PRIMARY CARE PROVIDER (PCP) SCOPE OF RESPONSIBILITIES – STAR, CHIP AND CHIP PERINATE

The PCP’s scope of practice includes the development and oversight of the member’s treatment and care plan, which includes access to health care 24 hours a day, seven days a week.

Services should be provided without regard to race, religion, sex, color, national origin, age, or physical or behavioral health status, upon the written or verbal prescription order or refill from a prescribing provider. Blue Cross and Blue Shield of Texas (BCBSTX) members select a contracted primary care provider (PCP) as their main provider of health care services within the first 30 days of the effective date of enrollment. If, after 30 days of the effective date of enrollment, the member has not selected a PCP, BCBSTX assigns a PCP to the member.

BCBSTX furnishes each PCP with a current list of enrolled members assigned to the PCP and, from time to time, we provide each PCP with information about enrolled members’ potential medical needs so that PCPs can better provide and coordinate their care.

The PCP provides routine, preventive and urgent services. The PCP also provides information to the member or legal representative about the illness, the course of treatment and prospects for recovery in terms the member or representative can understand. PCP responsibilities include providing or arranging for:

- Routine and preventive health care services, including immunizations
- Emergency care services
- Hospital services
- Ancillary services
- Specialty referrals
- Interpreter services
- Coordination and continuity of care for members
- Case coordination and enhanced services for children with special health-care needs and children with disabilities
- PCPs also coordinate care with clinic services, such as therapeutic, rehabilitative or palliative services for outpatients.
- PCPs must cooperate with any court-ordered services.

Note: The screening provider is responsible for administration of immunizations and should not refer children to local health departments to receive immunizations.

PCPs can offer behavioral health services when:
- Clinically appropriate and within the scope of his or her practice
- The member’s current condition is not so severe, confounding or complex as to warrant a referral to a behavioral health provider
- The member is willing to be treated by the PCP
- The services rendered are within the scope of the benefit plan
SPECIALTY CARE PHYSICIAN AND OTHER PROFESSIONAL PROVIDER RESPONSIBILITIES

Specialist physicians or other professional providers, licensed with additional training and expertise in a specific field of medicine, supplement the care given by primary care providers (PCPs). Access to contracted network specialists is through the member’s PCP.

In limited cases, such as family planning and evaluation, diagnosis, treatment and follow-up of sexually transmitted diseases (STDs), the member can self-refer. In addition, members with disabling conditions, special health care needs, and chronic or complex conditions may request that their PCP be a specialist as long as that specialist agrees. Specialist physicians or other professional providers acting as a PCP must follow all responsibilities of a PCP.

PCPs refer members to plan-contracted network specialist physicians or other professional providers for conditions beyond the PCP’s scope of practice that are medically necessary. Specialists diagnose and treat conditions specific to their area of expertise. Specialist care is limited to plan benefits.

If the member’s condition requires urgent care, the specialist should see the member within 24 hours. For routine care, the specialist should see the member within two weeks.

Specialist physicians or other professional providers and facilities are responsible for ensuring the necessary prior authorization has been obtained prior to providing services.

Specialists must follow all provider responsibilities and Texas Health and Human Services Commission (HHSC) mandated provisions as outlined in the HHSC-mandated provisions section.

PHARMACY PROVIDER RESPONSIBILITIES

Texas Medicaid & Healthcare Participation Enrollment

BCBS TX will no longer pay for any prescriptions written by providers who are not enrolled with Texas Medicaid & Healthcare Participation (TMHP) starting October 16, 2017, for STAR members and January 1, 2018, for CHIP members. This includes refills and prescriptions filled out-of-state. To ensure your patients continue to receive their medications, please visit: http://www.tmhp.com/Pages/default.aspx
Pharmacy Providers Are Responsible for:
- Adhering to the Formulary and Preferred Drug List (PDL)
- Coordinating with the prescribing physician
- Ensuring members receive all medications for which they are eligible
- Coordination of benefits when a member also has other insurance benefits

Emergency Prescriptions
A pharmacist may use his or her clinical judgment to dispense a 72-hour emergency supply of a medication if prior authorization is not available within 24 hours through the Prime Point-of-Sale System.

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

STAR 1-855-457-0405
CHIP 1-855-457-0403

OUT-OF-NETWORK REFERRALS
BCBSTX recognizes that there may be instances when an out-of-network referral is justified. Case Management will work with the medical director and the primary care provider to find appropriate out-of-network providers when medical necessity for services has been determined. Out-of-network referrals will be authorized on a limited basis. Case Management may be contacted at 877-560-8055 for questions regarding referrals to out-of-network providers.

ACCESS TO NETWORK OPHTHALMOLOGIST AND THERAPEUTIC OPTOMETRIST
Members have the right to select a network ophthalmologist or therapeutic optometrist for eye care services other than surgery without a referral from their primary care provider (PCP).

UPDATING PROVIDER INFORMATION
Plan providers are required to inform both BCBSTX and Maximus, the Administrative Services Contractor for HHSC, of any changes to their address, telephone number, group affiliation, and other material facts.
TEXAS HEALTH STEPS PROGRAM

Texas Health Steps is the user-friendly name given to the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program. The program is one of the most comprehensive medical and dental screening, prevention and treatment programs for children of low-income families.

Texas Health Steps provides payment for periodic, comprehensive evaluations of a child’s health, development and nutritional status, as well as vision, dental and hearing services for STAR recipients from birth to age 20. The periodic medical evaluations are based on American Academy of Pediatrics (AAP) recommendations for preventive health care with modifications to meet federal or state regulations. BCBSTX provides medical screening visits following federally mandated Texas Health Step program guidelines:

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

For more information, refer to the Texas Medicaid Provider Procedures Manual.

Texas Health Steps primary care providers (PCPs) are an integral part of this program. PCPs will offer age-appropriate preventive care screening and testing during each medical checkup and during an acute illness episode, if appropriate. The Texas Medicaid Provider Procedures Manual provides a list of periodicity and screening requirements.
CHILDREN OF MIGRANT FARMWORKERS

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

OFFICE HOURS

To maintain continuity of care, the physician or other professional provider must be available 24 hours a day by telephone or have an on-call physician or other professional provider take calls. Office hours must be conspicuously posted and members must be informed about the provider’s availability at each site. Please review the Medical Appointment Standards in the Access to Care chapter of this manual.

AFTER-HOURS SERVICES

Plan members have access to quality, comprehensive health care services 24 hours a day/seven day a week. Members can call their primary care provider (PCP) with a request for medical assessment after PCP normal office hours.

The PCP must have an after-hours system in place to help ensure that members can reach their PCP or an on-call physician with medical concerns or questions. Answering service or after-hours personnel must forward member calls directly to the PCP or on-call physician, or instruct members that the provider will contact the member within 30 minutes of the call.

The answering service or after-hours personnel must ask members if the call is an emergency. In the event of an emergency, they must immediately direct members to dial 911 or to proceed directly to the nearest hospital emergency room.

If staff or an answering service is not immediately available, an answering machine may be used but is required to instruct members with emergency health care needs to call 911 or go directly to the nearest hospital emergency department. Further answering machine instructions are required to direct members to an alternative contact number so the member can reach the PCP or an on-call provider with medical concerns or questions. The answering machine must also provide instructions in both English and Spanish.

BCBSTX prefers that the PCP use a plan-contracted, in-network physician and/or other professional providers for on-call services. When that is not possible, the PCP must use best efforts to help ensure that covering/on-call physicians who are not contracted with BCBSTX abide by the terms of the BCBSTX provider contract.

BCBSTX monitors PCP compliance with after-hours access standards on a regular basis. Failure to comply with after-hours access standards may result in corrective action.
Members can call the 24-Hour Nurse Advice Line to speak to a registered nurse. Nurses provide health information regarding illness and options for accessing care, including emergency services, if appropriate.

24 Hour Nurse Advice Line: 844-971-8906
TTY: 711

Non-English speaking members who call their PCP after hours can expect to receive language appropriate messages with appropriate care instructions. These instructions direct the member to dial 911 or to proceed directly to the nearest hospital emergency room in the event of an emergency. In a non-emergency situation, they will receive instructions on how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone interpreter for the member. All calls answered by an answering service must be returned.

**PHYSICIAN AND OTHER PROFESSIONAL PROVIDER CONTRACT TERMINATION**

A terminated physician or other professional provider who is actively treating members must continue to treat members until the provider’s date of termination. That date is the 90-day period following written notice of termination, or time lines determined by the medical group contract.

Once we receive a physician’s or professional provider’s notice to terminate a contract, we notify members impacted by the termination. BCBSTX sends a letter to inform the affected members of:

- The impending termination of their physician or other professional provider
- Their right to request continued access to care
- The Customer Service telephone number to make PCP changes or forward referrals to Case Management for continued access to care consideration

If the PCP’s contract is ending, we arrange for continuity of care by the terminating provider for members who need continued access to care. The PCP and members can call Customer Service for their specific plan (STAR or CHIP) or the TTY line for members with speech or hearing loss.

Customer Service - Providers: 877-560-8055
Customer Service - Members: 888-657-6061
TTY (for hearing and speech impaired) 711

Members under the care of specialists can also submit requests for continued access to care, including continued care after the transition period, by calling Customer Service. They should request a ‘care management referral for continuity of care’ using the Case Management Referral Form located on our website at http://www.bcbstx.com/provider/medicaid/forms.html in the section titled Forms.
CHAPTER 14

TERMINATION OF THE ANCILLARY PROVIDER/PATIENT RELATIONSHIP

Under certain circumstances, a provider may terminate the professional relationship with a member as provided for and in accordance with the provisions of this manual. Providers may not terminate the relationship between themselves and a member because of the member’s medical condition or the amount, types or cost of covered services required by the member.

Disenrollees

Case managers are responsible for assisting in the transition of a disenrolling member when the member requests that Case Management be transferred to another health plan. This must occur without disruption of any regimen of care that qualifies as a continuity of care condition. The case manager works with the member, involved providers and the case manager at the new health plan to help ensure an orderly transition.

REFERRALS

Primary care providers (PCPs) coordinate and make referrals to appropriate specialists, ancillary providers, or community services. Providers are expected to refer members to network facilities and contractors as appropriate. When this is not possible, providers should follow the appropriate process for requesting out-of-network referrals.

Members have the right to select an obstetrics/gynecologist (OB/GYN) doctor without referrals from their PCPs.

All PCPs:
- Are expected to refer members to specialists for specialty care, including Texas Health Steps, behavioral health care services, other services such as pharmacy and programs provided by the State of Texas, health education classes and community resource agencies when appropriate.
- Must coordinate with the Women, Infants, and Children (WIC) Program Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. (Also refer to the HHSC-Mandated Provisions in this section for WIC requirements.)
- Must coordinate with the local tuberculosis (TB) control program to help ensure that all members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT), if necessary.
- Must report to the Texas Department of State Health Services (DSHS) or the local TB control program any member who is noncompliant, drug resistant, or who is or may be posing a public health threat. (Also, see HHSC-Mandated Provisions for tuberculosis requirements.)
- Are responsible for screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.
Providers must document referrals, including referrals to ‘carved-out services.’ Carved-out services include those that a BCBSTX member is entitled to that are covered by the State of Texas, but not covered under the BCBSTX benefit agreement.

- Must inform members of the costs for non-covered services prior to rendering such services and must obtain a signed Member Private Pay Form Agreement from the member.
- Are expected to help members schedule appointments with other providers and health education programs.
- Are expected to track and document appointments, clinical findings, treatment plans and care received by members referred to specialists, other health care providers or agencies regarding continuity of care.

MEDICAL RECORDS STANDARDS

Providers are required to maintain medical records in a manner that permits effective and confidential member care and quality review. BCBSTX performs medical record reviews upon signing of a contract and at a minimum, every three years thereafter to help ensure that providers are in compliance with these standards.

Medical records are stored and retrieved in a manner that protects patient information according to the Confidentiality of Medical Information Act. The Act prohibits health care providers from disclosing any individually identifiable information regarding a patient’s medical history, behavioral and physical condition, or treatment without the patient’s or the patient’s legal representative’s consent or specific legal authority.

Records required through a legal instrument may be released without patient or patient representative consent. Physicians and their professional providers must be familiar with the security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and be in compliance.

Providers may not charge Medicaid members for their medical records when requested.

Security

The medical record must be secure and inaccessible to unauthorized personnel in order to prevent loss, tampering, disclosure of information and alteration or destruction of the record. Information must be accessible only to authorized personnel within the provider’s office, BCBSTX, the Texas Health and Human Services Commission (HHSC) or to persons authorized through a legal instrument. Records must be made available to us for purposes of quality review, Healthcare Effectiveness Data and Information Sets (HEDIS) and other studies.

Storage and Maintenance

Active medical records should be stored in one central medical record area and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, and that permits effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.
Availability of Medical Records

The medical records system must allow for prompt retrieval of each record when the patient comes in for an encounter. Physicians and other professional providers are required to maintain comprehensive and accurate medical records to ensure quality and continuity of care. Each provider must maintain and make available medical records in accordance with the applicable provider agreement.

Medical Record Documentation Standards

Every medical record is, at a minimum, to include:

• The patient’s name or identification (ID) number on each page in the record
• Personal biographical data including home address, employer, emergency contact name and telephone number, home and work telephone numbers, and marital status
• All entries dated with month, day and year
• All entries containing the author’s identification (for example, handwritten signature, unique electronic identifier or initials) and title
• Identification of all physicians or other professional providers participating in the member’s care and information on services furnished by these providers
• A problem list, including significant illnesses and medical and psychological conditions
• Presenting complaints, diagnoses, and treatment plans, including the services to be delivered
• Physical findings relevant to the visit including vital signs, normal and abnormal findings, and appropriate subjective and objective information
• Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions)
• Information on advance directives
• Past medical history, including serious accidents, operations, illnesses and, for patients 14 years old and older, substance abuse. For children and adolescents, past medical history relates to prenatal care, birth, operations and childhood illnesses.
• Physical examinations, treatment necessary and possible risk factors for the member relevant to the particular treatment
• Prescribed medications, including dosages and dates of initial or refill prescriptions
• For patients 14 years and older, appropriate notation concerning the use of cigarettes, alcohol and substance abuse (including anticipatory guidance and health education)
• Information on the individuals to be instructed in assisting the patient
• Legible medical records that are dated and signed by the physician, physician assistant, nurse practitioner or nurse midwife providing patient care
• An up-to-date immunization record for children or an appropriate history for adult
• Documentation attempts to provide immunizations. If the member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the member or guardian of the member shall be documented in the member’s medical record.
• Evidence of preventive screening and services in accordance with BCBSTX’s preventive health practice guidelines
• Documentation of referrals, consultations, test results and inpatient records
• Include notations of information about the patient’s test results
• Notations of patient appointment cancellations or ‘no shows’ and the attempts to contact the patient to reschedule
• No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure
• Documentation on whether an interpreter was used, and, if so, that the interpreter also was used in follow-up

ADVANCE DIRECTIVES
Recognizing a person’s right to dignity and privacy, our members have the right to execute a living will to identify their wishes concerning health care services should they become incapacitated. Physicians and/or providers may be requested to assist members in procuring and completing necessary forms. Refer to BCBSTX’s website at http://bcbstx.com/provider/medicaid/index.html for more information.

Also see www.dads.com for more information.

COORDINATION WITH THE TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
Physicians and other professional providers must cooperate and coordinate with the Texas Department of Family and Protective Services (DFPS) and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS.

Physicians and other professional providers participate, whenever possible, in the preparation of the medical and behavioral care plan in conjunction with DFPS. They also continue to provide all covered services to a member receiving services from or in the protective custody of DFPS, until the member is disenrolled from us or placed into foster care.

Physicians and other professional providers are responsible for providing medical records to DFPS, recognizing and referring suspected cases of abuse or neglect within 48 hours, using the appropriate referral process to DFPS, and scheduling medical and behavioral health appointments within 14 days, unless required earlier by DFPS.