TIN for provider identification. Should the system not accept your billing NPI or federal TIN, the system will route your call to a Provider Customer Service representative who will help you with your query. To help you, we may ask you for your TIN.
- Watch for (and confirm) plan batch status reports from your vendor/clearinghouse to ensure your claims have been accepted by BCBSTX.
- Correct any errors and resubmit the claim (electronically) immediately to prevent denials due to untimely filing.

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

For EDI claims submissions that require attachments, please contact your clearinghouse for guidelines. Contact BCBSTX's Electronic Commerce Services at ecommerceservices@bcbstx.com to:

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

Paper Claims and Correspondence Mailing Address

- Here is the address and fax number to file paper claims:
  Blue Cross and Blue Shield of Texas
  Attn: Claims
  PO Box 650712
  Dallas, TX 75265-0712
  Fax: **1-877-886-2593**

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.

Tips on 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 federal Centers for Medicare and Medicaid Services 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 a copy for your records.
- Do not staple claims for different services and dates together.
- 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 and Taxonomy Code
- The provider's federal Tax Identification Number
- National Provider Identifier
- 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.

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:

- **1-877-560-8055** (for STAR and CHIP)
- **1-877-784-6802** (for STAR Kids)

Claim Forms

There are two types of forms used for submitting claims for reimbursement. They are:

- The CMS-1500 for professional services
- The CMS-1450 (UB-04) for institutional services

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

CMS-1500 Claim Form

Who should use a CMS-1500 claim form?

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

Providers can see a sample CMS-1500 form, along with a table that provides details on each field and instructions in how to properly complete that field, in Attachment E.

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.

Providers can see a sample CMS-1450 form, along with a table that provides details on each field and instructions in how to properly complete that field, in Attachment F.

Claim Form Filing Limits

All claims must be submitted within 95 days of the service date unless otherwise noted in a provider's contractual agreement with BCBSTX. We will deny claims that are received past the filing limit. Providers should 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 date and the BCBSTX receipt date.

DETAILS ON FORM FILING TIME LIMITS

Form	Type of Service to be billed	Time limit to file (refer to 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; 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

Form	Type of service to be billed	Time limit to file (refer to provider contract to confirm correct filing limits for claims)
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 of 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	If you have a question about claims processing, contact your electronic connectivity vendor (Availity or your preferred vendor) or call BCBSTX Provider Customer Service. Also, you can request your claims status by filing out the Claims Status Form, which can be found here.	30 business days after BCBSTX's receipt of claim, contact Provider Customer Service at: STAR and CHIP: **1-877-560-8055** STAR Kids: **1-877-784-6802**
Provider Appeal	To request a claims appeal, please fill out the Claims Reconsideration Form, which can be found here.	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 from the date of service or discharge date
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

THE IMPORTANCE OF A CLEAN CLAIM

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 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 that the claim be corrected and resubmitted. If providers use 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 ensure that claims that "errored out" from the EDI gateway are corrected and resubmitted.

Claims Editing

BCBSTX uses claims editing software to incorporate editing rules that determine whether to pay, reject 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.

COMMON REASONS FOR REJECTED AND DENIED CLAIMS

Many claims are denied or rejected because of common billing errors. Those include the member's number being incomplete or incorrect and missing authorization numbers and other codes. See more info on those issues, along with possible resolutions in Attachment G.

STANDARDIZED CODES FOR SERVICES

To ensure 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 health care 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 codes maintained by the American Medical Association. 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. 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 codes when coding claims:

- CPT codes: Refer to the current edition of the physicians' CPT manual, published by the American Medical Association You can find more info on the AMA website.
- HCPCS codes: Refer to the current edition of HCPCS published by the Centers for Medicare and Medicaid Services. You can find more info online.

Providers can also consult the Texas Medicaid Provider Procedures Manual for billing tips.

CATEGORIES WHERE CLINICAL SUBMISSIONS REQUIRED

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). That might include:
  - 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 services reviews and specific benefit exclusions).
- Claims that we suspect might involve inappropriate or inaccurate 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

(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 10-digit number that the federal Centers for Medicare & Medicaid Services (CMS) issues to providers of medical and health services and supplies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the creation of the NPI standard. It is intended to improve the efficiency of the health care system and reduce fraud and abuse.

Providers may apply for an NPI individually online at the National Plan and Provider Enumeration System (NPPES) website. They can also obtain a paper application by calling NPPES at **1-800-465-3203**.

Entity Type 1 and Entity Type 2 Providers

Any individual health care provider should apply for an Entity Type 1 NPI.

Organizations such as hospitals apply for an Entity Type 2 NPI. Organizations would include medical groups, group practices, Federally Qualified Health Centers and Rural Health Centers.

Special Rules for Texas Health Steps NPIs

There are special NPI-related rules for Texas Health Steps providers and claims:

- 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 claims.
- Only use billing NPI Box 33A on the CMS-1500 on claims for both Type 1 and Type 2 entities.
- On paper claims, include the EP1 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 claims and include the EP1 benefit code to avoid claims returned for resubmission.

You can learn more about Texas Health Steps bill lower in the Texas Health Steps Billing subsection.

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 Texas Medicaid & Healthcare Partnership (TMHP). You can attest (register and report) your NPI at www.tmhp.com

Attesting makes processing and paying your claims more efficient and accurate. You can verify your NPI assignment at the National Plan and Provider Enumeration System (NPPES) website.

CMS has developed regulations for sending batches of claims through something 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.

All providers must apply for an NPI — even if they don't currently bill to Medicaid or other publicly funded programs.

Online Resources for NPI Information

The following organizations offer more NPI information on their websites:

- National Plan and Provider Enumeration System (NPPES)
- Workgroup for Electronic Data Interchange
- National Uniform Claims Committee
- Texas Medicaid & Healthcare Partnership

Benefit Codes

Providers must submit claims with the appropriate benefit code for services. For electronic claims, add the appropriate 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 benefit code field blank.

(An * shows codes that BCBSTX requires for submitting claims; all other codes are required by HHSC when sending claims 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
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 and diagnosis codes. Providers can learn more in the Texas Medicaid Provider Procedures Manual.

Family Planning Services	Family Planning Diagnosis Codes
99201	Z30011
99202	Z30013
99203	Z30014
99204	Z30018
99205	Z3002
99211	Z3009
99212	Z302
99213	Z3040
99214	Z3041
99215	Z3042
J7296	Z30430
J7297	Z30431
J7298	Z30432
J7300	Z30433
J7301	Z3049
J7307	Z308
	Z309
	Z9851
	Z9852

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

Billing Requirements for CHIP Perinatal Postpartum Visits

A CHIP Perinatal mother's eligibility terminates at the end of the month the baby is born. Providers who call to check benefits after the month of the baby's birth will be advised that the CHIP Perinatal mother is not eligible.

But CHIP Perinatal mothers are entitled to a maximum of two postpartum visits — even after their eligibility ends. To be reimbursed for these postpartum visits, providers must bill using the CPT delivery codes that include postpartum care. These codes apply only 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 ended, the provider will not receive payment for the postpartum care. If the claim is submitted with the incorrect code, the original delivery claim with the correct code may resubmitted within the 120-day claims reconsideration deadline.

You can learn more about CHIP Perinatal in Section 5: Member Eligibility. You can also learn more about CHIP Perinatal billing requirements in the TMPPM.

BILLING REQUIREMENTS FOR CLINICIAN ADMINISTERED DRUGS

A National Drug Code and Healthcare Common Procedure Coding System 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 CMS Clean Claim Standards. You can see a list of BCBSTX covered and preferred drugs at this webpage.

BILLING REQUIREMENTS FOR 340B DRUG DISCOUNT PROGRAM

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

Texas Medicaid requires all pharmacies to submit actual drug acquisition costs under the 340B program in the “ingredient cost” in field 409-D9 of the National Council for Prescription Drug Programs Universal Claim Form. Pharmacies must also complete the “gross amount due” with appropriate dispensing fee in field 430-DU of the NCPDP form, and identify the claim/encounter by providing “8” in the “basis of cost” field 423-DN.

COORDINATION OF BENEFITS

When applicable, BCBSTX coordinates benefits with any other carrier or program that the member may have for coverage, including Medicare. Providers should indicate ‘other coverage’ information on the appropriate claim form.

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

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

(Coordination of Benefits information can also be entered and submitted through electronic claims submission. Providers should contact Availity for more information.)

We deny Coordination of Benefits claims received without at least one of the above three items. Providers should submit the claim to the other carrier first. Providers should ensure that the information they submit explains any coding listed on the other carrier’s PRA or letter explaining denial of coverage or reimbursement. We cannot process a claim without this information.

BCBSTX must receive Coordination of Benefit claims within 95 days from the date on the other carrier’s or program’s PRA or letter of denial of coverage.

When submitting Coordination of Benefits claims, specify the other coverage in:

- Boxes 9a-d of the CMS-1500 claim form
- Electronic Loop for 1500 in the electronic submission

Here are details on how to provide information for those boxes and forms:

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	Other 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	Insurance Group No.	Group Number

COPAYMENTS FOR CHIP

CHIP providers are responsible for collecting any copayments at the time of service, in accordance with CHIP's cost-sharing limitations. The appropriate copayment is listed on the member's ID card.

Families that meet the enrollment period cost-sharing limit must report that to Maximus, the state Medicaid program's enrollment broker. When Maximus notifies BCBSTX that the cost- sharing limit has been reached, BCBSTX will issue the CHIP member a new member ID card within five days. That ID card will show 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 COPAYMENTS

CHIP copayments are not required for some services and for some members. These include:

- Immunizations, Well-Child, Well-Baby
  No copayments apply, at any income level, for well-child or well-baby visits or immunizations. Members are responsible for normal payments associated with unauthorized non-emergency services provided by out-of-network providers, and for non-covered services.
- 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 BCBSTX identifies 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.
- CHIP Perinatal

No copayments are applicable at any income level.

THIRD-PARTY RECOVERY

Providers may not interfere with the state's right or BCBSTX's right, acting as the state's agent, to recovery from third-party billing.

CLAIMS PROCESSING

Here is how our claims processing works:

All submitted claims are assigned a unique Document Control Number. 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 the timely submission of a claim.

Document Control Numbers are composed of 11 digits:

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

Claims entering the system are processed on a line-by-line basis except for inpatient claims. Inpatient claims are processed on a whole-claim basis (with 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 made pending for manual review.

As a provider, 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.

Entities submitting claims for services not rendered by a health care provider are subject to suspension by the Texas Health and Human Services Commission (HHSC).

Claims Returned for Correction/Additional Information

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

Claims Filed with Wrong Plan

If you file a claim with the wrong insurance carrier, you should provide documentation verifying the initial timely claims filing within 95 days of the date of the other carrier's denial letter or PRA. If you do that, BCBSTX processes your claim without denying it for failure to file within timely filing guidelines.

CAPITATION PAYMENTS

BCBSTX Medicaid does not have capitated rates.

CLAIMS PAYMENTS

BCBSTX reviews all claims received 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 year, 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 Payments

BCBSTX will adjudicate (finalize as paid or denied) a clean electronic pharmacy claim within 18 days from the point-of-sale process, and paper pharmacy claims within 21 days of submission. BCBSTX will pay pharmacy providers interest at a rate of 18 percent per year, calculated daily on clean claims for pharmacy claims that are not adjudicated within the specified time for paper or electronic submissions.

How We Make Payments

Providers can receive payments by check or through electronic funds transfers. You can also receive Remittance Advices (RAs) by paper or electronically.

- Paper RAs and payments by check

Unless providers set up electronic payments and electronic remittance advices (see below), BCBSTX will send payments and Remittance Advices in a paper format.

- Electronic funds transfer

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

- Electronic Remittance Advices

Providers can receive Electronic Remittance Advices (ERAs) through a mailbox set up between a provider or clearinghouse and BCBSTX. The ERA files 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. For more information and to enroll in ERAs, visit www.bcbstx.com/provider/claims/era.html. If you have questions, call BCBSTX's EDI Services department at **1-800-746-4614.**

Overpayments

When we discover a claims overpayment, BCBSTX will notify the provider. When that happens, providers should mail a check in the amount of the overpayment to BCBSTX.

Checks should be mailed to BCBSTX with a copy of the overpayment notification and the Provider Refund Form.

- Mail 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 1421
  5505 North Cumberland Ave, Ste 307
  Chicago, IL 60656-1471

All the provider would like the overpayment auto-recouped (overpayment is deducted from future claims), the provider should notify their Network Provider Representative.

If the provider believes that BCBSTX is wrong about overpayment, the provider should contact their Network Provider Representative. If you are not sure who your Network Provider Representative is, please contact 1**-855-212-1615**.

Claim Status Inquiry and Follow-Up

In most cases, you will 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.

Claim Status Online

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

Claim Status by Telephone

You can also confirm that BCBSTX received your claim by calling Provider Customer Service at:

- **1-877-560-8055** (for STAR and CHIP)
- **1-877-784-6802** (for STAR Kids)

Representatives are available Monday through Friday, 8 a.m. to 5 p.m. CT, except for holidays.

Representatives can answer any questions and provide further instructions regarding claim follow-up. They can:

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

Claim Status via Network Provider Representative

You can also confirm status with your Network Provider Representative by completing the Claim Status Form. Durable medical equipment providers should complete the DME Claim Status Form.

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 timely filing guidelines — 120 days from the date of the Provider Remittance Advice — to prevent denials.

Claims Reconsideration

Claims reconsideration is a request for a review of a previously submitted claim to BCBSTX for payment. A provider can file a claims reconsideration if a claim was rejected at the EDI gateway, denied, or underpaid in the BCBSTX claim system.

For a claim reconsideration please contact Provider Customer Service at:

- Phone:
  1-877-560-8055 (for STAR and CHIP) and
  1-877-784-6802 (for STAR Kids),
  or complete the Claims Reconsideration Form or Durable medical equipment DME Review Form and submit to: TexasMedicaidNetworkDepartment@bcbstx.com.

Claims Payment Appeals Procedure

BCBSTX Claim Payment Appeals (or Provider Appeal) is defined as a request for review of an action or adverse determination. That could be any denial, reduction or termination of benefits in whole or in part. You can see more details about the claim's payment appeals process in Section 10: Complaints and Appeals. You can also see details about appealing a claims payment recoupment in that section.

ACUTE CARE, PROVIDER AND ANCILLARY BILLING CLAIMS

After Hours Services

BCBSTX considers normal business hours for primary care providers as Monday through Friday from 8 a.m. to 5 p.m. CT. BCBSTX will reimburse at after-hour rates for services provided outside of the provider's normal business hours. To receive the additional reimbursement, providers should bill CPT code 99050 in addition to the codes reflecting the services rendered.

Clinician-Administered Drugs (STAR Kids)

BCBSTX may reimburse providers only for clinician-administered drugs and biologicals whose manufacturers participate in the CMS Drug Rebate Program. The drugs and biologicals also must show as active on the CMS list for the date of service that the drug is administered.

Clinician-administered drugs that do not have a National Drug Code will not be reimbursed.

Something called the "Texas NDC-to-HCPCS Crosswalk" identifies relationships between NDCs and Medicaid-payable HCPCS codes. The crosswalk helps with billing and coding and is a reference for converting HCPCS billing units to valid NDC unit calculations. You can learn more about and access the crosswalk online.

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 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 member's 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

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

An emergency medical condition is any condition that includes acute and severe symptoms (including severe pain) that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that failure to seek immediate medical care could result in:

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

Covered services include hospital-based emergency department services (the room and ancillary services) needed to evaluate or stabilize an emergency medical condition and/or emergency behavioral health condition. Covered services also include services by emergency providers.

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 providers in the emergency department is based on Section 104 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. TEFRA requires that Medicaid limit reimbursement for non-emergent and non-urgent 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 emergency services. The procedure code billed may include 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 provider 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 facility charges for 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 that 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 for non-emergent and non-urgent physicians' services:

- Services furnished in rural health clinics
- Surgical services that are provided in an ambulatory surgical center or hospital-based ambulatory surgical center
- Anesthesiology and radiology services
- Prenatal services when billed with modifier TH and the appropriate E/M procedure code to the highest level of specificity

Hospital Readmissions Policy

Hospital 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.

ACUTE CARE BILLING INSTITUTIONAL CLAIMS (SPECIAL BILLING)

Hospital and Institutional Billing Requirements by Service Category

There are special billing requirements for each of the services listed below. A 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.

Emergency Department 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 E/M, surgical or other procedure, or any other service rendered to the client in the emergency department. The procedure code must accurately reflect the services rendered in the hospital's emergency department. Emergency department ancillary services that we also cover include, but are not limited to:

- Laboratory services
- Radiology services
- Respiratory therapy services
- Diagnostic studies (including ECGs, computed tomography, or 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 the outpatient facility. 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 department 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 emergency department or clinic, the emergency department 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 emergency department or clinic.

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

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

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

If the emergency department 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.

Special billing instructions and requirements for emergency department visits:

- Emergency room visits should be billed with CPT codes 99284 and 99285.
- International Classification of Diseases (ICD) principal diagnosis codes are required for all services provided in an emergency room.
- Each service date should be billed as a separate item.
- Revenue codes 0450 through 0452 and 0459 are required, as are CPT codes 99284 and 99285.
- Newborns, Value-added Services, SSI, Compounded medications, NEMT services, etc.

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

Urgent Care Visits

Urgent care refers to non-scheduled, non-emergency hospital services required to prevent serious deterioration of a patient's health status because 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 or outpatient department/emergency department. Those requirements cover all diagnostic and therapeutic services provided, including:

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

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

Current ICD principal diagnosis codes are required for all services provided in an urgent care setting or designated facility.

Outpatient Laboratory, Radiology and Diagnostic Services

Texas Medicaid covers only professional and technical services performed by a CLIA-certified laboratory – a lab certified under standards set by Clinical Laboratory Improvement Amendments of 1988.

Provider documentation must be maintained in the member's medical record. That documentation must describe the medical need for administering the laboratory test.

The provider is responsible for giving 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 member visit when the specimen is collected by drawing a blood sample through venipuncture or collecting a urine specimen by catheterization. More than one charge can occur if 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 which it sends specimens. That reimbursement happens only 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:

- 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:

- 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 code grouping, medical records might be requested by BCBSTX for review and determination of the appropriate code 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).

Infusion Therapy Visits

Billing requirements for outpatient infusion therapy visits apply to each outpatient hospital visit for infusion therapy services, including:

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

An outpatient infusion therapy visit calls for a single service date.

Billing requirements for outpatient infusion therapy pharmaceuticals apply to the drugs (for example, chemotherapy, hydration and antibiotics) used during each outpatient visit for infusion therapy services. Blood and blood products are considered “other services.”

Present On Admission (POA) Codes

Medicaid present on admission (POA) reporting is required for all inpatient hospital claims. “Present on admission” relates to whether a patient diagnosis was present when the patient was admitted to the health care facility.

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 in the emergency department, during 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 is present
N	Diagnosis was not present at the time of admission	No payment will be made by Medicare when an HAC is present
Note: Texas Medicaid follows Medicare guidelines for payments referenced in this table		
POA Value	Description	Payment
U	Documentation was insufficient	No payment will be made by Medicaid when an HAC is present
W	Clinically undetermined	Payment will be made by Medicaid when an HAC is present
(blank)	Exempt from POA reporting	Exempt from POA reporting
Texas Medicaid follows Medicare guidelines for payments referenced in this table		

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.

PAYMENT RESPONSIBILITIES WHEN MEMBERS CHANGE PLANS OR MCOS

The table below outlines payment responsibilities when a member changes plans or managed care organizations.

	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

Texas Health Steps Billing

Texas Health Steps medical checkups reflect the federal and state requirements for a preventive checkup.

Preventive care medical checkups are a benefit of the Texas Health Steps program if they are provided by enrolled Texas Health Steps providers and all the required components are completed. An incomplete preventive medical checkup is not a benefit. The Texas Health Steps periodicity schedule specifies screening procedures required at each stage of the member's life to ensure that health screenings occur at age-appropriate points.

Components of a medical checkup that have an available CPT code are not reimbursed separately on the same day as a medical checkup. Exceptions are initial point-of-care blood lead testing, mental health screening for adolescents, postpartum depression screening and tuberculin skin test.

Texas Health Steps Billing Details

Texas Health Steps providers are not required to bill other insurance before billing Medicaid. If a provider is aware of other insurance, the provider may choose whether 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 member's other insurance before submitting the claim to Medicaid.
- If the provider chooses to bill Medicaid and not the member's other insurance, the provider is indicating that they accept 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 member 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 the state's Texas Vaccine for Children (TVFC) program. 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 Texas Health Steps 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
- Leave 24J on the CMS-1500 blank.

For additional billing guidelines, 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. (For CHIP members, a copay will apply for the acute care services.)

Preventive Medicine Services — New Patient

Here are procedure codes for an initial comprehensive medical examination and evaluation for a new patient, along with the ordering of appropriate immunizations and laboratory or diagnostic procedures:

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

Here are procedure codes for an initial comprehensive medical examination and evaluation for an existing patient, along with the ordering of appropriate immunizations and laboratory or diagnostic procedures:

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

Billing for Oral Evaluation and Fluoride Varnish

Texas Health Steps provides oral health services through the Oral Evaluation and Fluoride Varnish (OEFV) program. The services are provided in conjunction with the Texas Health Steps medical checkup. They include immediate oral evaluation and fluoride varnish application.

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

Providers must attend the FDH training or OEFV training offered by the DSHS Oral Health program to be certified to bill for these services. Providers can learn more information about each program at the DSHS website.

CHIP Preventive Visits and Acute Care Services

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

BCBSTX strongly recommends that an initial health assessment, consisting of a complete history and physical, be conducted within 90 days of an adult member's date of enrollment.

New Patient

Below are codes for preventive services for a new patient. These are codes for an initial comprehensive preventive medicine evaluation and management of a patient. That would include an age- and gender-appropriate history, examination, counseling, risk factor reduction interventions, and the ordering of appropriate immunizations and laboratory and diagnostic procedures.

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

Established Patient

Below are codes for preventive services for an established patient. These are codes for an initial comprehensive preventive medicine evaluation and management of a patient. That would include an age- and gender-appropriate history, examination, counseling, risk factor reduction interventions, and the ordering of appropriate immunizations and laboratory and diagnostic procedures.

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

Maternity and Newborns

Maternity Services

Inpatient maternity care includes usual and customary care for all pregnant members. Medicaid reimburses prenatal care, deliveries and postpartum care as individual services.

BCBSTX requires itemization of maternity services when providers submit claims for reimbursement. Providers should 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.

To bill for maternity services, 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 provide only prenatal care and choose to submit prenatal visit charges on one claim form have the filing deadline applied to the estimated date of confinement (due date) that must be stated in Block 24D of the CMS-1500 claim form.

Here are other details on coverage of maternity services:

- 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.

Billing for Prenatal and Postpartum Services

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.

Other requirements:

- Providers should use the appropriate evaluation and management and antepartum or postpartum CPT codes for reimbursement. Providers should indicate the estimated date of confinement (due date) in Box 24D of the CMS-1500 claim form.
- If a member is admitted to the hospital during the pregnancy, the diagnosis necessitating the admission should be the primary diagnosis on the claim.
- If the member’s pregnancy is 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.

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.

CHIP Perinatal Labor and Delivery Coverage

For members who are eligible for CHIP Perinatal services, those services include newborn services and inpatient hospital charges related to the delivery of the newborn. Pre-term or false labor that does not result in a birth are not CHIP Perinatal services. CHIP Perinatal covers inpatient services — limited to labor with delivery — for women with income at or below 202 percent of the federal poverty level. CHIP Perinatal also covers newborn services.

Vaginal and Cesarean Claims

Medicaid and CHIP delivery charges should be billed with the appropriate CPT codes.

BCBSTX covers any cesarean section, labor induction or any delivery following labor induction that meet these 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.

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.

Claims will be denied, or recoupment will occur for associated claims for deliveries that are performed prior to 39 weeks and are determined to be not medically necessary. That includes:

- 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 the intensive care unit, due to complications of the delivery for the mother.

Home deliveries must be billed with procedure code 59409 or 59410. (Code 59410 for vaginal deliveries include postpartum care.) Licensed midwives will not be reimbursed for home deliveries.

Here are the modifiers that providers should use when submitting delivery claims:

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

Newborns

After a BCBSTX member gives birth, providers should bill using the mother's Medicaid ID number until the state assigns a permanent Medicaid ID number to the newborn. Providers also need to furnish BCBSTX with the name, date of birth, and other pertinent information about the newborn by contacting Provider Customer Service at **1-877-560-8055** (for STAR and CHIP) and **1-877-784-6802** (for STAR Kids).

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, providers should 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 a retail pharmacy before the state has established the newborn's permanent ID, the pharmacy can contact BCBSTX Customer Service from 8 a.m. to 8 p.m. CT at **1-888-657-6061.** Representatives can help verify member eligibility. BCBSTX Customer Service will provide the pharmacy with the newborn's BCBSTX 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 BCBSTX Customer Service and select the prompt for the after-hours triage team. The triage team will provide the pharmacy with the temporary plan identification number for the newborn if we are able to verify eligibility.

Providers should submit newborn claims using only the state-issued Medicaid ID number of the newborn or the mother's ID number. 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, providers should ask members to take these important steps as soon as their babies are born:

- Immediately contact the Texas HHSC or their social worker to request the required forms to be completed.
- Complete and return the required forms to the state to enroll their newborn in STAR, CHIP or STAR Kids.

BCBSTX requires that providers notify us of all deliveries within three days of delivery. Also, providers should notify BCBSTX when they receive a newborn's permanent Medicaid ID number.

Prior authorization is waived on circumcisions until the child is one year old. Circumcision charges should be billed with appropriate CPT codes.

Sports and Camp Physicals

Sports physical examinations are not a direct benefit of STAR, CHIP or STAR Kids. If the member is due for a Texas Health Steps medical checkup and a comprehensive medical checkup is completed, that 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 follow these steps to conduct and get reimbursed for a sports and camp physical:

- The PCP verifies the eligibility of the member and that the member has not received a sports and camp physical within the past year.
- The provider conducts a physical that meets the minimum requirements defined by a sports or camp physical.
- The provider submits claim(s) with procedure code 99080 to BCBSTX within 95 days of the date of service. If the sports and camp physical claim is not submitted, payment will be denied.

The claim form should be sent via:

- Electronic submission through Availity (Payor Id: 66002 or another electronic clearinghouse)
- Or mail:
  Blue Cross and Blue Shield of Texas
  Attn: Sports/Camp Physicals
  PO Box 650712
  Dallas, TX 75265-0712

BCBSTX will reimburse providers $25 for a sports and camp physical. Providers are not eligible for any additional payment for services from BCBSTX provided during a sports or camp physical.

Sterilization Claims

Providers should use the CMS-1500 claim form and follow appropriate coding guidelines for billing for sterilization procedures. Providers should 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 under the "Legal" heading.

Texas Vaccines for Children

BCBSTX providers who administer vaccines to children 0-18 years of age may enroll in the Texas Vaccines for Children program, which in most cases furnishes the actual vaccine to providers. 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 program.

In giving vaccinations, providers must follow the most current recommendations from the federal Advisory Committee on Immunization Practices unless those recommendations conflict with guidelines from the TVFC program. In those cases, providers must follow the TVFC guidelines.

Providers must also give vaccine information statements produced by the federal Centers for Disease Control and Prevention to vaccine recipients or their caregivers. The VISs explain the benefits and risks of the vaccines and toxoids administered.

To enroll in Texas Health Steps and the TVFC program, providers should visit the TVFC website.

Reimbursement for TVFC

BCBSTX will reimburse only for 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 provider's 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 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, 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 the U1 modifier and the appropriate administration procedure code on another line of Box 24D.

HPV Vaccines

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 providers to bill or request payment from members of STAR, CHIP, CHIP Perinatal, or STAR Kids for any remaining charges or services not covered by BCBSTX for services rendered.

You may bill the member only if:

- A specific service or item is provided at the member's request
- You have obtained and keep a written Member Acknowledgment Statement signed by the member, or member representative under informed consent, that states:

"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:

- The service is not a benefit of Texas Medicaid (for example, cellular therapy)
- All services are 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 are provided to a "private pay patient." If you accept a member as a private pay patient, you must advise the member at the time the service is provided that they are accepted as a private pay patient and that they are responsible for paying for all services received.

In this situation, BCBSTX and HHSC strongly encourage you to ensure the member signs written notification so there is no question how the member was accepted. Without written and signed documentation that the member has been properly notified of the private pay status, you cannot seek payment from a STAR, CHIP or STAR Kids member. (Providers can see a sample private pay agreement in Attachment H.)

A provider attempting to bill or recover money from a member in violation of these stated conditions may be subject to exclusion from Texas Medicaid.

Services That Must be Billed to the Texas Health and Human Services Commission

Some services must be billed directly to Texas HHSC, rather than BCBSTX. These include:

- Community Resource Coordination Groups
- Early Childhood Intervention Program - Case Management (Therapies are billed to the plan)
- Local school districts
- Texas Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program
- Texas Department of State Health services, including community behavioral health programs, Title V Maternal and Child Health, Children with Special Health Care Needs Programs
- Other state and local agencies and programs such as food stamps, the Women, Infants, and Children's Program and Case Management for Children and Pregnant Women
- 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. It is sometimes required to correct or ameliorate a member's disability, condition or illness.

DME Prior Authorization

All custom-made DME requires prior authorization. Some other DME services may also require prior authorization. Prior to dispensing, please contact the BCBSTX Utilization Management department at **1-877-560-8055** (for STAR and CHIP) and **1-877-784-6802** (for STAR Kids). Services that require prior authorization will be denied if approval is not obtained from the Utilization Management department.

DME Billing

DME providers should bill with the appropriate modifier to identify rentals versus purchases (and new or used).

Modifier	
NU	New Purchase
UE	Used Purchase
RR	Rental Monthly

DME Rental

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 practices. 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 with approval.

DME Purchase

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 Utilization Management department. After prior authorization is obtained for purchase, new equipment must be provided and the rental discontinued.

Wheelchairs/Wheeled Mobility Aids

We follow Medicaid guidelines when calculating payments for wheelchair claims. Claim 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 manufacturer's suggested retail price (MSRP) of the wheelchair. That includes all wheelchair accessories, modifications, or replacement parts. (For replacement parts, the name of the Rehabilitation and Assistive Technology of America (RESNA) certified technician who does the work is required.).

The wheelchair provider must mark each catalog page or invoice line so it can be matched to the appropriate claim line.

For wheeled mobility aids (like scooters, walkers and canes), 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 Questions or Status Request

Claim questions or status requests about DME claim submissions can be obtained by contacting BCBSTX Provider Customer Service at **1-877-560-8055** (for STAR and CHIP) or **1-877-784-6802** (for STAR Kids). You can also contact your Network Provider Representative at **1-855-212-1615**. You can call the same numbers with questions about an adjudicated/paid claim.

You can submit an electronic inquiry on status by using a DME Claim Status Request Form and sending via email to TexasMedicaidNetworkDepartment@bcbstx.com. You can also submit an electronic review request for an adjudicated/paid claim by using a DME Review Request Form and sending to the same email address.

Other Service Types

LTSS Claims Filing:

All providers rendering Long Term Services and Supports, with the exception of atypical providers (who do not provide a medical service – non-emergency transportation providers, for example), must use the CMS 1500 claim form or the HIPAA 837 Professional Transaction when billing claims.

You can learn more and find a LTSS Billing Matrix here.

Nursing Facility or Intermediate Care Facility

For individuals with intellectual disabilities, claims should be sent to TMHP.

Minor Home Modification

Home modifications are services that provide adjustments or improvements to a member's home based on health care needs to enable them to live in their homes. These modifications ensure safety and accessibility for the eligible member. BCBSTX will pay for minor home modifications approved by a prior managed care organization. The lifetime limit for minor home modifications is $7,500.

Ambulance Services

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.

Anesthesia

Anesthesia services are a benefit of Texas Medicaid with specific benefits and limitations to reimbursement. Medicaid may reimburse anesthesiologists, certified registered nurse anesthetists and anesthesiologist assistants for administering anesthesia as defined within their individual scope.

When billed 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, providers should use the procedure code with the highest Relative Value Unit (RVU) — a standard value Medicaid uses to determine the cost of services.

For accurate reimbursement, apply the total minutes and dollars for all anesthesia services rendered on the highest 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 TMHP 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 name and NPI of the performing surgeon or referring provider 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.

We recommend using specific procedure codes for claim submission. Providers should 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 procedures performed at an Ambulatory Surgical Center or Hospital-based Ambulatory Surgical Center 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 the Texas 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. Click on "Resources" and then "Online Fee Lookup."

Behavioral Health Billing

For behavioral health services, including inpatient, intensive inpatient, outpatient, intensive outpatient, substance abuse, medication assisted opioid treatment and other chemical dependency treatment, all claims must be submitted in the same manner as medical claims. (See "Submitting a Claim" at the top of this section.)

Some behavioral services require prior authorization. For more details on benefits and prior authorization and other needs, please call Provider Customer Service at **1- 877-560-8055** (for STAR and CHIP) and **1-877-784-6802** (for STAR Kids.)

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). Providers should contact the BCBSTX Utilization Management department at **1-877-560-8055** (for STAR and CHIP) or at **1-877-784-6802** (for STAR Kids) for authorization prior to delivery of services.

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 member with little or no professional assistance. (The member must have completed an appropriate course of training.)
- Home dialysis performed by an appropriately trained member (and the member's caregiver) at home.
- Dialysis furnished in a facility on an outpatient basis at an approved renal dialysis facility.

Provider reimbursement for supervision of End-Stage Renal Disease members on dialysis is based on a monthly capitation payment that is calculated by Medicare. The capitation payment is a comprehensive payment that covers all 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 hospitals. Physician supervision of outpatient ESRD dialysis includes any services that are rendered by the attending physician during office visits. Those services include:

- Routine monitoring of dialysis
- 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 disease

Dialysis centers and other entities that 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.

Home Health Services

Home health services include home health skilled nursing, home health aide, physical therapy and occupational therapy services. They also include DME and expendable medical supplies that are provided to eligible Medicaid clients at their residence.

The benefit period for home health services is up to 60 days with a current plan of care for the member.

Here are important billing requirements for home health agency providers:

- Claims are approved or denied according to eligibility, prior authorization status and whether medically appropriate.
- Claims must represent one month's worth of medical supplies, according to the billing requirements. Providers should file these services on a CMS-1450 (UB-04) claim form.
- OT and PT are always billed as POS 2 (home) on the CMS-1450 (UB-04) claim form and may be prior authorized to be provided in the home of the client or the home of the caregiver/guardian.

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 the Texas Health Steps Comprehensive Care Program.

Texas Medicaid does not reimburse separately for associated DME charges — like 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 non-powered pressure-reducing mattress overlay
- Non-powered pressure-reducing mattress
- Powered pressure-reducing mattress overlay system
- Powered pressure-reducing mattress
- Advanced non-powered pressure-reducing mattress overlay
- Powered pressure-reducing mattress overlay
- Advanced non-powered pressure-reducing mattress
- Sheepskin and lamb's wool pads
- Decubitus care accessories

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 CCP.

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-DME Exceptional Circumstances process.

All home health care must be pre-authorized. Providers should contact the BCBSTX Utilization Management department at **1-877-560-8055** (for STAR and CHIP) or at **1-877-784-6802** (for STAR Kids) for authorization prior to delivery of the service.

Home Infusion Therapy

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

Here are important billing requirements:

- Providers should submit all claims within the contracted filing limit of 95 days from the date of service.
- Authorization is required from the BCBSTX Utilization Management department for all infusion therapy and should be obtained before the services are rendered.
- Providers should 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 Texas Medicaid Provider Procedures Manual.

Hospice

Texas HHSC manages its 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.

Providers who have policy questions about hospice can call HHSC at **1-512-438-3161**. Providers with general questions about the hospice programs – including billing, claims, rate key issues and authorizations – can call 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

The hospice care section of the Texas Medicaid Provider Procedures Manual provides detailed billing instructions.

Occupational Therapy

The practice of occupational therapy includes:

- Evaluation and treatment of a person whose ability to perform activities of daily 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.

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 help a patient obtain or regain skills needed for activities of daily living (ADL) or functional skills needed for daily life. The patient may have lost these skills through an acute medical condition, acute exacerbation of a medical condition or a chronic medical condition related to injury, disease or other medical causes. ADLs include 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. Providers should contact the BCBSTX Utilization Management department at **1-877-560-8055** (for STAR and CHIP) or at **1-877-784-6802** (for STAR Kids) for authorization prior to delivery of the service.

The correct billing form for occupational therapy depends on the setting.

Providers should use the CMS-1500 claim form when:

- Providing services in an office, clinic or outpatient setting.

Providers should use the CMS-1450 (UB-04) claim form when:

- Providing services in a rehabilitation center
- Occupational therapists affiliated with home health agencies provide therapy in a patient's home

When billing occupation therapy claims, providers 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 and 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 chronic disorders or the acute exacerbation of chronic disorders, or a chronic medical condition of the musculoskeletal or 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. Providers should contact the BCBSTX Utilization Management department at **1-877-560-8055** (for STAR and CHIP) or at **1-877-784-6802** (for STAR Kids) for authorization prior to delivery of the services.

The correct billing form for physical therapy depends on the setting.

Providers should use the CMS-1500 claim form when:

- providing services in an office, clinic setting or outpatient setting.

Providers should use the CMS-1450 (UB-04) claim form when:

- Providing services in a rehabilitation center
- Physical therapists affiliated with home health agencies provide 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. Providers should contact the BCBSTX Utilization Management department at **1-877-560-8055** (for STAR and CHIP) or at **1-877-784-6802** (for STAR Kids) for authorization prior to SNF admission.

Speech Therapy

Speech therapy is a benefit of Texas Medicaid for the treatment of chronic, acute, or acute exacerbations of pathological or traumatic conditions of the head or neck that 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. They also treat cognitive disorders, social communication disorders and swallowing (dysphagia) deficits.

All speech therapy must be pre-authorized. Evaluations do not require pre-authorization. Providers should contact the BCBSTX Utilization Management department at **1-877-560-8055** (for STAR and CHIP) or at **1-877-784-6802** (for STAR Kids) for authorization prior to delivery of the services.

The correct billing form for speech therapy depends on the setting.

Providers should use the CMS-1500 claim form when:

- Providing services in an office, clinic setting, or outpatient setting

Providers should use the CMS-1450 (UB-04) claim form when:

- Providing services in a rehabilitation center
- Speech therapists affiliated with home health agencies provide 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 members who are 21 years of age and older
- Therapy services that are provided after the member 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 that are not considered medically necessary because they do not require the skills of a therapist. These would include:
    - General exercises to promote overall fitness and flexibility or improve athletic performance.
    - Activities to provide diversion or general motivation.
    - Supervised exercise for weight loss
    - Emotional support, adjustment to extended hospitalization and/or disability, and behavioral re-adjustment.
    - Therapy prescribed primarily as an adjunct to psychotherapy.
- Treatment solely for the instruction of other agency or professional personnel in the client's physical, occupational or speech therapy program
- 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
    - 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)
- Therapy that is for general conditioning or fitness, or for educational, recreational or work-related activities that do not require the skills of a therapist.
- Therapy provided by a licensed therapist who is related to or a legal representative of the member (for example, biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage)

Auxiliary personnel, licensed therapy assistants and licensed speech-language pathology interns (clinical fellows) are not eligible to enroll as therapist providers in Texas Medicaid.

But auxiliary personnel (aides, orderlies, students or technicians) 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.

Equipment and supplies used during therapy visits are not reimbursed separately; they are considered part of the therapy services provided.

Section 10: Complaints and Appeals

Provider Complaint Processes

PROVIDER COMPLAINT PROCESS FOR STAR AND STAR KIDS

Providers who have complaints involving dissatisfaction or concerns about another provider, operation of BCBSTX and complaints not related to a claim determination or adverse determination can file a complaint with BCBSTX. (For complaints relating to a claim or adverse determination, see "Claims Payment Appeal Procedure" subsection below.)

Complaints submitted to BCBSTX are tracked, analyzed for trends and resolved within 30 days. Providers can submit complaints by phone, fax, email or by mail.

- Phone
  1-888-657-6061 (STAR)
  1-877-688-1811 (STAR Kids)
  TTY 711 (for members with hearing or speech loss)
  Fax: **1-877-886-2593**
- **Email:** TX_Medicaid_A&G_Complaints@bcbstx.com
- **Mail:**
  Blue Cross and Blue Shield of Texas
  Attn: Complaints
  PO 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 (fax cover pages, emails, and phone communication) in reference to complaints. Providers should also maintain all communications to and from BCBSTX.

COMPLAINTS ABOUT BCBSTX TO TEXAS HHSC

A provider has the right to file a complaint about BCBSTX with the Texas Health and Human Services Commission (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 with a CHIP-related complaint should follow the same process as the STAR and STAR Kids process.

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 by phone, fax, email or in a mailed letter.

- Phone: **1-800-252-3439**
- Fax: **1-512-475-1771**
- Email: ConsumerProtection@tdi.texas.gov
- Mail:
  Texas Department of Insurance Consumer Protection (MC: CO-CP)
  PO Box 12030
  Austin, TX 78711-2030

Member Complaint Processes

MEMBER COMPLAINT PROCESS FOR STAR AND STAR KIDS

A member has the right to file a complaint to both BCBSTX and Texas HHSC. A BCBSTX member representative can assist the member with filing a complaint.

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

- Phone:
  1-888-657-6061 (STAR)
  1-877-688-1811 (STAR Kids)
  TTY 711 (for members with hearing or speech loss)
- Fax:
  1-877-886-2593
- **Email:**
  GPDTXMedicaidAG@bcbsnm.com

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

A member will receive an acknowledgement letter within five business days of receipt of the complaint. BCBSTX will resolve the complaint within 30 days. Members will receive a resolution letter at the completion of the complaint investigation.

FILING A COMPLAINT WITH HHSC

If a member is not satisfied with the BCBSTX resolution, they may file a complaint with Texas HHSC. They may file that complaint by mailed letter or through an HHSC website.

- By mailed letter:
  Texas Health and Human Services Commission Ombudsman Managed Care Assistance Team
  PO Box 13247
  Austin, TX 78711-3247
- Through HHSC Ombudsman website:
  hhs.texas.gov/managed-care-help (click on “Complete our online form.”)

MEMBER COMPLAINT PROCESS FOR 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 STAR and STAR Kids members do. BCBSTX CHIP member representative also can assist CHIP members with filing a complaint.

A CHIP member with a complaint may call or submit it in writing with the BCBSTX Complaint Department:

- Phone**:**
  1-888-657-6061
  TTY 711 (for members with hearing or speech loss)
- Mail:
  Blue Cross and Blue Shield of Texas
  Attn: Complaints
  PO Box 660717
  Dallas, TX 75266

A CHIP member will receive an acknowledgement letter within five business days of receipt of the complaint. BCBSTX will resolve the complaint within 30 days. CHIP members 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, they can file a complaint with TDI. Providers may submit complaints by phone, fax, email or in a mailed letter.

By phone:

- Phone: **1-800-252-3439**
- Fax: **1-512-475-1771**
- Email: ConsumerProtection@tdi.texas.gov
- Mail
  Texas Department of Insurance Consumer Protection (MC: CO-CP)
  PO Box 12030
  Austin, TX 78711-2030

Provider Appeal Processes

CLAIMS PAYMENT APPEAL PROCEDURE

A BCBSTX Provider Appeal is defined as a request for review of an action or adverse determination. That could be any denial, reduction or termination of benefits in whole or in part. That could include:

- 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 and return to BCBSTX within 120 days of receiving the Provider Remittance Advice.

Claims submitted on a BCBSTX Provider Appeal Form will be processed as an appeal and not a claims reconsideration.

Provider appeals are not considered if they involve a:

- A claim corrected by the provider
- General inquiry/question
- Claim denial that requires additional information

Providers can submit the appeals form in these ways:

- Mail:
  Blue Cross and Blue Shield of Texas
  Attn: Appeal Department
  PO Box 660717
  Dallas, TX 75266-0717
- Fax: **1-877-866-2593**
- Email: GPDTXMedicaidAG@bcbsnm.com
- Electronically: Providers may also submit provider appeals through the Availity online tool.

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, they can pursue additional steps, including:

- Mediation (handled per the BCBSTX physician agreement)
- Arbitration (handled per the BCBSTX physician agreement)

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

- Mail
  Health and Human Services Commission Managed Care Operations – H320
  PO Box 85200
  Austin, TX 78708I

Complaints may also be emailed to:

HPM_complaints@hhsc.state.tx

PROVIDER APPEAL PROCESS FOR STAR AND STAR KIDS

A provider may file an appeal with BCBSTX. A provider may submit an appeal through a phone call or in writing, or through the BCBSTX Provider Portal (Availity).

- Phone:
  1-888-657-6061 (STAR)
  1-877-688-1811 (STAR Kids)
- Fax: **1-877-886-2593**
- Email: GPDTXMedicaidAG@bcbsnm.com
- Mail:
  Blue Cross and Blue Shield of Texas
  Attn: Complaints and Appeals
  PO Box 660717
  Dallas, TX 75266

BCBSTX maintains all documentation (fax cover pages, emails and phone communication) in reference to appeals. Providers should also maintain all communications to and from BCBSTX.

RECOUPMENT APPEAL PROCESS FOR STAR KIDS

Provider Appeal Process to HHSC (related to claim recoupment)

Upon notification of a claim's 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. **If member eligibility changed to fee-for-service on the date of service,** the 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 something called an Exception Request.
- The Explanation of Benefits form showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will authorize the Texas Medicaid & Healthcare Partnership (TMHP), the state's Medicaid administrator, to grant an authorization only 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 the provider sends a copy of the demand letter, it must identify the member's name and identification number, date of service and recoupment amount. The information should match the payment EOB.
- Completed clean claim. All paper claims must include both the provider's valid National Provider Identifier (NPI) and Texas Provider Identifier number. In cases where issuance of a prior authorization 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.

Providers should label the request "Expedited Review Request" at the top of the letter to ensure the appeal request is reviewed within 18 months of the date of service. HHSC Claims Administrator Contract Management reviews only appeals that are received within 18 months of the date-of-service.

Providers should mail fee-for-service related appeal requests to:

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

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.

- Providers should 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.

2. **If member eligibility changed from one managed care organization 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 showing the original payment. The EOB showing the recoupment and/or the MCO's "demand" letter for recoupment must identify the member's name, identification number, date of service, and recoupment amount. The information should match the payment EOB.
- Documentation must identify the member's name, identification number, date of service, recoupment amount and other claim information.

Providers should label the request "Expedited Review Request" at the top of the letter to ensure the appeal request is reviewed within 18 months of the date of service.

- Providers can mail, fax or email the appeals, or submit them online.
  Mail appeals to:
  Blue Cross and Blue Shield of Texas
  Attn: Appeals Department
  PO Box 660717
  Dallas, TX 75266
- Fax appeals to: **1-877-886-2593**
- Email to: GPDTXMedicaidAG@bcbsnm.com
- Submit appeals online at: www.bcbstx.com/provider/medicaid/claims-and-eligibility/claims (under Appeals)

RECOUPMENT APPEALS PROCESS FOR STAR

Provider Appeals Process to HHSC (related to claim recoupment due to member disenrollment)

Providers 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 form showing the original payment. This is also used when issuing the retro-authorization as HHSC will authorize the Texas Medicaid and Healthcare Partnership to grant an authorization only 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 a copy of the demand letter, it must identify the member's name, identification number, date of service 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 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 appeals to:
  Texas Health and Human Services Commission HHSC Claims Administrator Contract Management
  Mail Code-91X
  PO Box 204077
  Austin, TX 78720-4077I

PROVIDER APPEAL PROCESS FOR CHIP

A provider may file an appeal with BCBSTX by submitting an appeal through Availity, the BCBSTX provider portal, or by filing an appeal in writing to BCBSTX.

- Providers can write:
  Blue Cross and Blue Shield of Texas
  Complaints and Appeals
  PO Box 660717
  Dallas, TX 75226

If a provider is dissatisfied with the resolution of the appeal for a CHIP member service, and has exhausted the BCBSTX complaints and appeals process, the provider has the right to appeal to TDI through mail, fax, email or phone.

- By mail:
  Texas Department of Insurance Consumer Protection (MC: CO-CP)
  PO Box 12030
  Austin, TX 78711-2030
- By phone: **1-800-252-3439**
- By fax: **1-512-475-1771**
- By email: ConsumerProtection@tdi.texas.gov

A Member Appeal Processes

MEMBER APPEAL PROCESS FOR STAR, CHIP AND STAR KIDS

What can I do if the MCO denies or limits my member's request for a covered service?

If BCBSTX denies or limits a STAR or STAR Kids member's request for covered services, the member has the right to file an appeal. A member also can appeal when BCBSTX denies payment for services in whole or in part. A member can file an appeal by phone, or in writing.

BCBSTX notifies members by Notice of Adverse Benefit Determination letter when services are denied.

A member must file a request for an appeal with BCBSTX within 60 days of getting that letter. BCBSTX 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 of the oral or written appeal request. The deadline may be extended for up to 14 days at the request of a member or if BCBSTX shows Texas HHSC that there is a need for additional information and that the delay is in the member's interest.

To ensure the continuity of current authorized services, the member must file the appeal within 10 days of the BCBSTX letter, or by the intended date of the proposed action, whichever is later.

Members will receive a letter explaining the cause for the decision's delay if BCBSTX needs extra time to gather all the information regarding the requested service. Members can file a complaint if they disagree with BCBSTX's decision to extend the timeframe for the decision on the appeal.

The member may be required to pay the cost of services furnished while the appeal is pending a final decision. BCBSTX will reimburse the member if the appeal is decided in their favor. For help in filing an appeal, members can call **1-888-657-6061** (for STAR and CHIP) and **1-877-688-1811** (for STAR Kids).

STAR and STAR Kids 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.

EXPEDITED MEMBER APPEAL PROCESS

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 help members file an expedited appeal. We accept expedited appeals orally or in writing.

Members may call the Customer Advocate Department or write to BCBSTX to request an expedited appeal.

By phone:

- Phone:
  1-888-657-6061 (for STAR and CHIP)
  1-877-688-1811 (for STAR Kids)
- TTY 711 (for members with hearing or speech loss)
- Fax: **1-877-866-2593**
- 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 will:

- 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 STAR AND STAR KIDS MEMBER

If a STAR or STAR Kids member disagrees with the BCBSTX appeal decision, the member has the right to ask for a State Fair Hearing. The member may give BCBSTX the name of a person the member wants to represent them at the hearing. A provider may be the member's representative if the provider is named as the member's authorized representative.

The member or their representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter denying their appeal.

To ask for a State Fair Hearing, the member or their representative can call or write BCBSTX.

- Phone:
  1-888-657-6061 (for STAR)
  1-877-688-1811 (for STAR Kids)
  Fax: **1-877-886-2593**
- Mail:
  Blue Cross and Blue Shield of Texas
  Attn: Complaints and Appeals Department
  PO Box 660717
  Dallas, TX 75266

If a 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 services the health plan denied, based on previously authorized services. Those services can continue 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 services BCBSTX denied will be stopped.

When a member asks for a State Fair Hearing, they will get a packet giving them the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, the member or their representative can explain why the member needs the services 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

Can a member ask for an External Medical Review?

If a member disagrees with the health plan's internal appeal decision, the member can 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 them by writing a letter telling BCBSTX the name of the person the member wants to represent them. A provider may be the member's representative.

The member or their 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.

To ask for an External Medical Review, the member or their representative should either complete a medical review request form and fax or mail it to BCBSTX or call the BCBSTX Customer Advocate Department.

BCBSTX will provide members with the External Medical Review request form when we send the decision letter on the internal appeal. After completing the form, members can send:

- Fax: **1-877-886-2593**
- Mail:
  Blue Cross and Blue Shield of Texas
  Attn: Complaints and Appeal Department
  PO Box 660717
  Dallas, TX 75266-0717
- Members can also call the Customer Advocate Department at:
  1-888-657-6061 (for STAR and CHIPS)
  1-877-688-1811 (for STAR Kids)
- **Email:** GPDTXMedicaidAG@bcbsnm.com

If a member asks for an External Medical Review within 10 days from the time the member gets the appeal decision from BCBSTX, the member can keep getting any services the health plan denied, based on previously authorized services. They can keep getting those services 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 BCBSTX, the services BCBSTX denied will be stopped.

The member or their representative 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 request. The member or their representative must submit the request to withdraw the request for the review in writing (via mail, email, or fax) or verbally (by phone or in person).

An Independent Review Organization is a third-party organization contracted by HHSC to conduct an External Medical Review. 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. The member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

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 requests by contacting 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.

MEMBER REQUEST FOR EMERGENCY EXTERNAL MEDICAL REVIEW

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 their representative may ask for an emergency External Medical Review and emergency State Fair Hearing. They can do that 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.

INTERNAL AND EXTERNAL REVIEW PROCESS FOR CHIP

If a CHIP member disagrees with a BCBSTX appeal decision, the member has the right to ask for an external review by an External Review Organization. CHIP members in most cases must complete the first level of the BCBSTX appeal process resulting in an adverse decision before filing a request for an ERO review. The exception is in cases of life-threatening conditions.

The ERO has no connection to BCBSTX or with health care providers that were involved in a member's treatment.

The CHIP ERO is MAXIMUS Federal Services. It performs a secondary clinical review of the health plan's denial. There is no cost to the member for an external review. To request an external review, the member or authorized representative must provide the following information: name and address, phone number, email address, whether the request is expedited or standard, a completed Appointment of Representative Form if someone is filing on the member's behalf, and a brief summary of the reason the member disagrees with BCBSTX decision.

Members may also complete a Federal External Review Request Form to provide this information and include their adverse determination letter from BCBSTX when sending their request to MAXIMUS.

- Requests for external review can be mailed or faxed directly to MAXIMUS at:
  MAXIMUS Federal Services
  3750 Monroe Avenue, Suite 705
  Pittsford, NY 14534
- Fax number: **1-888-866-6190**

The MAXIMUS Federal Services examiner will contact BCBSTX immediately after receiving the request for an external review. Within five business days, BCBSTX will give the examiner all documents and information used to make the internal appeal decision. The member or member's representative will receive written notice of the final external review decision as soon as possible. The member will receive notice no later than 45 days after the examiner receives the request for an external review.

The ERO's decision is final.

If CHIP members need help with the ERO process, they can call the BCBSTX Customer Advocate department at **1-866-657-6061.**

Section 11: Member Rights and Responsibilities

(Please note: Members have a right to make recommendations about the BCBSTX member rights and responsibilities policy by calling the Customer Advocate Department at **1-888-657-6061.**)

STAR and STAR Kids Member Rights and Responsibilities

STAR AND STAR KIDS MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. A primary care provider 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 or 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 BCBSTX 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 BCBSTX or to the state Medicaid program about your health care, your provider or your health plan.
   b. Access the Medically Dependent Children Program and Deaf/Blind Multi-Disability Program escalation help line for members receiving waiver services through the MDCP or the DBMD. (You can learn more about the MDCP/DBMC escalation help line below.)
   c. Get a timely answer to any complaint you file.
   d. Use the BCBSTX appeal process and be told how to use it.
   e. Ask for 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 Review from the state Medicaid program and receive information about how that process works*.
   (* Applies to STAR Kids members 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, seven days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan representatives. 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 make copayments or any other amounts for covered services.

STAR AND STAR KIDS MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.
   c. Learn what choices of health plans are available in your area.
2. You must abide by BCBSTX and Medicaid policies and procedures. That includes the responsibility to:
   a. Learn and follow BCBSTX 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 BCBSTX.
   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 your medications.

You must follow BCBSTX rules relating to our ModivCare non-emergency medical transportation services. Those rules include:

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.

We 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 STAR Member Handbook or the STAR Kids Member Handbook and Your Rights for Appeal of an Adverse Determination.

MDCP/DBMD Escalation Help Line

What is the MDCP/DBMD escalation help line?

This 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, call **1-844-999-9543** and representatives will work to connect you with the right people.

Is the escalation help line the same as the Texas Health and Human Services Office of the Ombudsman?

No. The MDCP/DBMD escalation help line is part of the Medicaid program. The Texas Health and Human Services Ombudsman offers an independent review of concerns and can be reached at 1-866-566-8989. You can also get information and help at this webpage.

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?

Any members or their authorized or legal representatives can call.

Can members call any time?

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

CHIP Member Rights and Responsibilities

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 them 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 BCBSTX decides whether a service is covered or medically necessary. You have the right to know about the BCBSTX people who decide those things.
5. You have a right to know the names of the hospitals and other providers in the BCBSTX 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 they need 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 BCBSTX, your child may be able to continue seeing that doctor for three months, and BCBSTX must continue paying for those services. Ask BCBSTX about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist without a referral from her primary care provider and without first checking with BCBSTX. Ask your plan how this works. Some plans may require you to 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 BCBSTX, 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 BCBSTX network doctors, hospitals and others who provide services to your child. If BCBSTX says it will not pay for a covered service or benefit that your child's doctor thinks are medically necessary, you have a right to have another group, outside of BCBSTX, tell you if they think your doctor or BCBSTX is 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. BCBSTX 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 help your child 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 BCBSTX doctors and other providers to pick treatments for your child that all of you have agreed upon.
4. If you have a disagreement with BCBSTX, you must try first to resolve it using the BCBSTX complaint process.
5. You must learn about what BCBSTX does and does not cover. Read your CHIP 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. You are responsible for paying your doctor and other providers the 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 their medications.

CHIP Perinatal Member Rights and Responsibilities

CHIP Perinatal 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 CHIP 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 BCBSTX decides whether a service is covered or medically necessary. You have the right to know about the BCBSTX people who decide those things.
4. You have a right to know the names of the hospitals and other CHIP Perinatal providers 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 BCBSTX.
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 BCBSTX, doctors, hospitals and other providers.
10. You have the right to talk to your CHIP 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 BCBSTX says it will not pay for a covered perinatal service or benefit that your unborn child's doctor thinks are medically necessary, you have a right to have another group, outside BCBSTX, 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 CHIP 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 BCBSTX, you must try first to resolve it using the BCBSTX complaint process.
4. You must learn about what BCBSTX does and does not cover. Read your CHIP Member Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members or health plans.
7. Talk to your provider about all your medications.

Members Rights to Designate an OB/GYN

Members have the right to pick an OB/GYN without a referral from their primary care provider. The OB/GYN must be in the same network as the member's 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

Reporting Fraud, Waste or Abuse by a Provider or Client

Do you want to report Fraud, Waste or Abuse?

Let us know if you think a doctor, dentist, pharmacist, other health care provider or a person getting benefits is potentially taking part in fraud, waste or abuse. Let us know if you think someone is:

- Getting paid for services that weren't given or necessary
- Not telling the truth about a medical condition to get medical treatment
- Letting someone else use their Medicaid ID
- Using someone else's Medicaid or CHIP ID
- Not telling the truth about the amount of money or resources they have 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 BCBSTX.

To report fraud, waste or abuse, you can do any of the following:

- Call the OIG Hotline at **1-800-436-6184**.
- Visit the Office of Inspector General's
- Contact BCBSTX's Special Investigations Department at:
  Blue Cross and Blue Shield of Texas
  Special Investigations Department
  1001 E Lookout Drive, Building A
  Richardson, TX 75082
  Toll-free Number: **1-800-543-0867**

To report fraud, waste or abuse, 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 or was enrolled (STAR, STAR Kids or 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: Special Access Requirements

Interpretation/Translator Services

Interpreter Services, including 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.

BCBSTX provides language services at no cost to members who speak English as a second language. Members can request assistance by calling the Customer Advocate department toll-free, from 8 a.m. to 5 p.m., Central Time, Monday through Friday, to ask for help. (See numbers in table below.)

Interpreter services are also available for members who call the 24/7 Nurse line. The Nurse line is staffed with highly trained nurses 24 hours a day/seven days a week. In an emergency members should be instructed to call **911**.

Interpreter Services Resource	STAR Kids	STAR/CHIP
Customer Advocate department	**1-877-688-1811 (TTY: 711)**	**1-888-657-6061 (TTY: 711)**
24/7 Nurse line	**1-844-971-8906 (TTY: 711)**	**1-844-971-8906 (TTY: 711)**

Other Services for Members with Speech or Hearing Loss

Sign language interpreters may be scheduled in advance by calling the Customer Advocate Department at the numbers listed above.

Interpreter services for the hearing impaired are also available 24 hours a day, seven days a week through Relay Texas at **1-800-735-2988**. The Relay Texas TTY service is a state-sponsored program.

Face-to-Face Interpreters

Members can request face-to-face or phone interpretation at no cost. These services are available via video conferencing or over-the-phone. For help with these interpreter services, please call the Customer Advocate department at the numbers listed above. We ask that members call at least three business days in advance to schedule face-to-face or over-the-phone interpretation.

Scheduling and Canceling Interpretation Services

We request three business days' notice to schedule an interpreter and 24 hours' notice (Monday through Friday) to cancel an interpreter service.

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.

Provider Responsibilities

Providers must ensure that members know of the available interpreter services, which come at no cost to providers or members. BCBSTX discourages the use of minors, friends and family members to act as interpreters.

24/7 Nurse line

We encourage 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 line has access to interpreters after hours.

Written Materials

Members who need auxiliary aids and services or need written or oral interpretation to understand the information given to them — including materials in alternative formats such as large print, braille or other languages — may call the BCBSTX Customer Advocate Department number for their health plan as listed in the table above. Written materials — such as patient education pages, referrals and consent forms — should be at a sixth-grade reading level.

Cultural Sensitivity

BCBSTX acknowledges the diversity of its membership and provider network. We appreciate the challenges providers may encounter integrating into their delivery of health care the appropriate culturally diverse behaviors, values, norms, practices, attitudes and beliefs about the causes of disease and about prevention and treatment. All of that is known as cultural competence. In addition, a member's health and reading literacy level may add to the complexity of the relationship.

Medical advances and better preventive medicine have helped to increase life expectancies and improved general health for many Americans. But health disparities are still very evident in the African American, Hispanic, Asian/Pacific Islander, Native American/Alaskan Native and other populations.

We are eager to help your office increase its cultural competence and help decrease 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 education and reference webpage.

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 much 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 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.

You can find tips online that can help you determine a member's reading literacy levels and provide appropriate communications for them. Providers should work to have any reading materials for members written in a simple form — and not exceed a sixth-grade reading level.

BCBSTX Training for Cultural Competency

This information about cultural competency is meant to help providers comply with the requirements of Title VI of the Civil Rights Act of 1964 and other federal and state laws and regulations enacted since then. Those include the Americans with Disabilities Act, and Texas Health and Human Services Commission policies for delivering culturally competent health care.

BCBSTX also provides ongoing provider training in cultural competency. That happens through quarterly webinars and refresher trainings on an as-needed basis. It also happens during routine on-site visits and upon request. Your local, state and national provider organizations are also likely to have information and resources available as well.

Providers may also 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 appropriate to a member's condition and needs.

Members with disabilities, special health care needs or chronic or complex conditions have the right to designate a specialty care provider as their primary care provider if the SCP agrees.

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. To learn more about the training, providers can call **1-855-212-1615.** To learn more about service coordination, providers can call the Customer Advocate Department at **1-877-688-1811**.

VALUE-ADDED SERVICES

BCBSTX also offers members access to free services in addition to Medicaid-covered benefits and services. We call these "value-added services." Some of them might be helpful to members with special needs. You can read more about value-added services in Section 6: Covered Services. Value-added services have restrictions and limitations.

Section 13: Health Insurance Portability and Accountability Act

To improve the efficiency and effectiveness of the health care system, the U.S. Congress approved the Health Insurance Portability and Accountability Act of 1996. The law includes provisions that require national standards for electronic health care transactions, medical code sets, unique health identifiers and security. It also requires privacy protections for the identifiable health information of individuals.

The U.S. Office for Civil Rights administers and enforces HIPAA's Privacy Rule and Security Rule. The federal Centers for Medicare and Medicaid Services administers other HIPAA rules, including:

- Transactions and standards for code sets that classify medical diagnoses, procedures and other medical information
- Employer identifier standard
- National provider identifier standard

The Enforcement Rule provides standards for the enforcement of all of HIPAA's administrative simplification rules.

You can read more about the HIPAA administrative simplification rules on the CMS website.

HIPAA Privacy Rule

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information. The rule applies to health plans, health care clearinghouses and any health care providers that conduct certain health care transactions electronically.

The rule requires appropriate safeguards to protect the privacy of personal health information of individuals. It sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The rule also gives patient's rights over their health information. Those include rights to examine and obtain a copy of their health records, and to request corrections.

In compliance with the privacy regulations, BCBSTX provides each member with a privacy notice. That notice describes how BCBSTX can use or share a member's health records and how the member can get access to the information. The notice also informs 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.

Provider Services can also help with HIPAA questions. Provider Services can be reached at the following

- Phone numbers
  1-877-560-8055 (STAR and CHIP)
  1-877-784-6802 (STAR Kids)

Members can call the BCBSTX Customer Advocate department with any questions about the privacy regulations.

HIPAA 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.

HIPAA BREACH NOTIFICATION RULE

The HIPAA Breach Notification Rule requires HIPAA-covered entities and their business associates to provide notification following a breach of protected health information. Another federal law calls for the Federal Trade Commission to enforce similar breach notification provisions for vendors of personal health records and their third-party service providers.

Definition of a Breach

A breach is an impermissible use or disclosure under the HIPAA Privacy Rule that compromises the security or privacy of protected health information. An impermissible use or disclosure of PHI is presumed to be a breach unless the covered entity or its business associate demonstrates there is a low probability that the protected health information has been compromised.

That probability of compromise will be judged in part through a risk assessment. Among the factors it will consider are:

- 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 shared or viewed.
- The extent to which the risk to the protected health information has been mitigated.

Breach Notification Requirements

Following a breach of protected health information, covered entities must notify the affected individuals, the U.S. Department of Health & Human Services and, in certain circumstances, the media of the breach. In addition, business associates must notify covered entities if a breach occurs at or by the business associate.

TRANSACTIONS AND CODE SETS REGULATION ADOPTED STANDARDS AND OPERATING RULES

HIPAA requires 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, including:

- Health plans
- Health-care clearinghouses
- Any health care providers who conduct electronic transactions with any health plan, not just those who accept Medicare or Medicaid

ADOPTED STANDARD CODE SETS

The HIPAA Code Sets regulation requires that all medical codes used in electronic transactions use national standard coding.

Adopted Standard Code Sets include:

Outpatient procedure and physician services coding - Current Procedure Terminology codes

CPT codes, maintained by the American Medical Association, are used to describe medical procedures. You can learn more about CPT codes on the AMA website.

- Supplies/not included in CPT - Health Care Common Procedure Coding System. This code set, established by CMS, primarily represents items, supplies and non-physician services not covered by the AMA CPT codes.
- **Diagnosis Coding - ICD-10-CM**

This code set is the International Classification of Diseases, 10th edition, Clinical Modification.

- **Hospital inpatient procedure coding - ICD-10-PCS**

This code set is the International Classification of Diseases, 10th edition, Procedure Coding System.

Also, a National Drug Code is required for applicable claims to identify clinician-administered drugs. Reimbursable CADs are found on the Texas Vendor Drug website.

Appendix

Attachment A – Breast Pump Coverage Breast Pump Coverage in STAR, CHIP and STAR Kids

Texas Medicaid STAR, CHIP and STAR Kids 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 STAR, CHIP or STAR Kids client member number. However, if a mother is no longer eligible for Texas Medicaid or STAR, CHIP or STAR Kids and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's Medicaid client member 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. The Texas Health and Human Service Commission (HHSC) mails the pregnant woman an Emergency Medicaid application 30 days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

**These newborns will be in FFS Medicaid until they are enrolled with a STAR managed care organization. Claims should be filed with the Texas Medicaid & Healthcare Partnership (TMHP) using the newborn's Medicaid ID if the mother does not have coverage.

Attachment B: 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 of the Texas Department of Assistive and Rehabilitative Services 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 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 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 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 • Medical supplies
Hospice Services Provided by Department of Health and Human Services	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 the Department of Health and Human Services at **1-800-368-1019**
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 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 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 **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 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 is not available. This applies to all drugs requiring 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. The PDL is available online at www.txvendordrug.com 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: **1-855-457-0405** CHIP: **1-855-457-0403.**
Prior Authorization	Prior authorization 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: **1-855-457-0405** Fax: **1-877-560-8055** CHIP: **1-855-457-0403** 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 • Confidential HIV testing • Immunizations • Tuberculosis care • Family Planning services • Texas Health Steps medical checkups • Prenatal services • Texas Vaccines for Children 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 is a Medicaid financing program and is a joint program of the Texas Education Agency and the Texas Health and Human Services Commission. Primary care providers should educate eligible members about SHARS. SHARS allows local school districts/shared services arrangements 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, and • Have individual Educational Plans 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 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. • Need 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, 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. All confirmed or suspected cases are reported immediately (within 24 hours) to the Local Tuberculosis Control Health Authority. All Health and Human Services Commission reporting procedures are to be followed. A contact investigation and Directly Observed Therapy referral is initiated. Upon request, LTCHA, HHSC and Department of Health Services 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 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. • 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 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 C: 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-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: • 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: • Miscarriage or • 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 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 Perinatal 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 Perinatal 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 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 procedures • Appropriate provider- administered medications • Ultrasounds • Histological examination of tissue samples

Covered Benefit	Description of Services	CHIP Perinatal Members (Unborn Child)
Hospital Services – 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 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 • 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: • Laboratory and radiological services that directly relate to antepartum care and/or the delivery of the covered CHIP Perinatal until birth. • 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. • 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 or its treatment	• 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 • 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 of the unborn child	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

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 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- drugs for infertility • We do not reimburse claims for nutritional supplies or equipment under the • We offer free prescription delivery from those our Pharmacy Provider Service Area network. **Quantity Supply:** All medications will be limited day supply at all retail pharmacies. If a medical the defined one-month supply of medication,	
Prior Authorization	Prior authorizations 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 monitoring of the patient's drug therapy. These special handling such as temperature controlled unavailable at retail pharmacy stores. Self-injectable medications will be covered under 34-day supply per fill. Office-based injectables are covered under the	

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. • 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 D: 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 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 and Healthcare Common Procedure Coding System 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 (only for Members 18 of age and older) 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 may 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, 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, is a team- based health care delivery model led by a health care provider/provider team 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 Services through the Texas Health Steps Program

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 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 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, nurse practitioner, clinical nurse specialist, and physician assistant in a licensed birthing center.

Covered Benefit	Description of Services
Prescribed pediatric extended care center (PPECC) services	Prescribed Pediatric Extended Care Centers 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, Private Duty Nursing and Community First Choice 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 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 • 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 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 E – CMS-1500 Form

Sample CMS-1500 and Details on Fields

CMS-1500 CLAIM FORM (IMAGE –SAMPLE ONLY)

Overall Guidance for CMS-1500

Modifier Codes

Use modifier codes when appropriate with the corresponding Healthcare Common Procedure Coding System or Current Procedural Terminology codes. For paper claims, all modifiers should immediately follow the procedure code in Box 24D of the CMS-1500 form.

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 provider's National Provider Identifier 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 and Rural Health Clinics may put their billing/group NPI number in Box 24J and 33. Refer to the recommended fields for the CMS-1500 sections for field descriptions.

DETAILS ON COMPLETING FIELDS IN CMS-1500

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 member's last name, first name and middle initial as printed on the Medicaid identification form. If the insured uses a last name suffix (for example, 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. For example: 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.
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-9D must 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 not 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.

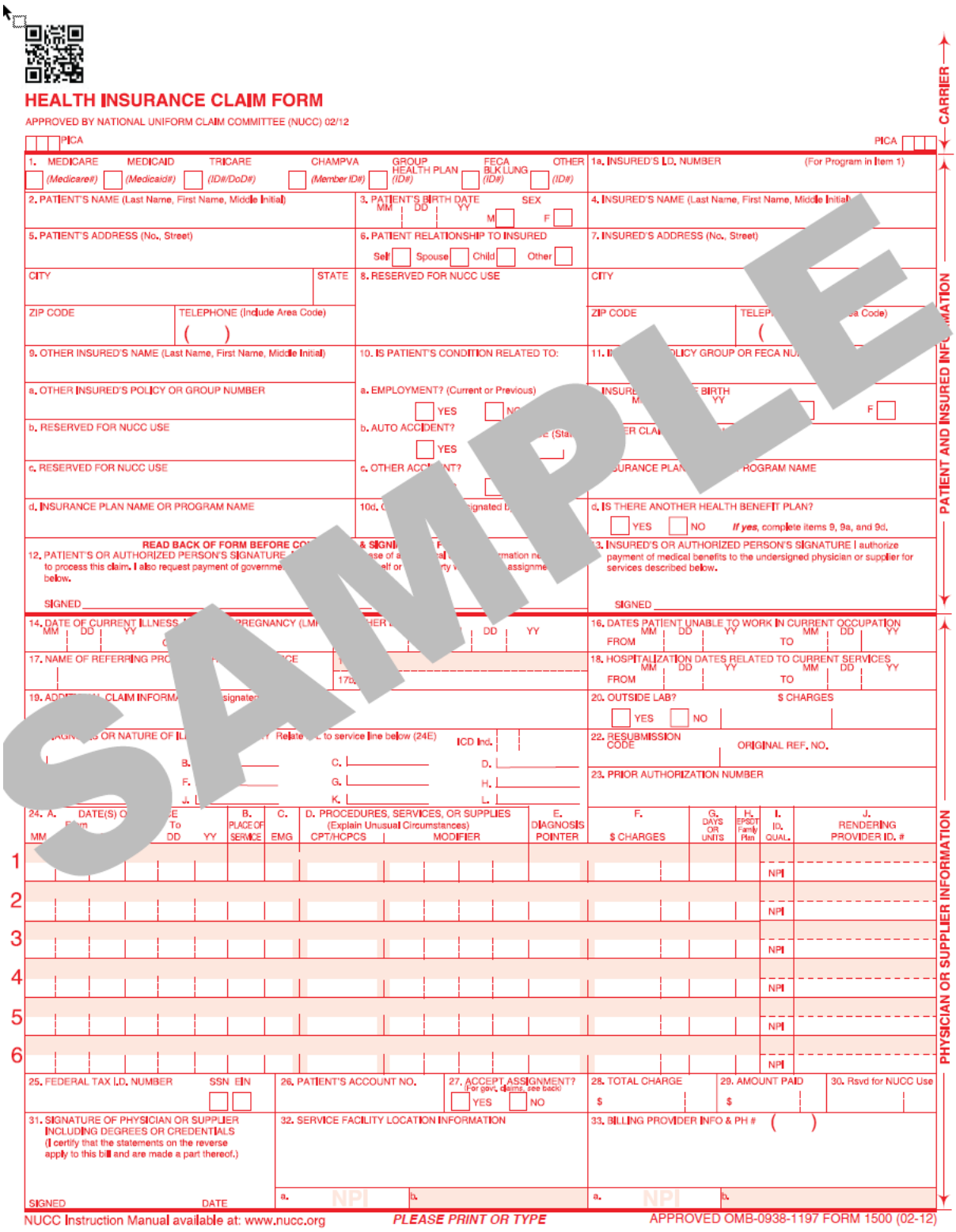
Field 17	Name of Referring Physician or Other Source	Date format: MM/DD/YYYY. Enter the name (First Name, Middle Initial, Last Name) and credentials of the professional who referred, ordered or supervised the service(s) or supplies on the claim. If multiple providers are involved, enter one provider using the following priority order: Referring Provider Ordering Provider 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 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** 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.

HCFA 1500 Sample



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

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEP a Code) (

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. I OLICY GROUP OR FECA NU

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

INSUR BIRTH M YY F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES E (Sta

ER CLA

c. RESERVED FOR NUCC USE

c. OTHER ACC NT?

URANCE PLA ROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. C ignated b

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE CO & SIGNI F

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE se of a al mation ne to process this claim. I also request payment of governme elf or ty assignme below.

SIGNED

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 MM DD YY PREGNANCY (LM HER DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PRO CE

17a.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMA signatio

20. OUTSIDE LAB? YES NO $ CHARGES

AGNOSIS OR NATURE OF IL Relate to service line below (24E) ICD Ind.

22. RESUBMISSION CODE ORIGINAL REF. NO.

B. C. D. F. G. H. J. L.

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 gov. 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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI 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)

SAMPLE

Attachment F – CMS-1450 Form

Sample CMS-1450 and Details on Fields

CMS 1450 Claim Form (Image -- Sample Only)

Overall Guidance for CMS-1500

CMS-1450 (UB-04) Revenue Codes

CMS-1450 revenue codes are required for all institutional claims.

Inpatient Coding — Institutional

For institutional inpatient coding, use these guidelines:

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

Outpatient Coding — Institutional

For institutional outpatient coding, use these guidelines:

- For HCPCS codes, refer to the current edition of HCPCS published by CMS.
- For 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. Using only revenue codes on outpatient claims will cause delay or denial of the claim for lack of information.
- When using an unlisted CPT/HCPCS code for a claim, provide the name of the drug or medication in Box 43.

Help From TMPPM

Providers can also consult the Texas Medicaid Provider Procedures Manual for billing tips.

DETAILS ON COMPLETING FIELDS CMS-1450

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: Hospital Skilled nursing Home health agency Clinic (rural health clinic [RHC], federally qualified health center [FQHC], and renal dialysis center [RDC]) Special facility Second Digit—Bill Classification (except clinics and special facilities): Inpatient (including Medicare Part A) Inpatient (Medicare Part B only) Outpatient Other (for hospital-referenced diagnostic services, for example, laboratories and X-rays) 7Intermediate care Second Digit—Bill Classification (clinics only): Rural health Hospital-based or independent renal dialysis center Free standing 5CORFs Third Digit—Frequency: Nonpayment/zero claim Admit through discharge Interim-first claim Interim-continuing claim Interim-last claim Late charges-only claim Adjustment of prior claim Replacement of prior claim
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 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 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.

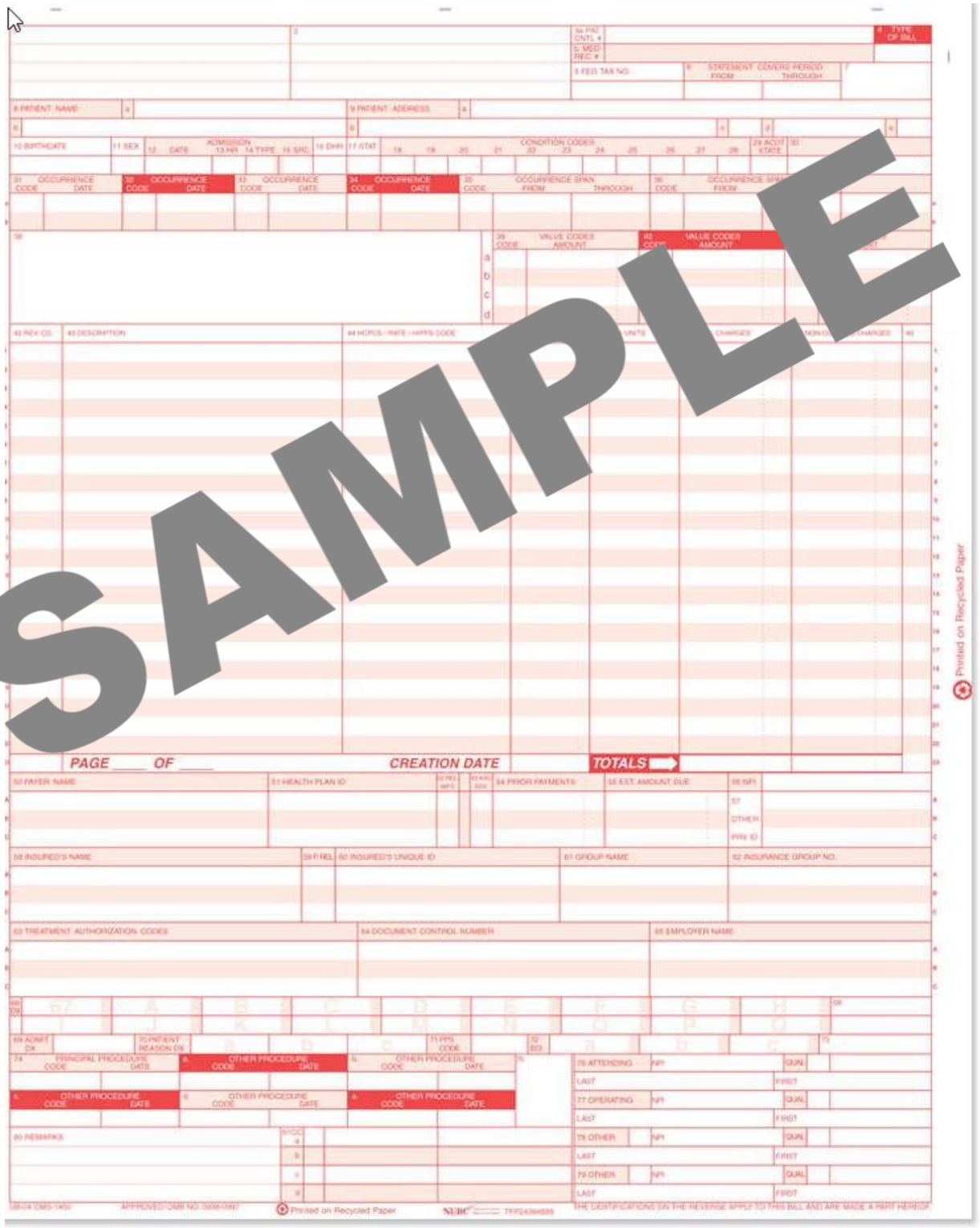
Field 42 – 43	Revenue Code and Description (Rev. Cd.)	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right 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 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 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 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 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 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.

UB04 – 1450 Claims Form Sample



Attachment G – Rejected/Denied Claims

COMMON REASONS FOR REJECTED AND DENIED CLAIMS

Many claims are rejected or denied for common billing errors. Here are common problems, their likely causes, and possible resolutions.

Problem	Explanation	Resolution
Member's ID Number is incomplete 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. Use 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 (Box 24 on CMS-1500 and Box 63 on CMS-1450 (UB-04)) 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 to calculate reimbursement. Durable Medical Equipment (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.

Attachment H – Private Pay Agreement



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 I: Provider Standard Contract Provisions

As reference in Section 3 – Provider Roles and Responsibilities in the Provider Manual, Providers must adhere to the "Provider Standard Contract Provisions" BCBSTX encourages providers to visit HHSC Uniform Managed Care Manual website specially for Chapter 8.1 "Provider Contract List". Please note the standard contract provisions are subject to change and BCBSTSX encourage providers to visit the HHSC Uniform Managed Care Manual landing page, which can be found here: https://www.hhs.texas.gov/services/health/medicaid-chip/managed-care- for the most updated information.

No.	Category	Standard Contract Provision	Provider Standard Contract Provisions MCO - Dental Program Type								MCO – Pharmacy Services	MCO Contract Page
			CHIP MCO	STAR MCO	STAR+ PLUS MCO	STAR Health MCO	STAR Kids	Dual Demo MMP	Children's Medicaid Dental Contractors	CHIP Dental Contractors		
1.	72-Hour	Include the following information in the cover letter to the initial Medicaid network pharmacy provider	UMCC[1]	UMCC	UMCC	Att. B-1, §	Att B-1,	DDMMP			✓	
	Emergency Supply	Agreement, and all amendments and renewals: If prior authorization for a medication is not immediately available, a 72-hour emergency supply may be dispensed when the pharmacist on duty recommends it as clinically appropriate and when the medication is needed without delay. *Please consult the Vendor Drug Program Pharmacy Provider Procedures Manual, the Texas Medicaid Provider Procedures Manual, and [insert the name of the MCO's provider manual and chapter and page reference] for information regarding reimbursement for 72-hour emergency supplies of prescription claims. It is important that pharmacies understand the 72-hour emergency supply policy and procedure to assist Medicaid clients.*	Att. B-1, § 8.1.21.1 RSA[1] Att. B-1, § 8.1.24.1	Att. B-1, § 8.1.21.1	Att. B-1, § 8.1.21.1 S+P Exp.[2] Att. B-1, § 8.1.42.1 S+P MRSA[3] Att. B-1, § 8.1.16.2	8.1.20.2	§8.1.17.2	§2.5.7.1.5.9				
2.	Access to Records	The Network Provider agrees to provide at no cost to the Texas Health and Human Services Commission (HHSC): 1. all information required under the MCO's managed care contract with HHSC, including but not limited to, the reporting requirements and other information related to the Network	UMCC Att. B-1, §8.1.20 RSA Att. B- 1, §8.1.20	UMCC Att. B-1, §8.1.20	UMCC Att. B-1, §8.1.20 S+P Exp. Att. B-1, §8.1.20	Att. B-1, §8.1.26	Att. B1, §8.1.22	DDMMP §5.4.1.2	Att. B-1, §8.1.14	Att. B-1, §8.1.14	✓	

[1] RSA is the CHIP Rural Service Area Contract.

[2] S+P Exp. is the STAR+PLUS Expansion Contract.

[3] S+P MRSA is the STAR+PLUS Medicaid Rural Service Area (MRSA) Contract.

		Provider's performance of its obligations under the contract; and 2. any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by HHSC.			S+P MRSA Att. B-1, § 8.1.22							
3.	Access to Records	The MCO's provider agreement must specify that upon receipt of a record review request from the Health and Human Services Commission Office of Inspector General (OIG) or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, a provider must provide, at no cost to the requesting agency, the records requested within three business days of the request. If the OI, or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request or in less than 24 hours, the provider must provide the records requested at the time of the request or in less than 24 hours. The request for record review includes clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, charting; billing records, invoices, documentation of delivery items, equipment, or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical documentation; computer records and data; and/or contracts with providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in OIG imposing sanctions against the provider as described in 1 TEX. ADMIN. CODE Chapter 371 Subchapter G.	UMCC Att. B-1, §8.1.19 RSA Att. B-1, §8.1.19	UMCC Att. B-1, §8.1.19	UMCC Att. B- 1, §8.1.19 S+P Exp. Att. B-1, §8.1.19 S+P MRSA Att. B-1, § 8.1.21	Att. B-1, §8.1.25	Att. B1, §8.1.21	DDMMP §5.4.1	Att. B-1, §8.1.13	Att. B-1, §8.1.13	✓	
4.	Administrative Requirements	Updates to contact information. Network Providers must inform both the MCO and HHSC's administrative services contractor of any changes to the Provider's address, telephone number, group affiliation, etc.	UMCM[5] Ch. 3.3	UMCM Ch. 3.3	UMCM Ch. 3.3	UMCM Ch. 3.14	UMCM Ch. 3.34	UMCM Ch. 3.3	UMCM Ch. 3.18	UMCM Ch. 3.18	✓	

5.	Advance Directives	Provider must comply with the requirements of state and federal laws, rules and regulations relating to advance directives.		UMCC Att. B-1, §8.2.11	UMCC Att. B-1, §8.2.11 S+P Exp. Att. B-1, §8.1.32 S+P MRSA Att. B-1, § 8.1.34	Att. B-1, §8.1.34.1	Att. B-1, §8.1.35	DDMMP §5.3.3				
6.	Audit or Investigation	The Network Provider agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the Network Provider contract and any records, books, documents, and papers that are related to the Network Provider contract and/or the Network Provider's performance of its responsibilities under this contract: 1. The United States Department of Health and Human Services or its designee; 2. The Comptroller General of the United States or its designee; 3. MCO Program personnel from HHSC or its designee; 4. The Office of Inspector General; 5. The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;	UMCC Att. A, §9.02 RSA Att. A, §9.02	UMCC Att. A, §9.02	UMCC Att. A, §9.02 S+P Exp. Att. A, §9.02 S+P MRSA Att. A, § 9.02	Att. A, §9.02	Att. B-1, §9.02	DDMMP §2.1.5.1	Att. A, §9.02	Att. A, §9.02	✓	

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		6. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC; 7. The Office of the State Auditor of Texas or its designee; 8. A State or Federal law enforcement agency; 9. A special or general investigating committee of the Texas Legislature or its designee; and 10. Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC. The Network Provider must provide access wherever it maintains such records, books, documents, and papers. The Network Provider must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein. Requests for access may be for, but are not limited to, the following purposes: 1. examination; 2. audit; 3. investigation; 4. contract administration; 5. the making of copies, excerpts, or transcripts; or 6. any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.										
7.	Audit or Investigation	*[Network Provider] understands and agrees that the acceptance of funds under this contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. [Network Provider] further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost.*	UMCC Att. A, §9.04 RSA Att. A, §9.04	UMCC Att. A, §9.04	UMCC Att. A, §9.04 S+P Exp. Att. A, §9.04 S+P MRSA Att. A, § 9.04	Att. A, §9.05	Att. A, §9.05	DDMMP §C.2.1	Att. A, §9.04	Att. A, §9.04	✓	
8.	Behavioral Health	Network Providers who are Primary Care Physicians (PCPs) must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.	UMCC Att. B-1, §8.1.15.4[4]	UMCC Att. B-1, §8.1.15.4	UMCC Att. B-1, §8.1.15.4 S+P Exp. Att. B-1, §8.1.15.4 S+P MRSA Att. B-1, § 8.1.15.4	Att. B-1, §8.1.17. 4	Att. B-1, §8.1.16.3	DDMMP §C.6.3.1				

[4] This requirement applies to a PCP who provides services to CHIP Perinate Newborns. The PCP requirements do not apply to CHIP Perinates.

			RSA Att. B1, 8.1.15.4[5]									
9.	Behavioral Health	Network Providers who provide inpatient psychiatric services to a Member must schedule the Member for outpatient followup or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Behavioral health providers must contact Members who have missed appointments within 24 hours to reschedule appointments.	UMCC Att. B-1, §8.1.15.5[8] RSA Att. B1, 8.1.15.5[9]	UMCC Att. B-1. §8.1.15.5 10	UMCC Att. B-1. §8.1.15.5 11 S+P Exp. Att. B-1, §8.1.15.5 12 S+P MRSA Att. B-1, § 8.1.15.5	Att. B-1, §8.1.17. 5	Att. B-1, §8.1.16.4	DDMMP §C.6.4.3-C.6.4.4				
10.	Behavioral Health	Network Providers who are behavioral health providers must: 1. Submit to the MCO for inclusion into the Health Passport treatment plans and referrals to other providers. 2. Document the outcome measurement scores				Att. B-1, §8.1.17						

[8] This requirement applies to a PCP who provides services to CHIP Perinate Newborns. The PCP requirements do not apply to CHIP Perinates.

[9] This requirement applies to a PCP who provides services to CHIP Perinate Newborns. The PCP requirements do not apply to CHIP Perinates.

[10] This requirement does not apply to STAR HMOs in the Dallas SA, whose Members receive Behavioral Health Services through the NorthSTAR Program.

[11] This requirement does not apply to STAR+PLUS MCOs in the Dallas SA, whose Members receive Behavioral Health Services through the NorthSTAR Program. [12] This requirement does not apply to STAR+PLUS MCOs in the Dallas SA, whose Members receive Behavioral Health Services through the NorthSTAR Program.

[5] This requirement applies to a PCP who provides services to CHIP Perinate Newborns. The PCP requirements do not apply to CHIP Perinates.

		in the Health Passport. 3. Function as a member of the PCP Team by coordinating with the PCP and Service Manager as appropriate. 4. Testify in court as needed for child protection litigation.										
11.	Behavioral Health	Network Providers who are behavioral health providers must provide a monthly summary form, to be provided by the MCO. The following information must be included in the monthly summary form for the Health Passport: 1. Primary and secondary (if present) diagnosis. 2. Assessment information, including results of a mental status exam. 3. Brief narrative summary of the Member's clinical visits/progress. 4. Scores on each outcome rating form(s). 5. Referrals to other providers or community resources. 6. Referrals to other providers or community resources.				Att. B-1, §8.1.12 and §8.1.17						
		7. Evaluations of each Member's progress at intake, monthly, and at termination of the Health Care Service Plan, or as significant changes are made in the treatment plan. 8. Any other relevant care information.										
12.	Behavioral Health	Network Providers who are Primary Care Providers (PCPs) must use the Texas Health Steps BH forms, at a minimum, for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders, including possible substance abuse or chemical dependency. The PCP must submit completed Texas Health Steps screening and evaluation results to the MCO to include in the Health Passport.				Att. B-1, §8.1.17						
12.1	Cancellation of Product Orders	A Network Provider that offers delivery services for covered products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products must reduce, cancel, or stop delivery if the Member or the Member's authorized representative submits an oral or written request. The Network Provider must maintain records documenting the request.	UMCC Att. B-1, §8.1.27 RSA Att. B-1, §8.1.27	UMCC Att. B-1, §8.1.27	UMCC Att. B- 1, §8.1.27 S+P Exp. Att. B-1, §8.1.44 S+P MRSA Att. B-1, § 8.1.16.7	Att. B-1, §8.1.21	Att. B-1, §8.1.17.17				✓	

13.	Behavioral Health	All behavioral and physical health providers (including PCPs, OB/GYNs, internists, and other relevant provider types) must share amongst each other clinical information regarding Members with co- occurring behavioral and physical health conditions, to the extent allowed by federal law.	UMC C 16.7.2. 7.2.3	UMCC 16.7.2. 7.2.3	UMCC 16.7.2. 7.2.3	UMCC 16.7.2. 7.2.3	UMCC 16.7.2. 7.2.3	UMCC 16.7.2. 7.2.3	UMCC 16.7.2. 7.2.3	UMCC 16.7.2. 7.2.3		
14.	Coordination between Behavioral Health Services Provider and PCP	Network Provider must comply with the most recent version of the *Psychotropic Medication Utilization Parameters for Foster Children* found at http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp.				Att. B-1, §8.1.17. 4					✓	
15.	Claims Payment	The payment methodology applicable to this Network Provider contract is: **[Note: Here, the MCO must provide a complete description of the payment methodology or payment amounts.]** If the methodology refers to a fee schedule that is not attached to the contract, then the MCO must comply with the following requirement. If the basis of the fee	UMCC Att. B-1, §§8.1.4.8 & 8.1.18.5 RSA Att. B-1, §§8.1.4.8 & 8.1.18.5	UMCC Att. B-1, §§8.1.4.8 & 8.1.18.5	UMCC Att. B- 1, §§8.1.4.8 & 8.1.18.5 S+P Exp. Att. B-1, §§8.1.4.8 & 8.1.18.5 S+P	Att. B-1, §§8.1.4 & 8.1.24.5	Att. B-1, §8.1.20.5	DDMMP §2.7.4.1	Att. B-1, §§8.1.5.9 & 8.1.12.5	Att. B-1, §§8.1.5.9 & 8.1.12.5	✓	
		schedule is information: 1) outside of the MCO's control, such as the Texas Medicaid fee schedule, then the contract must clearly identify the source of information. The contract must include the procedure by which the Provider may readily access the source of information electronically, telephonically, or as otherwise agreed by the parties; or 2) within the MCO's control, then the contract must include a toll- free number or electronic address for requesting an electronic or hard copy of the fee schedule. The contract must state that the MCO will provide a copy of the fee schedule, and all information necessary to determine the amount of compensation no later than 10 business days after receipt. For purposes of this requirement, the term "all information necessary" to determine compensation has the meaning assigned in 28 Tex. Admin. Code § 11.901(a)(11). The MCO cannot charge Network Providers fees for accessing or obtaining copies of fee schedules or other information regarding claims payment.			MRSA Att. B- 1, §§ 8.1.4.8 & 8.1.20.5						

16.	Claims Payment	In order to submit a clean claim, Network Provider must provide the following information with the claim: **[NOTE: Here, the MCO must include a complete**	UMCC Att. B-1, §8.1.18.5	UMCC Att. B-1, §8.1.18.5	UMCC Att. B-1, §8.1.18.5	Att. B-1, §8.1.24. 5	Att. B-1, §8.1.20.5	DDMMP §§5.1.9.6 and 2.17.3.2	Att. B- 1, §8.1.12. 5	Att. B-1, §8.1.12.5	✓	
		listing of all required information. Include claims coding and processing guidelines for the applicable provider type.]	RSA Att. B- 1, §8.1.18.5		S+P Exp. Att. B-1, §8.1.18.5 S+P MRSA Att. B-1, § 8.1.20.5							
17.	Claims Payment	MCO will provide the Network Provider at least 90 Days' notice prior to implementing a change in the abovereferenced claims guidelines, unless the change is required by statute or regulation in a shorter timeframe.	UMCC Att. B-1, §8.1.18.5 RSA Att. B-1, §8.1.18.5	UMCC Att. B-1, §8.1.18.5	UMCC Att. B-1, §8.1.18.5 S+P Exp. Att. B-1, §8.1.18.5 S+P MRSA Att. B-1, § 8.1.20.5	Att. B-1, §8.1.24. 5	Att. B-1, §8.1.20.5	DDMMP §2.7.5.8	Att. B- 1, §8.1.12. 5	Att. B-1, §8.1.12.5	✓	
18.	Claims Payment	Network Providers must submit claims for processing or adjudication to the following entity/entities: **[NOTE: Here, the MCO must provide a complete list of all entities to whom the Network Providers must submit claims. The list must include the name of the entity, the address to which claims must be sent, an explanation for determination of the**	UMCC Att. B-1, §8.1.18.5 RSA Att. B-1, §8.1.18.5	UMCC Att. B-1, §8.1.18.5	UMCC Att. B-1, §8.1.18.5 S+P Exp. Att. B-1, §8.1.18.5	Att. B-1, §8.1.24. 5	Att. B-1, §8.1.20.5	DDMMP §2.7.4.1	Att. B- 1, §8.1.12. 5	Att. B-1, §8.1.12.5	✓	
		correct claims payer based on services rendered, **and a phone number the Provider may call to make** **claims inquiries.]**			S+P MRSA Att. B-1, § 8.1.20.5							
19.	Claims Payment	The MCO must notify Network Providers in writing of any changes in the list of claims processing or adjudication entities at least 90 Days prior to the effective date of change.	UMCC Att. B-1, §8.1.18.5 RSA Att. B-1, §8.1.18.5	UMCC Att. B-1, §8.1.18.5	UMCC Att. B-1, §8.1.18.5 S+P Exp. Att. B-1, §8.1.18.5	Att. B-1, §8.1.24. 5	Att. B-1, §8.1.20.5	DDMMP C6.1.15	ü	ü	✓	

					S+P MRSA Att. B-1, § 8.1.20.5							
20.	Clean Claims Payment	The MCO shall adjudicate (finalize as paid or denied adjudicated) clean claims for: (1) healthcare services within 30 Days from the date the claim is received by the MCO; (2) pharmacy services no later than 18 Days of receipt if submitted electronically, or 21 Days of receipt if submitted non-electronically; The MCO will pay Network Providers interest at a rate of 18% per annum on all clean claims that are not	UMCC Att. B-1, §8.1.18.5 RSA Att. B-1, §8.1.18.5	UMCC Att. B-1, §8.1.18.5	UMCC Att. B- 1, §8.1.18.5 S+P Exp. Att. B-1, §8.1.18.5 S+P MRSA Att. B-1, §	Att. B-1, §8.1.24. 5	Att. B-1, §8.1.20.5	DDMMP §§5.1.9.3-5.1.9.4	Att. B- 1, §8.1.12. 5	Att. B-1, §8.1.12.5	✓	
		adjudicated within 30 Days.			8.1.20.5							
21.	Claims Payment	The MCO's provider agreement must specify that program violations arising out of performance of the contract are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG) as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.	UMCC Att. B-1, §8.1.18.5 RSA Att. B-1, §8.1.18.5	UMCC Att. B-1, §8.1.18.5	UMCC Att. B-1, §8.1.18.5 S+P Exp. Att. B-1, §8.1.18.5 S+P MRSA Att. B-1, § 8.1.20.5	Att. B-1, §8.1.24. 5	Att. B-1, §8.1.20.5	DDMMP §§2.1.4.4, 2.1.5.8, and C.6.6	Att. B-1, §8.1.5.2	Att. B-1, §8.1.5.2	✓	
20.1	Claims Submission	Network Providers must comply with the requirements of Texas Government Code § 531.024161, regarding the submission of claims involving supervised providers.	UMCC Att. B-1, §8.1.18.1 RSA Att. B-1, §8.1.18.1	UMCC Att. B-1, §8.1.18.1	UMCC Att. B-1, §8.1.18.1 S+P Exp. Att. B-1, 8.1.18.1 S+P MRSA Att. B-1, § 8.1.20.1	Att. B-1, §8.1.24. 1	Att. B-1, §8.1.20.1	DDMMP §2.18.1.8	Att. B- 1, §8.1.12. 1	Att. B-1, §8.1.12.1		

22.	Complaints and Appeals	The following complaint and appeal processes apply to the Network Provider contracts: **[Note: Here, the MCO should include a clear description of its Provider complaint and appeal processes. The processes must comply with the requirements of the HHSC Managed Care Contract, and must be the same for all Providers in a particular HMO Program. In addition, for Medicaid Program providers, the processes must comply with the requirements of 42 C.F.R. § 438.414. For CHIP providers, the processes must comply with the requirements of Chapter 843, Subchapter G of the Texas Insurance Code.]**	UMCC Att. B-1, §8.4.1 RSA Att. B-1, §8.1.4.10	UMCC Att. B-1, § 8.2.4	UMCC Att. B- 1, §8.2.4 S+P Exp. Att. B-1, §8.1.25 S+P MRSA Att. B-1, § 8.1.27	Att. B-1, §8.1.31	Att. B1, §8.1.27	DDMMP §2.7.6.6.4.1	Att. B-1, §8.2.3	Att. B-1, §8.3.1	✓	
23.	Complaints and Appeals	The Network Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Member complaints.	ü	ü	ü	ü	ü	ü	ü	ü	✓	
24.	Confidentiality	Network Provider must treat all information that is obtained through the performance of the services included in this Network Provider contract as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of	UMCC Att. A, §11.01(a) RSA Att. A, §11.01(a)	UMCC Att. A, §11.01(a)	UMCC Att. A, §11.01(a) S+P Exp. Att. A, §11.01(a) S+P MRSA Att. A, § 11.01(a)	Att. A, §11.01(a)	Att. A, §11.01 (a)	DDMMP §§5.2, C.3.6, and C.6.1.5	Att. A, §11.01(a)	Att. A, §11.01(a)	✓	
		HHSC Programs.										
25.	Confidentiality	Network Provider may not use information obtained through the performance of this Network Provider contract in any manner except as is necessary for the proper discharge of obligations and securing of rights under this contract.	UMCC Att. A, §11.01(c) RSA Att. A, §11.01(c)	UMCC Att. A, §11.01(c)	UMCC Att. A, §11.01(c) S+P Exp. Att. A, §11.01(c) S+P MRSA Att. A, § 11.01(c)	Att. A, §11.01(c)	Att. A, §11.01 (c)	DDMMP §§5.2, C.3.6, and C.6.1.5	Att. A, §11.01(c)	Att. A, §11.01(c)	✓	

26.	Confidentiality – HIPAA	Network Provider shall protect the confidentiality of Member Protected Health Information (PHI), including patient records. Network Providers must comply with all applicable Federal and State laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of protected health information.	UMCC Att. A, §§7.02, 7.07, 11.01, & 11.03(a) RSA Att. A, §§7.02, 7.07, 11.01, & 11.03(a)	UMCC Att. A, §§7.02, 7.07, 11.01, & 11.03(a)	UMCC Att. A, §§7.02, 7.07, 11.01, & 11.03(a) S+P Exp. Att. A, §§7.02, 7.07, 11.01, &	Att. A, §§7.02, 7.06, 11.01, & 11.03(a)	Att. A, §§7.02, 7.06, 11.01, & 11.03 (a)	DDMMP §§5.2, C.3.6, and C.6.1.5	Att. A, §§7.02, 7.07, 11.01, & 11.03(a)	Att. A, §§7.02, 7.07, 11.01, & 11.03(a)	✓	
					11.03(a) S+P MRSA Att. A, §§7.02, 7.06, 11.01, & 11.03(a)							
27.	Co-payments and Deductibles	The Network Provider is responsible for collecting at the time of service any applicable CHIP copayments or deductibles in accordance with CHIP cost-sharing limitations.	UMCC Att. B-1, §8.1.23[13] RSA Att. A, §10.11[14] Att. B- 1, 8.1.25							Att. B-1 ~~A, §8.1.16.1~~[15]	✓	
28.	Co-payments and Deductibles	Network Providers shall not charge: 1. cost-sharing or deductibles to CHIP Members of Native American Tribes or Alaskan Natives;	UMCC Att. B-1, §8.1.23[16] RSA Att.							Att. A, §10.10, Att. B-1 §8.1.16	✓	

[13] Co-payments and deductibles do not apply to CHIP Perinates and CHIP Perinate Newborns.
[14] Co-payments and deductibles do not apply to CHIP Perinates and CHIP Perinate Newborns.
[15] Co-payments and deductibles do not apply to CHIP Perinate Newborns.
[16] Co-payments and deductibles do not apply to CHIP Perinates and CHIP Perinate Newborns.

		2. copayments or deductibles to a CHIP Member with an ID card that indicates the Member has met his or her cost-sharing obligation for the balance of their term of coverage; 3. copayments for well-child or well-baby visits or immunizations (CHIP MCO and CHIP RSA); or 4. copayments for routine preventive and diagnostic dental services (CHIP Dental).	A, §10.11[6] Att. B-1, 8.1.25									
29.	Co- payments	Copayments are the only amounts that Network Providers may collect from CHIP Members, except for costs associated with unauthorized non-emergency services provided to a member by out- of-network providers for non-covered services.	UMCC Att. B-1, §8.1.23[7] RSA Att. A, §10.11[8] Att. B- 1, 8.1.25							Att. B-1, §8.1.16[20]	✓	
30.	Costs of Non-covered Services	The Network Providers must inform Members of the costs for non- covered services prior to rendering such services and must obtain a signed private pay form from such a member.	UMCC Att. B-1, §8.1.23 RSA Att.	UMCC Att. B-1, §8.1.23	UMCC Att. B-1, §8.1.23 S+P Exp.	Att. A, §10.09	Att. A, §10.09	DDMMP §2.4.2	Att. A, §10.10(b)	Att. A, §10.10(b)	✓	
			A, §10.11(a)(7)		Att. A, §10.10 S+P MRSA Att. A, § 10.10							

[6] Co-payments and deductibles do not apply to CHIP Perinates and CHIP Perinate Newborns.
[7] Co-payments and deductibles do not apply to CHIP Perinates and CHIP Perinate Newborns.
[8] Co-payments and deductibles do not apply to CHIP Perinates and CHIP Perinate Newborns. [20] Co-payments and deductibles do not apply to CHIP Perinate Newborns.

31.	DME	Include the following information in the cover letter to the initial Medicaid network pharmacy provider agreement, and all amendments and renewals: *Please consult the Texas Medicaid Provider Procedures Manual, Durable Medical Equipment (DME) and Comprehensive Care Program (CCP) sections, and [insert the name of the MCO's provider manual and chapter and/or page reference] for information regarding the scope of coverage of durable medical equipment (DME) and other products commonly found in a pharmacy. For qualified children, this includes medically necessary over-the- counter drugs, diapers, disposable/expendable medical supplies, and some nutritional products. It also includes medically necessary nebulizers, ostomy supplies or bed pans, and other supplies and equipment for all qualified Members. [Insert MCO's name] encourages your pharmacy's participation in providing these items to Medicaid clients.*		UMCC Att. B-1, §8.1.21	UMCC Att. B-1, §8.1.21 S+P Exp. Att. B-1, §8.1.42 S+P MRSA Att. B-1, §8.1.16	Att. B-1, §8.1.20	Att. B1, §8.1.17	DDMMP §2.7.6.6.5			✓	
32.	Early Childhood Intervention (ECI)	Network Providers must cooperate and coordinate with local ECI programs to comply with federal and state requirements relating to the development, review and evaluation of Individual Family Service Plans (IFSP). Network Provider understands and agrees that any Medically Necessary Health and Behavioral Health Services contained in an IFSP must be provided to the Member in the amount, duration, scope, and service setting established in the IFSP.	UMCC Att. B-1, §8.1.9 RSA Att. B1, §8.1.9	UMCC Att. B-1, §8.1.9	UMCC Att. B- 1, §8.1.9 S+P Exp. Att. B-1, §8.1.9 S+P MRSA Att. B-1, § 8.1.9	Att. B-1, §8.1.9	Att. B1, §8.1.10					
31.1	Electronic Visit Verification	Network Providers using the EVV system must maintain compliance with HHSC minimum standards detailed in UMCM, Chapter 8.7, Section IX.			UMCC Att. B-1, §8.2.17 S+P Exp. Att. B-1, §8.1.33.3 S+P MRSA Att. B-1, §8.1.35.3	Att. B-1, §8.1.37	Att. B-1, §8.1.36.1	DDMMP §2.1.4.6				
33.	Family Planning	If a member requests contraceptive services or family planning services, the Network Providers must also provide the Member counseling and education about		UMCC Att. B-1, §8.2.2.2	UMCC Att. B-1, §8.2.2.2	Att. B-1, §8.1.28. 2	Att. B-1, §8.1.24.2	DDMMP §2.8.2.1.4			✓	

		family planning and available family planning services.			S+P Exp. Att. B-1, §8.1.22.2 S+P MRSA Att. B-1, § 8.1.24.2							
34.	Family Planning	Network Providers cannot require parental consent for Members who are minors to receive family planning services.		UMCC Att. B-1, §8.2.2.2	UMCC Att. B-1, §8.2.2.2 S+P Exp. Att. B-1, §8.1.22.2 S+P MRSA Att. B-1, § 8.1.24.2	Att. B-1, §8.1.28. 2	Att. B-1, §8.1.24.2				✓	
35.	Family Planning	Network Provides must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Members.		UMCC Att. B-1, §8.2.2.2	UMCC Att. B-1, §8.2.2.2 S+P Exp. Att. B-1, §8.1.22.2	Att. B-1, §8.1.28. 2	Att. B-1, §8.1.24.2	DDMMP §2.8.2.1.4			✓	
					S+P MRSA Att. B-1, § 8.1.24.2							
36.	First Dental Home Initiative	[For contracts with First Dental Home Initiative Provider] The Network Provider certifies that he or she has completed the training and registration requirements for Texas Health Steps First Dental Home Initiative providers.				Att. B-1, §8.1.18. 1			Att. B-1, §8.1.4.5			

37.	Fraud and Abuse	The Network Provider understands and agrees to the following: 1. HHSC Office of Inspector General ("OIG") and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Network Providers and their employees, agents, contractors, and patients; 2. requests for information from such entities must be complied with, in the form and language requested; 3. Network Providers and their employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury	UMCC Att. A, Art. 9; Att. B-1, §8.1.19 RSA Att. A, Art. 9; Att. B-1, §8.1.19	UMCC Att. A, Art. 9; Att. B-1, §8.1.19	UMCC Att. A, Art. 9; Att. B-1, §8.1.19 S+P Exp. Att. A, Art. 9; Att. B-1, §8.1.19 S+P MRSA Att. A, Art. 9;Att.	Att. A, Art. 9; Att. B-1, §8.1.25	Att. A, Art. 9; Att. B-1, §8.1.21	DDMMP §§2.1.5 and C.6.6	Att. A, Art. 9; Att. B-1, §8.1.13	Att. A, Art. 9; Att. B-1, §8.1.13	✓	
		proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at the Network Provider's own expense; and 4. compliance with these requirements will be at the [Network Provider's] own expense.			B-1, § 8.1.2 1							

38.	Fraud and Abuse	The Network Provider understands and agrees to the following: 1. Network Providers are subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care or dental care and the Medicaid and/or CHIP Programs, as applicable; 2. Network Providers must cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste; 3. Network Providers must provide originals and/or copies of any and all information as requested by HHSC or the state or federal agency, allow access to premises, and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge; 4. If the Network Provider places required records in another legal entity's records, such as a hospital, the Network Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and 5. Network Providers must report any suspected fraud or abuse including any suspected fraud and abuse committed by the MCO or a Member to the HHSC Office of Inspector General.	UMCC Att. A, Art. 9; Att. B-1, §8.1.19 RSA Att. A, Art. 9; Att. B-1, §8.1.19	UMCC Att. A, Art. 9; Att. B-1, §8.1.19	UMCC Att. A, Art. 9; Att. B-1, §8.1.19 S+P Exp. Att. A, Art. 9; Att. B-1, §8.1.19 S+P MRSA Att. A, Art. 9;Att. B-1, § 8.1.21	Att. A, Art. 9; Att. B-1, §8.1.25	Att. A, Art. 9; Att. B-1, §8.1.21	DDMMP §§2.1.5 and C.6.6	Att. A, Art. 9; Att. B-1, §8.1.13	Att. A, Art. 9; Att. B-1, §8.1.13	✓	
39.	Fraud and Abuse	If the Network Provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), the Network Provider must: 1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the Network Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social		UMCC Att. A, Art. 9; Att. B-1, §8.1.19	UMCC Att. A, Art. 9; Att. B-1, §8.1.19 S+P Exp. Att. A, Art. 9; Att. B-1, §8.1.19 S+P	Att. A, Art. 9; Att. B-1, §8.1.25	Att. A, Art. 9; Att. B-1, §8.1.21	DDMMP §§2.1.5, 2.1.5.9, and C.6.6	Att. A, Art. 9; Att. B-1, §8.1.13		✓	

		Security Act. 2. Include as part of such written policies detailed provisions regarding the Network Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse. 3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and the Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.			MRSA Att. A, Art. 9;Att. B-1, § 8.1.21							
40.	Insurance	Network Provider shall maintain, during the term of the Network Provider contract, Professional Liability Insurance of $100,000 per occurrence and $300,000 in the aggregate, or the limits required by the hospital at which Network Provider has admitting privileges. **[NOTE: This provision will not apply if the Network Provider is a state or federal unit of government, or a municipality, that is required to comply with, and is subject to, the provisions of the Texas and/or Federal Tort Claims Act. This provision also will not apply to Nursing Facilities.]**	UMCC Att. A, §17.01(b) RSA Att. A, §17.01(b)	UMCC Att. A, §17.01(b)	UMCC Att. A, §17.01(b) S+P Exp. Att. A, §17.01(b) S+P MRSA Att. A, §17.01(b)	Att. A, §17.01(b)	Att. A, §17.01 (b)	DDMMP §4.9.2.1	Att. A, §17.01(b)	Att. A, §17.01(b)	✓	
41.	Laws, Rules, and Regulations	The Network Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Network Provider Contract and the MCO's managed care contract with HHSC, the HMO Program, and all persons or entities receiving state and federal funds. The Network Provider understands and agrees that Att. B-1, §any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Network Provider contract, or any violation of the MCO's contract with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.	UMCC Att. A, §7.02 RSA Att. A, §7.02	UMCC Att. A, §7.0 2	UMCC Att. A, §7.02 S+P Exp. Att. A, §7.02 S+P MRSA Att. A, §7.02	Att. A, §7.02	Att. A, §7.02	DDMMP Appendix C	Att. A, §7.02	Att. A, §7.02	✓	

42.	Laws, Rules, and Regulations	The Network Provider understands and agrees that the following laws, rules, and regulations, and all subsequent amendments or modifications, apply to the Network Provider contract: 1. environmental protection laws: a. Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq* .) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products; b. National Environmental Policy Act of 1969 (42 U.S.C. §4321 *et seq* .) and Executive Order 11514 (“Protection and Enhancement of Environmental Quality”) relating to the	UMCC Att. A, §§7.04-7.07 RSA Att. A, §§7.04-7.07	UMCC Att. A, §§7.04-7.07	UMCC Att. A, §§7.04-7.07 S+P Exp. Att. A, §§7.04-7.07 S+P MRSA Att. A, §§7.04-7.07	Att. A, §§7.04-7.06	Att. A, §§7.04 - 7.06	DDMMP Appendix C	Att. A, §§7.04-7.07	Att. A, §§7.04-7.07	✓	

		institution of environmental quality control measures; c. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, “Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans”); d. State Clean Air Implementation Plan (42 U.S.C. §740 *et seq* .) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and e. Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water; 2. state and federal anti-discrimination laws: a. Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d *et seq.*) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15; b. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq* .);										

		c. Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107); d. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688); e. Food Stamp Act of 1977 (7 U.S.C. §200 *et seq* .); f. Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16; and g. the HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement. 3. The Immigration and Nationality Act (8 U.S.C. § 1101 et seq.) and all subsequent immigration laws and amendments; 4. the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and 5. the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 *et.seq* .										
42.1	Lead Screening	In accordance with Texas Health & Safety Code Chapter 88 and related rules at 25 Tex. Admin. Code		UMCC Att. B-1, §	UMCC Att. B-1, §	Att. B-1, § 8.1.28.3.5	Att. B-1, §8.1.24.3					
		Chapter 37, Subchapter Q, Providers must (1) report all blood lead results to the Childhood Lead Poisoning Program (if not performed at the DSHS state laboratory) and (2) follow-up on suspected or confirmed cases of childhood lead exposure with the Childhood Lead Poisoning Prevention Program, and follow the Centers for Disease Control and Prevention guidelines for testing children for lead and follow-up actions for children with elevated lead levels located at http://www.dshs.state.tx.us/lead/pdf_files/pb_109_physician_reference.pdf.		8.2.2.3.1 and § 8.2.10	8.2.2.3.1 and § 8.2.10 S+P Exp. Att. B-1, §8.1.22.3.1 and § 8.1.31 S+P MRSA Att. B-1, § 8.1.24.3.1 and § 8.1.33		and §8.1.33					

43.	Liability	In the event the MCO becomes insolvent or ceases operations, the Network Provider understands and agrees that its sole recourse against the MCO will be through the MCO's bankruptcy, conservatorship, or receivership estate.	ü	ü	ü	ü	ü	ü	ü	ü	✓	
44.	Liability	The Network Provider understands and agrees that the MCO's Members may not be held liable for the MCO's debts in the event of the entity's insolvency.	ü	ü	ü	ü	ü	ü	ü	ü	✓	
45.	Liability	The Network Provider understands and agrees that the Texas Health and Human Services Commission	UMCC Att.	UMCC Att. A,	UMCC Att. A,	Att. A, §4.06	Att. A, §4.05	DDMMP	Att. A, §4.05	Att. A, §4.05	✓	
		(HHSC) does not assume liability for the actions of, or judgments rendered against, the MCO, its employees, agents or subcontractors. Further, the Network Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to the Network Provider by the MCO or any judgment rendered against the MCO. HHSC's liability to the Network Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 et seq.).	A, §4.05 RSA Att. A, §4.05	§4.0 5	§4.05 S+P Exp. Att. A, §4.05 S+P MRSA Att. A, §4.05			§5.3.5				
46.	Main Dentists	Main Dentists must: 1. provide children enrolled in CHIP (birth through age 18) with preventive services in accordance with the American Academy of Pediatric Dentistry (AAPD) recommendations, and children enrolled in Medicaid (birth through age 20) with preventive services in accordance with the Texas Health Steps dental periodicity schedule; 2. assess the dental needs of Members for referral to specialty care providers and provide referrals as needed; and 3. coordinate Members' care with specialty care providers after referral.				Att. B-1, §8.1.18. 2			Att. B-1, §8.1.4.1	Att. B-1, §8.1.4.1		

47.	Marketing	Network Provider agrees to comply with state and federal laws, rules, and regulations governing marketing. In addition, the Network Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in HHSC's Uniform Managed Care Manual.	UMCC Att. B-1, §8.1.6; UMCM Ch. 4.3 RSA Att. B1, §8.1.6; UMCM Ch. 4.3	UMCC Att. B-1, §8.1.6; UMCM Ch. 4.3	UMCC Att. B-1, §8.1.6; UMCM Ch. 4.3 S+P Exp. Att. B-1, §8.1.6; UMCM Ch. 4.3 S+P MRSA Att. B-1, §8.16; UMCM Ch. 4.3	Att. B-1, §8.1.6; UMCM Ch. 4.3	Att. B-1, §8.1.6; UMCM Ch. 4.3	DDMMP §2.7.6.6.16	Att. B-1, §8.1.7; UMCM Ch. 4.3	Att. B-1, §8.1.7; UMCM Ch. 4.3	✓	
48.	Marketing	The Network Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Network Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.	UMCC Att. B-1, §8.1.6; UMCM Ch. 4.3 RSA Att. B-1, §8.1.6; UMCM	UMCC Att. B-1, §8.1.6; UMCM Ch. 4.3	UMCC Att. B-1, §8.1.6; UMCM Ch. 4.3 S+P Exp. Att. B-1, §8.1.6; UMCM	Att. B-1, §8.1.6; UMCM Ch. 4.3	Att. B-1, §8.1.6; UMCM Ch. 4.3	DDMMP §2.7.6.6.16	Att. B-1, §8.1.7; UMCM Ch. 4.3	Att. B-1, §8.1.7; UMCM Ch. 4.3	✓	
			Ch. 4.3		Ch. 4.3 S+P MRSA Att. B-1, §8.16; UMCM Ch. 4.3							
49.	MCO's Responsibility	The MCO will initiate and maintain any action necessary to stop a Network Provider or employee, agent, assign, trustee, or successor- in-interest from maintaining an action against HHSC, an HHS Agency, or any Member to collect payment from HHSC, an HHS Agency, or any Member, excluding payment for non-covered services. This provision does not restrict a CHIP Network Provider from collecting allowable copayment and deductible amounts from CHIP Members. Additionally, this provision does not restrict a CHIP Dental Network Provider from collecting payment for services that exceed a CHIP Member's benefit cap.	UMCC Att. A, §4.05 Att. B-1, §8.1.23 RSA Att. A, §4.05 & 10.12	UMCC Att. A, §4.05 Att. B-1, §8.1.23	UMCC Att. A, §4.05 Att. B-1, §8.1.23 S+P Exp. Att. A, §§4.05 & 10.10 S+P MRSA Att. A, §§4.05 & 10.10	Att. A, §§4.06 & 10.10	Att. A, §4.05 and §10.09	DDMMP Appendix C	Att. A, §§4.05 & 10.10	Att. A, §§ 4.05 & 10.10	✓	

50.	Network Dental Providers	Network Providers must provide: 1. Urgent care, including urgent specialty care, within 24 hours; and				Att. B-1, §8.1.3.1			Att. B-1, §8.1.4.2	Att. B-1, §8.1.4.2		
		2. Therapeutic and diagnostic care within 14 days. In addition, Main Dentists must make referrals for specialty care on a timely basis, based on the urgency of the Member's medical condition, but no later than 30 days.										
51.	Provider Network Requirements, Medicaid Agreements, TPI and NPI[21]	Network Acute Care Providers serving Medicaid Members must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in the Medicaid Program, and must have a Texas Provider Identification Number (TPIN). All Network Providers, both CHIP and Medicaid, must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D (for most Providers, the NPI must be in place by May 23, 2007.)	UMCC Att. B-1, §8.1.4 RSA Att. B1, §8.1.4	UMCC Att. B-1, §8.1.4	UMCC Att. B- 1, §8.1.4 S+P Exp. Att. B-1, §8.1.4 S+P MRSA Att. B-1, § 8.1.4	Att. B-1, §8.1.4	Att. B1, §8.1.4		Att. B-1, §8.1.5	Att. B-1, §8.1.5	✓	
52.	Medical Consent Requirements	Network Providers must comply with medical consent requirements in Texas Family Code §266.004, which require the Member's Medical Consenter to consent to the provision of medical care.				Att. B-1, §8.1.3						
53.	Medical Consent	Network Providers must notify the Medical Consenter about the provision of Emergency Services no later				Att. B-1,						

[21] Providers rendering FQHC services at an FQHC are not required to obtain an individual NPI/TPI at this time.

	Requirements	than the second Business Day after providing Emergency Services, as required by Texas Family Code §266.009.				§8.1.3						
54.	Member Communications	The MCO is prohibited from imposing restrictions upon the Network Provider's free communication with a Member about the Member's medical conditions, treatment options, MCO referral policies, and other MCO policies, including financial incentives or arrangements and all managed care plans with whom the Network Provider contracts.	ü	UMCC Att. B-1, §8.2.5	UMCC Att. B-1, §8.2.5 S+P Exp. Att. B-1, §8.1.26 S+P MRSA Att. B-1, §8.1.28	Att. B-1, §8.1.32	Att. B1, §8.1.28	DDMMP §5.1.10.1	Att. B-1, §8.2.4	ü	✓	

54.1	Member Protections	Network Providers must inform the MCO of any reports of abuse, neglect, or exploitation made regarding a member. This includes provider self- reports and reports made by others that the provider becomes aware of.			UMCC Att. A, Article 2, Definition s; Att. B- 1, §8.1.4.6, §8.3.12 S+P Exp. Att. A, Article 2,	Att. A, Article 2, Definitions; Att. B- 1, §8.1.4.4.2	Att. A, Article 2, Definitions; Att. B- 1, §8.1.4.4	DDMMP §1.2, §140, §2.9.1.1.13.8 , §5.1.14				
					Definition s; Att. B- 1. §8.1.4.6, §8.1.52 S+P MRSA Att. A, Article 2, Definition s; Att. B- 1. §8.1.4.6, §8.1.53							
55.	Payment for Services	The Network Provider is prohibited from billing or collecting any amount from a Medicaid Member for [*for health care MCOs, insert the term "health care services" here, for dental MCOs, insert the term "dental services" here, for PBMs, insert the term "pharmacy services" here*] provided pursuant to this Network Provider contract. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service.		UMCC Att.B-1§ 8.1.23	UMCC Att. B-1§ 8.1.23 S+P Exp. Att. A, §10.10 S+P MRSA Att. A, § 10.10	Att. A, §10.09	Att. A. §10.09	DDMMP §C.3.1	Att. A, §10.10(a)			
56.	Payment for Services	The Network Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to the Network Provider contract.	UMCC Att. A, §4.05 Att. B-1, §8.1.23 RSA Att. A, §§4.05 & 10.12	UMCC Att. A, §4.05 Att. B-1, §8.1.23	UMCC Att. A, §4.05 Att. B-1, §8.1.23 S+P Exp. Att. A, §§4.05 & 10.10 S+P MRSA Att. A, §§ 4.05 & 10.10	Att. A, §§4.06 & 10.09	Att. A, §§4.05 & 10.09	DDMMP §5.3.5	Att. A, §§4.05 & 10.10	Att. A, §§4.05 & 10.10	✓	

57.	Primary Care Physicians (PCPs)	PCPs must be accessible to Members 24 hours per day, 7 days per week.	UMCC Att. B-1, §8.1.4 RSA Att. B-1, §8.1.3[22]	UMCC Att. B-1, §8.1.4	UMCC Att. B- 1, §8.1.4 S+P Exp. Att. B-1, §8.1.4 S+P MRSA	Att. B-1, §8.1.4.2	Att. B-1, §8.1.4.10.1	DDMMP §2.8.1.1				
					Att. B-1, § 8.1.4							
58.	Primary Care Physicians (PCPs)	PCPs must provide preventative care: 1. to children under age 21 in accordance with AAP recommendations for CHIP Members and CHIP Perinatal Newborns, and the THSteps periodicity schedule published in the THSteps Manual for Medicaid Members; and 2. to adults in accordance with the U.S. Preventative Task Force requirements.	UMCC Att. B-1, §8.1.4.2 RSA Att. B-1, § 8.1.3.1[23]	UMCC Att. B-1, §8.1.4.2	UMCC Att. B-1, §8.1.4.2 S+P Exp. Att. B-1, §8.1.4.2 S+P MRSA Att. B-1, § 8.1.4.2	Att. B-1, §8.1.4.2	Att. B-1, §8.1.4.10.1					
59.	Primary Care Physicians (PCPs)	A PCP must: 1. Assess the medical needs and behavioral health needs of Members for referral to specialty care providers and provide referrals as needed; 2. Coordinate Members' care with specialty care providers after referral; and 3. Serve as a Medical Home to Members.	UMCC Att. A, Article 2,"PCP" Definition; Att. B-1, §8.1.4.2 RSA Att. A, Article 2,"PCP" Definition;	UMCC Att. A, Article 2,"PCP" Definition ; Att. B-1, §8.1.4.2	UMCC Att. A, Article 2,"PCP" Definition ; Att. B-1, §8.1.4.2 S+P Exp. Att. A, Article	Att. A, Article 2,"PCP" Definition; Att. B- 1, §8.1.4.2	Att. A, Article 2, "PCP" Definition; B-1, §8.1.4.10.1	DDMMP §§2.7.1.12.5 and C.6.3				
			Att. B-1, §8.1.4.2[24]		2,"PCP" Definition ; Att. B-1, §8.1.4.2 S+P MRSA Att. A, Article 2,"PCP" Definition ; Att. B-1, § 8.1.4							

60.	Provider Responsibilities	At the request of HHSC for DFPS, Providers must testify in court as needed for child protection litigation.				Att. B-1, §8.1.11						
61.	Professional Conduct	While performing the services described in the Network Provider contract, the Network Provider agrees to: 1. comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and 2. otherwise conduct themselves in a businesslike	UMCC Att. A, §4.07 RSA Att. A, §4.07	UMCC Att. A, §4.07	UMCC Att. A, §4.07 S+P Exp. Att. A, §4.07 S+P MRSA	Att. A, §4.08	Att. A, §4.07	DDMMP §2.7.3	Att. A, §4.07	Att. A, §4.07	✓	

[24] This requirement applies to a PCP who provides services to CHIP Perinate Newborns. The PCP requirements do not apply to CHIP Perinates.

		and professional manner.			Att. A, § 4.07							
62.	Quality Assessment and Performance and Improvement (QAPI)	Network Provider agrees to comply with the MCO's QAPI Program requirements.	UMCC Att. B-1, §8.1.7 RSA Att. B1, §8.1.7	UMCC Att. B-1, §8.1.7	UMCC Att. B-1, §8.1.7 S+P Exp. Att. B-1, §8.1.7 S+P MRSA Att. B-1, § 8.1.7	Att. B-1, §8.1.7	Att. B1, §8.1.7	DDMMP §§2.7.5.3.2 and 2.14	Att. B-1, §8.1.8	Att. B-1, § 8.1.8		
63.	Service Coordination	All Home and Community Support Services Agency (HCSSA) providers, adult day care providers, and residential care facility providers must notify the MCO if a Member experiences any of the following: · a significant change in the Member's physical or mental condition or environment; · hospitalization; · an emergency room visit; or · two or more missed appointments.			ü		ü	ü				
64.	Termination	The Network Provider contracts must contain the MCO's process for terminating Provider contracts.	UMCC Att. B-1,	UMCC Att. B-1,	UMCC Att. B-1,	Att. B-1,	Att. B-1,	DDMMP §§5.6 and	Att. B- 1,	Att. B-1, §8.1.5.10	✓	
		For CHIP HMOs and managed care organizations participating in the CHIP Perinatal Program, the process must comply with the Texas Insurance Code and TDI regulations.	§8.1.4.9 RSA Att. B-1, §8.1.4.9	§8.1.4.9	§8.1.4.9 S+P Exp. Att. B-1, §8.1.4.9	§8.1.4.1 0	§8.1.4.7	C.6.1.2	§8.1.5.1 0			

65.	Termination	The MCO must follow the procedures outlined in applicable state and federal law regarding termination of a provider contract, including requirements of Insurance Code §843.306 and 28 Tex. Admin. Code § 11.901.	UMCC Att. B-1, §8.1.4.9 RSA Att. B-1, §8.1.4.9	UMCC Att. B-1, §8.1.4.9	UMCC Att. B- 1, §8.1.4.9 S+P Exp. Att. B-1, §8.1.4.9 S+P MRSA Att. B-1, § 8.1.4.9	Att. B-1, §8.1.4.1 0	Att. B-1, §8.1.4.7	DDMMP §C.6.1.2	Att. B- 1, §8.1.5.1 0	Att. B-1, §8.1.5.10	✓	
66.	Termination for Gifts or Gratuities	Network Provider may not offer or give anything of value to an officer or employee of HHSC or the State of Texas in violation of state law. A “thing of value” means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law.	UMCC Att. A, §12.03(b)(5) RSA Att. A, §12.03(b)(5)	UMCC Att. A, §12.03(b)(5)	UMCC Att. A, §12.03(b)(5) S+P Exp. Att. A, §12.03(b)(5) S+P	Att. A, §12.03(b)(5)	Att. A, §12.03(b)(5)		Att. A, §12.03(b)(5)	Att. A, §12.03(b)(5)	✓	
		The MCO may terminate this Network Provider contract at any time for violation of this requirement.			MRSA Att. A, §12.03(b)(5)							

Attachment J: Primary Care Quality Incentive Program

Overview

Blue Cross and Blue Shield of Texas is committed to supporting providers in delivering high-quality, cost-effective care to our Medicaid STAR, CHIP, and STAR Kids members. The Primary Care Quality Incentive Program is designed to reward participating providers for achieving or exceeding specific quality and performance benchmarks. The program aligns with state and federal quality initiatives and aims to improve health outcomes, patient experience, and the overall value of healthcare services.

DEFINITIONS

- **Covered Person** means for the purpose of calculating any incentive payment due and payable under the PC QIP, any person enrolled in Medicaid Managed Care or the Children's Health Insurance Program and assigned to a BCBSTX Medicaid/CHIP plan and entitled to receive Covered Services pursuant to: (i) the terms of a Coverage Agreement, and (ii) the Provider Networks covered under the terms of this Agreement, at the time Health Care Service(s) are furnished.
- **Designated Member(s)** means those Covered Person(s) currently enrolled with Texas Health and Human Services Commission as a member of its Medicaid program and assigned to BCBSTX as their designated health plan that have been assigned to a Provider Care Provider to act as the Member's PCP under a BCBSTX Medicaid Plan. The assignment of Designated Members will be done through attribution based on historical utilization and communicated to Provider as outlined in this Agreement.
- **HHSC** means the Texas Health and Human Services Commission, which is the single state agency responsible for the Texas Medicaid program.
- **Healthcare Effectiveness Data and Information Set (HEDIS®)** means the method used to measure the clinical quality performance of certain dimensions of care and service of health plans.
- **Performance Period** means the calendar year period from January 1 to December 31
- **Primary Care Provider** means a Participating Provider who has been selected by the Covered Person or assigned by BCBSTX to be primarily responsible for treating and coordinating the Covered Person's health care needs. The Provider Manual contains a description of the types of Health Care Providers who are eligible to qualify as a PCP.
- **Quality Improvement Program** means the BCBSTX initiative intended to incentivize Provider physicians to provide quality care and maintain patient satisfaction standards in the delivery of Covered Services to eligible Designated Members.
- **Qualifying Measure(s)** means the applicable measures of the QIP used to track the performance of the QIP against established goals.
- **Social Determinants of Health** refer to the non-medical factors that influence health outcomes.

Providers must be in good standing with BCBSTX and comply with all program requirements to participate. Should provider elect to not participate in the PC QIP, they must provide notice as required under the terms of their participation agreement(s).

Eligibility and Membership Assignment. BCBSTX shall leverage a combination of member election and a historical claims-based attribution methodology to assign Designated Members to Provider for the terms covered under this Attachment.

- BCBSTX shall distribute membership reports to the Provider on an ongoing basis. The membership report shall be for all Designated Members, who have been assigned to Provider by BCBSTX. BCBSTX may modify membership report to account for changes in member PCP assignment. At the sole discretion of BCBSTX, the distribution of the membership report shall be contingent upon the successful execution of a Confidential Data Release Agreement between Provider and BCBSTX.

- BCBSTX shall have sole determination to define assignment processes and methodologies for the terms covered under this Attachment. Upon written request, BCBSTX shall furnish a summary of assignment processes and methodologies to Provider.

General Provisions. Provider acknowledges and agrees that all payments are conditioned upon the following:

- All information, including diagnoses, treatment plans, and follow up care, shall be recorded in Provider's medical record;
- All information recorded in the medical record shall be complete, accurate, and truthful; and
- BCBSTX may collect, evaluate, and review Provider medical records in connection with payment pursuant to the PC QIP, in accordance with the medical records provisions of the Provider's participation agreement(s).
- Provider agrees to submit all documentation requested by BCBSTX to support any claims for payment and Encounters under this Attachment within fifteen (15) business days of such request for documentation.
- Provider agrees to screen Designated Members for Social Determinants of Health gaps and needs. Provider agrees to do so using a standard validated instrument or other means widely accepted by the clinical and research community.
- Provider agrees to supply BCBSTX with a supplemental data file, upon request, to support the collection of supplemental data. Monthly file must be formatted in accordance with BCBS specifications which will be provided upon request.
- In the event of a termination, Provider shall make payment to BCBS for recovery of any overpayments made prior to such termination taking effect. BCBSTX shall make any underpayments due to the Provider prior to such termination taking effect.
- Provider will not directly or indirectly limit, inhibit, discontinue, or refuse to furnish, recommend, or make referrals for Medically Necessary Health Care Services to Designated Members for any reason, including but not limited to, any financial incentive tied to the achievement of the compensation benchmarks under this Attachment.

QIP COMPENSATION

QIP Payments. The QIP will be established by BCBSTX on an annual basis.

- **Qualifying Measures.** The applicable Qualifying Measures as outlined in the table below shall establish measurement criteria, pass thresholds, and payment amounts. The QIP Qualifying Measures may be modified by BCBSTX upon thirty (30) days' advanced written notice to Provider.
- **QIP Reimbursement & Payment.** QIP reconciliations shall occur no more than seven (7) months after the close of the applicable Performance Period and earned QIP payments shall be made no more than eleven (11) months after the close of the Performance Period.

EXHIBIT 1: Clinical Measures and Performance Measures

QIP QUALIFYING MEASURES

For completions occurring after Provider has attained a Pass Threshold for a particular measure, payments to Provider shall be made on a per completion basis. For the avoidance of doubt, full measure technical specifications are defined by the National Committee for Quality Assurance. Should a Designated Member complete the measure criteria during a Performance Period in which that individual has been attributed to more than one Provider, the Provider to whom the Designated Member is attributed to at the end of the Performance Period will be credited with the measure.

Measures and Measure Criteria	Pass Threshold	Payment Amount and Payment Criteria
WCV - Well-Child Visits 3-11*- Children 3-11 years of age who received one or more well-child visits with a primary care practitioner during the measurement year.	**0%**	BCBSTX shall pay $5 for each completion above the Pass Threshold
WCV - Well-Child Visits 12-17*- Children 12-17 years of age who received one or more well-child visits with a primary care practitioner during the measurement year.	**0%**	BCBSTX shall pay $5 for each completion above the Pass Threshold
W30 - Well-Child Visits in the First 30 Months of Life (0-15 months) *- Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life.	**0%**	BCBSTX shall pay $5 for each completion above the Pass Threshold
W30 - Well-Child Visits in the First 30 Months of Life (16-30 months) * - Assesses children who turned 30 months old during the measurement year and had at least 2 well-child visits with a primary care physician during their first 15 months of life.	**0%**	BCBSTX shall pay $5 for each completion above the Pass Threshold
Immunizations for Adolescents (Combo 2) - Assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.	**0%**	BCBSTX shall pay $12.50 for each completion above the Pass Threshold
CIS - Childhood Immunization Status (Combo 10)- Children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	**0%**	BCBSTX shall pay $12.50 for each completion above the Pass Threshold
WCC - Weight Assessment and Counseling Measures*- Children and adolescents 3-17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence of: **Body Mass Index percentile documentation**.	**0%**	BCBSTX shall pay $2.50 for each completion above the Pass Threshold
WCC - Weight Assessment and Counseling Measures*- Children and adolescents 3-17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence of: **Counseling for nutrition.**	**0%**	BCBSTX shall pay $2.50 for each completion above the Pass Threshold
WCC - Weight Assessment and Counseling Measures*- Children and adolescents 3-17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence **Counseling for Physical Activity**	**0%**	BCBSTX shall pay $2.50 for each completion above the Pass Threshold

Measures and Measure Criteria	Pass Threshold	Payment Amount and Payment Criteria
Follow-Up Care for Children Prescribed ADHD Medication (ADD) – Initiation Phase - Children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.	**0%**	BCBSTX shall pay $4 for each completion above the Pass Threshold
CCS - Cervical Cancer Screening - Women who met any of the following criteria: **Women 21–64 years of age** who had cervical cytology performed within the last 3 years. **Women 30–64 years of age** who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. **Women 30–64 years of age** who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.	**0%**	BCBSTX shall pay $12.50 for each completion above the Pass Threshold
GSD- Percentage of members 18-75 with diabetes (Type 1 and 2) whose hemoglobin A1c (HbA1c) or glucose management indicator (GMI) was <8.0%. Adequate control	**0%**	BCBSTX shall pay $12.50 for each completion above the Pass Threshold
BCS – Breast Cancer Screening -The percentage of women 40-74 years of age who had a mammogram to screen for breast cancer.	**0%**	BCBSTX shall pay $5 for each completion above the Pass Threshold
PPC- Prenatal and Postpartum Care- Prenatal Care- Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	**0%**	BCBSTX shall pay $12.50 for each completion above the Pass Threshold
PPC- Prenatal and Postpartum Care- Postpartum Care- Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	**0%**	BCBSTX shall pay $12.50 for each completion above the Pass Threshold

Disclosures

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX.

Davis Vision is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide vision benefits administration for members with coverage through BCBSTX.

DentaQuest is an independent company that provides dental benefits for Blue Cross and Blue Shield of Texas plans.

ModivCare is an independent company that has contracted with Blue Cross and Blue Shield of Texas to provide transportation services for members with coverage through BCBSTX.

Prime Therapeutics LLC is a separate company contracted by Blue Cross and Blue Shield of Texas to provide pharmacy solutions. BCBSTX as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

Walgreens Mail Service is contracted to provide mail pharmacy services to members of Blue Cross and Blue Shield of Texas.

BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

Blue365 is a discount program only for Blue Cross and Blue Shield of Texas members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Members should check their benefit booklet or call the Customer Service number on the back of their ID card for specific benefit facts. Use of Blue365 does not change monthly payments, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors that take part in this program. BCBSTX does not guarantee or make any claims or recommendations about the program's services or products. Members should consult their doctor before using these services and products. BCBSTX reserves the right to stop or change this program at any time without notice.

Hearing services are provided by Start Hearing, Beltone™, HearUSA and TruHearing®. Vision services are provided by ContactsDirect®, Croakies, Davis Vision℠, EyeMed Vision Care, Glasses.com, Jonathan Paul Fitovers, and LasikPlus®.
The relationship between the Blue365 vendors and BCBSTX is that of independent contractors.