FirstCare STAR and CHIP

RESOURCE BOOK

Provider Workshop
9-26-2017

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STAR Covered Services

STAR Covered Services modified by Versions 2.1, 2.3, and 2.6

The following is a non-exhaustive, high-level listing of Acute Care Covered Services included under the Medicaid STAR Program.

STAR MCOs are responsible for providing a benefit package to Members that includes all Medically Necessary services covered under the traditional, fee-for-service Medicaid programs except for Non-capitated Services. Non-capitated Services are listed in Attachment B-1, **RFP Section 8.2.2.8**. Non-capitated services are not included in the STAR MCOs' Capitation Rates; however, STAR MCOs must coordinate care these Non-capitated Services so that Members have access to a full range of Medically Necessary Medicaid services, both capitated and non-capitated.

STAR MCOs may also elect to include Value-added Services in their benefit packages, if approved by HHSC (see UMCM Chapter 4.5 "Physical and Behavioral Health Value-Added Services Template").

STAR Program benefits are subject to the same benefit limits and exclusions that apply to the traditional, fee-for-service Medicaid programs, with the following three (3) exceptions. Adult STAR Members are provided with three (3) enhanced benefits compared to the traditional, fee-for-service Medicaid coverage:

1. waiver of the three (3) prescription per-month limit;
2. waiver of the 30-day spell-of-illness limitation; and
3. waiver of the $200,000 individual annual limit on inpatient services.

For a complete listing of the limitations and exclusions that apply to each Medicaid benefit category, STAR MCOs should refer to the current ***Texas Medicaid Provider Procedures Manual***, which can be accessed online at: http://www.tmhp.com.

The services listed in this Attachment are subject to modification based on changes in Federal and State laws, regulations, and policies.

STAR Covered Services include: modified by Versions 2.1, 2.9, 2.11, 2.13, 2.16, and 2.19

STAR Covered Services include Medically Necessary:

- Emergency and non-emergency ambulance services
- Audiology services, including hearing aids, for adults and children
- Behavioral Health Services, including:
  - Inpatient mental health services for Children (birth through age 20)
  - Acute inpatient mental health services for Adults
  - Outpatient mental health services
  - Psychiatry services
  - Mental Health Rehabilitative Services
  - Counseling services for adults (21 years of age and over)
  - Outpatient substance use disorder treatment services including:
    - Assessment
    - Detoxification services

        - Counseling treatment
        - Medication assisted therapy
    - Residential substance use disorder treatment services including:
        - Detoxification services
        - Substance use disorder treatment (including room and board)
- Birthing services provided by a physician and certified nurse midwife (CNM) in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency Services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
    - The MCO may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.
    - The MCO may provide substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting.
- Laboratory
- 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 checkups and Comprehensive Care Program (CCP) Services for children (birth through age 20) through the Texas Health Steps Program, including private duty nursing, Prescribed Pediatric Extended Care Center (PPECC) services, certified respiratory care practitioner services, and therapies (speech, occupational, physical)
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
- Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Drugs and biologicals provided in an inpatient setting
- Podiatry
- Prenatal care

- Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center
- Primary care services
- Preventive services including an annual adult well check for patients 21 years of age and over
- Radiology, imaging, and X-rays
- Specialty physician services
- Mental Health Targeted Case Management
- Mental Health Rehabilitative Services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)
- Telemedicine
- Telemonitoring, to the extent covered by Texas Government Code §531.01276
- Telehealth

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	September 1, 2011	Initial version of Attachment B-2.1, "CHIP Covered Services."
Revision	2.1	March 1, 2012	"Birthing Center Services" is added as a clarification item. "Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center" is added as a clarification item. Attachment B-2.1 is modified to clarify Drug Benefits for CHIP Perinate Members. CHIP Exclusions from Covered Services is modified to clarify that over the counter drugs, contraceptives, and medications prescribed for weight loss or gain are not a covered benefit. CHIP Exclusions from Covered Services for CHIP Perinates is modified to clarify that over the counter drugs contraceptives, and medications prescribed for weight loss or gain are not a covered benefit.
Revision	2.2	June 1, 2012	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.3	September 1, 2012	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.4	March 1, 2013	CHIP Exclusions from Covered Services is modified to add Coverage while traveling outside of the United States and U.S. Territories.
Revision	2.5	June 1, 2013	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.6	September 1, 2013	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.7	September 1, 2013	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.8	January 1, 2014	Inpatient General Acute and Inpatient Rehabilitation Hospital Services (CHIP Perinatal Coverage) is modified to clarify the eligibility thresholds.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Birthing Center Services (CHIP Perinatal Coverage) is modified to clarify the eligibility thresholds. Exclusions for CHIP Perinatal is modified to clarify the eligibility thresholds.
Revision	2.9	February 1, 2014	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.10	April 1, 2014	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.11	September 1, 2014	Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies is modified to add a limited set of disposable medical supplies when they are obtained from an authorized pharmacy provider. CHIP Perinatal Program Exclusions From Covered Services For CHIP Perinates is modified to add a limited set of disposable medical supplies when they are obtained from an authorized pharmacy provider. CHIP & CHIP Perinatal Program DME/Supplies is modified to add a limited set of disposable medical supplies when they are obtained from an authorized pharmacy provider.
Revision	2.12	October 1, 2014	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.13	March 1, 2015	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.14	May 1, 2015	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.15	June 1, 2015	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.16	September 1, 2015	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."
Revision	2.17	March 1, 2016	Contract amendment did not revise Attachment B-2.1, "CHIP Covered Services."

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	2.18	June 1, 2016	Contract amendment did not revise Attachment B-2.1, “CHIP Covered Services.”
Revision	2.19	September 1, 2016	Contract amendment did not revise Attachment B-2.1, “CHIP Covered Services.”
Revision	2.20	December 1, 2016	Contract amendment did not revise Attachment B-2.1, “CHIP Covered Services.”
Revision	2.21	February 1, 2017	Contract amendment did not revise Attachment B-2.1, “CHIP Covered Services.”
Revision	2.22	March 1, 2017	Contract amendment did not revise Attachment B-2.1, “CHIP Covered Services.”

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

CHIP Covered Services

Covered CHIP services must meet the CHIP definition of Medically Necessary Covered Services. There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays apply until a family reaches its specific cost-sharing maximum.

Covered CHIP Perinatal services must meet the definition of Medically Necessary Covered Services. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinatal Members. CHIP Perinate Newborns are eligible for 12-months continuous coverage, beginning with the month of enrollment as a CHIP Perinate.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)

Inpatient General Acute and Inpatient Rehabilitation Hospital Services
 	
Inpatient General Acute and Inpatient Rehabilitation Hospital Services modified by Version 2.8
	Services include, but are not limited to, the following:
	▪ 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
	▪ 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, etc.)
	▪ Oxygen services and inhalation therapy
	▪ Radiation and chemotherapy
	▪ Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care
	▪ In-network or out-of-network facility and 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.
	▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care
	▪ Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:
	  ▪ dilation and curettage (D&C) procedures;
	  ▪ appropriate provider-administered medications;
		For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit.
		For CHIP Perinates in families with income above the Medicaid eligibility threshold (Perinates who do not qualify for Medicaid once born), benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy.
		
		Services include:
		▪ Operating, recovery and other treatment rooms
		▪ Anesthesia and administration (facility technical component
		
		Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or 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) are a covered benefit. Inpatient services associated with miscarriage

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	▪ ultrasounds, and ▪ histological examination of tissue samples. ▪ Surgical implants ▪ Other artificial aids including surgical implants ▪ 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 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; or ▪ severe traumatic skeletal and/or congenital craniofacial deviations; or ▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	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.
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: ▪ 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.
Outpatient Hospital, 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 health care 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	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 health care 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) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)

	▪ 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 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; 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 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; or
	  ▪ severe traumatic skeletal and/or congenital craniofacial deviations; or
	▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
		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.
		
		(1) Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth.
		
		(2) Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or non-viable pregnancy.
		
		(3) Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis.
		
		(4) Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis 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

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
		client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. (5) Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.

Physician/Physician Extender Professional Services	Services include, but are not limited to, the following:
	▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations)
	▪ 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 CRNA
	  ▪ Second surgical opinions
	  ▪ Same-day surgery performed in a Hospital without an over-night stay
	  ▪ Invasive diagnostic procedures such as endoscopic examinations
	▪ Hospital-based Physician services (including Physician-performed technical and interpretive components)
	▪ 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.
		Services include, but are not limited to the following:
		▪ Medically necessary physician services are limited to prenatal and postpartum 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 Physician (other than surgeon) or CRNA
		  ▪ Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.
		  ▪ Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.)
		▪ Hospital-based Physician services (including Physician performed technical and interpretive components)

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	▪ Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician 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. ▪ Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. ▪ 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; or ▪ severe traumatic skeletal and/or congenital craniofacial deviations; or ▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	▪ Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation. ▪ Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT. ▪ Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional 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.
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 (ante partum) care visits that include: (1) One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; (2) one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and (3) one (1) visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and two (2) 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

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
		maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: ▪ interim history (problems, marital status, fetal status); ▪ physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and ▪ laboratory tests (urinanalysis 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).
Birthing Center Services Birthing Center Services added by Version 2.1 and modified by Version 2.8	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) Limitation: Applies only to CHIP members.	Covers birthing services provided by a licensed birthing center. Limited to facility services related to labor with delivery. Applies only to CHIP Perinate Members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).
Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center Services Rendered by a CNM or physician in a licensed birthing center added by Version 2.1	CHIP Members: Covers prenatal services and birthing services rendered in a licensed birthing center. CHIP Perinate Newborn Members: Covers services rendered to a newborn immediately following delivery.	Covers prenatal services and birthing services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: (1) one (1) visit every four (4) weeks for the first 28 weeks or pregnancy; (2) one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and (3) one (1) visit per week from 36 weeks to delivery.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
		More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and two (2) 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 and is subject to retrospective review. Visits after the initial visit must include: ▪ interim history (problems, marital status, fetal status); ▪ physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and ▪ laboratory tests (urinanalysis 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).
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies modified by Version 2.11	$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	Not a covered benefit, with the exception of a limited set of disposable medical supplies, published at http://www.txvendordrug.com/formulary/limited-hhs.shtml and only when they are obtained from a CHIP-enrolled pharmacy provider.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	▪ 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. (See Attachment A)	
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.
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: ▪ Neuropsychological and psychological testing. ▪ When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination ▪ Does not require PCP referral	Not a covered benefit.
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services	Not a covered benefit.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	• Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development) ▪ When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination ▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services ▪ Does not require PCP referral	
Inpatient Substance Abuse Treatment Services	Services include, but are not limited to: ▪ Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs ▪ Does not require PCP referral	Not a covered benefit.
Outpatient Substance Abuse Treatment Services	Services include, but are not limited to, the following: ▪ Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. ▪ Intensive outpatient services ▪ Partial hospitalization ▪ Intensive outpatient services is defined as an organized non-residential service 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 ▪ Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training ▪ Does not require PCP referral	Not a covered benefit.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
Rehabilitation Services	Services include, but are not limited to, the following: ▪ Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: ▪ Physical, occupational and speech therapy ▪ Developmental assessment	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 (6) 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.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	MCO cannot require authorization 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 lay person definition of emergency health condition ▪ Hospital emergency department room and ancillary services and physician services 24 hours a day, seven (7) days a week, both by in-network and out-of-network providers ▪ Medical screening examination ▪ Stabilization services ▪ Access to DSHS designated Level 1 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.	MCO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. ▪ Stabilization services related to the labor with delivery of the covered unborn child. ▪ Emergency ground, air and water transportation for labor and threatened labor is a covered benefit ▪ Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
		Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Services include, but are not limited to, the following: ▪ Using up-to-date FDA guidelines, all non-experimental 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.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: ▪ One (1) examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization ▪ One (1) pair of non-prosthetic eyewear per 12-month period	Not a covered benefit.
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12-month period limit for a plan- approved program ▪ Health Plan defines plan-approved program. ▪ May be subject to formulary requirements.	Not a covered benefit.
Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination and community referral.	Covered benefit.
Drug Benefits Drug Benefits modified by Version 2.1	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting. Services must be medically necessary for the unborn child.
[Value-added services]	*See RFP Attachment B-2.1*	

CHIP Exclusions from Covered Services modified by Versions 2.1 and 2.4

CHIP EXCLUSIONS FROM COVERED SERVICES

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e., cannot be prescribed for family planning)
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and 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
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping

- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)

Exclusions from Covered Services for CHIP Perinates modified by Versions 2.1, 2.8, and 2.11

EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES

- For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies, with the exception of a limited set of disposable medical supplies, published at http://www.txvendordrug.com/formulary/limited-hhs.shtml, when they are obtained from an authorized pharmacy provider.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the labor with delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to labor or threatened labor, miscarriage or non-viable pregnancy, and/or delivery of the covered unborn child.

- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or post partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor with delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ

CHIP DME/ Supplies modified by Version 2.11

CHIP DME/SUPPLIES

Note: DME/SUPPLIES are not a covered benefit for CHIP Perinate Members (Unborn Child), with the exception of a limited set of disposable medical supplies, published at http://www.txvendordrug.com/formulary/limited-hhs.shtml, when they are obtained from an authorized pharmacy provider.

SUPPLIES	COVERED	EXCLUDED	COMMENTS / MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for treatment of craniofacial anomalies requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.

SUPPLIES	COVERED	EXCLUDED	COMMENTS / MEMBER CONTRACT PROVISIONS
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	

SUPPLIES	COVERED	EXCLUDED	COMMENTS / MEMBER CONTRACT PROVISIONS
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan

SUPPLIES	COVERED	EXCLUDED	COMMENTS / MEMBER CONTRACT PROVISIONS
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

HIPAA Guidance for Providers & Frequently Asked Questions (FAQs)

What Types of Direct Identifiers are considered Protected Health Information (PHI)?

1. Names;
2. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes;
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, and date of death;
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code.

Citation: 45 CFR 164.514 Other requirements relating to uses and disclosures of protected health information.

How are Confidentiality and Encryption Federally Defined?

1. *Confidentiality* means the property that data or information is not made available or disclosed to unauthorized persons or processes.
2. *Encryption* means the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key.

Citation: 45 CFR 164.304 Definitions.

Which Types of Safeguards must be Present in a Provider Office?

1. *Administrative safeguards* are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's or business associate's workforce in relation to the protection of that information.

2. *Physical safeguards* are physical measures, policies, and procedures to protect a covered entity's or business associate's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.
3. *Technical safeguards* means the technology and the policy and procedures for its use that protect electronic protected health information and control access to it.

Citation: 45 CFR 164.304 Definitions.

What are the General Rules under the Security Standards?

1. Ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity or business associate creates, receives, maintains, or transmits.
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information.
3. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under subpart E (Privacy of Individually Identifiable Health Information) of this part.
4. Ensure compliance with this subpart by its workforce.

Citation: 45 CFR 164.306 Security standards: General rules.

How is a Breach Federally Defined?

1. *Breach* means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E (Privacy of Individually Identifiable Health Information) of this part which compromises the security or privacy of the protected health information.

Citation: 45 CFR 164.402 Definitions.

is removed from prepayment review only when determined appropriate by the HHSC-OIG. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns is performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions up to and including exclusion and contract cancellation, as deemed appropriate by the HHSC-OIG as defined in the rules in 1 TAC §§371.1701, 371.1703, 371.1705, 371.1707, 371.1709, 371.1711, 371.1713, and 371.1715. Providers placed on prepayment review must submit all paper claims and supporting medical record documentation to the following address:

Texas Medicaid & Healthcare Partnership
Attention: Prepayment Review MC-A11 SURS
PO Box 203638
Austin, Texas 78720-3638

1.6.8 Provider Certification/Assignment

Texas Medicaid service providers are required to certify compliance with or agree to various provisions of state and federal laws and regulations. After submitting a signed claim to TMHP, the provider certifies the following:

- Services were personally rendered by the *billing provider* or under supervision of the billing provider, if allowed for that provider type, or under a substitute arrangement.
- The information on the claim form is true, accurate, and complete.
- All services, supplies, or items billed were medically necessary for the client's diagnosis or treatment. Exception is allowed for special preventive and screening programs (for example, family planning and THSteps).
- Health records document all services billed and the medical necessity of those services.
- All billed charges are usual and customary for the services provided. The charges must not be higher than the fees charged to private-pay patients.
- The provider will not bill Texas Medicaid for services that are provided or offered to non-Medicaid patients, without charge, discounted or reduced in any fashion including, but not limited to, sliding scales or advertised specials. Any reduced, discounted, free, or special fee advertised to the public must also be offered to Texas Medicaid clients.
- Services were provided without regard to race, color, sex, national origin, age, or handicap.
- The provider of health care and services files a claim with Texas Medicaid agreeing to accept the Medicaid reimbursement as payment in full for those services covered under Texas Medicaid. In accordance with 1 TAC §354.1005, the reimbursement for services covers the costs for a covered service, and any function incidental to the provision of a covered service (refer to subsection 1.6.9, "Billing Clients" for more information). The client with Medicaid coverage, or others on their behalf, must not be billed for the amount above that which is paid on allowed services or for services denied or reduced as a result of errors made in claims filing, claims preparation, missed filing deadlines, or failure to follow the appropriate appeal process. However, the client may be billed for noncovered services for which Texas Medicaid does not make any payment. Before providing services, providers should *always* inform clients of their liability for services that are not a benefit of Texas Medicaid, including use of the Client Acknowledgment Statement.
- The provider understands that endorsing or depositing a Texas Medicaid check is accepting money from federal and state funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under federal and state laws.

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Providers must not bill for, and agree not to bill for, any service provided for which the client bears no liability to pay (i.e. free services). The only exceptions to this ban on billing for services that are free to the user are:

- Services offered by or through the Title V agency when the service is a benefit of Texas Medicaid and rendered to an eligible client
- Services included in the Texas Medicaid client's individualized education plan (IEP) or individualized family service plan (IFSP) if the services are covered under the Title XIX state plan, even though they are free to the users of the services

Refer to: Subsection 7.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*).

Subsection 1.6.8.1, "Delegation of Signature Authority" in this section.

1.6.8.1 Delegation of Signature Authority

A provider delegating signatory authority to a member of the office staff or to a billing service *remains responsible* for the accuracy of all information on a claim submitted for payment. A provider's employees or a billing service and its employees are equally responsible for any false billings in which they participated or directed.

If the claim is prepared by a billing service or printed by data processing equipment, it is permissible to print "Signature on File" in place of the provider's signature. When claims are prepared by a billing service, the billing service must obtain and keep a letter on file that is signed by the provider authorizing claim submission.

1.6.9 Billing Clients

A provider cannot require a down payment before providing Medicaid-allowable services to eligible clients, bill, nor take recourse against eligible clients for denied or reduced claims for services that are within the amount, duration, and scope of benefits of Texas Medicaid if the action is the result of any of the following provider-attributable errors:

- Failure to submit a claim, including claims not received by TMHP
- Failure to submit a claim to TMHP for initial processing within the 95-day filing deadline (or the initial 365-day deadline, if applicable)
- Submission of an unsigned or otherwise incomplete claim such as omission of the Hysterectomy Acknowledgment Statement or Sterilization Consent Form with claims for these procedures
- Filing an incorrect claim
- Failure to resubmit a corrected claim or rejected electronic media claim within the 120-day resubmittal period
- Failure to appeal a claim within the 120-day appeal period. Errors made in claims preparation, claims submission, or appeal process
- Failure to submit a claim to TMHP within 95 days of a denial by the DSHS Family Planning Program for family planning services
- Failure to submit a claim within 95 days from the disposition date from Medicare or a primary third party insurance resource
- Failure to obtain prior authorization for services that require prior authorization under Texas Medicaid

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Providers must certify that no charges beyond reimbursement paid under Texas Medicaid for covered services have been, or will be, billed to an eligible client. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business.

Medicaid reimbursement is considered as payment in full for those services covered under Texas Medicaid. In accordance with 1 TAC §354.1005, the reimbursement for services is intended to cover the costs for a covered service, or any function incidental to the provision of a covered service, including, but not limited to:

- Signing, completing, or providing a copy of a health assessment form, such as a physical examination form required for the eligible client's enrollment in school or participation in school or other activities;
- Providing a copy of a medical record requested:
  - By or on behalf of any health care practitioner for purposes of medical care or treatment of the eligible client;
  - As a supplement to a health assessment form or other form provided incidental to a covered service; or
  - By an eligible client, for any reason, for the first time in a one-year period; and
- Providing a copy of any subsequent amendment, supplement, or correction to a medical record requested by or on behalf of the eligible client.
- If the provider has already provided the eligible client a free copy of the medical record within a one-year period, the provider is required to provide only the amended, supplemented, or corrected portion of the record, if requested, without having to copy the entire record.

Note: *A provider may bill or otherwise charge a client a reasonable fee for providing a paper copy of a medical record outside of the above scenarios. A reasonable fee for providing a paper copy of the requested records shall be a charge of no more than $25.00 for the first twenty pages and $.50 per page for every copy thereafter per 22 TAC §165.2.*

Completion of required forms submitted by a nursing facility to the physician for signature is also considered incidental to a covered service. It is not acceptable for the physician to charge Texas Medicaid clients, their family, or the nursing facility for telephone calls, telephone consultations, or signing forms.

In accordance with current federal policy, Texas Medicaid and Texas Medicaid clients cannot be charged for the client's failure to keep an appointment. Only billings for services provided are considered for payment. Clients may not be billed for the completion of a claim form, even if it is a provider's office policy.

Letters of inquiry about client billing are sometimes sent to providers in lieu of telephone calls from TMHP representatives. In either case, it is mandatory that the questions be answered with the requested pertinent information. Upon receipt, TMHP forwards these letters to HHSC. HHSC uses the information to resolve client billing/liability issues. It is mandatory that these letters be signed, dated, and returned within ten business days.

Refer to: The *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about spell-of-illness.

Subsection 4.6, "Medically Needy Program (MNP)" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

Private Pay Agreement on the TMHP website at www.tmhp.com.

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1.6.9.1 Client Acknowledgment Statement

Texas Medicaid only reimburses services that are medically necessary or benefits of special preventive and screening programs such as family planning and THSteps. Hospital admissions denied by the Texas Medical Review Program (TMRP) also apply under this policy.

The provider may bill the client only if:

- A specific service or item is provided at the client's request.
- The provider has obtained and kept a written Client Acknowledgment Statement signed by the client 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."
    - "Comprendo que, según la opinión del (*nombre del proveedor*), es posible que Medicaid no cubra los servicios o las provisiones que solicité (*fecha del servicio*) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsibilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

A provider is allowed to bill the following to a client without obtaining a signed Client Acknowledgment Statement:

- Any service that is not a benefit of Texas Medicaid (for example, cellular therapy).
- All services incurred on noncovered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered days. Spell of illness limitations do not apply to medically necessary stays for Medicaid clients who are 20 years of age and younger.
- The reduction in payment that is due to the Medically Needy Program (MNP) is limited to children who are 18 years of age and younger and pregnant women. The client's potential liability would be equal to the amount of total charges applied to the spend down. Charges to clients for services provided on ineligible days must not exceed the charges applied to spend down.
- All services provided as a private pay patient. If the provider accepts the client as a private pay patient, the provider must advise clients that they are accepted as private pay patients at the time the service is provided and responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the client signs written notification so there is no question how the client was accepted. Without written, signed documentation that the Texas Medicaid client has been properly notified of the private pay status, the provider cannot seek payment from an eligible Texas Medicaid client.
- The client is accepted as a private pay patient pending Texas Medicaid eligibility determination and does *not* become eligible for Medicaid retroactively. The provider is allowed to bill the client as a private pay patient if retroactive eligibility is not granted. If the client becomes eligible retroactively, the client notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Texas Medicaid claims. If the client becomes eligible, the provider *must* refund any money paid by the client and file Medicaid claims for all services rendered.

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A provider attempting to bill or recover money from a client in violation of the above conditions may be subject to exclusion from Texas Medicaid.

Important: *Ancillary services must be coordinated and pertinent eligibility information must be shared. The primary care provider is responsible for sharing eligibility information with others (e.g., emergency room staff, laboratory staff, and pediatricians).*

1.6.10 General Medical Record Documentation Requirements

The Administrative Simplification Act of HIPAA mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system or the American Dental Association's (ADA) Current Dental Terminology (CDT) system be used to report professional services, including physician and dental services. Correct use of CPT and CDT coding requires using the most specific procedure code that matches the services provided based on the procedure code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

HHSC and TMHP routinely perform retrospective reviews of all providers. HHSC ultimately is responsible for Texas Medicaid utilization review activities. This review includes comparing services billed to the client's clinical record. The following requirements are general requirements for all providers. Any mandatory requirement not present in the client's medical record subjects the associated services to recoupment.

Note: *This list is not all-inclusive. Additional and more specific requirements may apply to special services areas.*

Note: *Health-care documentation that is maintained by a provider in a client's record can be maintained in a language other than English; however, when TMHP, HHSC, or any other state/federal agency requests a written record or conducts a documentation review, this health-care documentation must be provided in English and in a timely manner.*

- (Mandatory) All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.
- (Mandatory) Medicaid-enrolled providers must submit claims with their own TPI except when under the agreement of a substitute provider or *locum tenens*.
- (Mandatory) Each page of the medical record documents the patient's name and Texas Medicaid number.
- (Mandatory) A copy of the actual authorization from HHSC or its designee (e.g., TMHP) is maintained in the medical record for any item or service that requires prior authorization.
- (Mandatory) Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.
- (Mandatory) The selection of evaluation and management codes (levels of service) is supported by the client's clinical record documentation. Providers must follow either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services published by CMS, when selecting the level of service provided.
- (Mandatory) The history and physical documents the presenting complaint with appropriate subjective and objective information.

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- (Mandatory) The services provided are clearly documented in the medical record with all pertinent information regarding the patient's condition to substantiate the need and medical necessity for the services.
- (Mandatory) Medically necessary diagnostic lab and X-ray results are included in the medical record and abnormal findings have an explicit notation of follow-up plans.
- (Mandatory) Necessary follow-up visits specify time of return by at least the week or month.
- (Mandatory) Unresolved problems are noted in the record.
- (Desirable) Immunizations are noted in the record as *complete* or *up-to-date.*
- (Desirable) Personal data includes address, employer, home/work telephone numbers, sex, marital status, and emergency contacts.

Note: *An unenrolled provider that renders services and attempts to use the TPI of a provider who is enrolled in Medicaid will not be reimbursed for the services. During retrospective review, any services that were rendered by a provider that was not enrolled in Texas Medicaid and were billed using the provider identifier of a Medicaid-enrolled provider are subject to recoupment.*

1.6.11 Informing Pregnant Clients About CHIP Benefits

Section 24, S.B. 1188, 79th Legislature, Regular Session, 2005, requires that Medicaid providers rendering services to a pregnant Medicaid client must inform the client of the health benefits for which the client or the client's child may be eligible under the CHIP.

CHIP is available to children whose families have low to moderate income, who earn too much money to qualify for Texas Medicaid, and who do not have private insurance. Some clients may have to pay an enrollment fee.

To qualify for CHIP, a child must be:

- A Texas resident
- 18 years of age or younger
- A citizen or legal permanent resident of the United States
- Must meet all income and resource guidelines

CHIP benefits include:

- Physician, hospital, X-ray, and lab services
- Well-baby and well-child visits
- Immunizations
- Prescription drugs
- Dental services
- DME
- Prosthetic devices (with a $20,000 limit per 12-month period)
- Case coordination and enhanced services for children with special health-care needs and children with disabilities
- Physical, speech, and occupational therapy
- Home health services
- Transplants
- Mental health services

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National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The Case for the Enhanced National CLAS Standards

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.
— Dr. Martin Luther King, Jr.

Health equity is the attainment of the highest level of health for all people (U.S. Department of Health and Human Services [HHS] Office of Minority Health, 2011). Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age (World Health Organization, 2012), such as socioeconomic status, education level, and the availability of health services (HHS Office of Disease Prevention and Health Promotion, 2010). Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion (LaVeist, Gaskin, & Richard, 2009). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006). By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization's ability to address health care disparities.

The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for Achieving Health Equity (HHS National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Similar to these initiatives, the enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

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HHS Circular C-027
Health and Human Services Enterprise
Fraud, Waste, and Abuse
Reporting, Responsibilities, and Coordination

Purpose

The purpose of this circular is to establish health and human services enterprise policy concerning program integrity responsibilities and coordination, as well as the required reporting of suspected fraud, waste, and abuse. These terms, as they apply to the Inspector General (IG), are defined in 1 Texas Administrative Code (TAC) §371.1607.

These terms are, for purposes of this circular, defined as follows:

Fraud: Any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person. The term does not include unintentional technical, clerical, or administrative errors.

Examples of fraud include:

- falsifying financial records to conceal theft of money or property;
- intentionally misrepresenting the costs of goods or services provided; and
- accepting a bribe or kickback.

Waste: Practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services.

Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls. Examples of waste include:

- purchase of unneeded supplies or equipment; and
- purchase of goods at inflated prices.

Abuse: Practices that are inconsistent with sound fiscal or business practices and that result in unnecessary costs.

Abuse may include misapplication or misuse of public resources. Abuse can occur in financial or non-financial settings.

Examples of abuse include:

- requesting staff to perform personal errands or work tasks for supervisors;
- misusing an employee's position for personal gain; and
- making travel choices that are unnecessarily extravagant, or expensive.

Background

Government has a responsibility to safeguard taxpayer dollars and maintain the highest standard of integrity, impartiality, and conduct. To help meet this responsibility, each employee of a health and human services (HHS) agency has an obligation to participate in a combined effort to protect the resources and interests of HHS and the State of Texas.

This circular outlines specific program integrity expectations and the responsibilities of executives, managers, and employees. It includes requirements for reporting suspected fraud, waste, and abuse to the IG and the State Auditor's Office (SAO), and confirms the requirement for full agency cooperation in any investigation, audit, or review.

Directive

Fraud, waste, and abuse discovered by HHS employees and contractors must be reported. HHS agencies must establish program specific processes including control systems that assist in the prevention, deterrence, and detection of fraud, waste, and abuse. Using these tools and other observations, employees must report fraud, waste, and abuse are reported to IG and SAO.

Each HHS agency commissioner is responsible for:

- designating an executive of that agency as the internal coordinator of the agency's fraud, waste, and abuse prevention programs; and
- designating one or more executives of the agency who will, in turn, act as liaison to and coordinate that agency's fraud, waste, and abuse prevention programs with the IG.

Each HHS agency manager is responsible for:

- Establishing and maintaining management controls designed to ensure program integrity. Management controls must provide for the security and accountability of resources, and safeguard state assets against loss from unauthorized use or disposition.

- Establishing and maintaining procedures that provide for:
  - appropriate separation of duties;
  - proper authorization of transactions and activities;
  - independent checks on performance;
  - security of confidential information;
  - adequate documentation and maintenance of records;
  - control over physical assets;
  - required reporting of suspected fraud, waste, and abuse;
  - anonymity, if desired, for individuals reporting fraud, waste, and abuse; and
  - freedom from reprisal during or after any investigation for individuals reporting or suspected of involvement in fraud, waste, or abuse.

- Incorporating fraud, waste, and abuse prevention and detection procedures into business processes, practices, and systems.

- Periodically evaluating the effectiveness of management controls, including those designed to prevent and detect fraud, waste, and abuse.

- Ensuring compliance with laws, regulations, rules, policies, and procedures.

Each HHS agency employee is responsible for:

- fraud, waste, and abuse prevention and deterrence;
- acting with propriety in the use of state resources;
- following the Health and Human Services Ethics Policy (Circular C-025);
- abiding by laws, regulations, rules, policies, and procedures that apply to the HHS Enterprise and to the employee's HHS agency; and
- appropriately reporting fraud, waste, and abuse.

The Internal Audit Director for each HHS agency is responsible for:

- Evaluating the potential for the occurrence of fraud and how the organization manages fraud risk as part of the agency risk assessment performed by Internal Audit.
- Considering fraud risks in the development of a proposed annual audit plan, as required by the Texas Internal Auditing Act (Government Code, Chapter 2102) and applicable auditing standards.
- Assessing the risk of fraud during the planning phase of each audit engagement. When factors or risks indicate the likelihood that fraud may have occurred and may materially impact the area under audit, the Internal Audit Director will design procedures to provide reasonable assurance of detecting such fraud (as required by the Texas Internal Auditing Act and applicable auditing standards).
- Communicating fraud findings identified during internal and external audits, special projects, and other activities to executive management and appropriate managers.

HHSC, in consultation with the Inspector General, will set clear objectives, priorities, and performance standards for the IG that emphasize:

- coordination of investigative efforts to aggressively recover money;
- allocation of resources to cases that have the strongest supportive evidence and the greatest potential for recovery of money; and
- maximization of opportunities for referral of cases to the Office of the Attorney General (OAG).

In performing the above, the OIG is required to:

- conduct independent, fact based, and objective investigations, audits, and reviews (including aiding internal and external authorities that have concurrent jurisdiction, as appropriate).
- report incidents determined to have merit to executive management, the OAG, and other authorities as appropriate.
- refer information to internal and external authorities that have jurisdiction, as appropriate (so that they may pursue independent investigations, audits, and reviews consistent with their authority).
- establish and maintain information collection methods that do not infringe upon the rights of individuals and are consistent with due process of law.
- offer training and consultation to each HHS agency to assist them in understanding their responsibilities, time limits, and to promote establishment of appropriate procedures.

The SAO is authorized and required to:

- Audit any entity receiving funds from the state in accordance with an annual audit plan which is developed based on risk assessment. In performing this duty, the State Auditor is authorized and entitled to investigate and has encouraged receipt of, reports of suspected fraud, waste, or abuse occurring in all HHS programs and agencies.

Each HHS agency and program must:

- Adopt procedures for the required reporting to the IG and the SAO of suspected fraud, waste, and abuse as required by this directive.
- Assure all employees and contractors are informed of their responsibilities and have access to their area's adopted procedures for reporting and preventing fraud, waste, and abuse.
- Authorize and provide to OIG and the SAO, as applicable, full access to any information maintained internally or externally (including full access to records held by the agency or program – including its employees, contractors, and vendors – concerning any incident of reported or suspected fraud, waste, or abuse).

Reporting Fraud, Waste, and Abuse

All employees or contractors who believe fraud, waste, or abuse (including employee misconduct if that misconduct would constitute fraud, waste, or abuse as defined in statute) have occurred are required by Texas Government Code, Section 321.022 to immediately report the questioned activity to both the IG and the SAO. **A report made to the SAO does not satisfy an HHS employee's responsibility under this circular to also report the fraud, waste, or abuse activity to the IG, and vice versa.**

A report to the IG must be made through one of the following avenues:

- IG Toll Free Hotline 1-800-436-6184
- IG Website: https://oig.hhsc.state.tx.us/Fraud_Report_Home.aspx
- IG Mailing Address: Office of Inspector General
Attn: Fraud, Waste, & Abuse Intake
MC 1300
P.O. Box 85200
Austin, Texas 78708-5200

A report to the SAO must be made through one of the following avenues:

- SAO Toll Free Hotline: 1-800-TX-AUDIT
- SAO website: http://sao.fraud.state.tx.us/

In making a report, it is best to provide as much of the following information as possible, including:

- The name, address, telephone number, and e-mail address of person making the report (anonymity is acceptable).
- The date(s) the incident(s) occurred.
- The date the incident was discovered.
- A detailed description of the incident, including any known program area, case numbers, or identifying characteristics that will assist the investigation.
- The name, address, telephone number(s), and email address of each person involved in the incident.
- The name, address, contact number, and e-mail address of each known witness.
- Whether the incident was reported to any other government agencies and, if so, which government agencies.

Once they become aware of fraud, waste or abuse, all HHS employees or contractors are to follow these guidelines:

- Immediately report the incident, providing as much of the information described above as possible.
- Once the reporting HHS employee or contractor decides that an incident meets the criteria requiring a report to IG and SAO for review, do not attempt to further investigate or otherwise contact the suspected or involved individuals to determine facts or demand restitution.
- It is IG's responsibility to inform executive management and the HHSC Office of Chief Counsel of fraud, waste, and abuse investigations. As a result, reporting HHS employees should avoid discussing a reported incident with anyone who does not have a business need to have such information.
- Refrain from retaliation. Retaliation will not be tolerated against any individual providing information or concerning any suspected individual.

Reporting Employee Misconduct

For more information about employee responsibilities and consequences for violating rules of conduct, refer to the HHS Human Resources Manual, Chapter 4.

Some activities that warrant action by managers, up to and including termination, do not meet the IG's aforementioned definitions of fraud, waste, or abuse. Such acts may occur independently or in conjunction with fraud, waste, or abuse. In instances where there are multiple or complex concerns, managers should seek executive and/or IG assistance in understanding how they should proceed, which issues they may address, and which issues may require referral to the IG.

Managers have the discretion to refer suspected employee misconduct that does not constitute fraud, waste, or abuse to the IG for investigation. Where a manager elects to make such a referral, the manager may not determine the merits of the allegations, but instead must work cooperatively with the IG's Internal Affairs Section in any resulting investigation. For any such referral, the IG's Internal Affairs Director reserves the right to decline to investigate the matter for reasons such as the necessity to devote limited resources to the IG's core responsibilities. In such situations, an independent management investigation of the matter may then proceed.

If employee misconduct creates a risk of imminent danger or bodily harm, managers should consider placing the employee on emergency leave in accordance with human resources policy and in consultation with HR Employee Relations Staff and agency Legal Services. Managers should inform the IG of any such safety measures that were employed prior to any referral to IG.

Protection for Reporting Violations of Law, and Confidentiality

HHS employees who report suspected fraud, waste, abuse, or misconduct may fall within the protection of the Whistleblower Act in Texas Government Code, Chapter 554. HHS Policy protection from retaliation is also provided under HHS Human Resources Manual, Chapter 13 – Grievances.

Reports made to the IG involving fraud, waste, or abuse, are confidential by law, and not subject to release in response to an open records request, subpoena, or other means of legal compulsion. Throughout the investigative processes, every effort will be made to maintain the anonymity and to protect the rights of the individuals directly connected with a report of fraud, waste, or abuse. The IG will disclose the results of an audit, review, or investigation in a final report that is produced after all findings are complete (including legal proceedings), and such final reports are open to the public. The IG, in the interim, may disclose information obtained from an investigation, audit, or review to appropriate HHS legal staff and/or client representatives based upon applicable confidentiality law, and in accordance with established program integrity related procedures. The IG has an obligation to provide management with timely and sufficient information to support management's obligations to protect program integrity and to manage the workforce effectively.

Inquiries

Inquiries concerning the content of this circular or requests for assistance with fraud, waste, and abuse training should be addressed to:

Mail: Office of Inspector General
Policy and External Relations Division
Center for Policy and Outreach
MC 1330
P.O. Box 85200
Austin, Texas 78708-5200

Phone: (512) 491-2000

Email: OIG.GeneralInquiries@hhsc.state.tx.us

PT/OT CPT Codes	Provider Notification
All PT/OT provider letters	The billing structure for PT/OT is changing. This may affect how you bill for therapy services. Please refer to provider notification "*Physical, Occupational, and Speech Therapy Benefits for All Ages to Change for Texas Medicaid September 1, 2017"* posted June 30, 2017 for detailed information regarding billing structure changes, prior authorization changes, required modifiers, claims filing changes, clarification to benefits, and Current Procedural Terminology (CPT®) codes end-dating August 31, 2017. To request prior authorization for PT/OT GROUP treatment, providers must list CPT code 97150 on their prior authorization request form for dates of service on or after September 1, 2017. For dates of service on or after September 1, 2017, CPT code 97150 will be reimbursed as a PT/OT ENCOUNTER and limited to once per day. CPT codes 97039, 97139, and S8990 are end-dating August 31, 2017 and are no longer a benefit of Texas Medicaid for dates of service on or after September 1, 2017.
PT/OT-Home Health Agency	The billing structure for PT/OT is changing. For dates of service on or before August 31, 2017, PT/OT CPT codes are approved in VISITS. For dates of service on or after September 1, 2017, CPT codes representing skilled therapy services (timed treatment CPT codes) are approved as UNITS.
97799	The billing structure for PT/OT CPT code 97799 is changing. For dates of service on or before August 31, 2017 this CPT code is approved in UNITS or VISITS depending on the provider type. For dates of service on or after September 1, 2017, this CPT code is approved as a PT/OT ENCOUNTER. Note: A PT/OT ENCOUNTER is limited to once per day.
97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028	The billing structure for PT/OT CPT codes 97012, 97014, 97016, 97018, 97022, 97024, 97026, and 97028 is changing. For dates of service on or before August 31, 2017 these CPT codes are approved in UNITS or VISITS depending on the provider type. For dates of service on or after September 1, 2017, requests for these CPT codes are approved as PT/OT ENCOUNTERS and reimbursable only when billed with one or more time-based CPT codes. Note: A PT/OT ENCOUNTER is limited to once per day.

ST CPT Codes	Provider Notification
All ST Provider Letters	The billing structure for ST is changing. This may affect how you bill for therapy services. Please refer to provider notification "*Physical, Occupational, and Speech Therapy Benefits for All Ages to Change for Texas Medicaid September 1, 2017"* posted June 30, 2017 for detailed information regarding billing structure changes, prior authorization changes, required modifiers, claims filing changes, clarification to benefits, and Current Procedural Terminology (CPT) codes end-dating August 31, 2017.
97535 GN	Your request for CPT code 97535 with GN modifier has been approved until August 31,2017. CPT code 97535 with the GN modifier is end-dating August 31, 2017 for speech therapy providers.
92507, 92508, 92526- Home Health Agency	Dates of service on or before August 31, 2017 are approved in VISITS for CPT codes 92507, 92508, and 92526. For dates of service on or after September 1, 2017, all requests are approved as ST ENCOUNTERS for CPT codes 92507, 92508, and 92526. For dates of service on and after September 1, 2017, CPT codes 92507 and 92526 will not be reimbursed on the same date of service. Note: A speech therapy ENCOUNTER is limited to once per day.
92507, 92508, 92526- Other Provider Types	Dates of service on or before August 31, 2017 are approved in UNITS for CPT codes 92507, 92508, and 92526. For dates of service on or after September 1, 2017, all requests are approved as ST ENCOUNTERS for CPT codes 92507, 92508, and 92526. For dates of service on or after September 1, 2017, CPT codes 92507 and 92526 will not be reimbursed when billed on the same date of service. Note: A speech therapy ENCOUNTER is limited to once per day.

MCG Cite AutoAuth Provider Training 06/2017

Contents

1. Portal Authorization Enhancements
2. Who is MCG and what is their purpose?
3. Web Portal Access
4. Verification of Service Codes
5. Submission Process
6. MCG Cite AutoAuth
7. Status of Authorization Search
8. FAQ’s
9. Appendix

Enhanced Portal Authorizations

Effective 06/22/2017

- Upon authorization submission via the FirstCare Provider Self-Service portal, providers will be redirected to MCG Cite Auto Auth in order to attach clinical and complete authorization requests
- Authorization decisions will continue to be made and communicated by FirstCare, through fax, letter and online at FirstCare.com.
- You will be able to check the status of authorizations submitted, and there will be a short interval between submission and display on the provider portal
- Please have all authorization elements ready prior to beginning the authorization process in the provider portal

Who is MCG and what is their purpose?

- MCG is a web-based software developed to give transparency into how care is provided
- Healthcare groups leveraging MCG solutions, are able to improve patient outcomes.
- MCG uses evidence-based care guidelines that allow providers and health plans to drive effective care
- Annually, more than 140,000 references are reviewed and ranked, with over 39,000 unique citations
- Eight of the ten largest U.S. health plans and more than 1,600 hospitals use MCG's evidence-based guidelines and software. Today, our informed care strategies affect over 208 million covered lives

Web Portal Access

Log into https://my.firstcare.com/en/Providers

Bookmark this site for future reference

Internet Explorer 10 -11 and the latest version of Firefox and Chrome are recommended browsers for optimal results

Web Portal Access

FirstCare HEALTH PLANS

PROVIDERS ▼ | Log In / Register | Find a Provider | Contact Us | Español

Caring for patients.
Support for providers.

Providers

Becoming a Provider

Providers

Search Providers

- Navigate to https://my.firstcare.com/en/Providers
- Click on the “Log IN/ Register” option on the tool bar

Web Portal Access

FirstCare HEALTH PLANS

SELF-SERVICE PORTAL

User Name | Password | Login

I don't have my User Name or Password

Members | Providers | Employers | Agents | Health Care Reform Resource Center

Welcome to the FirstCare Health Plans Portal

ANNOUNCEMENTS
Nurse24™

Have a medical question? Talk to a nurse anytime…24 hours a day, 7 days a week. 1-855-828-1013

Are you a provider interested in joining our provider network?
Learn More

Welcome to the FirstCare Health Plans Portal

Click one of the links below to login as a:

Member
Provider
Employer
Agent

- Input your User Name and Password in the designated fields above and click "Login"
- If you do not have a User Name and Login, please contact FirstCare Customer Service or your Provider Relations Representative (Contact information is located on the last page of this document)

Verification of Service Codes

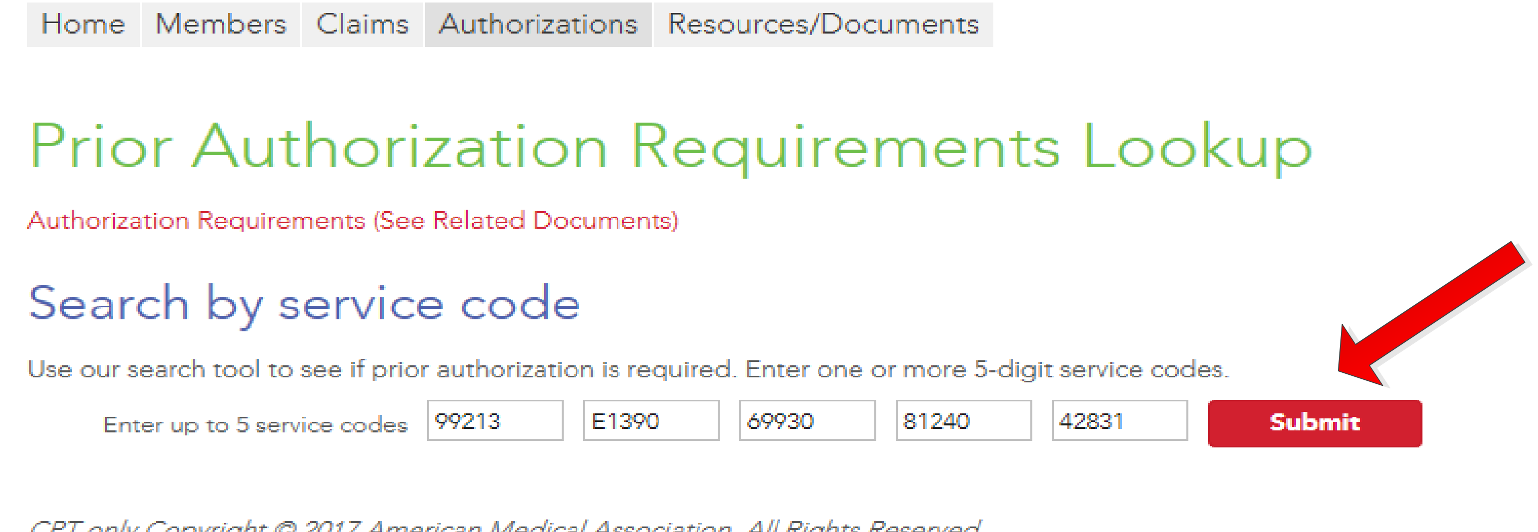
FirstCare HEALTH PLANS
PROVIDER SELF-SERVICE
Welcome,
Username:

Home | Members | Claims | Authorizations | Resources/Documents

- Prior Authorization Requirements Lookup
- New Authorization Request
- Authorization Search
- Authorization Requirements (See Related Documents)

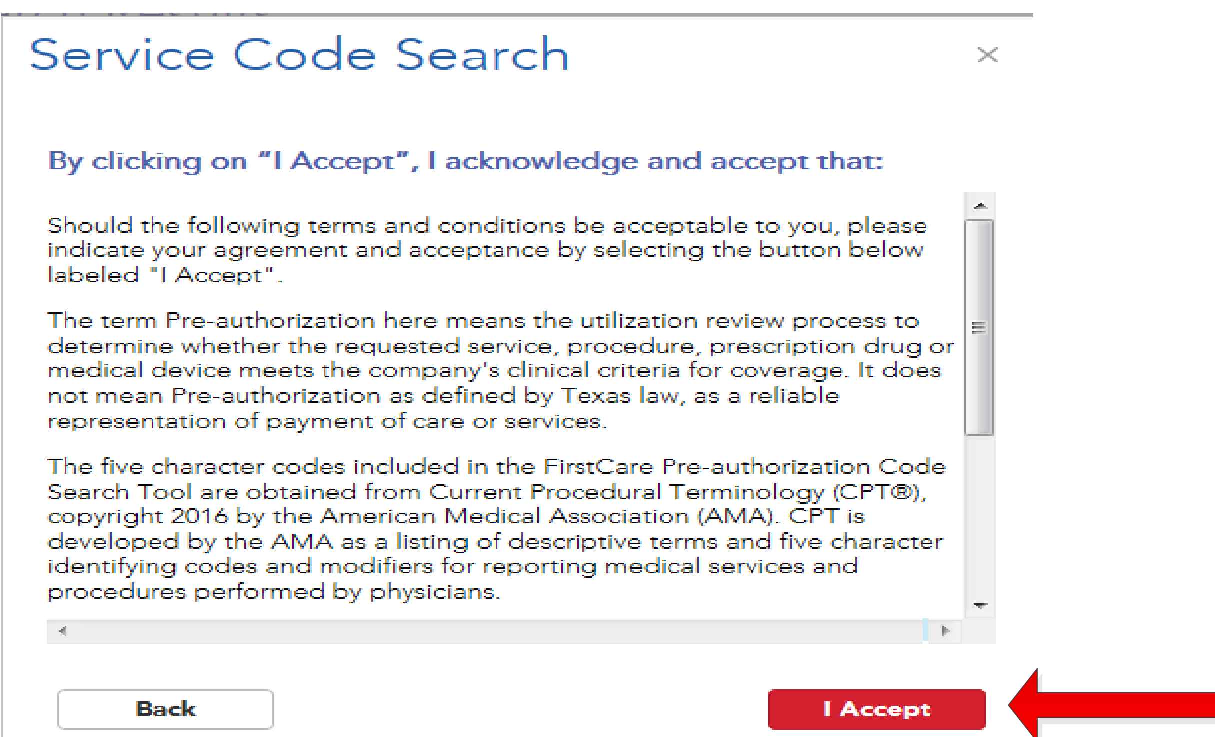
- Select “Authorizations” in the grey tool bar
- Choose the Authorization Search option in the sub menu

Verification of Service Codes



- Enter the procedure codes that require authorization verification (you may enter as many as 5 codes per search)
- Click Submit

Verification of Service Codes



- After reviewing the above disclaimer, click "I Accept"
- You will not be able to proceed with procedure code verification without selecting "I Accept"

Verification of Service Codes

Service Code Search Results

Service codes searched 99213 E1390 69930 81240 42831 . Results as of 03/15/2017 09:34 AM   Start a new search

Service code 99213 - OFFICE/OUTPATIENT VISIT EST

Preauthorization is NOT required. - The service code you entered is not part of the FirstCare preauthorization list. No authorization is required when this service is performed by participating FirstCare providers and as an outpatient procedure for a medical or surgical diagnosis. For nonparticipating (out-of-network) providers, the member's plan may require preauthorization for this service.

Service code E1390 - O2 CONC 1 DEL PORT 85%/>02 CONC AT PRSC FLW RATE

Preauthorization is required

This service code is part of the FirstCare preauthorization list. To submit the preauthorization request electronically, via the FirstCare Provider Self-Service portal, click here.

Service code 69930 - IMPLANT COCHLEAR DEVICE

Preauthorization is required

This service code is part of the FirstCare preauthorization list. To submit the preauthorization request electronically, via the FirstCare Provider Self-Service portal, click here.

Service code 81240 - F2 GENE

Preauthorization is required – Review guidance below
All genetic testing, except prenatal genetic testing requires prior authorization

This service code is part of the FirstCare preauthorization list. To submit the preauthorization request electronically, via the FirstCare Provider Self-Service portal, click here.

Service code 42831 - REMOVAL OF ADENOIDS

- The code search results display advising if authorization, per procedure code, is required

Verification of Service Codes

Service Code Search Results

Service codes searched 99213 E1390 69930 81240 42831 . Results as of 03/15/2017 09:34 AM   Start a new search

Service code 99213 - OFFICE/OUTPATIENT VISIT EST

Preauthorization is NOT required. - The service code you entered is not part of the FirstCare preauthorization list. No authorization is required when this service is performed by participating FirstCare providers and as an outpatient procedure for a medical or surgical diagnosis. For nonparticipating (out-of-network) providers, the member's plan may require preauthorization for this service.

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This service code is part of the FirstCare preauthorization list. To submit the preauthorization request electronically, via the FirstCare Provider Self-Service portal, click here.

Service code 69930 - IMPLANT COCHLEAR DEVICE

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This service code is part of the FirstCare preauthorization list. To submit the preauthorization request electronically, via the FirstCare Provider Self-Service portal, click here.

Service code 81240 - F2 GENE

Preauthorization is required – Review guidance below

All genetic testing, except prenatal genetic testing requires prior authorization

This service code is part of the FirstCare preauthorization list. To submit the preauthorization request electronically, via the FirstCare Provider Self-Service portal, click here.

Service code 42831 - REMOVAL OF ADENOIDS

- Select the "Start a new search" to enter additional procedure codes that require verification
- Select the "click here" link to begin a new authorization request

OR

Submission Process

FirstCare HEALTH PLANS

PROVIDER SELF-SERVICE

Welcome,
Username:

Home | Members | Claims | Authorizations | Resources/Documents

Prior Authorization Requirements Lookup
New Authorization Request
Authorization Search
Authorization Requirements (See Related Documents)

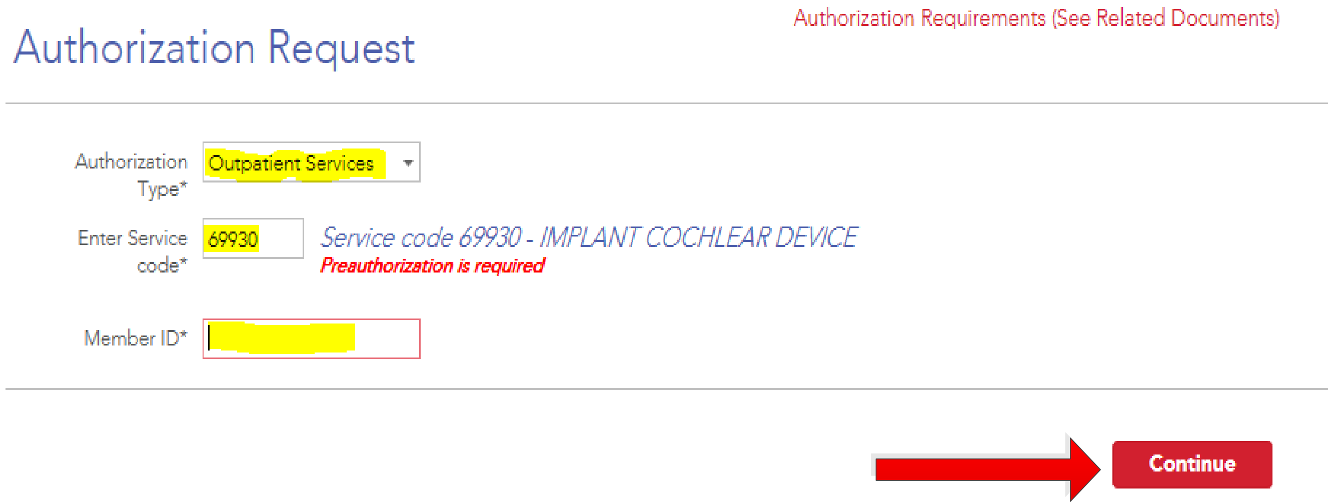
- Select “Authorizations” in the grey tool bar
- Choose the “New Authorization Request” option in the sub menu

Submission Process

- Select the desired authorization type from the drop down list
- Descriptions of Authorization Types may be found in the Appendix of this document (page 29)

Submission Process

- Input the Service Code and press tab (pressing tab will trigger the authorization verification check)
- Enter the member ID and press tab (pressing tab will trigger the member eligibility check)
- Click continue to proceed



Submission Process

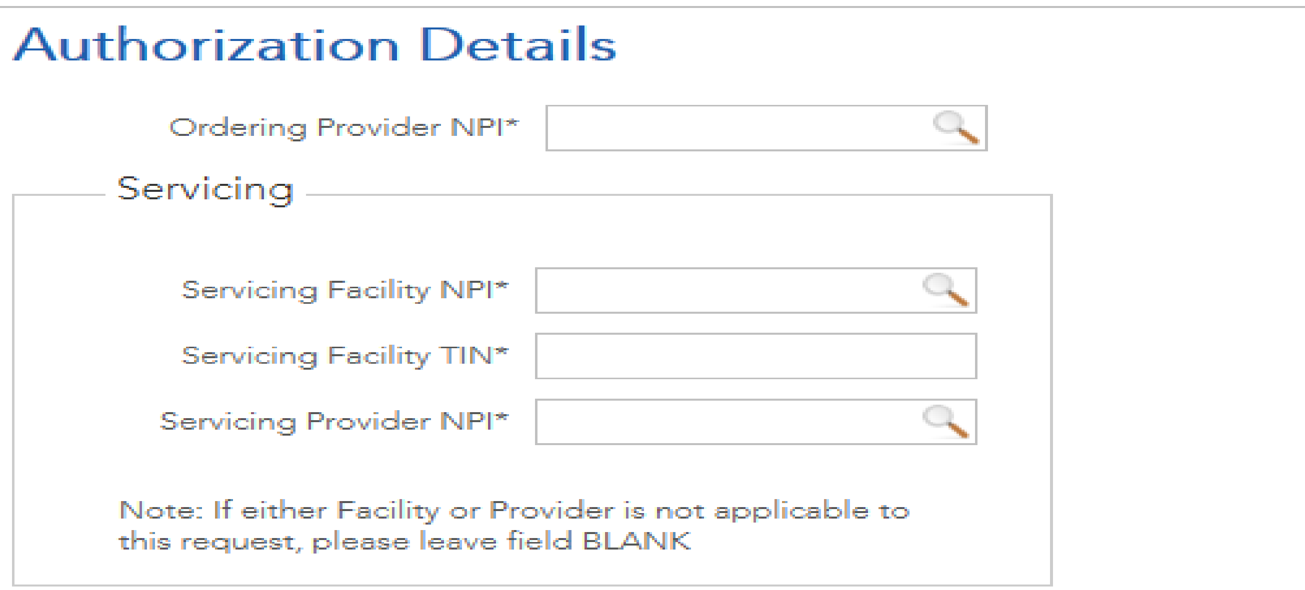
Contact Details

Who would you like to be contacted about this authorization?

Field	Value	Field	Value
Contact Name*	FirstCare Provider	Mailing Address*	123 Fake Street
Phone Number*	806-888-8888	City/State*	Lubbock / TX
Fax Number*	806-888-8889	Zip Code*	79410

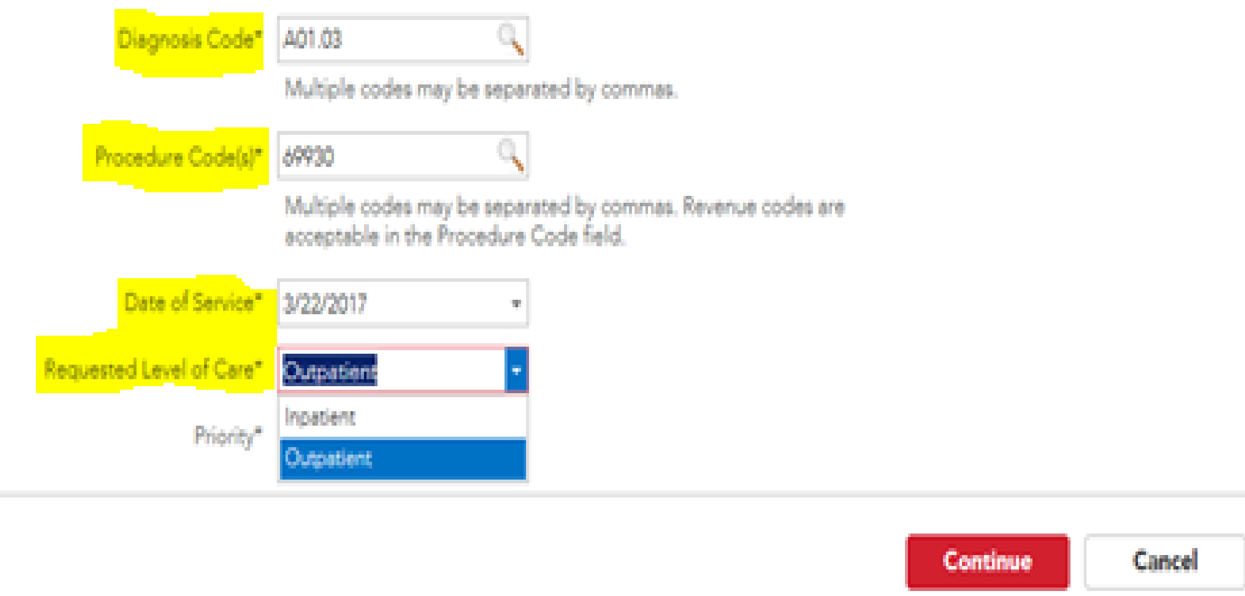
- Enter the contact information for the representative who is completing the authorization request
- Contact information is used by FirstCare to send approval/ denial letters and when additional information is needed for authorization review
- This information will remain populated for new authorization requests made during your log in session

Submission Process



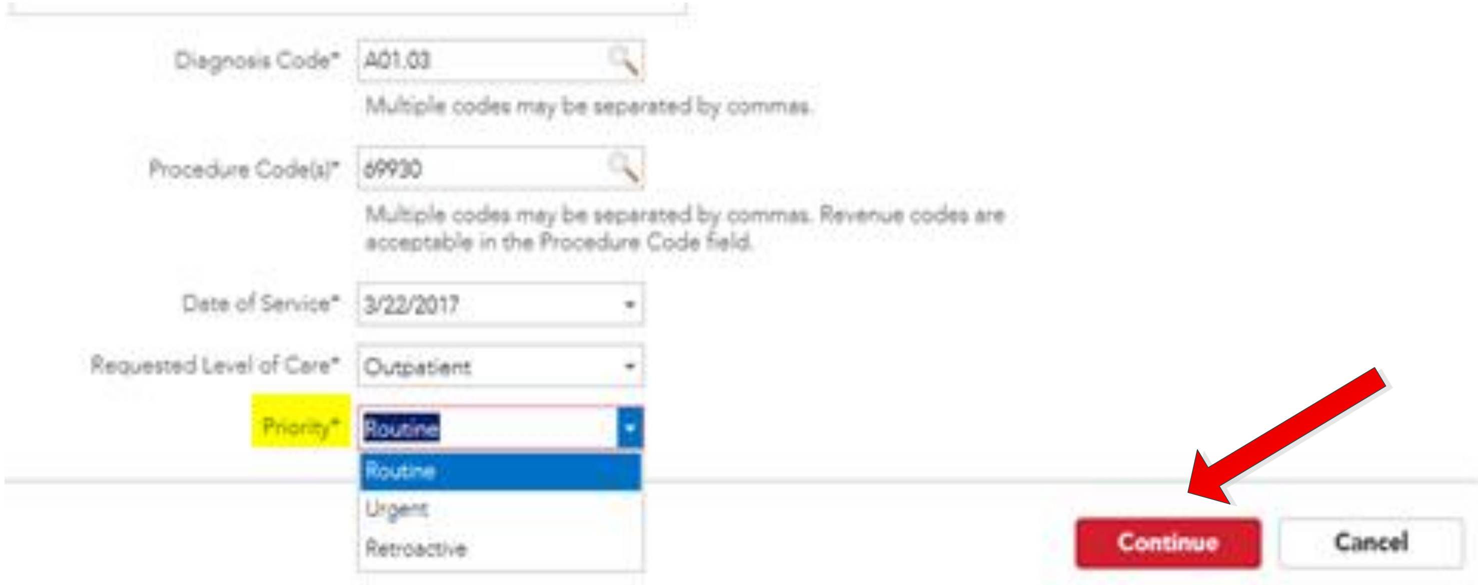
- Select the magnifying glass icon to choose the Ordering Provider from a list of network providers
- Complete the Authorization Details information by entering the Servicing Facility and/or Provider
- The Servicing Facility TIN will automatically populate when the Servicing Facility NPI is entered

Submission Process



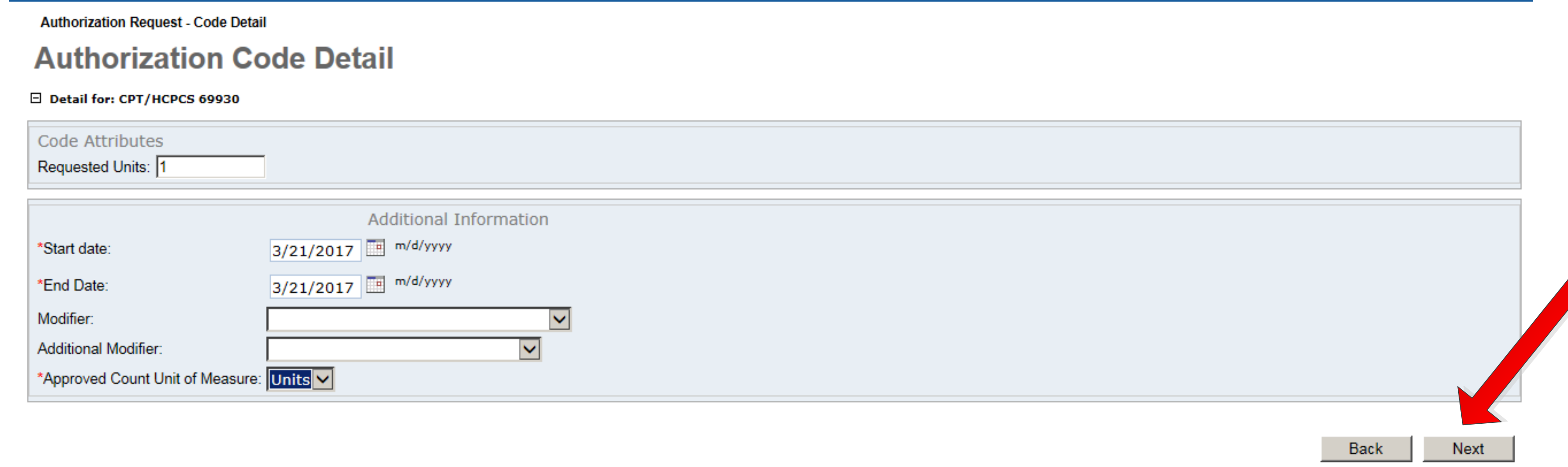
- Complete the required fields by inserting the diagnosis code, procedure code, and date of service
- Multiple procedure and diagnosis codes may be entered in these fields, separated by a comma
- Select the appropriate level of care, inpatient/ outpatient, depending on the selection criteria above

Submission Process



- Choose the priority level based on the definitions located in the Appendix of this document (page 30)
- Click continue
- You will now be routed to MCG to complete your authorization request

MCG Cite AutoAuth



- Your procedure code will appear in the upper left hand corner once routed to MCG (if multiple codes were submitted on the FirstCare Provider Portal Authorization Request Page they will display in separate boxes)
- Enter the start date, and date, modifiers if applicable, and the approved count of measure
  - -Please select “days” in the Approved Count Unit of Measure field when submitting an authorization request for anything other than DME.
  - -Please select “units” in the Approved Count Unit of Measure field when submitting an authorization request for DME.
- Click next to continue

MCG Cite AutoAuth

Authorization Request Review

Auto-Authorization : **EPS-00027412** Request Type : **Outpatient Services** Request Status : **NoDecisionYet**

⊞ **Patient :** Name : Date of Birth :

⊞ **Auto-Authorization : EPS-00027412**

⊞ **Requesting Provider :** Name :

⊞ **Rendering Provider :** Name :

⊞ **Place of Service :** Name : Date of Service : **4/6/2017**

⊞ **Procedure Code : 69930** Primary Code Type : **CPT/HCPCS** Requested Units : **1** Document Clinicals

Attach File

Name	Description	Date	
No files associated with this episode			

Submit Cancel Request Back

CareWebQI Version: 8.7 Content Version: 20.2

- You may review a summary of the pertinent authorization elements by clicking the boxes containing plus signs on the left of the toolbar
- Click on the Document Clinicals icon located on the right once all information has been verified

MCG Cite AutoAuth

Authorization Request Clinical Indication - CPT (69930)

Authorization Request Clinical Indication - CPT (69930)

Guideline: Cochlear Implant

The procedure is/was needed for appropriate care of the patient because of :

Adult, as indicated by **(Select All that apply)**

- [x] Initial unilateral cochlear implant and ...
- [ ] Sequential (second) cochlear implant, as indicated by ...

Back Next

CareWebQI Version: 8.7 Content Version: 20.2

- Select the applicable criteria for the requested service and click next

MCG Cite AutoAuth

Auto Authorization Response

Auto-Authorization : **EPS-00027412** Request Type : **Outpatient Services** Request Status : **Pended**

⊞ **Patient :**	Name :		Date of Birth :
⊞ **Auto-Authorization : EPS-00027412**			
⊞ **Requesting Provider :**	Name :		
⊞ **Rendering Provider :**	Name :		
⊞ **Place of Service :**	Name :		Date of Service : **4/6/2017**
⊞ **Procedure Code : 69930** Primary	Code Type : **CPT/HCPCS**	Requested Units : **1**	Status : **Pended**

Cancel Request Return To Episode Overview

DISCLAIMERS :

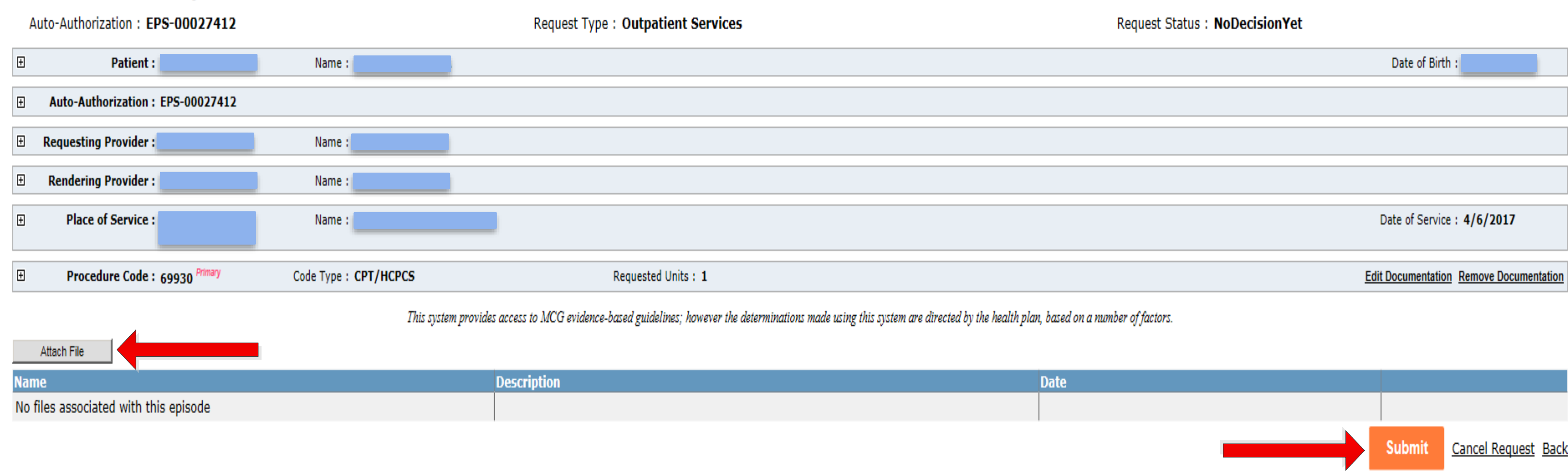
CPT/HCPCS (69930):

- This request has been pended for medical necessity review.

CareWebQI Version: 8.7 Content Version: 20.2

- Please note the disclaimers; the disclaimers are different for every authorization submitted and house important information regarding your request

MCG Cite AutoAuth



- Next, attach supporting documentation by selecting the "Attach File" option
- The "Submit Request" box, at the bottom of the page, will appear orange once all mandatory fields have been completed
- At this time you may submit your request, cancel the request, or go back to the previous page by selecting back
- If you choose to submit, select the "Submit Request" button
- You will be redirected back to the FirstCare Provider portal where additional authorizations may be submitted if desired

FirstCare™ HEALTH PLANS

MCG Cite AutoAuth

Authorization Request

Authorization Type*

Member ID*

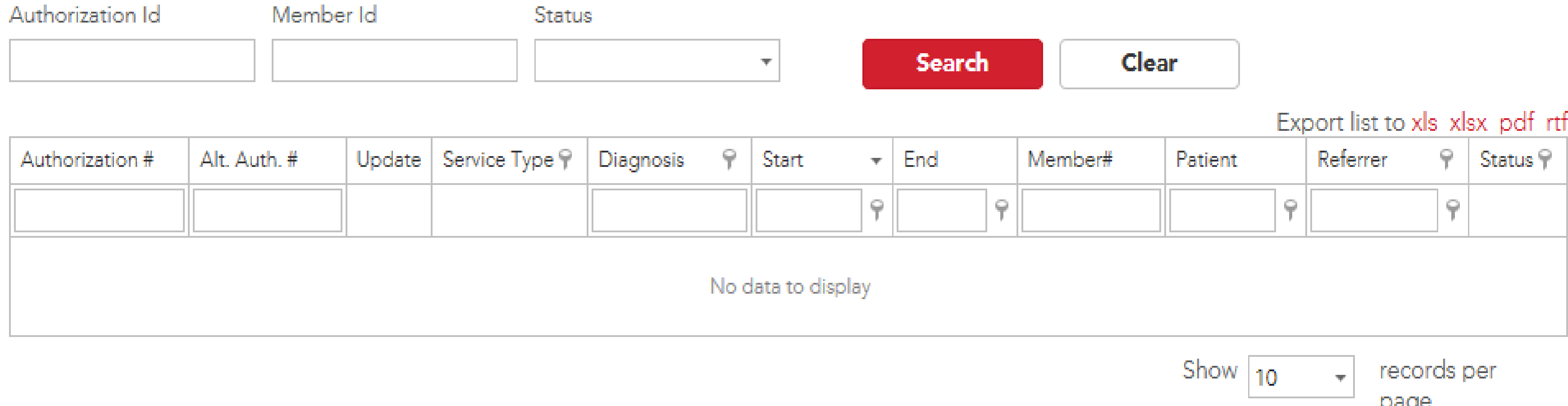
New Episode Created in MCG: EPS-00027206

- Please notate the MCG ID number located on the FirstCare Authorization Request page, and document for future authorization status inquiries
- If additional authorization requests are required, you may begin entering the next request from this screen

Status of Authorization Search

- Select “Authorization Search” in the grey tool bar
- Choose the Authorization Search option in the sub menu

Status of Authorization Search



- Input the Authorization ID and the Member ID to locate previously submitted authorization requests and the authorization status

FAQ’s

Item	Recommendation
Physical Therapy Requests (FirstCare Provider Portal)	• Choose the “Outpatient” Authorization Type in the FirstCare Provider Portal when entering Physical Therapy/ Occupational Therapy requests • Please enter a separate authorization request if additional services are being provided in the home outside of physical therapy
Home Health Requests (FirstCare Provider Portal)	• Choose the “Home Health” Authorization Type in the FirstCare Provider Portal when entering Home Health requests • Please enter a separate authorization request if Physical Therapy/ Occupational Therapy are also being provided
Home Health Providers (FirstCare Provider Portal)	• If your authorization request is for therapy ONLY, please choose the “Outpatient” Authorization Type. Please do not choose the “Home Health” Authorization Type

Appendix

Authorization Types

Authorization Type	Definition
Behavioral Health	• All requests for behavioral health services
DME	• All requests for Durable Medical Equipment
Home Health	• Any request for skilled services provided in the home; therapy only authorizations should be requested as outpatient services
Home Infusion	• Only enter this request type if the drug is on the Medical Benefit Drug Authorization list located on the provider portal
Medicaid, Over the Benefit Limit	• Use when services requested will exceed the Medicaid Benefit limit
Inpatient Medical/ SNF	• Use when a member is CURRENTLY inpatient for medical reasons
Inpatient Surgical	• Use when a member is CURRENTLY inpatient and has been admitted for surgical reasons
Medical Pharmacy	• Use for drugs on the Medical Benefit Drug Authorization list located on the provider portal
Non Emergent Ambulance	• All non emergent ambulance requests
Out of Network Physician Referral	• Use for referral to an out of network physician
Out of Network Services	• Use for services to be rendered at an out of network facility
Outpatient Services	• Use for general prior authorization requests not mentioned above • USE THIS REQUEST TYPE FOR PRIOR AUTHORIZATION OF ANY SURGERY, EVEN IF THE SURGERY WILL RESULT IN AN INPATIENT STAY

Appendix

Priority Types

Priority Type	Definition
Routine	• Anything not urgent
Urgent	• An urgent review should only be requested for a patient with a life-threatening condition or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition • A provider or facility may also request an urgent review to authorize treatment of an acute injury or illness if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health
Retrospective	• Anything where services have already begun

Contact Information

FirstCare Customer Service:

HMO: 1-800-884-4901

PPO: 1-800-240-3270

Medicaid: 1-800-431-7798

CHIP: 1-877-639-2447

Email: customerservice@firstcare.com

Please note that all calls should be directed to FirstCare at the numbers provided above.

my.firstcare.com

Provider Portal
Quick Reference Guide

Registration & Access

An activation code is required for new providers to access FirstCare's Provider Self-Service Portal. If you are a new provider, please follow the steps below to obtain an activation code to create a new account:

1. Contact the Provider Relations Team *(see contact information below)*.
2. Provide your group/provider/facility information, including:
   - Contact phone number
   - Email address
   - Billing address
   - NPI (Group & Individual)
   - Tax ID number
3. After your information is in our system, we'll provide you with an activation code.
4. Log in to the Provider Portal at my.firstcare.com and create a new user account.

Note: *If you already have access to the Provider Portal and need to add new users, simply follow the same steps above.*

Getting Help

If you have questions or need additional assistance, contact FirstCare Provider Relations.

Region	Phone Number	Email
Abilene area	1-325-670-3882 or 1-325-670-3884	prabilene@firstcare.com
Amarillo area	1-806-467-3200	prsupport@firstcare.com
Lubbock, Waco & all other areas	1-806-784-4380	prlubbock@firstcare.com

Navigation

Home
- News & updates

Members
- Search Member Profiles
  - Eligibility
  - Deductible/OOP
  - Other insurance info

Claims
- Claims search
- Electronic claims status
- Online claim submission

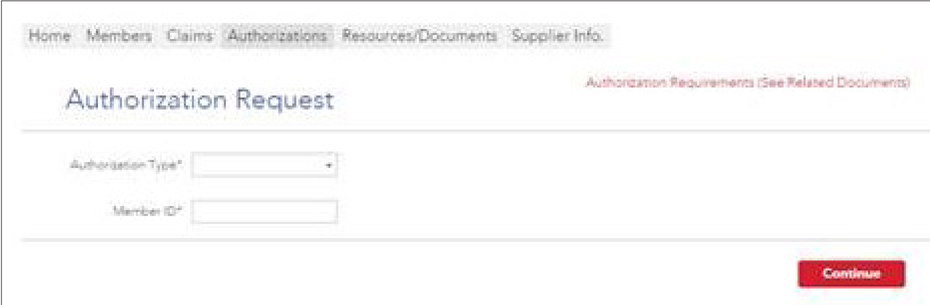
Authorizations
- Prior authorization look-up
- Authorization requests
- Authorization search
- Authorization documents
- Medical Necessity criteria

Resources/Documents
- Reports & resource documents
- Negative balance reports
- Document search
- Health Reform Resource Center

Supplier Info.
- General Information

Requesting an Authorization

1. Select authorization type and enter member ID.
2. Fill out contact information related to the authorization.
3. Provide all the details surrounding the authorization.
4. Upload a supporting document (optional).
5. Click "Submit."



Home Members Claims Authorizations Resources/Documents Supplier Info.

Authorization Request

Authorization Requirements (See Related Documents)

Authorization Type*

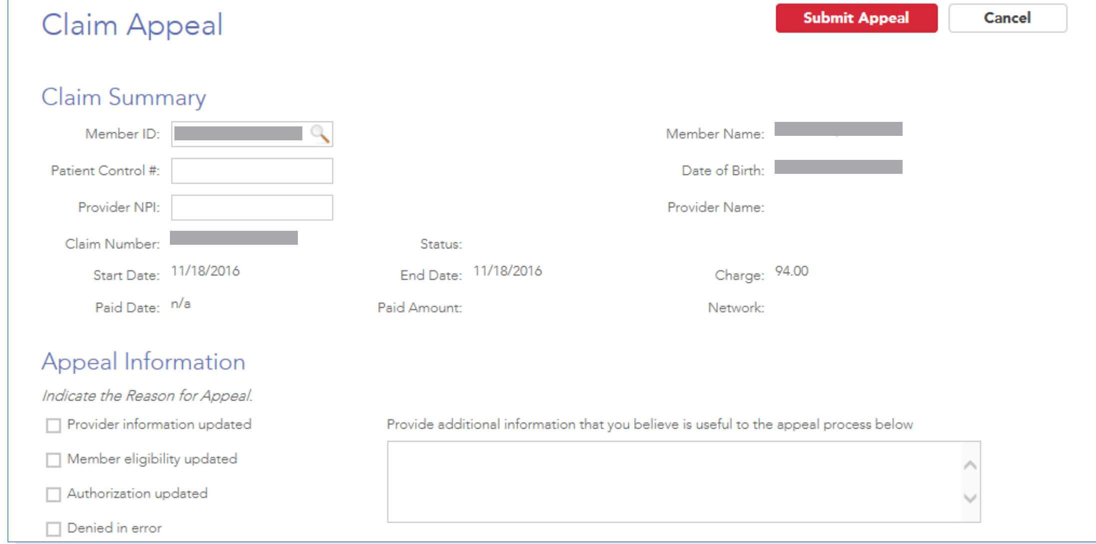
Member ID*

Continue

Appealing a Claim

1. Perform a claim search to find the claim or claim line to be appealed.
2. Click on the Claim ID hyperlink.
3. To appeal a single line, click on the Appeal hyperlink to the left of the line. To appeal the entire claim click "Appeal Claim" under the Claim Actions menu.
4. Enter the patient control number and the provider NPI.
5. Indicate the reason for the appeal.
6. Attach a related document (optional).
7. Click "Submit Appeal."

After your submission is complete, a reference number will be provided to track your appeal. Notation of the appeal will also be documented in the Message Center.



Claim Appeal

Submit Appeal Cancel

Claim Summary

Member ID:

Member Name:

Patient Control #:

Date of Birth:

Provider NPI:

Provider Name:

Claim Number:

Status:

Start Date: 11/18/2016

End Date: 11/18/2016

Charge: 94.00

Paid Date: n/a

Paid Amount:

Network:

Appeal Information

Indicate the Reason for Appeal.

- Provider information updated
- Member eligibility updated
- Authorization updated
- Denied in error

Provide additional information that you believe is useful to the appeal process below

Provider Relations Contacts List

Contact	Phone	Email	Counties
Abilene			
Craig Haterius	1-325-670-3882	chaterius@firstcare.com	Callahan, Coke, Coleman, Eastland, Fisher, Haskell, Jones, Kent, Knox, McCulloch, Mitchell, Nolan, Runnels, Shackelford, Stephens, Stonewall, Taylor, Throckmorton
Rose Russell	1-325-670-3884	rrussell@firstcare.com	Callahan, Coke, Coleman, Eastland, Fisher, Haskell, Jones, Kent, Knox, McCulloch, Mitchell, Nolan, Runnels, Shackelford, Stephens, Stonewall, Taylor, Throckmorton
Amarillo			
Velann Anderson	1-806-467-3201	Alternate Phone	Armstrong, Briscoe, Childress, Collingsworth, Donley, Hall, Potter, Randall
Cristal Phillips	1-806-467-3204	cphillips@firstcare.com	Carson, Castro, Dallam, Deaf Smith, Gray, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Parmer, Roberts, Sherman, Swisher, Wheeler
Austin/South Texas			
Ovidio Garcia	1-512-257-6386	ogarcia@firstcare.com	Dimmit, Edwards, Frio, Kerr, Kimble, Kinney, La Salle, Mason, Real, Terrell, Uvalde, Val Verde, Zavala
Lubbock			
Jose Herrera	1-806-784-4306	jherrera@firstcare.com	Bailey, Borden, Cochran, Dawson, Gaines, Howard, Scurry, Yoakum
Monica Ryan	1-806-784-4388	mryan@firstcare.com	Crosby, Dickens, Floyd, Garza, Hale, Hockley, Kent, Lamb, Lubbock, Lynn, Motely, Terry
Lorene Vela	1-806-784-4337	lvela@firstcare.com	Lubbock (CHCL, UMC, UMC Physicians)
Michele Bruce	1-806-784-4312	mbruce@firstcare.com	Lubbock (CMC, CMG)
Midland Odessa			
Irma Henson	1-806-784-4333	ihenson@firstcare.com	Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Jeff Davis, Loving, Martin, Midland, Pecos, Presidio, Reagan, Reeves, Upton, Ward, Winkler
San Angelo/Statewide			
Paul Kuder	1-512-257-6207	pkuder@firstcare.com	Brown, Concho, Crockett, Irion, Menard, Schleicher, Sterling, Sutton, Tom Green
Waco			
Ovidio Garcia	1-512-257-6386	ogarcia@firstcare.com	Bell, Bosque, Brazos, Burleson, Burnet, Coryell, Erath, Falls, Freestone, Grimes, Hamilton, Hill, Houston, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Navarro, Robertson, San Saba, Somervell, Walker, Washington
Wichita Falls			
Jose Herrera	1-806-784-4306	jherrera@firstcare.com	Archer, Baylor, Clay, Foard, Gaines, Hardeman, Hood, Jack, Palo Pinto, Parker, Tarrant, Wichita, Wilbarger, Young

FirstCare Contact Phone Numbers

Customer Service

HMO	1-800-884-4901
PPO	1-800-240-3270
Medicaid	1-800-431-7798
CHIP	1-877-639-2447
Marketplace	1-855-572-7238
Self-funded	1-888-249-7366
Behavioral Health	
Medicaid/CHIP	1-800-327-6934
All other products	1-800-327-6943

Prior Authorization

Phone	1-800-884-4905
Fax	1-800-248-1852
DME Fax	1-800-431-7738
Behavioral Health Fax	1-512-233-5949

Adjudication Review Center (Claims)

Address	PO Box 853935, Richardson, TX 75085-3936
Fax	1-512-257-6018

EFT—Emdeon

Website	www.emdeonepayment.com
Phone	1-866-506-2830

Language Line

Phone	1-800-874-9426
Organization Name	FirstCare
FirstCare Account #	704344
Personal Code	
PCP	6106
Specialists	6144

Complaints

Address	Attn: Complaints and Appeals 12940 N Highway 183, Austin, TX 78750
Fax	1-806-784-4319
Email	complaints@firstcare.com