MEDICAL APPOINTMENT STANDARDS

Standards for scheduling appointments follow guidelines published by the American College of Obstetricians and Gynecologists (ACOG); the National Committee for Quality Assurance (NCQA); as well as the Texas Health and Human Services Commission (HHSC).

Primary care providers (PCPs) and specialists must meet standards for appointment scheduling to help ensure that members have timely access to medical care and services. BCBSTX monitors provider compliance with appointment access standards on a regular basis. Failure to comply with outlined standards may result in corrective action.

PCPs and specialists must make appointments for members from the time of request as follows:

**General Appointment Scheduling**

- Emergency examinations: immediate access during office hours
- Urgent examinations: within 24 hours of request
- Non-urgent, routine, primary care examinations: within 14 days of request
- Specialty care examinations, within 30 days of request
- Outpatient behavioral health examinations, within 14 days of request; Routine Behavioral Visits, within 10 days of request; outpatient treatment, post-psychiatric inpatient care, within seven days from date of discharge
Services for Members Under the Age of 21 Years

- Well-child check with assigned PCP:
  - Within 14 days of enrollment for newborns
  - Within 90 days of enrollment for other eligible child members
- Preventive care visits: according to the American Academy of Pediatrics (AAP) periodicity schedule found within the Preventive Health Guidelines (PHG)

Prenatal and Postpartum Visits

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

Missed Appointment Tracking

When members miss appointments, providers must document the missed appointment in the member’s medical record. Providers must make at least three attempts to contact the member to determine the reason for the missed appointment. The medical record must reflect the reason for any delays in performing an examination, including any refusals by the member.

AFTER-HOURS SERVICES

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

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

The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, they must immediately direct the member to dial 9-1-1 or to proceed directly to the nearest hospital emergency room.

If staff or an answering service is not immediately available, an answering machine may be used but is required to instruct members with emergency health care needs to call 9-1-1 or go directly to the nearest hospital emergency department. Further answering machine instructions are required to direct members to an alternative contact number so the member can reach the PCP or an on-call provider with medical concerns or questions. The answering machine must also provide instructions in both English and Spanish.
BCBSTX monitors providers’ appointment availability and afterhours access to ensure members receive timely access to quality care and to ensure compliance to HHSC standards. As a provider in network, you may receive an annual request to demonstrate compliance to this contract standard. Providers who do not meet the standards will receive written notification of the non-compliance from the BCBSTX medical director, will be resurveyed and, if continued to be non-compliant, corrective action may be taken to address the issue(s).

**Unacceptable After-Hours Coverage**

BCBSTX outlines unacceptable after-hours coverage as:

- The office telephone is only answered during office hours
- The office telephone is answered after hours with a recording instructing patients to leave a message
- The office telephone is answered after hours with a recording that directs patients to the emergency room for any services needed
- Returning after-hours calls over 30 minutes after the call is received

BCBSTX prefers that the PCP use plan-contracted, in-network physicians or other professional providers for on-call services. When that is not possible, the PCP must use best efforts to help ensure that out-of-network on-call physicians or other professional providers abide by the terms of the BCBSTX Provider contract.

BCBSTX monitors PCP compliance with after-hours access standards on a regular basis. Failure to comply with after-hours access standards may result in corrective action.

Members can also call the 24-Hour Nurse Hotline to speak to a registered nurse. Nurses provide health information regarding illness and options for accessing care, including emergency services, if appropriate.

Non-English speaking members who call their PCP after hours can expect to receive language appropriate messages with appropriate care instructions. These instructions direct the member to dial 9-1-1 or to proceed directly to the nearest hospital emergency room in the event of an emergency. In a non-emergency situation, they will receive instructions on how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone interpreter for the member. All calls answered by an answering service must be returned.

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

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

- They are newly enrolled.
- They move out of the service area.
- Services are not available within the network.
- The physician’s or other professional provider’s contract terminates.
- They are disenrolling to another health plan.

A qualifying condition is a medical condition that may qualify a member for continued access to care/continuity of care, including, but not limited to:

- An acute condition (for example, cancer).
- A serious chronic condition (for example, hemophilia).
- Pregnancy, with 12 weeks or less remaining before the expected delivery date, through immediate postpartum care.
- A terminal illness.
- A degenerative and disabling condition, (a condition or disease caused by a congenital or acquired injury or illness that requires either a specialized rehabilitation program or a high level of care, service, resources or continued coordination of care in the community).

BCBSTX will help ensure that each member has access to a second opinion regarding the use of any medically necessary covered service. The member will be allowed access to a second opinion from a network physician or other professional provider, or out-of-network provider if a network physician or other professional provider is not available, at no cost to the member.

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

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

BCBSTX physicians or other professional providers, hospitals, ancillary and behavioral health providers help ensure continuity and coordination of care through collaboration. Primary care providers, other professional providers and ancillary providers must maintain accurate and timely documentation in the member’s medical record. This documentation must include, and is not limited to:

- Referrals to specialists
- Authorizations
- Consultations
- Treatment plans
- Other information to help ensure continuity of the member’s medical care

All physicians and other professional providers share responsibility in communicating clinical findings, treatment plans, prognosis and the member’s psychosocial condition to help ensure coordination of the member’s care.

Service coordination nurses review member physician or other professional provider requests for continuity of care and facilitate continuation with the current provider by obtaining authorizations, if needed, and until a short-term regimen of care is completed or the member transitions to a new practitioner.

Only a BCBSTX physician can make adverse determination decisions, which are sent in writing and mailed to the member and physician within three business days of the decision. Members and physicians or other professional providers can appeal the decision by following the procedures in the Complaints and Appeals section of this manual.

Reasons for continuity of care denials include, but are not limited to, the following:

- Not a qualifying condition
- Treating physician or other professional provider is not currently contracted with our plan
- Request is for change of primary care provider (PCP) only and not for continued access to care
- Member is ineligible for coverage
- Course of treatment is complete
- Services rendered are covered under a global fee
- Requested services are not a covered benefit

BCBSTX does not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provider coverage to any BCBSTX member.
Emergency and Non-Emergency Ambulance Transportation

BCBSTX covers emergency transportation without prior authorization. When a member’s condition is life threatening, and requires use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest appropriate facility, we will provide emergency transportation by ambulance.

Examples of conditions considered for emergency transport include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving cardiopulmonary resuscitation (CPR) treatment during transport, acute or severe injuries from auto accidents, and extensive burns.

Emergency transportation is also available for facility-to-facility transfers when the required emergency treatment is not available at the first facility. Non-emergent ambulance transportation will require prior authorization.

Medicaid Non-Emergency Transportation

The Texas Medical Transportation Program (MTP) provides non-emergency transportation (NEMT) to members who need help getting to medical appointments, dental appointments and the pharmacy, providing that the member:

- Has a current Medicaid identification (ID) card or Medicaid Verification Letter?
- Has no other means of transportation?
- Receives prior authorization from MTP, if required.

To obtain transportation, or reimbursement for gas members should call MTP at 1-877-633-8747 (1-877-MED-TRIP) between the hours of 8 a.m. and 5 p.m., Monday through Friday (except on federal holidays). Upon calling to schedule transportation, Members will be asked to provide the following information:

- Member’s nine-digit Medicaid number
- Medical physician or other professional’s name, address and phone number
- Date and time of the medical appointment, as well as service being provided

If STAR Kids BCBSTX members are not able to get transportation services through MTP they may access the BCBSTX VAS NEMT services through Medical Transportation Management (MTM). For more information on our VAS NEMT services through MTM see the VAS information in Chapter 4 of this manual. Call Customer Service for more information of routine and special transportation available to Members either through MTP or our VAS NEMT program.

PROVISION OF NON-COVERED SERVICES

Providers must inform members of the costs for non-covered services prior to rendering such services. They must also obtain a signed Acknowledgement Statement from the member stating that the member has been informed of these costs. A sample Member Acknowledgement Statement form is available on our website at http://bcbstx.com/provider/medicaid/index.html.
NEW ENROLLEES — CONTINUITY OF CARE

BCBSTX will help ensure that the care of newly enrolled members is not disrupted or interrupted. BCBSTX will take special care to provide continuity in the care of newly enrolled members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted. Upon notification from a Member or Provider of the existence of a prior authorization, BCBSTX will ensure that members receiving services through a prior authorization from either another MCO or FFS receive continued authorization of those services, including community based services.

BCBSTX will pay a member’s existing out-of-network provider for medically necessary covered services until the regimen of care is completed. The member’s records, clinical information and care can then be transferred to a network physician or other professional provider.

Payment to out-of-network physicians and other professional providers is made within the same time period required for those within the network. In addition, we will comply with out-of-network provider reimbursement rules as adopted by HHSC. However, we are not obligated to reimburse members’ existing out-of-network physicians or other professional providers for on-going care for:

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

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

If a member wants to change her OB/GYN doctor to one who is in the network, she must be allowed to do so if the physician or other professional provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy. BCBSTX’s obligation to reimburse the member’s existing out-of-network physician or other professional provider for services provided to a member past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care and follow-up checkup within the first six weeks of delivery.

MEMBERS WHO MOVE OUT OF THE SERVICE AREA

If a member moves out of the service area, BCBSTX will continue to provide services and pay out-of-network physicians and other professional providers for a specific period of time, which is the time left for which capitation on the member has been paid. That means that if a member’s capitation covers the month of June, BCBSTX will provide and pay for medically necessary covered services through the end of that month.
SERVICES NOT AVAILABLE WITHIN NETWORK

BCBSTX will provide members with timely and adequate access to out-of-network services for as long as those services are necessary and not available within the network. However, BCBSTX will not be obligated to provide members with access to out-of-network services if such services become available from a network physician or other professional provider.

When a physician or other professional provider refers a member to another provider for additional treatment or services, the referring provider must forward the National Provider Identifier (NPI), with the notification of the member’s eligibility. The member should be informed of whether the provider he/she is being referred to is an in- or out-of-network provider.

EMERGENCY DENTAL SERVICES

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

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

NON-EMERGENCY DENTAL SERVICES

Medicaid Non-Emergency Dental Services

BCBSTX is not responsible for paying for routine dental services provided to Medicaid members. These services are paid through Dental Managed Care Organizations. BCBSTX is responsible for paying for treatment and devices for craniofacial anomalies, and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for members age 6 months through 35 months. OEFV benefits includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.

• OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
• OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
• Documentation must include all components of the OEFV.
• Texas Health Steps providers must assist members with establishing a Main Dental Home and document member’s Main Dental Home choice in the member’s file.
• BCBSTX is responsible for treatment and devices for craniofacial anomalies.
ROLE OF A MAIN DENTAL HOME

Main Dental Home is the dental provider who supports an ongoing relationship with a member that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a member’s Main Dental Home begins no later than six months of age and includes referrals to dental specialists when appropriate. Provider types that can serve as Main Dental Home Providers are federally qualified health centers and individuals who are general dentists and pediatric dentists.

How to Help a Member Find Dental Care

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

If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can contact the Medicaid enrollment broker’s (Maximus) toll-free telephone number at 1-800-964-2777.

PROVIDER TRAINING AND COORDINATION OF SERVICES

BCBSTX will make training and coordination of services available to providers to help ensure that the needs of members with special access requirements are met. This includes, but is not limited to:

• General transportation (ambulance, wheelchair vans, etc.)
• Interpreters and translation services
• Member materials in print and other formats (digital, audio, Braille), written in plain language/appropriate grade level/culturally sensitive
• Communication strategies for successful interaction of physicians and physically/visually/speech/hearing impaired Members, as well as cultural sensitivity
• Physical access to provider offices, equipment and services

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