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7.1 Medicaid Managed Care

Texas Medicaid, administered by the Texas Health and Human Services Commission (HHSC), operates the Medicaid managed care program under the authority of federal waivers and state plan amendments approved by the Centers for Medicare & Medicaid Services (CMS).

7.1.1 Overview

Originally, the Texas Medicaid managed care program was called the State of Texas Access Reform (STAR) Program. The STAR Program was established to explore different methods of building a framework of managed care around segments of Texas Medicaid. In 1995, the Texas Legislature adopted Senate Bill (S.B.) 10 and related legislation that authorized HHSC to undertake a comprehensive restructuring of Texas Medicaid to incorporate managed care delivery systems statewide.

Currently, the Medicaid managed care program consists of two types of health-care delivery systems: health maintenance organizations (HMOs) and Primary Care Case Management (PCCM). HMOs provide services in the metropolitan areas. PCCM provides services in the remaining 202 rural counties. (See page 7-31 for a listing of PCCM counties.)

The principle objectives of Medicaid managed care are to emphasize early intervention and to promote improved health outcomes for the target population, with a special focus on prenatal and well-child care.

Clients enrolled in any of the Medicaid managed care programs may reside in metropolitan or rural areas. These programs include:

- The STAR Program operates under a 1915(b) waiver and provides acute and long term medical assistance in a Medicaid managed care environment for clients who reside in the Bexar, Dallas, El Paso, Harris, Harris Expansion, Lubbock, Nueces, Tarrant, and Travis metropolitan service areas (SAs) (see “STAR Program” on page 7-15).
- The STAR+PLUS Program operates under a 1915(b) waiver and 1915(c) waiver and provides integrated acute and long term services and supports in a Medicaid managed care environment for clients who reside in the Bexar, Harris, Harris Expansion, Nueces, and Travis SAs (see “STAR+PLUS Program” on page 7-21).
- The NorthSTAR Program, administered by the Department of State Health Services (DSHS), operates under a 1915 (b) waiver and provides integrated behavioral health services under contract with a behavioral health organization (BHO) for clients who reside in the Dallas SA (see “NorthSTAR Program” on page 7-27).
- The PCCM Program, administered by TMHP, operates under a state plan amendment for clients who reside in the 202 rural Texas counties (see “PCCM” on page 7-31).

- The Integrated Care Management (ICM) Program operates under a 1915 (b) and two 1915 (c) waivers. ICM administered by Evercare, is a Medicaid managed care program that is designed to serve aged, blind, and disabled Medicaid clients who reside in Tarrant and Dallas service areas (see “Integrated Care Management (ICM) Program” on page 7-24).
- STAR Health, administered by Superior HealthPlan, is a Medicaid managed care program that manages the health care for children who are enrolled in the foster care program. STAR Health provides services statewide. (see “STAR Health Program” on page 7-30).

The goals of Medicaid managed care are to:

- Improve the access to care for clients enrolled in the programs.
- Increase quality and continuity of care for clients.
- Decrease inappropriate usage of the health-care delivery system, such as emergency rooms (ERs) for nonemergencies.
- Achieve cost-effectiveness and efficiency for the state.
- Promote provider and client satisfaction.

Additional goals for the STAR+PLUS and ICM programs include:

- Integrating acute and long-term services and supports.
- Coordinating Medicare services for clients who are dual eligible.

Higher use of medical services by Texas Medicaid fee-for-service clients occurs when clients obtain care through ERs or access duplicative services for the same medical condition. In Medicaid managed care, clients assume a responsible role in achieving their personal health care by choosing a primary care provider, then actively participating with their primary care provider to access preventive primary care services. This collaborative approach to health-care delivery usually achieves cost savings for Texas Medicaid by reducing duplicative services and unnecessary emergency and inpatient care. Although many of the Medicaid managed care requirements are similar, each program has established specific objectives, eligibility and enrollment requirements, and claims filing processes, which are detailed in this section.

7.1.2 Third-Party Resources (TPR)

The Third-Party Liability program helps reduce Medicaid costs by shifting claims expenses to third-party payers. Third-party payers are entities or individuals that are legally responsible for paying the medical claims of Medicaid recipients. As a condition of eligibility, Medicaid recipients assign their rights (and the rights of any other eligible individuals on whose behalf he or she has legal authority under state law to assign such rights) to medical support and payment for medical care from any third party to Medicaid. Federal law and regulations require states to ensure Medicaid recipients use all other resources available to them to pay for all or part of their medical care before turning to Medicaid. Medicaid pays only after the
third party has met its legal obligation to pay (i.e., Medicaid is the payer of last resort). A third party is any individual, entity, or program that is, or may be, liable to pay for any medical assistance provided to a recipient under the approved state Medicaid plan. Third parties may include any of the following:

- Private health insurance
- Employment-related health insurance
- Medical support from absent parents
- Casualty coverage resulting from an accidental injury such as automobile or property insurance (including no-fault insurance)
- Court judgments or settlements from a liability insurer
- State workers’ compensation
- First party probate-estate recoveries
- Other federal programs (e.g., Indian Health, Community Health, and Migrant Health programs), unless excluded by statute

To report if a client has new/changed private health insurance, refer to the “Other Insurance Form” on page B-70.

To report if a client has been in an accident or injury, refer to the “Tort Response Form” on page B-116.

Note: Adoption agencies or foster parents are no longer considered a TPR. Medicaid is primary in these circumstances.

7.1.3 The Health Insurance Premium Payment (HIPP) Program

HIPP program clients should access their benefits through Texas Medicaid fee-for-service and should not be enrolled in managed care unless they choose to leave the HIPP program.

Refer to: “Health Insurance Premium Payment (HIPP) Program” on page 4-18.

7.1.4 Client Enrollment

HHSC has targeted specific client groups within the Texas Medicaid population for managed care enrollment. Refer to each program in this section for enrollment information.

In most cases, Medicaid managed care enrollment is not retroactive. For exceptions, see “Enrollment of Pregnant Women (Type Program 40)” on page 7-18, “Enrollment of Newborns” on page 7-18, and “Client Enrollment” on page 7-28.

7.1.4.1 Managed Care Eligibility and Effective Date

Providers must validate a client’s eligibility and membership within an identified plan. Providers must then pursue any prior authorization or administration requirements specific to that plan.

Benefits under the STAR and STAR+PLUS programs usually begin on the first day of the next month following selection of a primary care provider and plan. NorthSTAR has retroactive enrollment and does not require a primary care provider (see “Client Enrollment” on page 7-28).

Benefits under the PCCM and ICM programs usually begin on the first day of the next month following Medicaid eligibility. For example, a client who has become eligible for Medicaid benefits for the first time, may be certified and begin to receive benefits under Texas Medicaid on the same day. If the client is also determined to be eligible for managed care, a second and separate enrollment process takes place.

Benefits under STAR Health begin when the client is placed in conservatorship.

The client does not begin to receive services under Medicaid managed care until the first day of the following month (providing enrollment takes place before the cut-off date for the following month). Enrollments and disenrollments become effective on the first day of the month (refer to example 1).

Exception: Newborn enrollments are retroactive to the date of birth (DOB).

<table>
<thead>
<tr>
<th>STAR and STAR+PLUS Example 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
</tr>
<tr>
<td>Client selects health plan and primary care provider</td>
</tr>
<tr>
<td>Managed care benefits begin</td>
</tr>
</tbody>
</table>

If a client selects a plan and primary care provider after the cut-off date (approximately the 15th of the month) they will not be enrolled in managed care nor appear on a primary care provider’s patient list until the second month after their enrollment effective date (refer to example 2).

<table>
<thead>
<tr>
<th>STAR and STAR+PLUS Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
</tr>
<tr>
<td>Client selects health plan and primary care provider</td>
</tr>
<tr>
<td>Managed care benefits begin</td>
</tr>
</tbody>
</table>

Clients may receive services under Texas Medicaid fee-for-service from the first date of eligibility. Claims for these services are billed to TMHP. Once managed care enrollment is in effect, the provider must bill the client’s managed care organization for all capitated services or PCCM. Providers continue to bill noncapitated services to TMHP.

Note: All claims for Supplemental Security Income (SSI) clients in STAR are billed to TMHP.
PCCM
When a client in the PCCM area is determined Medicaid-eligible and is a mandatory enrollee, the client is automatically enrolled in PCCM. Enrollment into PCCM is prospective.

<table>
<thead>
<tr>
<th>Example</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid</td>
<td>January 2</td>
</tr>
<tr>
<td>Medicaid benefits begin</td>
<td>January 1</td>
</tr>
<tr>
<td>PCCM benefits begin (automatic enrollment)</td>
<td>February 1</td>
</tr>
</tbody>
</table>

Exception: Newborn enrollments are retroactive to the DOB.
Refer to: "Newborn Claims Submission" on page 7-21.

ICM
When a client is determined Medicaid eligible and is eligible for the ICM program, the client enrollment into the ICM program occurs prior to the cutoff date and the benefits begin on the first day of the following month.

ICM clients do not select a health plan for ICM (there is only one) and do not have to select a primary care provider for their benefits to begin. Babies born to ICM clients receive benefits through Texas Medicaid fee-for-service retroactive to their DOB; they will not be ICM members.

7.1.4.2 Automatic Reenrollment
If a client loses Medicaid eligibility and then regains eligibility within six months, the client is automatically reassigned to their previous health plan and primary care provider.

7.1.5 Primary Care Provider Changes

7.1.5.1 Client-Initiated Primary Care Provider Changes
A client may change primary care providers for the following reasons:
- The client is dissatisfied with the care or treatment they have received.
- The client’s condition or illness would be better treated by another provider type.
- The client’s new address is no longer convenient to the primary care provider’s location.

- The provider leaves the program (i.e., moves, no longer accepts Medicaid, is removed from Medicaid enrollment, is no longer managed career affiliated with the Medicaid managed care program, or is deceased).
- The client/primary care provider relationship is not mutually agreeable.

HMO and PCCM Primary Care Provider Changes
Primary care provider changes for PCCM, STAR, and STAR+PLUS can be received up to the last business day of the month and made effective the first day of the next calendar month, as shown in the following example:

<table>
<thead>
<tr>
<th>HMO and PCCM Primary Care Provider Changes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Request received</td>
<td>May 28</td>
</tr>
<tr>
<td>Change effective</td>
<td>June 1</td>
</tr>
</tbody>
</table>

STAR Health
Primary care provider changes for STAR Health are effective immediately.

ICM Primary Care Provider Changes
Client requests for primary care provider changes received prior to the middle of the month usually become effective on the first day of the following month. If a client’s request for a primary care provider change is received after the middle of the month, the change may become effective on the first day of the second month following the request, as shown in the example below.

<table>
<thead>
<tr>
<th>ICM Primary Care Provider Changes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Request received on or before</td>
<td>Mid-May</td>
</tr>
<tr>
<td>Change effective</td>
<td>June 1</td>
</tr>
<tr>
<td>Request received after</td>
<td>Mid-May</td>
</tr>
<tr>
<td>Change effective</td>
<td>July 1</td>
</tr>
</tbody>
</table>

7.1.5.2 Provider-Initiated Primary Care Provider Changes
A provider may request a client be reassigned to another primary care provider for any of the following reasons:
- The client is not included in the primary care provider’s scope of practice.
- The client is noncompliant with medical advice.
- The client consistently displays unacceptable office decorum.
- The client/primary care provider relationship is not mutually agreeable.

Any request by a provider to reassign a client to another primary care provider must be processed through the applicable managed care program. Before a request for reassignment can be initiated, reasonable measures must be taken to correct the client’s behavior. Reasonable measures may include education or counseling by health plan or PCCM staff. The health plan or PCCM will notify the client of the reassignment if all attempts to remedy the situation have failed. Providers
should also notify the client about the reassignment in writing and send a copy of the notification to the health plan or PCCM.

7.1.5.3 Medicaid Managed Care-Initiated Primary Care Provider Changes
In addition, a client may be reassigned to another primary care provider for any of the following reasons:

- The primary care provider is sanctioned by HHSC.
- The primary care provider exhibits a documented pattern of unacceptable quality of care.
- The primary care provider inappropriately reduces client’s right to access specialty services covered under Medicaid managed care.

7.1.6 Health Plan Changes

7.1.6.1 Client-Initiated HMO Plan Changes
Clients have the right to change plans.
Clients must call the enrollment broker to initiate a plan change. If a plan change request is received before the middle of the month, the plan change is effective on the first day of the following month. If the request is received after the middle of the month, the plan change will be effective on the first day of the second month following the request, as shown below.

| Example |
|------------------|------------------|
| Request received on or before | Mid-May |
| Change effective | June 1 |
| Request received after | Mid-May |
| Change effective | July 1 |

Note: All plan change requests must be processed by the enrollment broker.
The ICM, PCCM, and STAR Health programs only have one plan choice available. As a result, clients cannot change plans.

7.1.6.2 Health Plan Managed Care Administrator-Initiated Changes
Each health plan has a limited right to request that a client be disenrolled without the client’s consent. HHSC must approve any request for such disenrollment.
A health plan may request that a client be disenrolled for the following reasons:

- The client loans his or her Medicaid Identification Form (Form H3087) to another person to obtain services.
- The client continually disregards the advice of his primary care provider.
- The client repeatedly uses the ER inappropriately.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the client’s behavior. Reasonable measures may include education or counseling conducted by health plan staff. HHSC will notify the client of the disenrollment if all attempts to remedy the situation have failed. HHSC will also notify the client of the availability of appeal procedures and the HHSC fair hearing process. Neither the health plan nor a provider may request a disenrollment based on an adverse change in the client’s health or the utilization of services which are medically necessary for the treatment of a client’s condition.

7.1.7 Client Rights and Responsibilities

7.1.7.1 Client Rights
In Texas, Medicaid managed care clients have defined rights and responsibilities. Each health plan and primary care provider share the responsibility to ensure and protect client rights and to assist clients in understanding and fulfilling their responsibilities as plan clients.

Note: Please refer to “Client Rights and Responsibilities” on page 7-34 for information about client rights and responsibilities related to PCCM.

Medicaid managed care clients have the right to:

- Be treated fairly and with dignity and respect.
- Know that their medical records and discussions with their providers will be kept private and confidential.
- Request changes to their medical records (if incorrect).
- A reasonable opportunity to choose a health-care plan and primary care provider (the doctor or health-care provider they will see most of the time and who will coordinate their care) and to change to another plan or provider in a reasonably easy manner. These opportunities include the right to:
  - Be informed of available health plans and primary care providers in their areas.
  - Be informed of how to choose and change health plans and primary care providers.
  - Choose any health plan that is available in their area and choose a primary care provider.
  - Change their primary care provider.
  - Change health plans without penalty.
  - Be educated about how to change health plans or primary care providers.
  - Ask questions and get answers about anything they don’t understand, and that includes the right to:
    - Have their provider explain their health-care needs to them and talk to them about the different ways their health-care problems can be treated.
    - Be told why care or services were denied and not given.
• Consent to or refuse treatment and actively participate in treatment decisions, and that includes the right to:
  • Work as part of a team with their provider in deciding what health care is best for them.
  • Say yes or no to the care recommended by their provider.
• Utilize each available complaint and appeal process through the managed care organization and through Medicaid, receive a timely response to complaints, appeals, and fair hearings. These processes include the right to:
  • Make a complaint to their health plan or to the state Medicaid program about their health-care, provider, or health plan.
  • Get a timely answer to their complaint.
  • Access the health plan appeal process and the procedures for doing so.
  • Request a fair hearing from the state Medicaid program and request information about the process for doing so.
• Timely access to care that does not have any communication or physical access barriers. That the right to:
  • Have telephone access to a medical professional 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care.
  • Get medical care in a timely manner.
  • Be able to get in and out of a health-care provider’s office, including barrier free access for persons with disabilities or other conditions limiting mobility, in accordance with the Americans with Disabilities Act.
  • Have interpreters, if needed, during appointments with their providers and when talking to their health plan. Interpreters include people who can speak in their native language, assist with a disability, or help them understand the information.
  • Be given an explanation they can understand about their health plan rules, including the health-care services they can get and how to get them.
  • Not be restrained or secluded when doing so is for someone else’s convenience, or is meant to force them to do something they do not want to do, or to punish them.

7.1.7.2 Client Responsibilities
Medicaid managed care health plans and primary care providers should help clients understand their responsibilities. These include the responsibility to:
• Learn and understand each right they have under Medicaid. That includes the responsibility to:
  • Learn and understand their rights under the Medicaid program.
  • Ask questions if they do not understand their rights.
  • Learn what choice of health plan is available in their area.

• Abide by the health plan and Medicaid managed care policies and procedures. That includes the responsibility to:
  • Learn and follow their health plan rules and Medicaid rules.
  • Choose their health plan and a primary care provider.
  • Make any changes in their health plan and primary care provider in the ways established by Medicaid managed care and by the health plan.
  • Keep their scheduled appointments.
  • Cancel appointments in advance when they cannot keep them.
  • Always contact their primary care provider first for nonemergency medical needs.
  • Be sure they have approval from their primary care provider before going to a specialist (except for self-referred services).
  • Understand when they should and should not go to the ER.
• Share information relating to their health status with their primary care provider and become fully informed about service and treatment options. That includes the responsibility to:
  • Tell their primary care provider about their health.
  • Talk to their providers about their health-care needs and ask questions about the different ways their health-care problems can be treated.
  • Help their providers get their medical records.
• Actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
  • Work as a team with their provider in deciding what health care is best for them.
  • Understand how the things they do can affect their health.
  • Do the best they can to stay healthy.
  • Treat providers and staff with respect.

7.1.7.3 Advance Directives
Federal and state law require providers to maintain written policies and procedures for informing and providing written information to all adult clients 18 years of age or older about their rights under state and federal law, in advance of their receiving care (Social Security Act §§1902[a][57] and 1903[m][1][A]). The written policies and procedures must contain procedures for providing written information regarding the client’s right to refuse, withhold, or withdraw medical treatment advance directives.
These policies and procedures must comply with provisions contained in 42 Code of Federal Regulations (CFR) §§ 434.28 and 489, SubPart I, relating to the following state laws and rules:

- A client’s right to self-determination in making health-care decisions.
- The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
  - A client’s right to execute an advance written directive to physicians and family or surrogates, or to make a nonwritten directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition.
  - A client’s right to make written and nonwritten Out-of-Hospital Do-Not-Resuscitate Orders.
  - A client’s right to execute a Medical Power of Attorney to appoint an agent to make health-care decisions on the client’s behalf if the client becomes incompetent.

These policies can include a clear and precise statement of limitation if a participating provider cannot or will not implement a client’s advance directive. A statement of limitation on implementing a client’s advance directive should include at least the following information:

- A clarification of the provider’s conscience objections.
- Identification of the state legal authority permitting a provider’s conscience objections to carrying out an advance directive.
- A description of the range of medical conditions or procedures affected by the conscience objection.

A provider cannot require a client to execute or issue an advance directive as a condition for receiving health-care services. A provider cannot discriminate against a client based on whether or not the client has executed or issued an advance directive.

A provider’s policies and procedures must require the provider to comply with the requirements of state and federal law relating to advance directives.

7.1.8 Primary Care Provider Requirements and Information

Under Medicaid managed care HMOs, eligible Medicaid clients must select a health plan and a primary care provider. Under Medicaid managed care PCCM, eligible Medicaid clients do not select a health plan. PCCM eligible Medicaid clients select a PCCM primary care provider. The primary care provider furnishes primary care-related services, arranges for and coordinates referrals for all medically necessary specialty services, and is available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, 7 days a week (see “Continuous Access” on page 7-11). Primary care includes ongoing responsibility for preventive health care, health maintenance, treatment of illness and injuries, and the coordination of access to needed specialist providers or other services.

Primary care providers can choose to contract with PCCM and HMO health plans simultaneously. Providers should remember that choosing an HMO does not require that providers terminate their contracts with PCCM.

PCCM providers in the STAR metropolitan areas are encouraged to continue to provide ongoing health-care services to PCCM clients who live in contiguous areas. There may be instances where PCCM clients may choose a PCCM primary care provider in a metropolitan (STAR) SA.

Provider types who are eligible to serve as a primary care provider include:

- Pediatricians
- Family/general practitioners
- Internists
- Obstetrician/gynecologists
- Nurse practitioners or clinical nurse specialists (family practice, women’s health, or pediatrics)
- Certified nurse-midwives
- Physician assistants (PAs)
- Rural health clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Specialists willing to provide medical homes to clients who have special needs

PAs may be eligible to enroll with Medicaid managed care as primary care providers. Contact the individual Medicaid managed care health plan for enrollment information.

The primary care provider either furnishes or arranges for all the client’s health-care needs, including well check-ups, office visits, referrals, outpatient surgeries, hospitalizations, and health-related services. Although primary care providers are encouraged to assist clients in accessing these services, Medicaid managed care enrollees may self-refer for the following services:

- Emergency services
- Family planning
- Texas Health Steps (THSteps) services and immunizations
- Case management for Early Childhood Intervention (ECI)
- Case management for Children and Pregnant Women (CPW)
- Obstetric or gynecological services
- School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) case management
- DSHS case management
- Department of Aging and Disability Services (DADS) case management
• Behavioral health services (contact client’s health plan for specific requirements)
• Vision care (including ophthalmologic or therapeutic optometry)

THSteps providers must be enrolled with Medicaid to be reimbursed for services provided to clients. THSteps services are self-referred. Medicaid HMOs determine how their clients will access THSteps services. The HMO may require the client to go to an in-network THSteps provider or may allow the client to go to any Medicaid THSteps provider, whether or not they are in the HMO’s network. Clients in PCCM are encouraged to access their primary care provider for THSteps services, but may self-refer to any Medicaid THSteps provider. Providers who perform THSteps must work in collaboration with the client’s primary care provider to ensure continuity of care.

Female clients may access obstetrical and gynecological providers directly. Behavioral health providers must enroll with each HMO to be reimbursed for services provided to managed care clients. Although managed care clients may self-refer for behavioral health services, HMO health plan providers should contact the client’s health plan for specific in-network requirements. If a behavioral health provider practices in the Dallas SA, he/she must be enrolled as a network provider in the NorthSTAR BHO. Providers who perform THSteps must work in collaboration with the client’s primary care provider to ensure continuity of care.

Providers cannot enroll Medicaid clients; however, educating clients is encouraged. Medicaid clients must enroll through the official state enrollment form or by calling the STAR Help Line at 1-800-964-2777.

Providers should follow these rules when educating patients:
• Providers may not influence patients to choose one HMO health plan over another or one PCCM provider over another.
• HMO providers must inform patients of all Medicaid managed care health plans in which the providers participate.
• HMO providers participating in a Medicaid managed care HMO may display state-approved, health-related marketing materials in their offices, provided it is done equally for all HMOs in which they participate. HMO providers cannot give out or display plan-specific marketing items or giveaways to patients.
• Providers and subcontractors may only directly contact potential clients with whom they have an established relationship.
• HMO providers may inform patients of special services offered by all Medicaid managed care health plans in which the providers participate.

HMO providers may inform patients of particular hospital services, specialists, or specialty care available in all plans in which the providers participate.

HMO providers may assist a patient by contacting a plan (or plans) to determine if a particular specialist or service is available, if the patient requests this information.

HMO providers may not influence patients based on reimbursement rates or methodology used by a particular plan.

HMO providers can provide the necessary information for the patient to contact a particular plan but cannot promote any plan over another.

In no instances can HMO providers stock, reproduce, assist in filling out, or otherwise handle the enrollment form. Information can be provided as outlined above, and patients can be reminded that they can easily enroll over the telephone with the enrollment broker. However, the call must be made by the patient, not by the HMO provider or the provider’s agent.

HMO providers may assist clients with completing the Medicaid application.

PCCM providers may stock primary care provider selection forms and/or provide a blank primary care provider selection form to the client. They may assist the client in filling out the selection forms. However, they may not in any way influence or coerce the client in making a primary care provider selection. Each client must personally complete, sign, and mail their individual form. Providers are prohibited from supplying provider-identified stationary and/or envelopes to the client for this purpose.

HMO providers may display stickers indicating they participate in a particular Medicaid managed care health plan as long as they do not indicate anything more than “(health plan) is accepted or welcomed here.”

7.1.8.1 Continuous Access

Continuous access is an important feature of Medicaid managed care. Twenty-four-hour primary care provider availability enables clients to access and use services appropriately, instead of relying on ERs for after-hours care.

Continuous access can be provided through direct access to a primary care provider’s office and/or through on-call arrangements with another office or service. Clients should be informed of the primary care provider’s normal office hours and should be instructed how to access urgent medical care after normal office hours.
After-Hours Guidelines
Primary care providers are required to have at least one of the following arrangements in place to provide 24-hour, 7-day a week access for managed care clients:

- An office phone answered after hours by a medical exchange or a professional answering service. If an answering service is used, the following must be met:
  - The answering exchange or service must be able to contact the primary care provider or a designated back-up provider for immediate assistance.
  - The primary care provider, or designated back-up provider, must be notified of all calls.
  - All calls must be returned in a timely manner by the primary care provider or designated back-up.
  - The answering service must meet the language requirements of the major Medicaid population groups in the primary care provider’s area.
- An office phone answered after office hours by an answering machine that instructs the client (in the language of the major Medicaid population groups) to do one of the following:
  - Call the name and phone number of a medical facility where the client can request to speak with a medical professional to determine whether emergency treatment is appropriate.
  - Call another number where the primary care provider can be reached.
  - Call the name and telephone number of a medical professional serving as designated back-up. In this situation, the client must be able to speak with the back-up provider or a clinician who can offer immediate assistance.
- An office phone transferred after hours to another location where someone will answer and be able to contact the primary care provider or designated back-up provider.

Unacceptable telephone Arrangements
The telephone answering procedures listed below are not acceptable:

- An office telephone that is answered only during office hours.
- An office telephone that is answered by a recording or an answering service that directs clients to go to the ER.
- An office telephone answered after hours by an answering machine recording that tells clients to leave a message.
- An office telephone answering machine recording that informs clients of regular office hours and requests that they call back during those hours.
- PCCM providers may not direct clients to call the PCCM nurse helpline in order to meet the primary care provider 24-hour continuous coverage requirements.

7.1.8.2 Cultural Competency and Sensitivity
HHSC values the diversity of the Texas Medicaid population and requires Medicaid managed care to provide programs to support clients from diverse cultural backgrounds:

- Helplines are staffed by both Spanish- and English-speaking customer service representatives who, at any time, may access a multi-language translation service for assistance.
- Articles in the Texas Medicaid Bulletin and educational workshops include topics that focus on cultural sensitivity and the need for culturally competent staff in primary care provider offices.

Providers are expected to comply with the laws concerning discrimination on the basis of race, color, national origin, or sex.

Limited English Proficiency
Medicaid providers are required to provide services in the languages of the major Medicaid population groups they serve and to ensure quality appropriate translations. Title VI, section 601, of the Civil Rights Act of 1964 states that “no person in the United States shall on the basis of race, color, or national origin, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

HHSC requires Medicaid providers to ensure persons with limited English proficiency have equal access to the medical services to which they are legally entitled.

Meeting the requirements of Title VI may require the primary care provider to take all or some of the following steps at no cost or additional burden to the beneficiary with limited English proficiency:

- Have a procedure for identifying the language needs of patients/clients.
- Have access to proficient interpreters during hours of operation.
- Develop written policies and procedures regarding interpreter services.
- Disseminate interpreter policies and procedures to staff and ensure staff awareness of these policies and procedures and of their Title VI obligations to persons with limited English proficiency.

In order to meet interpretation requirements, providers may choose to incorporate into their business practice any of the following (or equally effective) procedures:

- Hire bilingual staff.
- Hire staff interpreters.
- Use qualified volunteer staff interpreters.
- Arrange for the services of volunteer community interpreters (excluding the client’s family or friends).
- Contract with an outside interpreter service.
• Use a telephone interpreter service such as Language Line Services.

• Develop a notification and outreach plan for beneficiaries with limited English proficiency.

Complaints and reports of non-compliance with Title VI regulations are handled by the Office for Civil Rights (OCR).

Additional information, including the complete guidance regulations are handled by the Office for Civil Rights (OCR), can be found on the Internet at www.hhs.gov/ocr/lep/guide.html.

7.1.8.3 Primary Care Provider-to-Client Ratio and Capacity

HHSC oversees all Medicaid managed care providers for accessibility and quality of care. If HHSC determines that providers do not have, or fail to maintain, the capacity or capability of providing quality, accessible care, their clients will be reduced through a freeze on new enrollments to the provider’s panel. HHSC may reassign current clients from the provider’s panel roster if required accessibility and quality of care to clients is jeopardized.

7.1.9 Medicaid Managed Care Complaints and Fair Hearings

Medicaid managed care providers may file complaints with HHSC if they find they did not receive full due process from the respective managed care health plan.

Appeals/grievances or dispute resolution is the responsibility of each managed care health plan or PCCM. Providers must exhaust the complaints or grievance process with their managed care health plan or PCCM before filing a complaint with HHSC.

Please refer to the respective health plan or PCCM for information about specific complaint policies and procedures. For PCCM, please see “Provider Complaints and Appeals” on page 7-52. For NorthSTAR, see “Complaints and Appeals” on page 7-29. For HMOs, refer to the respective health plan’s policies and procedures. For paper appeals, refer to “Paper Appeals” on page 6-3.

7.1.10 Prior Authorizations

Prior authorizations do not transfer with the client between plans. Providers are required to obtain prior authorization through the plan in which the client is enrolled for the actual date of service (DOS) in order for payment to be considered.

7.1.11 Claims Filing Information

TMHP processes claims for the following clients/programs:

• All PCCM claims (whether Temporary Assistance for Needy Families [TANF], TANF-related, or SSI)

• All ICM claims

• All SSI clients who are in the STAR Program

• The following services for PCCM, STAR+PLUS, ICM, or STAR clients:
  • ECI Case Management
  • DSHS case management (except for the Dallas SA where clients are enrolled in NorthSTAR)
  • DADS services (See NorthSTAR client eligibility section for excluded DADS clients)
  • CPW Case Management
  • SHARS
  • DARS
  • TSHSteps Dental (dentist services only)
  • Tuberculosis services provided by DSHS-approved providers
  • Vendor Drug Program (VDP) (out-of-office drugs)
  • Audiology services and hearing aids for children under the age of 21 (hearing screening services are provided through the TSHSteps Program and are capitated) through the Program for Amplification for Children of Texas (PACT)

A claim must be submitted to TMHP for processing for a patient who was classified as SSI on the date of admission to a hospital. However, if the patient was an HMO client as of the date of admission to the hospital and was admitted as TANF or TANF-related (i.e., not SSI-certified), but changed to SSI during the same hospital stay, the claim must be submitted to the client’s HMO for payment of the entire hospital stay.

Electronic claims submissions require a National Provider Identifier (NPI) only. If a claim is submitted electronically with a Texas Provider Identifier (TPI), the claim will be denied. If an electronic claim is submitted without an NPI, the claim will be denied.

Paper claims submissions require a TPI and NPI for the performing and billing provider. The performing provider’s TPI is required in block 24j in the shaded area, and NPI in block 24j in the unshaded area of the CMS-1500 claims form. The billing provider’s TPI is required in block 33B in the shaded area, and the NPI in block 33A in the unshaded area. An NPI is required in all other NPI provider identifier blocks. If the NPI and TPI are not in the proper blocks on the claim form and if the NPI is missing from any of the other NPI required blocks, the claim will be denied.

Paper claims submissions for the referring provider require the complete name of the referring provider in block 17 and an NPI in block 17b. The referring provider for a managed care client must be the client’s primary care provider. If there is not a referral from the primary care provider, a prior authorization number must be on the claim.

If the provider of services is not the client’s assigned primary care provider, the primary care provider’s name and NPI number must be entered in the Referring Provider field of the approved electronic format. If this information...
Section 7

is missing and the treating provider is not the assigned primary care provider on the dates of service, the claim will be denied.

Providers submitting claims for SSI voluntary clients must follow the client’s individual plan requirements for referrals, authorization, admission notification, and concurrent review. The plan is responsible for notifying TMHP of the services that they have approved so those claims can be processed accordingly. Claims for SSI clients who are voluntarily enrolled in PCCM or an HMO will be paid at Texas Medicaid fee-for-service rates.

All Texas Medicaid fee-for-service processing guidelines are followed in processing these claims including the 95-day filing deadline. Send claims through regular mail to the following address:

Texas Medicaid & Healthcare Partnership
PO Box 200555
Austin, TX 78720-0555

Claims delivered by UPS or other courier methods are to be addressed to the following:

Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

TMHP Electronic Claims Submission

Electronic claims submission is available to providers filing claims for ICM clients, PCCM clients, and all SSI voluntary clients in STAR HMOs. Electronic claims submission is available to providers filing claims for STAR+PLUS inpatient hospital clients. Providers must use their provider identifier when billing. For assistance with enrolling to file electronic claims, contact the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638, or a provider representative. Contact individual plans for information on electronic claims submissions to STAR HMOs (refer to chart, STAR Program SAs).

Refer to: “TMHP Electronic Data Interchange (EDI)” on page 3-1 for more information about electronic claims submission.

7.1.11.1 National Drug Code (NDC) Claims

All providers that submit professional or outpatient claims with physician-administered prescription drug procedure codes for PCCM and STAR voluntary SSI will be required to use the associated NDC.

Drug claims submitted with procedure codes in the “A” code series will not require an NDC. The NDC is only required on outpatient hospital claims and physician claims.

N4 must be entered before the NDC on claims. The NDC is an 11-digit number on the package or container from which the medication is administered.

The unit of measurement codes for all three forms are:

- F2—International unit
- GR—Gram
- ML—Milliliter
- UN—Unit

Unit quantities must also be provided on the claim.

Depending on the claim type, the NDC information must be submitted as indicated below. If submitting on a UB-04 CMS-1450 the NDC information must be submitted as indicated below:

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>Revenue codes and description</td>
<td>Enter N4, the 11-digit NDC number (number on package or container from which the medication was administered), the unit of measurement code, and the unit quantity with a floating decimal for fractional units (limited to 3 digits). Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025</td>
</tr>
</tbody>
</table>

If submitting on a CMS-1500 the NDC information must be submitted as indicated below:
7.11.2 Claims for Pregnant Women (Type Program 40)
Claims for pregnant women who are on type program 40 should be directed to the health plan listed on the Medicaid Identification Form (Form H3087). In some instances, a primary care provider will not be assigned for the first month of eligibility. These claims should be filed with the following temporary primary care provider number as the referring provider: PCCTP4001. For clients who do not yet have a primary care provider assigned, call the client’s health plan for more information. If a health plan name does not appear on a STAR client’s Medicaid Identification Form (Form H3087), call the STAR Help Line at 1-800-964-2777.

For PCCM clients who do not yet have a primary care provider assigned, call the PCCM Client Helpline at 1-888-302-6688 to select a primary care provider.

7.2 STAR Program

7.2.1 Overview
The principal objectives of the STAR Program are to emphasize early intervention and to promote improved access to quality care, thereby significantly improving health outcomes for the target population, with a special focus on prenatal and well-child care.

Currently, the STAR Program consists of only one type of health-care delivery system (HMO) in select Texas counties. The selected grouping of counties is known as an SA.

7.2.1.1 STAR HMO Model
In the HMO model, each STAR health plan is responsible for contracting with providers and/or delegated network to create a health-care provider delivery network. Mandatory clients who reside in one of the SA counties where this model is available are required to select a health plan and a primary care provider. The client selects the primary care provider from the HMO provider directory.

7.2.2 Client Eligibility
HHSC has targeted these client groups within the Texas Medicaid population for STAR Program enrollment:

<table>
<thead>
<tr>
<th>Base Plan</th>
<th>Category</th>
<th>Type Program</th>
<th>Description</th>
<th>Bexar, Dallas, Harris, Harris Expansion, Nueces, Tarrant, and Travis SAs</th>
<th>El Paso and Lubbock SAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>1</td>
<td>Money grant and Medicaid</td>
<td>M</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>3</td>
<td>Medical Assistance Only/ Retirement Survivors Disability Insurance (MAO/ RSDI) increase</td>
<td>M</td>
<td>M</td>
<td></td>
</tr>
</tbody>
</table>

V=Voluntary, M=Mandatory, X=Not Eligible
<table>
<thead>
<tr>
<th>Base Plan</th>
<th>Category</th>
<th>Type Program</th>
<th>Description</th>
<th>Bexar, Dallas, Harris, Harris Expansion, Nueces, Tarrant, and Travis SAs</th>
<th>El Paso and Lubbock SAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>7</td>
<td></td>
<td>12 months transitional Medicaid resulting from increase in earnings</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>02</td>
<td>20</td>
<td></td>
<td>4 months transitional Medicaid resulting from receipt of child support</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>02</td>
<td>29</td>
<td></td>
<td>12 through 18 months transitional Medicaid following end of state time-limited TANF</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>02</td>
<td>37</td>
<td></td>
<td>12 months transitional Medicaid resulting from loss of 90 percent earned income disregard</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>02</td>
<td>40</td>
<td></td>
<td>Pregnant women with income &lt;185 percent Federal Poverty Limit (FPL)</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>02</td>
<td>43</td>
<td></td>
<td>Children &lt; 1 year of age at 185 percent FPL</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>02</td>
<td>44</td>
<td></td>
<td>Children 6 years of age through 19 years of age at 100 percent FPL</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>02</td>
<td>45</td>
<td></td>
<td>Newborn of Medicaid eligible mother to 1 year of age</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>02</td>
<td>47</td>
<td></td>
<td>Children ineligible for TANF due to applied income of stepparent or grandparent</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>02</td>
<td>48</td>
<td></td>
<td>Children 1 year of age though 5 years of age at 133 percent FPL</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>02</td>
<td>61</td>
<td></td>
<td>TANF state plan, money grant and Medicaid</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>03 or 04</td>
<td>3</td>
<td>MAO RSDI increase, no Medicare</td>
<td>X</td>
<td>V</td>
</tr>
<tr>
<td>13</td>
<td>03 or 04</td>
<td>12</td>
<td>SSI manually certified adults, no Medicare</td>
<td>X</td>
<td>V</td>
</tr>
<tr>
<td>13</td>
<td>03 or 04</td>
<td>12</td>
<td>SSI manually certified children 20 years of age or younger, no Medicare</td>
<td>X</td>
<td>V</td>
</tr>
<tr>
<td>13</td>
<td>03 or 04</td>
<td>13</td>
<td>SSI recipient, adults, no Medicare</td>
<td>X</td>
<td>V</td>
</tr>
</tbody>
</table>

V=Voluntary, M=Mandatory, X=Not Eligible
To ensure reimbursement, it is essential that all health-care providers verify eligibility before medical care is provided to STAR Program clients, except in cases of emergency. In situations where emergency care must be provided, the client’s STAR health plan and primary care provider should be determined as soon as possible.

STAR Program clients’ Medicaid Identification Forms (Form H3087) will indicate their participation in the STAR Program. Additionally, STAR health plans provide their clients an HMO identification card. Both forms of identification should be requested when determining whether or not the client is a STAR Program client.

### 7.2.3 Client Enrollment

A STAR Program client may choose a STAR health plan and primary care provider. To maximize enrollment, the STAR Program offers four alternative ways that clients can enroll:

- **Telephone Enrollment.** A client can enroll in the STAR Program by calling 1-800-964-2777. A customer care representative will provide essential education about the program and details needed for enrollment.

- **Mail-in Enrollment.** If calling is not convenient, a client may enroll by completing the STAR Program enrollment form and dropping it in the mail using the postage-paid, self-addressed envelope. Enrollment forms are mailed to all eligible mandatory clients along with a brochure explaining the program and provider directories for each plan.

- **Onsite Enrollment.** In addition to telephone and mail-in enrollment, clients can enroll by talking with a STAR Program customer care representative at a local HHSC office, at Women, Infants, and Children (WIC) classes, community facilities, or during enrollment events.

- **Default Enrollment.** The final method of enrollment is through an assignment process. If a client does not exercise the right to choose a STAR health plan and primary care provider, the client will be assigned to a plan and/or primary care provider. The following factors are considered when processing a default enrollment:
  - Client’s past claims history, taking into account an established relationship with a STAR participating primary care provider
  - Client’s age
  - Client’s sex
  - Client’s geographic proximity to the primary care provider

<table>
<thead>
<tr>
<th>Base Plan</th>
<th>Category</th>
<th>Type Program</th>
<th>Description</th>
<th>Bexar, Dallas, Harris, Harris Expansion, Nueces, Tarrant, and Travis SAs</th>
<th>El Paso and Lubbock SAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>03 or 04</td>
<td>13</td>
<td>SSI recipient, children &lt;21, no Medicare</td>
<td>X</td>
<td>V</td>
</tr>
<tr>
<td>13</td>
<td>03 or 04</td>
<td>18</td>
<td>Disabled Adult Children denied SSI due to increase in RSDI benefits, no Medicare</td>
<td>X</td>
<td>V</td>
</tr>
<tr>
<td>13</td>
<td>03 or 04</td>
<td>19</td>
<td>Transitional SSI Medicaid, no Medicare</td>
<td>X</td>
<td>V</td>
</tr>
<tr>
<td>13</td>
<td>03 or 04</td>
<td>22</td>
<td>Early Age Widows/ Widowers, no Medicare</td>
<td>X</td>
<td>V</td>
</tr>
</tbody>
</table>

V=Voluntary, M=Mandatory, X=Not Eligible
7.2.3.1 STAR Help Line (STAR Enrollment Broker)

<table>
<thead>
<tr>
<th>Hours</th>
<th>8 a.m. to 8 p.m., Central Time, Monday through Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>1-800-964-2777</td>
</tr>
<tr>
<td>Telecommunications device</td>
<td>1-800-267-5008</td>
</tr>
</tbody>
</table>

7.2.3.2 Enrollment of Pregnant Women (Type Program 40)

Women who are on Medicaid type program 40 may be retroactively enrolled in STAR. Women who are certified for Medicaid type program 40 on or before the 10th of the month will be enrolled in STAR beginning the first of the month of certification. Those who are certified after the 10th of the month will be on Texas Medicaid fee-for-service the month of certification and will be enrolled in STAR beginning the first of the month following the month of certification.

There are two exceptions to this rule:

- Women who are certified at any time in their estimated month of delivery will be enrolled in STAR the first of the following month (prospective enrollment).
- Women who are certified at any time in their actual month of delivery (if known by HHSC before certification) will be enrolled in STAR the first of the following month (prospective enrollment). If the mother does not make a plan choice for the newborn, one will be chosen.

It is important that providers call the number listed on the Medicaid Identification Form (Form H3087) for plan and provider information.

**Example 1**: Woman Certified in Her 6th Month

<table>
<thead>
<tr>
<th>Client certified for Texas Medicaid</th>
<th>August 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid benefits begin</td>
<td>August 1</td>
</tr>
<tr>
<td>STAR Program benefits begin</td>
<td>August 1</td>
</tr>
</tbody>
</table>

**Example 2**: Woman Certified in Her 6th Month

<table>
<thead>
<tr>
<th>Client certified for Texas Medicaid</th>
<th>August 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid benefits begin</td>
<td>August 1</td>
</tr>
<tr>
<td>STAR Program benefits begin</td>
<td>September 1</td>
</tr>
</tbody>
</table>

**Example 3**: Woman Certified in Her 9th Month

<table>
<thead>
<tr>
<th>Client certified for Texas Medicaid</th>
<th>August 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid benefits begin</td>
<td>August 1</td>
</tr>
<tr>
<td>STAR Program benefits begin</td>
<td>September 1</td>
</tr>
</tbody>
</table>

A pregnant woman who is on type program 40 has 16 days from the date of application to choose a STAR health plan. If she does not choose a STAR health plan, one will be chosen for her.

Expeditied Medicaid Managed Care Enrollment for Pregnant Women

The enrollment broker contacts the client to begin the enrollment process and assists the client in selecting an HMO. The client may also contact the enrollment broker directly at 1-800-964-2777 (STAR Help Line). To protect continuity of care and client choice, the enrollment broker will work with each pregnant woman to select a health plan that includes her current prenatal care provider or to choose an obstetrical care provider that meets her needs.

Until coverage begins in a Medicaid managed care program, clients will be covered under Texas Medicaid fee-for-service. Clients may initially receive a Medicaid Identification Form (Form H3087) that shows them to be a client of a STAR health plan but does not list the plan name. To ensure proper billing, providers should call the enrollment broker at 1-800-964-2777 (STAR Help Line) to obtain the name of the client’s health plan. The health plan name should appear on the Medicaid Identification Form (Form H3087) the following month. However, client eligibility should always be verified.

Within 14 days of enrolling in a new health plan, a plan representative will contact the new client to help arrange the first prenatal appointment. Physicians should also expect contact from the health plans to facilitate prenatal appointments for new clients. Physicians and other prenatal care providers are encouraged to make prenatal appointments within two weeks.

Enrollment of Newborns

STAR health plans are responsible for all covered services provided to newborn clients. In the STAR Program, newborns are automatically assigned to the STAR health plan the mother is enrolled with at the time of the newborn’s birth. The effective date of the newborn’s enrollment is the same as the newborn’s DOB.

In the STAR+PLUS Program, newborns are enrolled in the STAR plan offered by the mother’s STAR+PLUS plan, if available. If the STAR+PLUS plan does not also provide STAR services in the SA, the newborn is automatically enrolled in Texas Medicaid fee-for-service until the mother selects a STAR plan for the newborn. If a plan is not chosen, one will be chosen.

As with the Texas Medicaid fee-for-service program, there may be a delay of up to several months from the DOB for a newborn to receive a Medicaid client number. Providers should check with each STAR health plan for claim filing requirements.

If the newborn has not yet been assigned a primary care provider, the Medicaid Identification Form (Form H3087) will indicate that the client is “Newborn” and instruct the provider to “Call Plan” to inquire about filing a claim.

Refer to: “Newborn Claims Submission” on page 7-21 and “STAR+PLUS Program” on page 7-21.
Timely Notification and Assignment of Medicaid ID for Newborns

Hospitals that submit their birth certificate information utilizing the DSHS, Bureau of Vital Statistics (BVS) electronic Certificate Manager software and the Hospital Report (Newborn Child or Children) (Form 7484), receive a rapid and efficient assignment of a newborn Medicaid identification number. This process expedites reimbursement to hospitals and other providers involved in newborn care.

Call 1-512-458-7367 for further questions or comments about this process.

### 7.2.4 Service Areas (SAs) and STAR HMO Choices

<table>
<thead>
<tr>
<th>SA</th>
<th>Counties</th>
<th>STAR Health Plans Available</th>
<th>STAR Health Plan Provider Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexar</td>
<td>Atascosa, Bexar, Comal, Kendall, Guadalupe, Wilson, and Medina</td>
<td>Aetna Community First Health Plans Superior Health Plan</td>
<td>1-800-248-7767  1-800-434-2347  1-877-391-5921</td>
</tr>
<tr>
<td>Dallas</td>
<td>Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall</td>
<td>Amerigroup Texas, Inc. Parkland Community Health Plan Unicare Health Plans of Texas</td>
<td>1-800-454-3730  1-888-672-2277  1-866-480-4830</td>
</tr>
<tr>
<td>Harris</td>
<td>Harris</td>
<td>Amerigroup Texas, Inc. Community Health Choice Molina Healthcare of Texas Texas Children’s Health Plan United Healthcare of Texas</td>
<td>1-800-454-3730  1-888-760-2600  1-866-449-6849  1-800-990-8247  1-866-331-2243</td>
</tr>
<tr>
<td>Lubbock</td>
<td>Crosby, Floyd, Garza, Hale, Hockley, Lamb, Lubbock, Lynn, Terry</td>
<td>FIRSTCARE Superior Health Plan</td>
<td>1-800-264-4111  1-877-391-5921</td>
</tr>
<tr>
<td>Nueces</td>
<td>Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio, Victoria</td>
<td>Amerigroup Community Care Driscoll Children’s Health Plan Superior Health Plan</td>
<td>1-800-454-3730  1-877-324-3627  1-877-391-5921</td>
</tr>
<tr>
<td>Tarrant</td>
<td>Denton, Hood, Johnson, Parker, Tarrant, Wise</td>
<td>Aetna Amerigroup Community Care Cook Children’s Health Plan</td>
<td>1-800-306-8612  1-800-454-3730  1-800-964-2247</td>
</tr>
<tr>
<td>Travis</td>
<td>Bastrop, Burnet, Caldwell, Hays, Lee Travis, Williamson</td>
<td>Amerigroup Community Care Superior Health Plan</td>
<td>1-800-454-3730  1-877-391-5921</td>
</tr>
</tbody>
</table>

Refer to: “PCCM” on page 7-31 for details relating to PCCM areas.

### 7.2.5 STAR Program Benefits

STAR Program clients receive all the benefits of Texas Medicaid fee-for-service and the following additional benefits:

- Annual adult well-checks
- Removal of the inpatient spell of illness limitation
- Unlimited medically necessary prescription drugs for adults

Note: HIPP Program clients should access their benefits through Texas Medicaid fee-for-service and should not be enrolled in managed care unless they choose to leave the HIPP program.

Refer to: “Health Insurance Premium Payment (HIPP) Program” on page 4-18.
7.2.5.1 Annual Adult Well-Check

An annual adult physical exam performed by the client’s primary care provider is an additional benefit of the STAR Program for clients 21 years of age or older. The annual physical exam is performed in addition to family planning services. This service is provided to healthy individuals for the purpose of promoting health and preventing injury or illness.

The annual examination should be age and health risk appropriate and should include all the clinically indicated elements of history, physical examination, laboratory/diagnostic examination, and patient counseling that are consistent with good medical practice. Providers are encouraged to adopt a nationally recognized, evidence-based standard for the elements of the annual exam, such as the guidelines published by the American Academy of Family Physicians at www.aafp.org.

This service is only reimbursable when performed by the current designated primary care provider on the date of service and is allowed once per state fiscal year (September 1 through August 31), per client.

The following appropriate codes may be billed:
- 99385 and 99386 for a new patient
- 99395 and 99396 for an established patient

7.2.5.2 Spell of Illness

STAR clients are not limited to the 30-day spell of illness.

7.2.5.3 Prescriptions

STAR Program members who are 21 years of age or older receive unlimited medically necessary prescription drugs. The elimination of the three prescription limit per month for adult clients enrolled in STAR allows the provider greater flexibility in treating and managing a client’s health-care needs. Prescription reimbursement continues to be processed through the VDP. All Medicaid clients who are 20 years of age or younger already receive unlimited medically necessary prescription drugs.

7.2.5.4 National Drug Code

All STAR providers that submit professional or outpatient claims with physician-administered prescription drug procedure codes will be required to use the associated NDC. Drug claims submitted with procedure codes in the “A” code series will not require an NDC. The NDC is only required on outpatient hospital claims and physician claims.

N4 must be entered before the NDC on claims. The NDC is an 11-digit number on the package or container from which the medication is administered.

The unit of measurement codes for all three forms are:
- F2—International unit
- GR—Gram
- ML—Milliliter
- UN—Unit

Unit quantities must also be provided on the claim.

The NDC information must be submitted as indicated below.

If submitting on a UB-04 CMS-1450 the NDC information must be submitted as indicated below:

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>Revenue codes and description</td>
<td>Enter N4, the 11-digit NDC number (number on package or container from which the medication was administered), the unit of measurement code, and the unit quantity with a floating decimal for fractional units (limited to 3 digits). Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025</td>
</tr>
</tbody>
</table>
If submitting on a CMS-1500 the NDC information must be submitted as indicated below:

**CMS-1500**

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>24A</td>
<td>Date of Service (DOS)</td>
<td>In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231</td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, services, or supplies</td>
<td>In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit.</td>
</tr>
<tr>
<td>24G</td>
<td>Days or units</td>
<td>In the shaded area, enter the NDC unit of measurement code.</td>
</tr>
</tbody>
</table>

### 7.2.6 Claims Filing Information

All claims for Medicaid managed care clients enrolled in a STAR HMO must be submitted to the STAR health plan in which the client is enrolled at the time of service (or date of admission for inpatient hospital claims). The STAR HMO, as a secondary payor, does not determine payment based on the primary payor’s authorization of services and/or approval of hospital stays. PCS services for STAR will be authorized and reimbursed by TMHP.

**Exception:** TMHP processes some claims for HMO clients. See “Prior Authorizations” on page 7-13 for details.

#### 7.2.6.1 Newborn Claims Submission

Newborns are automatically assigned to the STAR health plan the mother is enrolled with at the time of the newborn’s birth. The effective date of the newborn’s enrollment is the same as the newborn’s DOB. Claims for services provided to newborns should be filed with the mother’s STAR health plan. Providers filing claims for services provided to newborns are still responsible for meeting the Medicaid filing deadlines, which in most cases is within 95 days of each date of service.

**HMO Newborn Claims Filing**

Claims for newborns who are clients of an HMO should be filed directly with the client’s HMO. Health-care providers should file newborn claims using the newborn’s Medicaid identification number as soon as it is made available to them.

HMOs must pay providers for inpatient and professional services related to neonatal care for up to 48 hours after vaginal delivery and 96 hours after cesarean delivery. (Prior authorizations and primary care provider assignment cannot be a reason for denial of claims.)

HMOs may require prior authorizations for hospital and professional services beyond the 48/96 hour time limits.

Authorization requests, utilization review questions, and claim status inquiries and appeals should be directed to the STAR health plan in which the client is enrolled.

Note: Telephone numbers and addresses for claims submission and appeals for STAR HMOs can be found in the appropriate HMO provider policies and procedures manual for the appropriate SA.

Refer to: “Claims Filing Information” on page 7-23 for information about claims filing for STAR+PLUS.

“Claims Filing Information” on page 7-29 for information about claims filing for NorthSTAR.

### 7.3 STAR+PLUS Program

#### 7.3.1 Overview

The STAR+PLUS Program is an HMO delivery system. Clients eligible for Medicaid under the SSI Programs residing in Bexar, Harris/Harris Expansion, Nueces, and Travis SAs began enrolling in STAR+PLUS. STAR+PLUS integrates acute care and long term care into a Medicaid managed care delivery system for eligible Medicaid clients under the SSI Program. HHSC is the operating agency for STAR+PLUS. It is designed to improve access to care, provide care in the least restrictive setting, and provide more accountability and control on costs.
7.3.1.1 HMO Model

In the HMO model, the STAR+PLUS health plan is responsible for contracting with providers and/or delegated network to create a health-care provider delivery network. SSI clients who reside in one of the SA counties where this model is an option, and who have selected an HMO, are required to select a primary care provider from the HMO provider directory if they are not covered by Medicare. SSI clients who are also covered by Medicare (Dual Eligible clients) must select a STAR+PLUS HMO to receive Medicaid community based long term care.

Children born to STAR+PLUS clients will be enrolled with the STAR plan operated by the same HMO if available. If the STAR+PLUS plan does not also operate a STAR plan, the newborn is automatically enrolled into Texas Medicaid fee-for-service, and the mother is given the opportunity to choose a STAR health plan for the newborn.

7.3.1.2 Service Areas (SAs)

The STAR+PLUS Program is mandatory for clients 21 years of age or older and voluntary for clients 20 years of age or younger under SSI programs who reside in the following SAs: Bexar, Harris/ Harris Expansion, Nueces, and Travis.

The following STAR+PLUS health plans are available:

<table>
<thead>
<tr>
<th>SA</th>
<th>Counties</th>
<th>Health Plans</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexar</td>
<td>Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson</td>
<td>Molina Healthcare of Texas Superior HealthPlan, Amerigroup Community Care</td>
<td>1-866-449-6849, Option 1 1-877-391-5921, Option 3 1-800-454-3730</td>
</tr>
<tr>
<td>Harris/ Harris</td>
<td>Brazoria, Fort Bend, Galveston, Harris, Montgomery, Waller</td>
<td>Amerigroup Community Care Evercare of Texas, Inc. Molina Healthcare of Texas</td>
<td>1-800-454-3730 1-888-887-9003 1-866-449-6849, Option 1</td>
</tr>
<tr>
<td>Expansion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nueces</td>
<td>Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio, Victoria</td>
<td>Evercare of Texas, Inc. Superior HealthPlan</td>
<td>1-888-887-9003 1-877-391-5921, Option 3</td>
</tr>
<tr>
<td>Travis</td>
<td>Bastrop, Burnet, Caldwell, Hays, Lee, Travis, Williamson</td>
<td>Amerigroup Community Care Evercare of Texas, Inc.</td>
<td>1-800-454-3730 1-888-887-9003</td>
</tr>
</tbody>
</table>

7.3.1.3 Client Eligibility

HHSC has targeted these client groups within the Texas Medicaid population for STAR+PLUS Program enrollment:

- Enrollment for category 01, 03, 04 (SSI aged, blind and disabled clients) and the following program types are mandatory for STAR+PLUS:

<table>
<thead>
<tr>
<th>Type Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>Denied SSI clients who are Medicaid-eligible under Pickle provisions.</td>
</tr>
<tr>
<td>12</td>
<td>SSI client.</td>
</tr>
<tr>
<td>13</td>
<td>SSI client.</td>
</tr>
<tr>
<td>14</td>
<td>Note: Only those client that have been determined eligible for the 1915 (c) STAR+PLUS Waiver (SPW) will be enrolled in STAR+PLUS. All other clients in TP 14 are excluded from participation.</td>
</tr>
<tr>
<td>18</td>
<td>Disabled adult children denied SSI dues to increase in Social Security benefits.</td>
</tr>
<tr>
<td>22</td>
<td>Denied SSI clients who receive widow/ widower Social Security benefits.</td>
</tr>
<tr>
<td>51</td>
<td>Medicaid and community-based nursing care services.</td>
</tr>
</tbody>
</table>
• Enrollment for category 03 and 04, SSI blind and disabled children, and type program 19, Medicaid and community-based waiver program for children younger than age 21 years, may enroll in a STAR+PLUS HMO.
Refer to: “Client Enrollment” on page 7-6 for more information on eligibility effective dates.

7.3.1.4 Dual Eligible Clients
Many STAR+PLUS clients are eligible for Medicaid and Medicare. STAR+PLUS HMOs are not at risk for the delivery of acute care services needed by these clients.
Most STAR+PLUS clients with Medicare and Medicaid are Medicaid Qualified Medicare Beneficiaries (MQMBs). MQMBs receive Medicare benefits through a Medicare risk product (HMO) or Medicare fee-for-service insurance program. To reduce confusion, HHSC has mandated that STAR+PLUS MQMBs continue to receive all their acute care services as they do today, with Medicare being the primary payer and Texas Medicaid fee-for-service, through TMHP, the secondary payer. Providers are to continue billing for Medicare acute care services through the client’s Medicare HMO or fee-for-service insurer following the rules of the Medicare insurer. If the client is in both a Medicare and Medicaid HMO, the client uses the Medicare primary care provider, and providers follow the Medicare HMO’s medical management rules for authorization, concurrent review, etc. MQMBs choose a Medicaid HMO but do not choose a Medicaid primary care provider.
Refer to: Sections on MQMBs in this manual for further instructions.

“Claims Filing Information” on page 7-23 for MQMB reimbursement requirements.

Dual eligible adults continue to be limited to three prescriptions unless they have joined the Medicare HMO also offered by their STAR+PLUS plan. With the implementation of the Medicare prescription benefit in January 2006, dual eligible clients no longer receive any prescription benefit through Medicaid.

7.3.1.5 Ineligible Clients
Clients not eligible for STAR+PLUS who will remain in Texas Medicaid fee-for-service include clients who are:
• Participating in a Home and Community-Based Waiver other than the Nursing Facility Waiver:
  • Community Living Assistance and Support Services (CLASS) Waiver Program
  • Medically Dependent Children’s Program (MDCP) Waiver Program
  • Home- and Community-Based Services (HCS) Waiver Program
  • Mental Retardation Local Authority (MRLA) Waiver Program
  • Deaf/ Blind Multiple Disabled Waiver Program
  • Texas Home Living Waiver Program (TxHmL)
• Residents in a nursing facility
• Residents in intermediate care facilities for the mentally retarded (ICF-MR)
• Residents of state hospitals or institutions for mental diseases
• Frail Elderly (or 1929B) Program recipients
• Recipients of In-Home and Family Support Program Services
• Qualified Medicare Beneficiaries (QMBs)
• Undocumented aliens
• Clients who receive limited Medicaid benefits and do not qualify for participation in the VDP

7.3.2 STAR+PLUS Program Benefits
STAR+PLUS Program clients receive all the benefits of Texas Medicaid fee-for-service and the following additional benefits:
• Annual adult well-checks
• Prescriptions policy defined in “Prescriptions” on page 7-20 (for STAR+PLUS members that are not dual eligibles)
Note: HIPP Program clients should access their benefits through Texas Medicaid fee-for-service, and should not be enrolled in managed care unless they choose to leave the HIPP program.
Refer to: “Health Insurance Premium Payment (HIPP) Program” on page 4-18.

7.3.3 Spell of Illness Limitation
The spell of illness limitation is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

7.3.4 Claims Filing Information
The claims filing guidelines found in “Prior Authorizations” on page 7-13, also apply to STAR+PLUS.
In addition to the claim types found on page 7-13, TMHP processes claims for the following STAR+PLUS clients/programs:
• All crossovers for deductibles and coinsurance on STAR+PLUS MQMBs
• All claims for Medicaid-only services (e.g., refractions, hearing exams, etc.) provided to STAR+PLUS MQMBs
TMHP will process and consider for payment inpatient hospital accommodations and related inpatient services (anything billed on an inpatient UB-04 CMS-1450 claim form). These services must be prior authorized by the client’s HMO. After the provider requests prior authorization from the HMO, the HMO will forward the authorization to TMHP, and claims will be processed and
considered for payment against the services authorized by the HMO. Claims received by TMHP without a prior authorization from the HMO will be denied.

For STAR+PLUS clients, the HMO will be responsible for processing and paying professional services. All authorizations, if required, for these claims must be submitted to the HMO and all claims for professional services must be submitted to the HMO.

STAR+PLUS MQMBs receive services and have their acute care claims processed as though they are not in a Medicaid managed care program. TMHP is responsible for reimbursing all Medicare coinsurance and deductibles that meet Medicaid payment criteria, as well as for all services that are a benefit of the Medicaid program (refractions, hearing exams, etc.) that are not covered under the Medicare program.

PCS services will not be processed or authorized for STAR+PLUS managed care organization (MCO) clients. The STAR+PLUS MCOs will continue to deliver PCS to their clients.

7.3.4.1 STAR+PLUS Mental Health Claims
Freestanding psychiatric facility claims and inpatient claims with a behavioral health primary diagnosis submitted for clients who are enrolled in a STAR+PLUS plan will be processed by the STAR+PLUS HMOs. TMHP will deny these claims. Providers must file these types of claims with the appropriate HMO.

Claims for mental health case management and rehabilitative services that are delivered by mental health and mental retardation (MHMR) facilities are not included, since they remain carved out of the managed care model.

Note: This does not include claims for mental health case management and rehabilitative services delivered by Mental Health and Mental Rehabilitative (MHMR) facilities. Those services remain carved out of this managed care model.

7.4 Integrated Care Management (ICM) Program

7.4.1 Overview
ICM is a Medicaid managed care program designed to address the complex care needs of people with disabilities or who are 65 years of age or older. Specialized services, such as health-care coordination and long-term services and supports, will assist participants to perform their day-to-day activities. The ICM model was designed to serve aged, blind, and disabled Medicaid clients in the Dallas and Tarrant SAs.

7.4.2 ICM MCO Model
HHSC has selected Evercare of Texas, LLC as the health plan for ICM. Evercare is affiliated with UnitedHealth Group. Evercare provides service coordination for ICM members and maintains a provider network. Medicaid providers in the Tarrant and Dallas SAs who are interested in participating in the ICM program must complete a separate contract with Evercare.

All acute care providers must be enrolled as Texas Medicaid providers and have an NPI. For information and instructions on contracting with Evercare, providers can call UnitedHealthcare Network Management at 1-866-915-6474.

Providers of long-term services and support who are interested in receiving an Evercare ICM contract should call Evercare at 1-866-915-6474.

Evercare does not process claims or negotiate rates. ICM claims are processed and reimbursed according to the Texas Medicaid fee-for-service fee schedule.

7.4.2.1 Service Areas (SAs)
ICM, a noncapitated managed care program, is available in the Dallas and Tarrant SAs. The Dallas SA consists of Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties. The Tarrant SA consists of Denton, Hood, Johnson, Parker, Tarrant, and Wise counties.

7.4.3 Client Eligibility
ICM will provide coverage for the following:

- Clients who receive Medicaid and SSI and are 21 years of age or older.
- Clients who receive Medicaid services through the Community-Based Alternatives (CBA) waiver program. Services include nursing, therapies, and home modifications.
- Clients who receive Medicaid benefits because they are in an SSI-related program such as the Medical Assistance Only program.
- Clients who receive both Medicare and Medicaid and otherwise meet the criteria listed above. Medicare will continue to provide basic health-care needs for these individuals, such as doctor visits and prescription drug coverage. If these individuals need long-term services and supports, such as personal assistance at home, adult day care, or assisted living services, they may receive those services through the ICM program.

Children who are 20 years of age or younger and receive SSI may choose to participate in ICM. If they do not choose ICM they can remain in a Texas Medicaid fee-for-service program.

7.4.3.1 Dual Eligible Clients
For ICM clients who are enrolled in both Medicaid and Medicare, ICM is only responsible for long-term services and supports. Primary acute care and pharmacy services for this population are covered through and should be billed to Medicare. Enrollment in ICM will not change the way a client receives Medicare services.
7.4.3.2 Ineligible Clients
Persons enrolled in a 1915(c) Medicaid waiver program other than the CBA program are excluded from participation in the ICM program. This includes individuals enrolled in CLASS, HCS, and MDCP waiver programs. In addition, persons in institutional settings, including residents of a nursing facility or intermediate care facility for the mentally retarded (ICF-MR), are also excluded from participation in the ICM program.

7.4.4 Client Enrollment
Eligible adult Texas Medicaid clients, including those who qualify for Medicaid based on SSI eligibility or who qualify for CBA will automatically be enrolled in ICM. Children 20 years of age or younger who receive SSI can participate on a voluntary basis.

7.4.5 ICM Program Benefits
ICM-enrolled clients may receive the same acute care services that are payable under the Texas Medicaid fee-for-service plan and the PCCM plan, including:
- Ambulance and emergency services
- Audiometry services (clients 21 years of age or older)
- Behavioral health services (for clients in the Tarrant SA only) including detoxification services and psychiatry services, and counseling services for adults only
- Dialysis
- Durable medical equipment (DME) and supplies
- Inpatient and outpatient hospital services, including laboratory, radiology, imaging, and X-ray services
- Physical, occupational, and speech therapies
- Optometry, glasses, and contact lenses
Additional acute care services for clients 20 years of age or younger include:
- Inpatient and outpatient mental health services (Tarrant SA only)
- Outpatient chemical dependency services (Tarrant SA only)
- Medical checkups and Comprehensive Care Program (CCP) services for children through THSteps
ICM clients are provided with two enhanced benefits:
- Waiver of the three-prescription per month limit for Medicaid-only clients
- Inclusion of an annual adult well-check for clients 21 years of age or older.

Behavioral health services for ICM clients in the Dallas SA are provided by NorthSTAR.
Note: HIPP Program clients should access their benefits through Texas Medicaid fee-for-service and should not be enrolled in managed care unless they choose to leave the HIPP program.
Refer to: “Health Insurance Premium Payment (HIPP) Program” on page 4-18.

7.4.6 Spell of Illness Limitation
The Spell of Illness limitation is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days. ICM clients are limited to the spell of illness limitation.

7.4.7 Authorization
Evercare of Texas, LLC, is responsible for prior authorization of ICM services. Prior authorizations are required for all services rendered by non-contracted ICM providers. The following prior authorizations are required:
- All admissions includes acute care hospital and nursing homes
- Ambulance transfers (non-emergent assists)
- Automatic implantable cardiac defibrillators
- Blepharoplasty, upper lid including repair of Brow Ptosis
- Breast reconstruction, other than following mastectomy
- Breast reduction, other than mastectomy
- DME and DME supplies (per Medicaid guidelines)
- Home health services
- Home therapy occupational therapy (OT), physical therapy (PT), or speech therapy (ST)
- Initiation of nutritional therapy
- Ligation, vein stripping and Sclerotherapy
- Private duty nursing (Texas Health Steps only)
- Prosthetic Devices or Orthotics appliances (THSteps only)
- Reconstructive surgery, except cosmetic
- Respiratory syncytial virus (RSV) prophylaxis
- Therapy-nursing facility
- Therapy-outpatient (OT/ PT/ ST)
- Transplants (e.g., liver, kidney, heart, lung, etc.)
For acute care inpatient authorizations, providers may submit requests for prior authorization from the following:
- Inpatient Email: icm_inpatient_authorization@uhc.com
- Inpatient Fax Number: 1-877-825-7608
All other 'Acute Care' services requiring authorization should be sent to:

- Authorization Department Main Fax Number: 1-888-408-3468
- Main Authorization Email: icm_authorization@uhc.com
- Long Term Services and Supports (LTSS):
  - ICM Waiver Provider Intake Fax Line: 1-877-305-2896
  - LTSS services require approval and coordination from the member’s Evercare Service Coordinator. LTSS providers should continue to use DADS Authorization Forms as authorizations will continue to be displayed in MESAV. For questions regarding your ICM authorization call 1-866-915-6474.

7.4.8 ICM Claims Filing

Claims submitted for acute care services are processed by TMHP. If a claim is denied because of missing or unmatched authorization, the authorization correction should be coordinated with Evercare of Texas, LLC. After the updated authorization has been submitted by Evercare to TMHP, the provider may appeal the claim.

Claims for long-term services and supports will be processed by DADS. Long Term Services and Supports (LTSS) services require approval and coordination from the member’s Evercare service coordinator. LTSS providers should continue to use DADS authorization forms, as authorizations will continue to be displayed by MESAV. For questions regarding ICM authorization, call 1-866-915-6474.

TPI Referral Guideline

If a provider that an ICM client is being referred to is an ICM-contracted provider, the referring provider’s TPI does not need to be included on the claim form.

In-network specialists may bill for health-care services provided to ICM clients without a referral from the client’s primary care provider. Referrals are not required for mental health case management and rehabilitative services rendered by MHMR facilities.

Please see the TMHP Telephone and Address Guide for Acute care inpatient authorizations information. Refer to: “Integrated Care Management (ICM) Communication” on page xi.

7.4.8.1 National Drug Code (NDC) Claims

All providers that submit professional or outpatient claims with physician administered prescription drug procedure codes for ICM will be required to use the associated NDC.

Drug claims submitted with procedure codes in the “A” code series will not require an NDC. The NDC is only required on outpatient hospital claims and physician claims.

N4 must be entered before the NDC on claims. The NDC is an 11-digit number on the package or container from which the medication is administered.

The unit of measurement codes for all three forms are:

- F2—International unit
- GR—Gram
- ML—Milliliter
- UN—Unit
Unit quantities must also be provided on the claim. Depending on the claim type, the NDC information must be submitted as indicated below. If submitting on a UB-04 CMS-1450 the NDC information must be submitted as indicated below:

**UB-04 CMS-1450**

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>Revenue codes and description</td>
<td>Enter N4, the 11-digit NDC number (number on package or container from which the medication was administered), the unit of measurement code, and the unit quantity with a floating decimal for fractional units (limited to 3 digits). Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025</td>
</tr>
</tbody>
</table>

If submitting on a CMS-1500 the NDC information must be submitted as indicated below:

**CMS-1500**

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>24A</td>
<td>DOS</td>
<td>In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231</td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, services, or supplies</td>
<td>In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit.</td>
</tr>
<tr>
<td>24G</td>
<td>Days or units</td>
<td>In the shaded area, enter the NDC unit of measurement code.</td>
</tr>
</tbody>
</table>

7.4.8.2 Personal Care Services (PCS)

PCS are authorized by Evercare of Texas, LLC and are reimbursed by TMHP for ICM. Refer to: “Personal Care Services (PCS) (CCP)” on page 43-59.

7.5 NorthSTAR Program

7.5.1 Overview

NorthSTAR, in the Dallas SA, provides behavioral health services (mental health, chemical dependency, and substance abuse treatment) for Medicaid enrollees through a BHO. NorthSTAR also serves a clinically and financially eligible non-Medicaid population.

NorthSTAR is known as a behavioral health carve-out of the STAR Program in the Dallas SA. Medicaid provides access to physical health care while NorthSTAR provides mental health and chemical dependency (behavioral health) services.

NorthSTAR provides easier access to a comprehensive array of behavioral health services and providers. The program's goal is to provide clinically necessary behavioral health services to enrollees, through a network of qualified and credentialed providers.

In the NorthSTAR Program, ValueOptions is the sole BHO and is responsible for contracting with providers and maintaining a behavioral health-care provider delivery network. The BHO also:

- Offers education and support to the provider network.
- Performs utilization management through authorization of services, concurrent review, and special studies.
- Performs quality assurance monitoring and activities.
- Provides client services including education and outreach.
- Processes claims.
Section 7

7.5.2 Provider Requirements and Information

In the STAR Program, clients select a primary care provider from among the providers who have contracted with a STAR HMO or PCCM. In the NorthSTAR Program, a client may have several different providers for different specialty behavioral health services. The BHO will arrange behavioral health services and make referrals to specific providers within the BHO network.

Providers are encouraged to coordinate care with physical health providers in the Medicaid managed care and Texas Medicaid fee-for-service programs. Behavioral health providers may do this by notifying the Medicaid managed care or Texas Medicaid fee-for-service provider. Behavioral health providers may also notify the BHO that the client is receiving services.

Providers interested in becoming a ValueOptions network provider can obtain additional information by contacting ValueOptions at 1-888-800-6799.

Note: If a behavioral health provider practices in the Dallas SA, he must be enrolled as a network provider in the NorthSTAR BHO (ValueOptions) to provide services to NorthSTAR enrollees. Providers who serve NorthSTAR enrollees without being in the provider network or without prior authorization in nonemergency situations risk non-payment of claims.

7.5.3 Service Area (SA)

The NorthSTAR Program is available in the Dallas SA. The following counties are included: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall.

The ValueOptions Provider Services contact telephone number is 1-888-800-6799.

7.5.3.1 Client Eligibility

Most Medicaid clients residing in the Dallas SA must enroll in NorthSTAR. All STAR Program enrollees are subject to mandatory enrollment in NorthSTAR. Once enrolled in NorthSTAR, ValueOptions will coordinate enrollee behavioral health services.

Refer to: “Medicaid Identification Form H3087” on page 4-19 for a sample of the Medicaid Identification Form (Form H3087).

Note: NorthSTAR Program enrollment information is not reflected on the Medicaid Identification Form (Form H3087), but enrollment can be confirmed by the BHO or the enrollment broker.

Medicaid clients residing in the Dallas SA that are not eligible to enroll in a NorthSTAR BHO are:

- Medicaid clients living in a nursing facility
- Medicaid clients living in an ICF-MR
- Medicaid clients living in state hospitals’ Institutions for Mental Disease Over Age 65 Program
- To use each available complaint process and to receive a timely response to complaints.

- Children who are in the custody of the Department of Family and Protective Services (DFPS) (in foster care)
- Certain Medicaid clients that are ineligible for NorthSTAR such as type program 55

Refer to: “Client Enrollment” on page 7-17 for further information on STAR Program eligible client program types and for further information on STAR Program eligibility effective dates.

7.5.4 Client Enrollment

When a Medicaid enrollee requests services, the provider should contact ValueOptions or the enrollment broker to verify enrollment in NorthSTAR. If the client is not currently enrolled in NorthSTAR, the provider may give the client the telephone number of the enrollment broker so the client may become enrolled in NorthSTAR.

The enrollment broker staff is trained to assist potential clients in their understanding of both the STAR and NorthSTAR programs.

Medicaid clients must enroll via the enrollment broker if during regular working hours. If it is an emergency and after regular business hours, the NorthSTAR BHO can enroll a Medicaid client into NorthSTAR.

Medicaid clients may also mail in the enrollment using the NorthSTAR enrollment form. Non-Medicaid clients may be enrolled by NorthSTAR at designated enrollment sites.

Client enrollment is retroactive to the NorthSTAR eligibility certification date. Example:

<table>
<thead>
<tr>
<th>NorthSTAR Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client certified for Texas Medicaid in the NorthSTAR SA January 1</td>
</tr>
<tr>
<td>Medicaid benefits begin January 1</td>
</tr>
<tr>
<td>Client enrolls in NorthSTAR January 20</td>
</tr>
<tr>
<td>NorthSTAR benefits begin January 1</td>
</tr>
</tbody>
</table>

7.5.4.1 NorthSTAR Enrollment Broker

<table>
<thead>
<tr>
<th>Hours</th>
<th>8 a.m. to 8 p.m., Central Time, Monday through Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
<td>1-800-964-2777</td>
</tr>
<tr>
<td>Telephone TDD</td>
<td>1-800-267-5008</td>
</tr>
</tbody>
</table>

7.5.4.2 Guidelines for Working with NorthSTAR Clients

Clients enrolled in NorthSTAR, like any other clients, have these rights:

- To be treated with respect, dignity, privacy and confidentiality, and without discrimination.
- To consent to or refuse treatment and actively participate in treatment decisions.
- To receive timely access to care that does not have any communication or physical access barriers.
7.5.5 Claims Filing Information
All behavioral health claims for NorthSTAR enrollees in the Dallas SA must be filed to the NorthSTAR BHO, ValueOptions. Behavioral health specialists and hospitals are not to bill TMHP for behavioral health services provided to clients who are enrolled in or eligible for enrollment in the NorthSTAR Program.

Exception: Claims with a primary diagnosis of developmental disability (mental retardation, autism, pervasive developmental disorder) are submitted to TMHP.

If a behavioral health claim is submitted to TMHP for any diagnosis other than a developmental disability, it is denied. If it is paid erroneously, TMHP recoups it later.

7.5.5.1 Hospital Billing
In the Dallas SA, SSI clients are subject to mandatory enrollment in Medicaid managed care through the NorthSTAR Program. In some instances, general acute care hospitals treat a NorthSTAR client with a primary behavioral health diagnosis. In that instance, the general acute care hospital needs to seek authorization and reimbursement from ValueOptions using the CMS-1500 form for outpatient services and UB-04 CMS-1450 for inpatient services.

7.5.5.2 Behavioral Health Billing
Services provided under the STAR Program are billed to the STAR HMO in which the patient is enrolled. The STAR Program in the Dallas SA covers medically necessary physical health-care services and behavioral health services that are delivered by medical providers, such as primary care physicians, FQHCs, and RHCs. STAR also covers ambulatory laboratory and ancillary services required to diagnose or treat behavioral health conditions and psychological testing for certain non-behavioral health diagnoses.

The program-related forms are the CMS-1500 and UB-04 CMS-1450.

7.5.5.3 Prior Authorization Requirements
To receive payment for services to ValueOptions clients, providers must be enrolled with ValueOptions. (Exceptions include emergency care and medically necessary treatment episodes that began before the client joined a NorthSTAR plan.) ValueOptions requires that the provider obtain prior authorization for most nonemergency services. If the provider does not obtain prior authorization, they may not get payment for services. These rules apply whether the provider’s practice or facility is located in or out of the Dallas SA.

7.5.6 Complaints and Appeals
A complaint is defined as any dissatisfaction expressed in writing by the provider, or on behalf of that provider, concerning any aspect of the health plan. The term complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider’s satisfaction.

Appeals/grievances, hearings, or dispute resolution is the responsibility of ValueOptions. Providers must exhaust the appeals/grievance process with ValueOptions before filing a complaint with NorthSTAR Provider Relations.

Under the complaint process, NorthSTAR Provider Relations works with ValueOptions and providers to verify the validity of the complaint, determine if the established due process was followed in resolving appeals and grievances, and addresses other program/contract issues, as applicable. When filing a complaint, providers must submit a letter explaining the specific reasons they believe the final appeal decision by the NorthSTAR health plan is incorrect and copies of the following documentation as appropriate:
- All R&S reports of the claims/services in question, if applicable
- Provider’s claims/billing records (electronic or manual) related to the complaint
- Provider’s internal notes and logs when pertinent
- Memos from the state or the health plan indicating any problems, policy changes, or claims processing
- Discrepancies that may be relevant to the complaint
- Other documents such as receipts (e.g., certified mail)
- Original date-stamped envelopes, in-service notes
- Minutes from meetings, etc., if relevant to the complaint

All NorthSTAR providers must exhaust the ValueOptions complaint and appeals process first. After this process is exhausted and if the outcome is unsatisfactory, NorthSTAR providers may file complaints/appeals with NorthSTAR Provider Relations at the following address:

Department of State Health Services
NorthSTAR Enrollee/Provider Relations
PO Box 149347
Mail Code 2012
Austin, TX 78714-9347

Quality Improvement Monitoring
Direct quality of care concerns to ValueOptions or NorthSTAR Provider Relations at the following address:

Department of State Health Services
NorthSTAR Enrollee/Provider Relations
PO Box 149347
Mail Code 2012
Austin, TX 78714-9347

For paper appeals, refer to “Paper Appeals” on page 6-3.
7.6 STAR Health Program

7.6.1 Overview
The STAR Health program ensures that children taken into state conservatorship are able to receive the examinations, assessments, and care coordination they need within the first few days of their entry into conservatorship. Superior HealthPlan Network manages the health care for children who are enrolled in the Foster Care managed care program, STAR Health.

7.6.2 STAR Health Model
HHSC has selected Superior HealthPlan as the MCO for this program. Most Medicaid foster care claims for dates of service on or after April 1, 2008, are capitated services and must be filed to Superior HealthPlan.
Superior HealthPlan is responsible for assigning a primary care provider to clients when they are enrolled in the STAR Health Program. Foster care families are given the opportunity to change their primary care provider after this initial assignment.

7.6.3 Client Eligibility
All Medicaid clients in foster care are placed in this program with the following exceptions: children in the care of the Texas Youth Commission and Texas Juvenile Probation Commission; children from other states who are placed in Texas; and children in nursing homes or ICF-MR persons.

7.6.4 STAR Health Claims Filing
The following services are non-capitated services that are paid by TMHP:
- Case management for ECI
- Case management for CPW
- DADS mental retardation case management
- SHARS
- DARS Blind Children’s Vocational Discovery and Development Program
- Tuberculosis (TB) services
- County Indigent Health Care Program (CIHCP)
- Indian Health Services (IHS)
- Personal care services (PCS)
- Long-term care (LTC) services currently paid by the TMHP Claims Management System
All THSteps dental, vision, and mental health providers should submit claims for services rendered to foster care clients to Superior HealthPlan’s dental, vision, and mental health contractors.
For general provider information, please contact STAR Health at 1-866-439-2042.

For authorizations, please contact:
- Physical Health authorizations: 1-800-218-7508 (fax 1-800-690-7030)
- IMHS Behavioral Health authorizations: 1-866-218-8263
- TVHP Vision services authorizations: 1-800-642-9488
- Star Dent Dental Services Authorizations: 1-866-708-8795 (fax 1-281-313-7154)
Note: HIPP program clients should access their benefits through Texas Medicaid fee-for-service and should not be enrolled in managed care unless they choose to leave the HIPP program.
Refer to: “Health Insurance Premium Payment (HIPP) Program” on page 4-18.
7.7 PCCM

7.7.1 Overview

PCCM is a service delivery model under the Texas Medicaid managed care program and is administered by TMHP. It is not an HMO. PCCM is a network of primary care providers and hospitals under contract with HHSC. PCCM primary care providers and hospitals contract directly with HHSC. PCCM clients select or are assigned a primary care provider from among those who have contracted with HHSC. PCCM was originally implemented as one of the health-care delivery options available under the STAR Program, but is no longer part of the STAR Program.

PCCM is available in the following counties:

<table>
<thead>
<tr>
<th>PCCM Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson Andrews Angelina Archer Armstrong Austin</td>
</tr>
<tr>
<td>Bailey Bandera Baylor Bell Blanco Borden</td>
</tr>
<tr>
<td>Bosque Bowie Brazos Brewster Briscoe Brooks</td>
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<tr>
<td>Brown Burleson Callahan Cameron Camp Carson</td>
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<tr>
<td>Cass Castro Chambers Cherokee Childress Clay</td>
</tr>
<tr>
<td>Cochran Coke Coleman Collingsworth Colorado Comanche</td>
</tr>
<tr>
<td>Concho Cooke Coryell Cottle Crane Crockett</td>
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<tr>
<td>Culberson Dallam Dawson Deaf Smith Delta DeWitt</td>
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<tr>
<td>Dickens Dimmit Donley Duval Eastland Ector</td>
</tr>
<tr>
<td>Edwards Erath Falls Fannin Fayette Fisher</td>
</tr>
<tr>
<td>Foard Franklin Freestone Frio Gaines Gillespie</td>
</tr>
<tr>
<td>Glasscock Goliad Gonzales Gray Grayson Gregg</td>
</tr>
<tr>
<td>Grimes Hall Hamilton Haysdor Hardeman Hardin</td>
</tr>
<tr>
<td>Harrison Hartley Haskell Hemphill Henderson Hidalgo</td>
</tr>
<tr>
<td>Hill Hopkins Houston Howard Hudspeth Hutchinson</td>
</tr>
<tr>
<td>Irion Jack Jackson Jasper Jeff Davis Jefferson</td>
</tr>
<tr>
<td>Jim Hogg Jones Karnes Kenedy Kent Kerr</td>
</tr>
<tr>
<td>Kimble King Kinney Knox Lamar Lampasas</td>
</tr>
<tr>
<td>LaSalle Lavaca Leon Liberty Limestone Lipscomb</td>
</tr>
<tr>
<td>Live Oak Llano Loving Madison Marion Martin</td>
</tr>
<tr>
<td>Mason Matagorda Maverick McCulloch McLennan McMullen</td>
</tr>
<tr>
<td>Menard Midland Milam Mills Mitchell Montague</td>
</tr>
<tr>
<td>Moore Morris Motley Nacogdoches Newton Nolan</td>
</tr>
<tr>
<td>Ochiltree Oldham Orange Palo Pinto Panola Parmer</td>
</tr>
<tr>
<td>Pecos Polk Potter Presidio Rains Randall</td>
</tr>
<tr>
<td>Reagan Real Red River Reeves Roberts Robertson</td>
</tr>
<tr>
<td>Runnels Rusk Sabine San Augustine San Jacinto San Saba</td>
</tr>
<tr>
<td>Schleicher Scurry Shackelford Shelby Sherman Smith</td>
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<tr>
<td>Somervell Starr Stephens Sterling Stonewall Sutton</td>
</tr>
<tr>
<td>Swisher Taylor Terrell Throckmorton Titus Tom Green</td>
</tr>
<tr>
<td>Trinity Tyler Upshur Upton Uvalde Val Verde</td>
</tr>
<tr>
<td>Van Zandt Walker Ward Washington Webb Wharton</td>
</tr>
<tr>
<td>Wheeler Wichita Wilbarger Willacy Winkler Wood</td>
</tr>
<tr>
<td>Yoakum Young Zapata Zavala</td>
</tr>
</tbody>
</table>
The Southeast Region (Chambers, Hardin, Jefferson, Liberty, and Orange Counties) previously was part of the STAR Program. Culberson, Hudspeth, and Blanco Counties, previously STAR HMO counties, changed to PCCM-only counties on September 1, 2005.

### 7.7.2 Contact Numbers

**Provider Helpline:** 1-888-834-7226  
Monday through Friday, 7 a.m. to 7 p.m., Central Time  
Choose Option 5, then Option 1, then Option 5  
Fax: 1-512-506-7002

**Client Helpline:** 1-888-302-6688  
Monday through Friday, 7 a.m. to 7 p.m., Central Time  
PCCM Inpatient/Outpatient Prior Authorization Line: 1-888-302-6167  
Outpatient and Prior Authorization, Notifications, Prior Authorizations and Updates to Existing Authorizations Monday through Friday, 7 a.m. to 7 p.m., Central Time  
Fax: 1-512-302-5039

**Community Health Services (CHS) Helpline:** 1-888-276-0702  
**Case Management and Health and Program Benefit Education:**  
Monday through Friday, 8 a.m. to 5 p.m., Central Time  
(Voice mail is available outside of normal business hours.)

**The Nurse Helpline:** 1-800-304-5468  
24 hours a day, 7 days a week

### 7.7.3 Client Eligibility

HHSC has targeted the following client groups for PCCM enrollment:

<table>
<thead>
<tr>
<th>Type</th>
<th>Program</th>
<th>Enrollment Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regular TANF</td>
<td>M</td>
</tr>
<tr>
<td>3</td>
<td>MAO RSDI Increases—No Medicare</td>
<td>M*</td>
</tr>
<tr>
<td>7</td>
<td>12 months Medicaid denied due to earnings</td>
<td>M</td>
</tr>
<tr>
<td>12</td>
<td>SSI Manually Certified—No Medicare</td>
<td>M*</td>
</tr>
<tr>
<td>13</td>
<td>SSI Recipient—No Medicare</td>
<td>M*</td>
</tr>
<tr>
<td>18</td>
<td>Disabled Adult Children denied SSI due to increase in SS benefits—No Medicare</td>
<td>M*</td>
</tr>
<tr>
<td>19</td>
<td>Transitional SSI—No Medicare</td>
<td>V</td>
</tr>
<tr>
<td>20</td>
<td>04 months Medicaid—TANF</td>
<td>M</td>
</tr>
<tr>
<td>29</td>
<td>12 months transitional Medicaid—limited TANF</td>
<td>M</td>
</tr>
<tr>
<td>22</td>
<td>Early Age Widows/ Widowers—No Medicare</td>
<td>M*</td>
</tr>
</tbody>
</table>

M = Mandatory, V = Voluntary, M* = Mandatory adults ages 21 years or older

To verify a client’s eligibility and primary care provider, use one or more of the following eligibility resources:

- Medicaid Identification Form (Form H3087) and primary care provider change notification letter (letter can only be used to verify primary care provider; see “Primary Care Provider Changes” on page 7-35)
- Monthly panel report
- Daily primary care provider change list
- TMHP website at www.tmhp.com
- TMHP EDI
- Automated Inquiry System (AIS) at 1-800-925-9126, Option 1
- PCCM Provider Helpline at 1-888-834-7226
- TMHP Contact Center at 1-800-925-9126, Option 5

Providers have multiple options by which to verify a PCCM client’s Medicaid eligibility. Providers must verify eligibility through another source listed above even if a client presents a Medicaid Identification Form (Form H3087) and/or a primary care provider change notification letter. Services should not be denied to PCCM clients solely because a client does not present their H3087 or H1027 Medicaid identification forms.

In some situations, an eligibility response may indicate that the provider should contact PCCM to verify the primary care provider information. For more information, please call the TMHP Contact Center at 1-800-925-9126 or the PCCM Provider Helpline at 1-888-834-7226.

### 7.7.4 PCCM +PLUS

PCCM+PLUS provides enhanced care including additional care coordination services for clients who are elderly, blind, or disabled; reside in one of the 202 PCCM counties; and need additional support and care.
7.7.4.1 PCCM +PLUS Goals
The goals of PCCM +PLUS include:
• Improved client outcomes and quality of life.
• Improved coordination of care.
• Facilitation of hospital discharge planning and outpatient care for the client.
• Reduction in hospital readmissions.

7.7.4.2 PCCM +PLUS Plan of Care
After a client is enrolled in PCCM +PLUS, the primary care provider will be notified in a letter. The primary care provider will receive a suggested care plan based on collaboration with the client and the client's family.
TMHP encourages providers to use this care coordination resource by providing feedback and recommendations to create the care plan that best meets the client's needs.
PCCM +PLUS is designed to help clients use all of the available Medicaid resources. The provider's input is essential to the client's health care. TMHP PCCM +PLUS staff will partner with the primary care provider to coordinate health care.

7.7.4.3 Services Offered through PCCM +PLUS
The services offered by PCCM +PLUS are the same as those offered by CHS to PCCM clients, but with a focus on discharge management.
These services include the following:
• Counseling for clients who miss appointments
• Counseling for clients who inappropriately use the ER
• Education about obtaining PCCM services
• Management of high-risk pregnancies in conjunction with the client's physician
• Care coordination and education services for acute and chronically ill children
• Case management for chronic or complex cases identified and eligible for CHS
• Help in accessing state and community resources
• Help in improving healthy behaviors and treatment compliance
• Health education on a variety of topics
• Help with scheduling appointments

7.7.5 Client Enrollment
Enrollment into PCCM is mandatory for Medicaid clients residing in one of the PCCM counties and who meet the following criteria:
• Low-income families (primarily women and children)
• Blind and disabled individuals who receive SSI and are age 21 years or older
Children under the age of 21 who receive SSI may enroll on a voluntary basis. Elderly and disabled Medicaid clients who live in a nursing home or who are enrolled in community based long-term care will remain in Texas Medicaid fee-for-service. Clients on Medicare and individuals enrolled in the Medically Needy Program are not eligible for PCCM enrollment.
Note: HIPP program clients should access their benefits through Texas Medicaid fee-for-service and should not be enrolled in managed care unless they choose to leave the HIPP program.
Refer to: “Health Insurance Premium Payment (HIPP) Program” on page 4-18.

7.7.6 Online Provider Lookup
An online provider lookup is available on the public access portion of the TMHP website at www.tmhp.com. Provider information can be viewed by providers, clients, and anyone who accesses the TMHP website.
Providers can use the online update function to update their demographic information on the website. This allows users to view the most current information about the provider. To update demographic information online, authorized users log in to the TMHP website by clicking Log In on the homepage. Periodically, administrators may be required to verify their address when logging in to their account. This verification must be completed before the administrator can proceed to the secured portion of the website. The "My Account" page has a link to the Provider Demographic Update web page. Current information will be displayed with a button to allow editable fields to be changed. Demographic information may be updated only by authorized administrators. This authorization is controlled through the Permissions Management link, also located on the "My Account" page. Fields that can be updated online include the following:
• Address
• Telephone numbers
• Office hours
• Accepting new patients
• Additional sites where services are provided
• Languages spoken
7.7.7 Client Rights and Responsibilities

7.7.7.1 Client Rights

PCCM clients have defined rights and responsibilities. PCCM and primary care providers share the responsibility to ensure and protect client rights and to assist clients in understanding and fulfilling their responsibilities as plan clients.

PCCM clients have the right to:

• Be treated fairly and with dignity and respect.
• Know that their medical records and discussions with their providers will be kept private and confidential.
• A reasonable opportunity to choose a primary care provider (the doctor or health-care provider they will see most of the time and who will coordinate their care) and to change to another provider in a reasonably easy manner. These opportunities include the right to:
  • Be informed of available primary care providers in their areas.
  • Be informed of how to choose and change primary care providers.
  • Change their primary care provider.
• Ask questions and get answers about anything they don’t understand, and that includes the right to:
  • Have their provider explain their health-care needs to them and talk to them about the different ways their health-care problems can be treated.
  • Be told why care or services were denied and not given.

7.7.7.2 Client Responsibilities

PCCM and primary care providers should help clients understand their responsibilities. These include the responsibility to:

• Learn and understand each right they have under the Medicaid program. That includes the responsibility to:
• Learn and understand their rights under the Medicaid program.
• Ask questions if they do not understand their rights.
• Abide by PCCM and Medicaid managed care policies and procedures. That includes the responsibility to:
  • Learn and follow PCCM rules and Medicaid rules.
  • Choose a primary care provider.
  • Make any changes in their primary care provider in the ways established by Medicaid managed care.
  • Keep their scheduled appointments.
  • Cancel appointments in advance when they cannot keep them.
  • Always contact their primary care provider first for nonemergency medical needs.
  • Be sure they have approval from their primary care provider before going to a specialist (except for self-referred services).
  • Understand when they should and should not go to the ER.
• Share information relating to their health status with their primary care provider and become fully informed about service and treatment options. That includes the responsibility to:
  • Tell their primary care provider about their health.
  • Talk to their providers about their health-care needs and ask questions about the different ways their health-care problems can be treated.
  • Help their providers get their medical records.
• Actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
  • Work as a team with their provider in deciding what health care is best for them.
  • Understand how the things they do can affect their health.
  • Do the best they can to stay healthy.
  • Treat providers and staff with respect.

7.7.8 Primary Care Provider Selection and Changes

7.7.8.1 Selecting a Primary Care Provider
The primary care provider selection process allows new PCCM clients to choose their primary care provider before one is assigned. Clients can select a primary care provider by calling the PCCM Client Helpline at 1-888-302-6688 or mail the PCCM Primary Care Provider Selection form to TMHP.

PCCM clients have up to 75 days to select a primary care provider and 105 days to select a primary care provider for their newborn. If clients do not make a selection within the specified time period, a primary care provider will be auto-assigned.

Auto-Assignment
If a client does not exercise the right to choose a PCCM primary care provider, the client will be auto-assigned a primary care provider. The following factors are considered when processing an auto-assignment:
  • Client’s past claims history, taking into account an established relationship with a PCCM primary care provider
  • Client’s age
  • Client’s sex
  • Client’s geographic proximity to the primary care provider

PCCM clients are required to obtain health care from their selected or assigned primary care provider. If the Medicaid Identification Form (Form H3087) lists either PCCNEWB01 (newborns) or PCCPCCM01 (all clients except newborns) as the primary care provider, any PCCM enrolled primary care provider can render health-care services to the client.

7.7.8.2 Primary Care Provider Changes
PCCM clients may change their primary care provider by calling the PCCM Client Helpline at 1-888-302-6688 or by submitting the PCCM Primary Care Provider Selection Form located on the PCCM web page on the TMHP website at www.tmhp.com.

PCCM clients receive a primary care provider change notification letter after requesting a change to their primary care provider.

If a client request for a primary care provider change is successful, the notification letter will list the name of the new primary care provider and the effective date of the change. Clients will be instructed to take both the notification letter and their Medicaid Identification Form (Form H3087) to the new primary care provider’s office.

Successful requests for primary care provider changes that are received through the last business day of the month usually become effective on the first day of the next month and are reflected on the following:
  • All eligibility verification systems
  • The claims payment system
  • The client’s primary care provider change notification letter

Clients will also receive a notification letter if their primary care provider request is unsuccessful. If a change request is unsuccessful, the notification letter provides possible reasons that the request was not processed and a number for the client to call for assistance.

Refer to: “Client-Initiated Primary Care Provider Changes” on page 7-7 for information about effective dates of primary care provider changes.
7.7.8.3 Provider Initiated Primary Care Provider Changes

 Occasionally, the relationship between a client and their primary care provider may become unsatisfactory to one or both parties. A provider may request a client be reassigned to another primary care provider for any of the following reasons:

- The client is not included in the primary care provider’s scope of practice.
- The client is noncompliant with medical advice.
- The client consistently displays unacceptable office decorum.
- The client/primary care provider relationship is not mutually agreeable.

 If the relationship with the client is unsatisfactory due to behavioral issues on the client’s part, the primary care provider should contact PCCM CHS at 1-888-276-0702 to request assistance in resolving the problem. A community health coordinator can intervene and help providers with non-adherent and disruptive patients in most instances. The referral can also be made by submitting the PCCM Community Health Services Referral Request Form by fax to PCCM CHS at 1-512-302-0318. A copy of the PCCM Community Health Services Referral Request Form can be found on page B-73.

 If the relationship with the client cannot be improved, the provider must notify TMHP in writing to request reassignment of a client to another primary care provider before the request can be processed. The primary care provider must also notify the client in writing stating the reason for the reassignment. A copy of the letter to the client may serve as notification to TMHP.

 TMHP will notify the client of the reassignment in writing and request that the client choose another primary care provider. Primary care provider requests to reassign a client usually take 60 days before the change is made.

 7.7.9 Provider Enrollment

 Primary care providers can choose to contract with PCCM and HMO health plans simultaneously. A PCCM primary care provider’s contractual obligations are identified in the contract between HHSC and each primary care provider. PCCM primary care provider obligations are in addition to those required for Medicaid program participation and are intended to ensure that PCCM clients have access to quality health care from trained and credentialed providers.

 Refer to: “Primary Care Provider Requirements and Information” on page 7-10.

 “Provider Enrollment” on page 1-3.

 Important: All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC § 371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

 7.7.9.1 Credentialing Committee

 The Credentialing Committee is charged with the responsibility of reviewing each provider applicant’s file to ensure that enrolling physicians and other health-care professionals are qualified to perform services as PCCM providers.

 The committee reviews each provider applicant’s file and decides whether the provider should be recommended to the HHSC Medical Director as a primary care provider in the PCCM provider network. If HHSC approves the recommendation, the provider is accepted as a participating provider for three years.

 The Credentialing Committee is also charged with the responsibility of recredentialing PCCM providers, which occurs every three years after initial credentialing.

 The Credentialing Committee also reviews and approves credentialing policies and procedures for PCCM.

 7.7.9.2 Members of the Credentialing Committee

 The Credentialing Committee is comprised of the following members:

- Chair: Medical Director, HHSC Medicaid and Children’s Health Insurance Program (CHIP) Programs
- Co-Chair: Associate Medical Director, HHSC Medicaid and CHIP Programs
- Co-Chair: Medical Director, TMHP
- Associate Medical Director, TMHP
- Contracting and Credentialing Manager, TMHP
- Quality Services Officer, TMHP

 If a committee member is unable to attend a meeting, the member may appoint a designee.

 7.7.9.3 Credentialing Committee Frequency/Logistics

 The Credentialing Committee meets monthly, or as required, to review new applications for credentialing/recredentialing. The PCCM Contracting and Credentialing staff will have previously completed the initial screening for each provider in accordance with the standards of the National Committee for Quality Assurance (NCQA).
7.7.9.4 Credentialing Committee Action

The TMHP Medical Director, as the Co-Chair, is charged with implementing the credentialing and recredentialing standards for participating providers in PCCM. The HHSC Medical Director also reviews submitted documentation and recommends acceptance or rejection of each provider.

When a primary care provider’s PCCM credentialing file is complete, the TMHP Medical Director and Credentialing Committee verify all credentials and present their findings to the HHSC Medical Director for Medicaid and CHIP Programs (HHSC Medical Director), at the Credentialing Committee meeting. The HHSC Medical Director reviews the credentials and determines whether the applicant meets HHSC credentialing criteria. The decision to accept a provider as a PCCM primary care provider is made by HHSC in accordance with basic credentialing standards.

Based on this action, the HHSC executes the contract of approved providers. PCCM then notifies each approved applicant in writing of the application’s status. For approved providers, the notification includes:

- A fully executed provider contract.
- The date upon which the contract is effective.
- Conditions of participation in PCCM.
- Recredentialing requirements.

7.7.9.5 Credentialing Grievance Committee

The Credentialing Grievance Committee reviews provider requests for reconsideration of credentialing decisions. Applicants who are not approved are notified by certified mail of the denial, the reason for the denial, and the process for reconsideration. Applicants may request reconsideration by submitting evidence that the deficiency(ies) for which the original application was denied has/ have been corrected.

A provider has 30 days to request a reconsideration of a recredentialing denial to the Credentialing Grievance Committee. Such requests must be in writing and submitted to the following address:

Primary Care Case Management
Credentialing Grievance Committee
Credentialing Mail Code MC-B05
PO Box 204270
Austin, TX 78720-4270

Members of the Credentialing Grievance Committee
The Credentialing Grievance Committee is composed of the following members:

- Medical Director, HHSC Medicaid and CHIP Programs, or designee
- Medical Director, TMHP
- Contracting and Credentialing Manager, TMHP
- Provider Services Director, TMHP
- Staff person from HHSC Medicaid/CHIP/PCCM

Credentialing Grievance Committee
Frequency/Logistics
The Credentialing Grievance Committee convenes within 60 days after receipt of a grievance or request for reconsideration. The provider is notified of the date, time, and location of the grievance hearing before the Credentialing Grievance Committee. The provider may attend the grievance hearing.

Notification of the Credentialing Grievance Committee’s Decision
The provider is notified in writing of the decision of the Credentialing Grievance Committee within 45 days after adjournment of the hearing. The Credentialing Grievance Committee forwards its recommendations to HHSC following the hearing.

A decision of the Credentialing Grievance Committee may be submitted for reconsideration to:
Texas Health and Human Services Commission
Office of General Counsel
4900 N. Lamar, 4th Floor
Austin, TX 78751

7.7.9.6 Primary Care Provider Termination/Disenrollment

Primary care providers may terminate the PCCM agreement by providing 90 days prior written notice. Ninety days prior notice is requested to allow sufficient time to complete the reassignment process of clients in a primary care provider’s panel to new primary care providers.

Individual provider agreements will terminate automatically upon a provider’s death, the sale of the provider’s practice, or termination as a participant in Texas Medicaid.

HHSC may terminate a provider agreement by providing 30 days prior written notice. An HHSC initiated provider termination would be instituted for a provider who does not consistently meet plan requirements.

Refer to: “Monitoring Provider Performance” on page 7-45.

Clinics must notify PCCM within 30 days when a provider employee leaves the employ of or terminates his contract with the clinic, or is no longer willing to function as a primary care provider.

Termination or disenrollment notification should be sent to the following address:

Primary Care Case Management
Contracting and Credentialing Department MC-B05
PO Box 204270
Austin, TX 78720-4270

All correspondence must include the primary care provider’s contracted provider identifier on signed letterhead or providers should contact the Provider...
7.7.9.7 Additional Criteria for Primary Care Providers

All PCCM primary care providers must meet credentialing/ recredentialing criteria. Primary care providers are also required to meet the following criteria:

- Ability to Perform or Supervise the Ambulatory Primary Care Services of Clients. Provider performance is monitored on an ongoing basis. The PCCM Administrator follows up on evidence of poor performance and addresses identified problems immediately to ensure that high-quality care is delivered to clients.

- Admitting Privileges. The primary care provider must maintain admitting privileges with a hospital that is a participating provider in PCCM, or make arrangements with another Texas licensed physician who is an eligible Medicaid provider and who maintains admitting privileges with a contracted PCCM hospital.

7.7.9.8 Miscellaneous Provisions

Several other provisions apply to primary care provider participation in PCCM:

- A primary care provider agreement may be modified only by written agreement signed by all parties.

- A primary care provider agreement is not assignable by a primary care provider, either in whole or in part, without the prior written consent of the HHSC.

- Primary care provider agreements shall be governed and construed in accordance with the laws of the state of Texas.

- A primary care provider shall be required to bring all legal proceedings against HHSC in the Texas state courts.

- An agreement shall become effective only upon the primary care provider’s completion of the provider credentialing process and a determination by the HHSC or its designee that the primary care provider meets all of the requirements for participation in PCCM.

7.7.10 PCCM Reimbursement

In addition to Texas Medicaid fee-for-service payments, providers enrolled as PCCM primary care providers receive a case management fee of $5.00 per client, per month. The fee-for-service reimbursement for PCCM is based on the Texas Medicaid Reimbursement Methodology (TMRM) structure.

7.7.10.1 Case Management Fee

The case management fee is administrative compensation for managing the medical care of PCCM clients who have either selected or who have been assigned to the primary care provider’s practice as their medical home. The fee:

- Is paid to the primary care provider whether or not the client is seen that month.

- Is paid to the primary care provider in a separate check no later than the 10th state business day of each month.

Two reports are made available to primary care providers on a monthly basis. The client panel report lists the PCCM clients who have selected or who have been assigned to each primary care provider’s practice. This report is available electronically at www.tmhp.com, or in hard copy by calling the PCCM Provider Helpline at 1-888-834-7226. The second report, a case management summary, is produced by TMHP and accompanies the case management fee check.

If there are any discrepancies in either report, providers are to contact their TMHP provider relations representative. Providers are to call the Provider Helpline at 1-888-834-7226 prior to returning a check. This allows PCCM to provide the necessary research and assistance.


7.7.11 Support Services

7.7.11.1 Provider Support Services

PCCM core support services to primary care providers include:

- Provider Helpline. The PCCM Provider Helpline at 1-888-834-7226 is available to assist PCCM providers with a broad range of Medicaid and PCCM issues. Toll-free customer service lines are available Monday through Friday, from 7 a.m. to 7 p.m., Central Time, and are answered directly by call center representatives.

- Provider Relations Representatives. Provider relations representatives conduct informational and educational workshops, group meetings, and training sessions for office practices and groups when requested, and can assist in enrolling new primary care providers in PCCM. To contact the provider relations representative serving your area, call the TMHP Contact Center at 1-800-925-9126 or visit the TMHP website at www.tmhp.com.

- Medical Director Services. The TMHP Medical Director maintains overall responsibility for utilization management procedures, quality improvement activities and reporting, health education for both clients and providers, authorization requirements, and claim appeals related to the appropriateness of specific medical procedures or services. To contact the Medical Director, call 1-512-506-7000, and press “0” for the operator.
• Primary Care Provider and Hospital List. PCCM prepares and distributes to clients a listing of all PCCM providers. This listing identifies those providers who are accepting new patients, those who are accepting established patients only, and those who provide THSteps services. This listing is updated on a quarterly basis. To request a copy of the listing, contact the PCCM Provider Helpline at 1-888-834-7226 or visit the TMHP website at www.tmhp.com.

• Monthly Panel Report. PCCM provides to primary care providers a list of clients who have selected or who have been assigned to the primary care provider for management and coordination of their health care. This list is available online at www.tmhp.com, or by calling the PCCM Provider Helpline at 1-888-834-7226. Clients on this list are eligible for PCCM services throughout the entire month.

7.7.11.2 Client Support and Education

PCCM provides educational services to its clients. The most significant of these are three helplines:

• Client Helpline. The nonclinical Client Helpline at 1-888-302-6688 is the primary resource for clients seeking information or answers to questions. Clients may call the helpline to discuss concerns and file complaints regarding the operation and management of PCCM. The helpline operates from 7 a.m. to 7 p.m., Central Time, Monday through Friday. After hours, a recorded message instructs clients who need assistance with clinical, urgent, or emergent situations to contact the PCCM nurse helpline at 1-800-304-5468.

• Community Health Services (CHS). PCCM clients are eligible to receive services provided by CHS. CHS staff includes registered nurses, social workers, nutritionists, and health educators from all over Texas who can provide counseling for clients who do not keep appointments, or who inappropriately use the ER. CHS staff can also educate PCCM clients about the role of a primary care provider, the referral process, or the Medicaid change from Texas Medicaid fee-for-service to managed care. CHS staff can also provide information about disease prevention, care coordination, and location of resources. CHS staff is available to meet with clients in a provider’s office. Providers can refer clients for CHS services by calling the CHS toll-free number at 1-888-276-0702, Monday through Friday, 8 a.m. to 5 p.m., Central Time. A message can be left after 5 p.m. and before 8 a.m. TMHP staff will return calls on the next business day. Providers can also fax a PCCM Community Health Services Referral Request Form to 1-512-302-0318. Providers can refer up to four clients on a request form. The PCCM Community Health Services Referral form is located on page B-73.

• Nurse Helpline. PCCM provides a toll-free clinical nurse helpline at 1-800-304-5468 for all PCCM clients. The nurse helpline is staffed (nationally) by registered nurses who use physician-developed, symptom-based algorithms and 1,200 sets of self-care instructions to provide information, triage, and clinical assessment services for health plan clients 24 hours a day, 7 days a week. The nurse helpline nurses do not diagnose; they assess the client’s symptoms and guide the client to the most appropriate care setting. The nurse helpline number is widely publicized to PCCM clients. The nurse helpline can:
  • Provide triage, assistance, and reassurance to clients.
  • Direct clients to the most appropriate care setting.

If a nurse determines that a client needs emergency care, the nurse will direct the client to the nearest emergency facility or contact 9-1-1 on the client’s behalf.

In addition, PCCM publishes a semi-annual newsletter in both English and Spanish for client heads of household. The focus of the newsletter is on health-related topics (such as the importance of well-child care, and the significance of early entry into prenatal care), but it also provides useful information about services to improve clients’ access to health care, such as nonemergent medical transportation, community child care resources, and clinical services offered during nontraditional hours of operation.

Linguistic Services

It is the provider’s responsibility to ensure that interpretive services are available to his practice. Interpretive services include language interpreters, American Sign Language (ASL) interpreters, and Relay Texas (TDD) access. When interpretive services are necessary to ensure effective communications regarding treatment, medical history, or health education, PCCM providers may contact the PCCM nurse helpline at 1-800-304-5468. For assistance to clients who are hearing impaired, call Relay Texas (TDD) at 1-800-735-2988. If the provider’s staff is in need of translation services to meet requirements on limited English proficiency, call 1-800-752-0093.

Refer to: “Provider Responsibilities” on page 7-43.

“Cultural Competency and Sensitivity” on page 7-12.

7.7.11.3 Monthly Client Panel Report

Primary care providers can obtain their monthly panel report containing a list of clients assigned to them by accessing the TMHP website at www.tmhp.com. However, providers may request a paper panel report by calling the PCCM Provider Helpline at 1-888-834-7226. Providers are strongly encouraged to obtain their panel report from the TMHP website as it contains other valuable information only available electronically. This report verifies client assignments for the current month and identifies those who may be eligible for THSteps services.

Clients appearing on the monthly panel report are eligible for services for the entire calendar month.

Based on the number of clients appearing on the monthly panel report, the primary care provider receives a monthly case management fee check issued by TMHP. Providers may request to receive a monthly panel report by mail by calling the PCCM Provider Helpline at 1-888-834-7226.

Refer to: “Claims Filing Information” on page 7-54.
Panel Closings
PCCM primary care providers may choose to close their panel to new assignments. To close a panel, primary care providers should contact the PCCM Provider Enrollment, Contracting/Credentialing Department in writing (by mail or fax) to request a suspension of new enrollments or assignments to his practice. All correspondence must include the provider’s contracted provider identifier on signed letterhead. Should the provider choose to reopen his panel, contact the PCCM Contracting/Credentialing Department in writing (by mail or fax) to request the panel be reopened to new assignments. Providers should notify PCCM at least 30 days before reopening their panel. Providers may contact the Provider Enrollment, Contracting/Credentialing Department for a Provider Information Change Form to close and reopen a panel. Refer to: “Provider Information Change Form” on page B-81.

Panel Closings Involuntarily
For PCCM providers with multiple TPIs and with at least one attested TPI, TMHP transferred the clients from the unattested TPI to the attested TPI if the following criteria was met:
• The attested TPI suffix was credentialed with PCCM as the same type of provider as the unattested TPI suffix.
• The attested TPI suffix had the same physical address as the unattested TPI suffix.

For providers without an attested TPI who did not meet the criteria above, TMHP notified clients to choose a different primary care provider and the unattested provider’s panel report was closed.

7.7.12 Covered Services
PCCM clients are entitled to all medically necessary services that are benefits of Texas Medicaid. Except as specified below, primary care providers shall provide (directly or through referrals) all Medicaid-covered services. Refer to: “Referrals” on page 7-46.

Spell of Illness
Reimbursement to hospitals for adult inpatient services is limited to the patient “spell of illness.” The spell of illness is defined as “30 days of inpatient hospital care, which may accrue intermittently or consecutively.” After 30 days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the patient has been out of an acute care facility for 60 consecutive days.

Prescriptions
As in Texas Medicaid fee-for-service, adult PCCM clients 21 years of age or older are limited to three medicine prescriptions each month. When more than three prescriptions per month are needed, providers may prescribe maintenance medication(s) to cover more than a one month supply.

Annual Adult Physical Exams
Annual well visit exams are excluded for PCCM adult clients age 21 years of age or older except for well-woman annual exams provided as part of family planning or obstetrical and gynecological (OB/GYN) medical visits.

7.7.12.1 Self-Referred Services
PCCM clients may select any Medicaid-enrolled provider to access the following services without a referral:
• Emergency Services. In case of a medical emergency, clients may seek emergency medical services from the nearest facility. To ensure continuity of care, the emergency facility is asked to contact the client’s primary care provider within 24 hours or the next business day after providing services. Primary care providers or a primary care provider’s designee must be available to respond to an ER call promptly. If the emergency visit results in an admission, the facility also must notify PCCM to receive authorization prior to claims submission.

Refer to: “PCCM Inpatient Authorization Process” on page 7-47.
• OB/GYN Services. PCCM clients may select a PCCM-contracted OB/GYN as their primary care provider. As a primary care provider, the OB/GYN is responsible for providing or arranging all medically necessary services. PCCM clients may also seek direct services of any Medicaid-enrolled OB/GYN, family practitioner, or internal medicine provider who is not their primary care provider for the following services:
  • One well-woman examination per year
  • Care related to pregnancy
  • Care for all active gynecological conditions
  • Diagnosis, treatment, and referral to a Medicaid-enrolled specialist for any disease or condition within the scope of the designated professional practice of a licensed obstetrician or gynecologist, including treatment of medical conditions concerning the breasts

A referral from the PCCM client’s primary care provider is not required as long as the provider rendering services is a Medicaid-enrolled OB/GYN, family practitioner, or internal medicine provider.
• Family Planning Services. Family planning services include preventive health, medical counseling, and educational services that assist individuals in planning and/or preventing pregnancy and achieving optimal reproductive and general health. Primary care providers are encouraged to provide these services if requested by a client. Clients are not required to obtain family planning services through their primary care provider. Family planning is a service that does not require a primary care provider referral. Clients may go to a DSHS Family Planning state-contracted Medicaid facility for family planning services. Inpatient services must be delivered in a PCCM-contracted hospital/facility.
• THSteps. PCCM clients may select any THSteps-enrolled Texas Medicaid provider to perform THSteps services. If a THSteps medical checkup is performed by a provider who is not the client’s primary care provider, this information should be forwarded to the client’s primary care provider so that the client’s medical record can be updated.

Refer to: “Texas Health Steps (THSteps)” on page 43-1.

• Vision Services. Clients do not need a referral to access necessary covered vision services. Covered vision services are:
  • One eye exam each state fiscal year (September 1 through August 31) for clients 20 years of age or younger unless there is a diopter change of 0.5 or more.
  • Replacement of lost or damaged eyeglasses for clients 20 years of age or younger.
  • One eye exam every 24 months for assessing the need for eyeglasses for adults.
  • Unlimited medically necessary eye exams for a diagnosis of illness or injury.

Medicaid clients can select an ophthalmologist or therapeutic optometrist for Medicaid eye care benefit services (not surgery) without a referral from a primary care provider or any other type of prior authorization.

PCCM clients may also select therapeutic optometrists for the services listed below without a referral from a primary care provider or any other type of prior authorization:

Refer to: “Behavioral Health Services” on page 7-42.
“Psychiatric Services” on page 36-107.
“Psychologist” on page 38-1.
“Licensed Professional Counselor (LPC)” on page 30-1.
“Licensed Clinical Social Worker (LCSW)” on page 28-1.
“Licensed Marriage and Family Therapist (LMFT)” on page 29-1.

• Case Management for CPW. See “Case Management for Children and Pregnant Women (CPW)” on page 12-1.

• SHARS. Clients may select any qualified provider to access medically necessary and reasonable services to ensure that Medicaid-eligible children with disabilities receive the benefits mandated by federal and state legislation that guarantees a free and appropriate public education. See “School Health and Related Services (SHARS)” on page 42-1.

• School-Based Clinic Services. Clients may receive services from school-based clinics without a referral from their primary care provider. See “School Health and Related Services (SHARS)” on page 42-1.

• FQHC and RHC After-Hours Care. After-hours care provided by FQHCs and RHCs do not require a referral from the client’s primary care provider. After-hours care for FQHCs and RHCs is defined as care provided on weekends, on federal holidays, or before 8 a.m. and after 5 p.m., Monday through Friday. FQHCs and RHCs that provide after-hours services to PCCM clients must submit claims with modifier TU.

7.7.12.2 Community Health Services (CHS)
The goal of the PCCM CHS program is to facilitate the coordination of health related services required by PCCM clients. This means collaborating with providers, clients, and their families in identifying problems and resources, and removing barriers in accessing treatment and services. PCCM community health coordinators are located in all PCCM SAs. Examples of services offered by staff include:

• Provide counseling for clients who miss appointments.
• Provide counseling for clients who inappropriately use the ER.
• Educate clients about obtaining PCCM services.
• Management of high-risk pregnancies in conjunction with the client’s physician.
• Pediatric care coordination and education services for acute and chronically ill children.
• Case management for all chronic and/ or complex cases identified and eligible for CHS.
• Assistance in accessing state and community resources.
• Assistance in improving healthy behaviors and treatment compliance.
• Provide health education on a variety of health-related topics.

By offering the above services, PCCM assists both providers and clients with early, expedited access and intervention, increasing the likelihood of improved health outcomes.
Clients can be referred for health-care management and/or education on the following subjects:

- A newly diagnosed condition
- Asthma management
- Coronary artery disease
- Chronic obstructive pulmonary disease
- Dental health
- Diabetes management
- Effective use of benefits
- Hypertension
- Nutrition
- Otitis media
- Prenatal education
- Parenting and child development
- Puberty education
- Safety
- Smoking cessation

Community health coordinators assist clients in obtaining food, clothing, and other resources by linking them with public and/or private community organizations.

Providers interested in scheduling a community health education program in their office or referring a PCCM client for CHS can do so by:

- Completing the “Primary Care Case Management (PCCM) Community Health Services Referral Request Form” on page B-73 and faxing to 1-512-302-0318.
- Calling the CHS Intake staff at 1-888-276-0702, Monday through Friday, 8 a.m. to 5 p.m., Central Time. A message can be left between 5 p.m. and 8 a.m. TMHP staff will return calls on the next business day.

7.7.12.3 Behavioral Health Services

Behavioral health services are provided for the treatment of mental disorders, emotional disorders, and chemical dependency disorders. Behavioral health services do not require a primary care provider referral. PCCM clients may self-refer to any Medicaid-enrolled behavioral health provider for treatment. A referral from the client’s primary care provider is not required. A primary care provider may, in the course of treatment, refer a patient to a behavioral health provider for an assessment or for treatment of an emotional, mental, or chemical dependency disorder. A primary care provider may also provide behavioral health services within the scope of his practice.

PCCM clients may receive any behavioral health service that is medically necessary, currently covered by Texas Medicaid, and provided by a Medicaid-enrolled behavioral health provider. Behavioral health providers include psychiatrists, psychologists, LCSWs, LPCs, LMFTs, and TCADA licensed facilities. See each individual aforementioned section for benefits and limitations.

In addition, many services are offered through DADS and DSHS that do not require a referral. These include management for mental health and mental retardation, mental health rehabilitative services, and mental retardation diagnosis and assessment.

Behavioral health providers are encouraged to contact a client’s primary care provider to discuss the patient’s general health. Primary care providers are encouraged to maintain contact with the behavioral health provider to document behavioral health assessments and treatments and to inform the behavioral health provider of any condition the client may have that could impact the behavioral health service delivery. However, client approval for any exchange of information between the primary care provider and behavioral health provider is required. Please use the “Primary Care Case Management (PCCM) Behavioral Health Consent Form” on page B-71.

Primary care providers are responsible for documenting referrals to behavioral health providers and any known self-reerrals for behavioral health services in each client’s medical record.

Outpatient Services

Outpatient Behavioral health services that exceed 30 visits per client, per calendar year must be prior authorized by TMHP. Clinicians should plan therapy with the 30-encounter limitation in mind and should request extension authorizations before the client’s twenty-fifth visit. The current policies and guidelines require that authorizations be obtained before rendering service.

Fax the completed form, “Request for Extended Outpatient Psychotherapy/ Counseling Form” on page B-89 to TMHP/Special Medical Prior Authorizations at 1-512-514-4213 for prior authorization. Refer to individual provider sections of this manual for additional information on extension requirements (“Psychologist” on page 38-1, “Psychiatric Services” on page 36-107, “Licensed Clinical Social Worker (LCSW)” on page 28-1, “Licensed Marriage and Family Therapist (LMFT)” on page 29-1, “Licensed Professional Counselor (LPC)” on page 30-1) or contact TMHP at 1-800-925-9126.

Inpatient Services

PCCM requires notification for urgent or emergent inpatient psychiatric care in an acute care facility prior to claims submission for in-network facilities. Scheduled admissions for psychiatric care require prior authorization. Out-of-network admissions require notification within the next business day and submission of clinical information to determine appropriateness for transfer to a contracted facility. Fax the completed PCCM Inpatient/Outpatient Authorization Form to the PCCM Inpatient Prior Authorization Department at 1-512-302-5039 or call 1-888-302-6167.

Prior authorization is required for psychiatric admissions of patients 20 years of age or younger to a freestanding psychiatric facility. Fax the completed “Psychiatric Inpatient Initial Admission Request Form” on page B-82 to 1-512-514-4211 to obtain authorization. Inpatient
psychiatric admissions to freestanding facilities for clients 21 years of age or older are not covered under Texas Medicaid.

Refer to: “Psychiatric Hospital/Facility (Freestanding) (CCP)” on page 43-77 for additional information concerning the requirements of freestanding psychiatric admissions, or contact the TMHP Comprehensive Care Inpatient Psychiatric (CCIP) Unit at 1-800-213-8877.

7.7.13 Provider Responsibilities

In addition to the requirements listed in “Provider Requirements and Information” on page 7-28, PCCM primary care providers have clearly defined roles, responsibilities, and contractual requirements.

Verifying Primary Care Provider Assignment

At the time that an appointment is made, the provider should ask the client for the name of their primary care provider. If the client has made a recent change of their primary care provider, direct the client to go to the provider listed on their primary care provider change notification letter.

Note: Providers may not request primary care provider changes for their clients. Federal guidelines prohibit influence by providers on a patient’s choice of their primary care provider.

Primary Care Provider Services

PCCM defines the services to be provided and the responsibilities to be assumed by a PCCM primary care provider as follows:

• The primary care provider agrees to provide primary care services to PCCM clients. Primary care services are all medical services required by a client for the prevention, detection, treatment and cure of illness, trauma, or disease, which are covered and/or required services under Texas Medicaid. The primary care provider must ensure that clients 20 years of age or younger receive all services required by the THSteps program. All services must be provided in compliance with all generally accepted medical standards for the community in which services are rendered.

• Provide or arrange for medically necessary care within the following guidelines:
  • Urgent Care. Within 24 hours after the request
  • Routine Care. Within two weeks after the request
  • Physical/Wellness Exams. Within four to eight weeks after the request
  • Prenatal Care. Initial visit within 14 calendar days of the request or by the 12th week of gestation

• Refer clients to an approved Texas Medicaid provider or PCCM-contracted facility when the needed services are not available through the primary care provider’s office or clinic. Specialists to whom primary care providers refer clients also should schedule appointments within the timeframes described above. Primary care providers may contact the PCCM Provider Helpline at 1-888-834-7226 for a list of contracted facilities.

• Coordinate, monitor, and document medical treatment and covered services delivered by all providers to each client, including treatment during inpatient stays.

• Comply with all authorization and notification requirements of PCCM.

• Verify the eligibility of each client prior to providing covered services to determine whether the client is eligible for services under PCCM on the date of service.

• Coordinate care for children receiving services from or who have been placed in the conservatorship of DFPS. Primary care providers are responsible for furnishing or arranging for all medically necessary services while the child is under the conservatorship of DFPS and until the child is placed in foster care and is no longer eligible for PCCM enrollment.

• Cooperate with and participate in PCCM utilization management (UM) programs.

• Maintain hospital admitting privileges at a PCCM-contracted facility as applicable or maintain a referral relationship with a provider with admitting privileges.

• Provide preventive services using clinically accepted guidelines and standards.

7.7.13.1 Office and Medical Records Standards

To ensure that each onsite office or facility used to deliver health care to PCCM clients is safe, sanitary, and accessible, PCCM has defined standards for offices and other facilities:

• A site visit is conducted for each location as part of the evaluation process.

• An office compliance audit ensures that the facility meets defined standards.

• Evaluators use the visit as an opportunity to interact with the provider and office staff.

• Evaluators are prepared to explain the program and promote a strong network relationship.

For a provider to be considered for PCCM participation, all office sites must be in compliance with the “conditions of participation” stipulated in the provider contract. PCCM staff conducts an office onsite review at each primary care site prior to the acceptance of the provider into PCCM. Subsequently, Provider Relations staff performs routine audits at primary care office sites every two years.
The “Primary Care Case Management (PCCM) Pre-Contractual/Recredentialing Site and Medical Record Evaluation” on page B-76 is used to evaluate a provider’s office:

- Offices that are found to be marginally acceptable receive a follow-up visit within 90 days.
- PCCM may recommend that HHSC cancel a provider’s contract if office conditions do not meet defined standards after notice of required corrective action has been provided, and time to make changes has been made available.

### 7.7.13.2 Medical Records Standards

A PCCM provider is required to maintain comprehensive and accurate medical records to ensure quality and continuity of care. Each provider must maintain and make available medical records in accordance with the applicable provider agreement.

#### Content of Medical Record

Each patient’s medical record must include patient identification information, progress notes, and laboratory, referral, and consultation notes. Data to be maintained includes:

- **Patient identification information:**
  - Patient’s full name, address, and phone number
  - Patient’s history, including: past and present medical condition of patient and family, past illnesses and surgeries, X-ray and lab tests, immunizations, documentation of discussion of Advance Directives (patients 21 years of age or older)
- **Present physiological condition:**
  - Drug or allergy sensitivities
  - Current medications
- **Progress notes:**
  - Patient’s complaint or reason for visit
  - Results of physical examinations
  - Tests, procedures, and medications ordered by physician
  - Diagnoses and problems identified
  - Health education/preventive services performed
- **Laboratory, referral, and consultation notes:**
  - Laboratory and X-ray reports
  - Consultation and referral consultation reports
- **Copies of reports concerning hospital admissions including:**
  - Authorizations
  - Surgical reports
  - Discharge summaries

Refer to: “General Medical Record Documentation Requirements” on page 1-17.

In addition, PCCM providers performing THSteps comprehensive medical checkups must document all components of the checkup. These documentation requirements are detailed in “Documentation of Completed Checkups” on page 43-15.

Upon request, a provider will supply PCCM staff with copies of client medical records, as outlined in the provider agreement, for implementation of utilization management, quality improvement, and grievance programs.

#### Confidentiality of Medical Records

The relationship and all communication between physician and patient are privileged. Accordingly, the medical record containing information about the relationship is confidential.

A physician’s code of ethics, as well as Texas and federal laws, protect against the disclosure of the contents of medical records to persons or agencies that are not properly authorized to receive such information.

For a provider to release the contents of a patient’s medical record to a third party, the patient must first authorize the disclosure by signing and dating an authorization form. If the record is for a deceased individual, the executor of the estate must authorize the release.

PCCM’s policy is to allow only medical personnel and health professionals who are directly involved in the delivery or evaluation of a patient’s records to access the medical record. All requests for medical record information must be handled according to policy and law.

An authorization from the patient for release of medical information is not required when the release is requested by and made to PCCM, TMHP, HHSC, the external quality review organization, or the Texas Attorney General’s Medicaid Fraud Control Unit.

#### Medical Records Audits

PCCM Provider Relations staff performs a general medical record review of the primary care provider’s practice as part of the credentialing and recredentialing process and as part of the quality improvement program. The “Primary Care Case Management (PCCM) Pre-Contractual/Recredentialing Site and Medical Record Evaluation” on page B-76 is used to evaluate provider medical records as part of the credentialing and recredentialing process.

Medical record audit results are submitted to the Medical Director and, if necessary, to the Credentialing Committee for review. Depending upon review findings, the Credentialing Committee will assist the Medical Director in concluding the audit in one of three ways:

- Recommending that HHSC accept the provider.
- Recommending that HHSC reject the provider on the basis of poor medical record documentation and procedures.
- Recommending that HHSC accept the provider conditionally with the provision that certain changes must be made and standards must be met within a specified timeframe.
These recommendations apply to audits of an initial review of a provider as well as those of subsequent reviews.

If a provider has been found to be marginally in compliance with requirements, he will be given training and education directed at correcting the deficiency. PCCM will establish a system to audit this provider every 60 days for a maximum of three follow-up audits:

- Each audit must show substantial improvement over the previous audit.
- Following the third follow-up audit, if no improvement has been noted, PCCM will work with HHSC to apply sanctions and monitor performance closely.
- Subsequent to these measures, if the provider is still not in full compliance, PCCM will recommend to HHSC that the provider be terminated from the plan.

Medical records may also be reviewed in conjunction with provider profiling to identify opportunities to improve care and services.

Access and Availability Standards

PCCM staff routinely evaluates and monitors provider compliance with scheduling requirements. These scheduling requirements are designed to enhance access to health services and to provide assurance of service availability based on the urgency of need:

- Urgent Care. Within 24 hours after the request.
- Routine Care. Within two weeks after the request.
- Physical/Wellness Exams. Within four to eight weeks after the request.
- Prenatal Care. Initial visit within 14 calendar days of the request or by the 12th week of gestation.

Refer to: “Primary Care Provider Requirements and Information” on page 7-10.

7.7.14 Monitoring Provider Performance

PCCM is responsible for monitoring quality of care and, if necessary, recommending that HHSC disenroll providers who do not meet plan requirements.

Among the indicators used to monitor PCCM providers’ performance are:

- Client Comments and Complaints. The PCCM Complaints Department closely monitors the activities associated with client complaints as they relate to quality assurance and utilization management reviews for specific provider performances. The reports of these activities are used to trigger separate actions and inquiries about performance.
- Office Site Reviews. PCCM staff undertakes a variety of assessments as part of quality improvement activities and provider service activities. The results of these reviews are made part of the file of performance factors and indicators assessed during the credentialing process.
- Compliance With 24-Hour Access Standards. PCCM staff conducts audits to assess the degree of compliance with Medicaid managed care access standards. Client comments and complaints may trigger reviews of specific providers. The results of these reviews are considered in the credentialing process.
- Ability to Perform or Directly Supervise Ambulatory Primary Care Services for Clients. Provider performance is monitored on an ongoing basis. PCCM staff follows up evidence of poor performance and addresses identified problems immediately to ensure that high-quality care is delivered to plan clients.
- Admitting Privileges. PCCM staff verifies that each provider maintains membership on the medical staff with admitting privileges at a minimum of one accredited contracted hospital or has an acceptable (timely and complete transfer of patients and records) arrangement with a primary care provider who has such admitting privileges.
- Continuing Medical Education Credits. Provider Enrollment/Contracting and Credentialing staff monitors each provider’s activities in the area of continuing medical education credits.
- Education Sessions. PCCM provides a series of educational sessions that include aspects of UM and case management. Provider contracts require that each primary care provider attend at least one educational session each year.
- Valid Drug Enforcement Administration (DEA) Certification. Proof of DEA certification must be submitted as part of the application process and will be maintained by PCCM in its credentialing files.
- Performance Within Scope of Individual Licensure and PCCM Credentialing. PCCM staff provider applications include a statement providing assurance that a certified registered nurse practitioner, nurse midwife, or PA will perform services only within the scope of his licensure, and that the individual will be disciplined immediately if this agreement is violated.
- Compliance with Fraud and Abuse Policy. PCCM will recommend to HHSC that a network provider be suspended immediately upon notification from any source that the provider:
  - Has been terminated or suspended from participation in the Medicaid or Medicare Program.
  - Has lost his or her license.
  - Has been convicted of a criminal act.

PCCM employs the above indicators as part of its oversight function. Findings are cataloged and analyzed for patterns of performance that require special attention. Where warranted, the results are made part of the credentialing process. Failure to adhere to the above standards of performance will be grounds for suspension or termination.
7.7.15 Referrals

PCCM primary care providers function as the medical home for PCCM clients. Primary care providers are responsible for arranging and coordinating appropriate referrals to other providers, including specialists, and for managing, monitoring, and documenting the services of other providers.

Referrals are an integral component of PCCM’s health-care delivery program. Referrals ensure that clients gain access to all necessary and appropriate covered services and that care is delivered in the most clinically suitable and cost-effective setting.

Referral procedures are designed to capture the information needed to support and manage the utilization of services by the provider network. Proper documentation of referrals is necessary for accurate medical record keeping.

Primary care providers are responsible for the appropriate coordination and referral of PCCM clients for the following services:

- CPW case management services
- DARS case management services
- ECI case management services
- Mental retardation targeted case management
- SHARS
- Texas Commission for the Blind case management services
- THSteps medical case management
- THSteps dental (including orthodontics)
- Tuberculosis services
- Vendor drugs

A primary care provider who has been selected by a PCCM client, but the primary care provider change is not yet in effect, can make referrals to specialists while the change is pending by calling the PCCM Provider Helpline at 1-888-834-7226.

7.7.15.1 Open Specialty Referral Network

PCCM operates an open specialty referral network. Primary care providers may refer patients to any Texas Medicaid-approved specialist within the State of Texas that accepts PCCM clients for covered health services. Medically necessary referrals to specialists do not require authorization from PCCM.

For all referrals, primary care providers should furnish their provider identifier and complete information on treatment procedures and diagnostic tests performed prior to the referral. The referral should specify the following:

- Initial diagnosis/diagnoses
- Reason for the referral
- Services requested from the referral specialist
- Number of authorized visits (optional)

Primary care providers may make a referral to another primary care provider or a specialist during periods of absence or unavailability. Primary care providers may also make a referral if a client requests a second medical opinion.

After receiving a referral specialist’s report, if ongoing treatment for an illness is required, primary care providers have the discretion to specify the period of time or number of visits authorized for ongoing treatments to be given by the specialist.

The referring primary care provider’s identifier must be entered on all claims submitted by the treating provider, indicating the primary care provider authorized the services. It is the responsibility of the treating specialist to ensure that the patient continues to be an eligible PCCM client throughout the period of treatment.

7.7.15.2 Referral Form

No form for a referral to a specialist is required. However, primary care providers are encouraged to use the PCCM Referral Form. This form reflects accepted practices in the Texas medical community.

The use of this form will simplify:

- Dissemination of necessary information to the specialist.
- Documentation for the client’s medical record of the specialist’s diagnosis and treatment.

Refer to: “Primary Care Case Management (PCCM) Referral Form” on page B-75.

One copy of the referral form should be given to the specialist. One copy should be maintained in the client’s medical record.

7.7.16 Specialist Responsibilities

Specialists are responsible for furnishing medically necessary services to PCCM clients who have been referred by their primary care provider for specified treatment or diagnosis. While the specialist does not contract with PCCM, all facility services should be delivered in a contracted PCCM facility.

Specialists are responsible for verifying the eligibility of the referred client prior to providing treatment.

To ensure continuity of care for clients, the specialist must maintain communication with the client’s primary care provider. This communication should ensure that the primary care provider’s medical records adequately document the specialist services provided, all results or findings, and all recommendations. The specialist may use the lower half of the PCCM Referral Form for this purpose.

When a primary care provider refers a client to a specialist, the specialist should review the case with the primary care provider to fully understand the services being requested. Services requiring more than one visit should be coordinated with the primary care provider for
approval of additional visits. Referrals from a primary care provider must be documented in both the primary care provider’s and the specialist’s records.

If a specialist determines that a client’s condition warrants attention (e.g., hospitalization or diagnostic procedures), the specialist should seek authorization from the PCCM Inpatient/Outpatient Prior Authorization Department by telephone at 1-888-302-6167 or by fax at 1-512-302-5039.

Emergency treatment does not require authorization. Refer to: “Facility/ Hospital Services” on page 7-47.

7.7.16.1 Specialist-to-Specialist Referrals

Referrals from one specialist to another for a medically necessary service must be authorized by the client’s primary care provider or, if the client does not have a primary care provider, the specialist can call the PCCM Client Helpline to obtain a one-time appointment approval.

7.7.17 PCCM Inpatient Authorization Process

7.7.17.1 Definitions

Authorization. The process of obtaining approval for the delivery of services.

Routine/Nonemergent Condition. A symptom or condition that is neither acute nor severe and can be diagnosed and treated immediately, or that allows adequate time to schedule an office visit for a history, physical and/or diagnostic studies prior to diagnosis and treatment.

Urgent Condition. A symptom or condition that is not an emergency, but requires further diagnostic work-up and/or treatment within 24 hours to avoid a subsequent emergent situation.

Emergent/Emergency. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

• Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy

• Serious impairment to bodily functions

• Serious dysfunction to any bodily organ or part

Emergency services means covered inpatient and outpatient services that are as follows:

• Furnished by a provider that is qualified to furnish these services under this title

• Needed to evaluate or stabilize an emergency medical condition

Poststabilization Services. Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee’s condition.

Observation Services. Services received within a hospital setting, which are “reasonable and necessary” to evaluate an outpatient condition or determine the need for possible admission to the hospital as an inpatient.

Notification. The process by which a facility informs PCCM that a client has been admitted as an inpatient to their facility on an urgent or emergent basis.

7.7.17.2 Professional Services

ER Services

Primary care providers should become actively involved in educating PCCM clients regarding the appropriate use of the ER and other emergency services. Providers should also notify PCCM of any client who may need further education regarding the appropriate use of the ER by calling the Client Helpline at 1-888-302-6688, or by using the Primary Care Case Management (PCCM) Community Health Services Referral Request Form.

Refer to: “Primary Care Case Management (PCCM) Community Health Services Referral Request Form” on page B-73.

7.7.17.3 Facility/Hospital Services

Requests for prior authorization or notification of admissions for PCCM clients may be submitted via phone by calling the PCCM Inpatient Prior Authorization Department at 1-888-302-6167, faxed to 1-512-302-5039 using the Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form, or online through the TMHP website at www.tmhp.com. Online instructions for submitting authorization requests electronically can be found on the TMHP website at www.tmhp.com. Providers may request a prior authorization online for computed tomography (CT), computed tomography angiography (CTA), Magnetic resonance imaging (MRI), and magnetic resonance angiography (MRA) in addition to outpatient, nonemergent CT, CTA, MRI or MRA for the PCCM Program. The provider must check the authorization request status before services are provided to confirm whether the authorization has been approved or denied. See “Prior Authorization Requests Through the TMHP Website” on page 5-5 for additional information about mandatory documentation requirements and retention.

All requests must include the following information:

• Facility name and provider identifier

• Client name, Medicaid number (PCN), and DOB

• Requesting (admitting) physician’s name and provider identifier

• Name of person completing form

• Date completed

• Telephone number
• Fax number
• Admit date
• Diagnosis codes (primary, secondary, etc.)
• Diagnosis related groups (DRG) code (for DRG facilities)
• Procedure codes
• Discharge date
• Clinical information to support medical necessity if required

Note: Submit medical records pertaining only to the service for the prior authorization that is being requested.

If the provider’s request is determined to be incomplete, the Inpatient Prior Authorization Department contacts the provider requesting the specific information needed to make the authorization determination and places the request in pending status. If the requested information is not received by the second business day, the information is requested again. If the information is not received by the fourth business day from the date the request was placed in pending status, the request is denied. A denial letter is sent to the facility and/or the requesting physician. When the requested information is received within four business days from the original pend date, the authorization is processed.

For most admissions, a letter of notification/authorization is faxed to the requesting facility or the requesting physician once the determination is complete. For scheduled inpatient admissions, both the facility and the physician will receive faxed notification.

Authorization is a condition of reimbursement. It is not a guarantee of payment, and all inpatient admissions are subject to retrospective review by the HHSC Office of Inspector General Utilization Review Unit.

If the DRG submitted on a claim does not match the DRG on the authorization, one of the following will occur:

• If the lesser of the two DRGs can be derived, the claim will be paid at the lower amount.
• If the lesser of the two DRGs cannot be derived, the claim will be denied.

Claims are adjudicated based on the authorization that was completed at the time of the claim submission. To avoid a DRG mismatch and the denial of the claim when there is a change to an existing authorization (e.g., a change to the discharge date, diagnosis, DRG, or procedure), the facility is required to submit an updated Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form before the claim is submitted. The form can be submitted either by fax to 1-512-302-5039 or by contacting the Inpatient Prior Authorization Department at 1-888-302-6167.

Notification of urgent and emergent admissions is only required before a claim is submitted. Providers are encouraged to submit the notification after DRG information is complete to avoid updating the DRG because of a DRG mismatch and a change to the admitting diagnosis.

To ensure that day and cost outliers are reimbursed appropriately, if the client’s length of stay and/or services rendered are different or more complex than the ones that were authorized, providers should contact the PCCM Inpatient Prior Authorization Department to update the authorization before the claim is submitted.

For non-DRG facilities, the claim will pay at the lower number of inpatient days when the length of stay that is billed is different from the length of stay that was authorized. If there is a change to an existing authorization, providers should contact the PCCM Inpatient Prior Authorization Department with the update before the claim is submitted.

7.7.17.4 Emergency Room (ER) Services

ER providers are authorized by PCCM to furnish the medically necessary appropriate treatment of PCCM clients. The ER provider must perform the medical screening examination; i.e., assess the medical needs of a PCCM client who appears in the ER to determine the medical necessity of services and the appropriate setting for rendering services.

ER providers must determine a patient’s status based on the urgent, emergent, and nonemergent definitions noted in “Definitions” on page 7-47. In some cases, medically necessary services are needed to determine the patient’s condition. The necessity of these services must be documented in the medical record. ER providers are paid for medically necessary services required to determine and stabilize the patient’s condition.

If a determination is made that the client has a routine/nonemergent condition, the client’s primary care provider should be notified by telephone, fax, or electronic mail, so that follow-up care can be arranged by the primary care provider as appropriate.

If a determination is made that the client has an urgent condition, the client’s primary care provider should be notified by phone, fax, or electronic mail, so that follow-up care can be arranged within 24 hours.

If the client has an emergent condition, the ER must treat the client until the condition is stabilized or until the client can be admitted or transferred. Once the client is stabilized, the ER staff must notify the client’s primary care provider to arrange for medically necessary hospital admission or follow-up care. If the ER staff is unable to contact the primary care provider (or designated on-call provider) within one hour, the ER staff should treat the client and report the primary care provider’s unavailability by contacting the PCCM Provider Helpline at 1-888-834-7226.

Hospitals are eligible to bill for any services required in the medical screening examination and stabilization of a PCCM client. All services must be supported by the clinical record.

When treatment is provided to a PCCM client, professional and facility services must be billed separately.
Reimbursement of emergency facility and ancillary charges for diagnostic tests, monitoring, and treatment is based on the actual services rendered. The hospital is paid at its current Medicaid reimbursement rate.

7.7.17.5 Observation Services
Observation services are those received within a hospital setting, which are “reasonable and necessary” to evaluate an outpatient condition or determine the need for possible admission to the hospital as an inpatient. Some patients, while not requiring hospital admission, may require a period of observation in the hospital environment as an outpatient. Observation services may be provided in any part of the hospital where a patient placed in observation can be assessed, examined, monitored, and/or treated in the course of the customary handling of patients by the facility. Observation services after the 23rd hour are not payable by Texas Medicaid. If the patient is going to be admitted, the patient’s status must be changed from observation to inpatient prior to the 24th hour.

If an inpatient admission occurs from an observation status, the Inpatient Prior Authorization Department must be notified. Notification of admission is the responsibility of the admitting facility. If necessary, notification of admission is accepted from the physician’s office. The payment for the inpatient admission includes the observation stay. Notification of admission is required prior to claim submission to avoid claim denial.

Note: Inpatient admissions are subject to retrospective review by the HHSC Office of Inspector General Utilization Review Unit.

7.7.17.6 Urgent and Emergent Admissions
Notification of admission is required prior to claim submission to avoid claim denial. Notification of admission is the responsibility of the admitting facility. If necessary, notification of admission is accepted from the physician’s office. The following information should be included on the notification:

- Facility name and provider identifier
- Client name, Medicaid number (PCN), and DOB
- Requesting (admitting) physician’s name and provider identifier
- Name of person completing form
- Date completed
- Phone number
- Fax number
- Admit date
- Diagnosis codes (primary, secondary etc.)
- DRG code (for DRG facilities)
- Procedure codes
- Discharge date
- Clinical information to support medical necessity if required

Note: Submit medical records pertaining only to the service for the prior authorization that is being requested.

If the provider’s request is determined to be incomplete, the Inpatient Prior Authorization Department contacts the provider requesting the specific information needed to make the authorization determination and places the request in pending status. If the requested information is not received by the second business day, the information is requested again. If the information is not received by the fourth business day from the date the request was placed in pending status, the request is denied. A denial letter is sent to the facility and/or the requesting physician. When the requested information is received within four business days from the original pend date, the authorization is processed.

If an emergent admission is necessary, the hospital must notify PCCM prior to claim submission. Failure to notify the PCCM Inpatient Prior Authorization Department prior to claim submission will result in denial of the claim.

Notification of emergency admissions can be provided by calling the PCCM Inpatient Prior Authorization Department at 1-888-302-6167 or faxing to 1-512-302-5039.

7.7.17.7 Obstetrical/Newborn Notification Routine
Authorization is not required for routine obstetrical and newborn care within the routine length of stay (48 hours for vaginal deliveries and 96 hours for C-section deliveries).

Non-Routine
All obstetrical and newborn admissions with nonroutine clinical status (complicated condition or DRG) or non-routine length of stay (over 48 hours for vaginal deliveries and 96 hours for C-section deliveries) require notification of admission and clinical documentation prior to claim submission. Notification of admission is the responsibility of the admitting facility. However, if necessary, notification of admission is accepted from the physician. Notification of admission is required prior to claim submission to avoid claim denial.

7.7.17.8 Scheduled Inpatient Admissions
Prior authorization is required for all scheduled inpatient admissions. Prior authorization of admission is a shared responsibility of the admitting facility and physician, but only one provider (admitting facility or physician) is required to submit an authorization request.
7.7.17.9 Appeals of Denied Requests for Authorization

If an authorization request for admission or service is denied, the requesting provider will receive a denial letter from the PCCM Inpatient Prior Authorization Department. Where appropriate, the hospital or facility involved is also notified of the denial.

Requests for reconsideration for prior authorizations for inpatient services are subject to the following steps:

1) Provider submits a request for prior authorization to the prior authorization unit and obtains the authorization or a denial for the authorization from TMHP.

2) If the provider is not satisfied with the results of step 1, they can appeal step 1 by submitting additional information/documentation to TMHP. This step can be repeated multiple times as long as the provider is submitting additional information/documentation.

3) If the provider is not satisfied with the outcome determined by TMHP in step 2 and no additional information is available to submit to TMHP, the provider may submit a request for reconsideration to HHSC (only if step 1 is complete and step 2 is thoroughly exhausted).

These steps are applicable prior to filing the claim. Filing deadlines should be taken into consideration, and HHSC will not review if steps 1 and 2 were not followed.

Refer to: “Appeals” on page 6-1 and “Authorization Appeals” on page 7-53.

7.7.17.10 Out-of-Network Inpatient Services

Out-of-network hospitals are reimbursed only for inpatient services provided to PCCM clients as the result of an emergency admission. Out-of-network facilities must notify the Inpatient Prior Authorization Department of a client admission within the next business day following the admission. Medical documentation must be submitted with notification to determine appropriateness for transfer to a contracted facility. Scheduled medical and surgical admissions or any nonemergency admission must be precertified indicating the reason why the patient must be admitted or transferred to an out-of-network facility (i.e., the services needed are not provided in a network facility, the patient had an emergent condition requiring admission while away from the SA).

A routine OB/newborn admission to an out of network facility does not require notification or prior authorization.

Nonroutine OB/newborn services require prior authorization within the next business day following the determination that the services are nonroutine.

Refer to: “Obstetrical/Newborn Notification” on page 7-49 for the definition of routine and nonroutine OB/newborn Services.

After a patient in an out-of-network hospital is stabilized, additional services are considered noncovered benefits. The out-of-network hospital may, however, request an exception to the stabilization policy by contacting the PCCM Inpatient Prior Authorization Department at 1-888-302-6167:

- The hospital must state the circumstances surrounding the emergency admission and provide an estimate of the additional number of days required until the patient is discharged.
- PCCM grants exceptions based on the information provided by the noncontracted hospital and issues a authorization for billing purposes if an exception is granted.

Although in some cases the PCCM Inpatient Prior Authorization Department may require additional time to review the circumstances of the request for exception, it normally reviews the request and contacts the out-of-network hospital within 36 hours of its request. The Inpatient Prior Authorization Department will either provide the noncontracted hospital with a authorization or deny the exception request.

Should a stabilization exception be denied, any inpatient services provided to the PCCM client at the out-of-network hospital will cease to be a covered benefit 24 hours after the hospital is notified.

Nonemergency inpatient admissions are not a covered benefit at out-of-network hospitals and are considered for reimbursement only if authorization has been received from the PCCM Inpatient Prior Authorization Department or the client would experience an undue burden traveling to a network hospital. In this case, a hardship exemption may be granted. This exemption permits reimbursement of a nonemergency admission at an out-of-network hospital.

To obtain a hardship exemption, the attending physician or designee must contact the PCCM Inpatient Prior Authorization Department at 1-888-302-6167 before any nonemergency admission to an out-of-network hospital and provide details to substantiate why the client would experience an undue burden traveling to a network hospital.

If the details substantiate undue burden, the PCCM Inpatient Prior Authorization Department will grant the exemption and issue a authorization. The physician can then admit the patient to the out-of-network hospital.

Note: Under no circumstances will authorization for an undue travel burden be granted after a patient has been admitted for a nonemergency condition to an out-of-network hospital.

Primary care providers referring clients to specialists should make the specialist aware of the PCCM non-contracted hospital admission policy.
The following outpatient procedures require prior authorization:

- All laser surgeries
- CT
- CTA
- MRI
- MRA
- pH probe tests
- Some endoscopic procedures
- Some podiatry procedures
- Some surgical procedures

Prior authorization for clients with retroactive eligibility must be obtained by the PCCM provider within 95 days of the add date and before claims submission.

Refer to: “CT, CTA, MRI, and MRA” on page 39-3 for more information about MRI/MRA and CT/CTA authorizations.

The following outpatient procedures do not require prior authorization:

- Anesthesia services (type of service 7)
- Surgeries performed on an outpatient emergent basis (retrospective authorization must occur for claims payment)
- Application/removal of casts, splints, or strapping (excluding podiatry office procedures and services)
- Burns—local treatment (does not include skin grafts or long-term wound care)
- Catheterization of blood vessels (excluding heart catheterizations) for diagnosis or therapy (includes venous access, puncture of shunt, etc.)
- Cholecystectomy
- Circumcision, newborn and for phimosis (20 years of age or younger)
- Fractures/dislocations (closed or open treatment)
- Incision and drainage of abscesses
- Injection procedures for radiology or in conjunction with surgical procedures
- Intubation/tracheostomy tube changes
- Polysomnography
- Removal of foreign bodies
- Insertion or removal of pressure equalization tubes (myringotomy and tympanostomy)
- Repair of lacerations/wounds (includes the eye)
- Replacement of gastrostomy tubes
- Replantation of digits
- Sterilization procedures (male and female)
- Urodynamics
- Esophageal manometry
- Ultrasounds
- Holter monitors
- Tympanostomy
- Tonsillectomy for clients 11 years of age or younger
- Adenoidectomy for clients 11 years of age or younger
- Bronchoscopy
- Sigmoidoscopy
- Proctosigmoidoscopy
- Permanent removal of nail/nail matrix
- Colonoscopy (except with endoscopic ultrasound exam or fine needle biopsy)
- Esophageal Endoscopy (except for ablation procedures)
- Appendectomy for ruptured appendix or incidental removal
- Hernia repair (except initial repair 4 years of age or younger with strangulation or incarceration)
- Upper GI Endoscopy (except for drainage of psuedocyst or placement of gastrostomy tube)

Requesting Prior Authorization

Requests for prior authorization of outpatient services may be made by faxing a completed Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form to the Outpatient Prior Authorization Department at 1-512-302-5039, by calling 1-888-302-6167, or through the TMHP website at www.tmhp.com. Other forms will not be accepted for outpatient prior authorizations or updates.

Refer to: “Prior Authorization Requests Through the TMHP Website” on page 5-5.

The request must include the following information:

- Facility name and provider identifier
- Client name, Medicaid number (PCN), and DOB
- Requesting (admitting) physician’s name and provider identifier (if requesting authorization by paper)
- Online authorization requests submitted on the TMHP website requires an NPI. TPIs can no longer be submitted for authorization requests through the TMHP website at www.tmhp.com
- Name of person completing form
- Date completed
- Telephone and fax number
- Admit date
- Diagnosis codes (primary, secondary, etc.)
- Procedure codes
- Clinical information to support medical necessity is required

If the prior authorization request is determined to be incomplete, the Outpatient Prior Authorization Department faxes the provider a letter requesting the specific information needed to make the prior authorization determination and places the request in pending status.
At least two additional attempts to call and/or fax the provider to obtain this information will be made during the next four business days. If the requested information is not received by the fourth business day, a letter is sent to the client stating that the prior authorization request cannot be processed until the provider responds with the specific information necessary to complete the prior authorization request. This client letter is sent along with a copy of the initial letter to the provider that lists the specific information necessary to make the prior authorization determination. If the provider does not submit the information necessary to complete the prior authorization request within seven calendar days from the date of the letter sent to the client, a letter is sent to the provider and the client notifying them of the denial of service due to incomplete or missing information.

A letter of authorization determination is faxed to the requesting provider once the request is completed.

Authorization is a condition of reimbursement. It is not a guarantee of payment.

Claims are processed based on the authorization completed at the time of claim submission.

If there is a change in an existing authorization (i.e., change in diagnosis or change in procedure), the facility/provider is required to submit an updated Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form with clinical documentation supporting the change or contact the Outpatient Prior Authorization Department with the update prior to claim submission to avoid claim denial.

Providers performing urgent or emergent outpatient procedures that require authorization must contact the PCCM Outpatient Prior Authorization Department within seven calendar days to obtain the authorization.

7.7.19 Transportation Services

7.7.19.1 Nonemergency Transportation
Nonemergency transportation services are available to eligible Medicaid clients who have no other means of transportation. This service is known as the Medical Transportation Program (MTP) and is detailed in “Medical Transportation” on page I-1.

7.7.20 Provider Complaints and Appeals

7.7.20.1 Conflict Resolution
The relationship between client and primary care provider may become unsatisfactory to one or both parties. The primary care provider should contact the PCCM Provider Helpline or write to request assistance in resolving the situation.

PCCM will initiate one or more of the following steps:

- Contact the client and the provider to assess the situation and provide educational information that may clarify the situation, if applicable
- Refer the situation to CHS staff for education or to help clarify the situation
- Refer the situation to the Complaint Resolution Team, if applicable
- Begin complaint/grievance resolution
- Reassign the client to another primary care provider

7.7.20.2 Provider Complaints
Refer to: “Appeals” on page 6-1 for more information on provider complaints.

Provider Complaint Policy
PCCM takes seriously and acts on each provider complaint. Depending on the level and nature of the complaint, PCCM works with the provider to resolve the issue or directs the complaint to the appropriate PCCM department.

- Complaints Unit. Complaints that concern the relationship between a provider or provider’s staff and a client.
- Medical Affairs Division. Complaints that relate to utilization of services (including ER use), denial of continued stay, and all clinical and access issues. This includes provider’s appeal of an adverse authorization decision.
- PCCM Administration. Complaints that concern the relationship between a provider and any PCCM staff person or complaints about the overall plan management.

If the complaint relates to a medical issue, the Medical Affairs staff may assist in the resolution of the complaint.

The provider complaints process applies only to the resolution of disputes within the control of PCCM, such as administrative or medical issues. The provider complaint process does not apply to allegations of negligence against third parties, including other participating providers. These complaints are referred to HHSC for review and evaluation and are resolved by HHSC staff with support from PCCM staff.

Provider Complaint Procedures
The PCCM Complaints Unit handles all provider complaints. The processing of provider complaints is described below:

- Providers must submit their complaint in writing or by telephone. All requests to remove clients from their panel must be in writing (see “Provider-Initiated Primary Care Provider Changes” on page 7-7.)
- Providers will receive a written acknowledgement letter from PCCM within five business days of receipt of the complaint.
- Referrals to other departments, such as Provider Services or Medical Affairs, are made as appropriate.
• Complaints dealing with the quality of, access to, or continuity of care are referred to the PCCM Primary Care Provider Contract Compliance Department for follow-up and inclusion in the provider file.

• If the complaint cannot be resolved within 30 calendar days, the provider is notified in writing or by phone of the status of the complaint.

If the provider believes he or she did not receive due process from PCCM, the provider may file a complaint with HHSC. However, providers must exhaust the appeals/grievance process with PCCM before filing a complaint with HHSC.

Refer to: “Medicaid Managed Care Complaints and Fair Hearings” on page 7-13.

“Complaints to HHSC—Texas Medicaid Fee-for-Service and PCCM” on page 6-11.

7.7.20.3 Authorization Appeals

A denial is issued when an authorization or update to an existing request by a physician or a facility is not approved by the TMHP Medical Director or designee.

A medical necessity denial is issued when the documentation provided fails to support the need for requested service or the client’s condition/service requested does not warrant the level or location of care the provider requested.

A denial is also issued when the provider has failed to comply with PCCM policies and procedures. These include failure to:

• Notify of an inpatient stay.

• Obtain authorization for an elective/scheduled service prior to the delivery of service.

A denial may also be issued if:

• The provider or the location of service is not within the network.

• The patient is no longer eligible for coverage.

• The service is not a benefit of Texas Medicaid.

The appeals or authorization reconsideration process affords the provider the opportunity to dispute a denial and explain or justify the original request.

Refer to: “Appeals” on page 6-1.

“Appeals Procedures for Denials Other Than Medical Necessity

Level I: Review by TMHP

If the provider has evidence that he or she complied with policy, he may request a reconsideration of a denial by resubmitting the authorization request with additional information to support the reconsideration and a copy of the denial letter by fax to the PCCM Inpatient or Outpatient Prior Authorization Department that issued the denial prior to submitting the claim.

Level II: Additional Review by TMHP

If the provider is not satisfied with the results of the Level 1 review, they can appeal by submitting additional information/documentation to TMHP.

Level III: Review by HHSC

If a provider believes he or she did not receive full consideration under the appeals process, he may file an appeal with HHSC. Providers must exhaust the appeals process with TMHP before filing an appeal with the HHSC.

Refer to: “Complaints to HHSC—Texas Medicaid Fee-for-Service and PCCM” on page 6-11.

If it is determined that the provider did not receive full consideration, HHSC will work with the provider and PCCM to ensure that a proper review of the appeal is conducted.

Hospitals may appeal to the HHSC Medical and UR Appeals Unit only if they have followed the prior authorization process with TMHP. The Medical and UR Appeals Unit must receive the written appeal request within 120 days of the last R&S report. If the request is not received within 120 days, the appeal is not conducted, and the TMHP decision is considered final. This request must include a copy of the complete medical record, an original signed, properly completed, notarized Affidavit (see “Affidavit” on page B-4), and a letter explaining the reason for the appeal. Extensions of time are not granted for filing the written appeal request, submission of the complete medical record, or the original properly completed notarized affidavit in the format approved by HHSC.

Appeal Procedures for Medical Necessity Denials

Level I: Review by TMHP

Providers can appeal medical necessity denials by resubmitting the authorization request with additional clinical information to support the appeal and a copy of the denial letter by fax to the PCCM Inpatient or Outpatient Prior Authorization Department that issued the denial prior to submitting the claim.

Upon receipt of the request:

• The Medical Director or designee reviews the information and makes a determination.

• After the determination is made, the Medical Affairs nurse sends the resolution letter to the appealing provider.

If dissatisfied with the reconsideration decision, a provider can request another reconsideration by resubmitting the authorization request with additional clinical information not previously submitted to support the requested services and a copy of the denial letter by fax to the PCCM Inpatient or Outpatient Prior Authorization Department that issued the decision prior to submitting the claim.
Section 7

Once a provider has submitted a claim for services, reconsiderations for medical necessity cannot be performed by the PCCM Prior Authorizations Departments. The provider will need to follow the process for administrative claims appeals.

Refer to: "Appeals to HHSC Texas Medicaid Fee-for-Service and PCCM" on page 6-5.

Level II: Additional Review by TMHP
If the provider is not satisfied with the results of the Level 1 review, they can appeal by submitting additional information/documentation to TMHP.

Level III: Review by HHSC
Providers must exhaust the appeals process with TMHP before filing a complaint with HHSC.

If a provider believes he did not receive full consideration under the appeals process, he may file a complaint with HHSC.

Refer to: "Complaints to HHSC—Texas Medicaid Fee-for-Service and PCCM" on page 6-11. "Medicaid Managed Care Complaints and Fair Hearings" on page 7-13.
For paper appeals, refer to "Paper Appeals" on page 6-3.

7.7.21 Claims Filing Information
All PCCM claims are submitted to TMHP, whether TANF or SSI.

Electronic claims submissions require an NPI only. If a claim is submitted electronically with a TPI, the claim will be denied. If an electronic claim is submitted without an NPI, the claim will be denied.

Paper claims submissions require a TPI and NPI for the performing and billing provider. The performing provider’s TPI is required in block 24j in the shaded area, and NPI in block 24j in the unshaded area of the CMS-1500 claims form. The billing provider’s TPI is required in block 33B in the shaded area, and the NPI in block 33A in the unshaded area. An NPI is required in all other NPI provider identifier blocks. If the NPI and TPI are not in the proper blocks on the claim form and if the NPI is missing from any of the other NPI required blocks, the claim will be denied.

Paper claims submissions for the referring provider require the complete name of the referring provider in block 17 and an NPI in block 17b. The referring provider for a managed care client must be the client’s primary care provider. If there is not a referral from the primary care provider, a prior authorization number must be on the claim.

7.7.21.1 PCCM Newborn Claims Filing
PCCM newborns are automatically assigned to the PCCM at the time of the newborn’s birth. The effective date of the newborn’s enrollment is the same as the newborn’s date of birth. Claims filing procedures for PCCM newborns will continue to be handled under Texas Medicaid fee-for-service billing guidelines through TMHP.

Health care providers should file newborn claims using the newborn’s Medicaid Identification number as soon as it is made available to them. A referring provider identifier is not required when submitting claims for clients who have PCNEWB01 on their Medicaid Identification Form (Form H3087). Any Medicaid provider can see the newborn. Claims submitted for newborns will be accepted even if a primary care provider has not been selected or assigned. Parents of a newborn have up to 105 days to select a primary care provider for their baby. If parents do not select a primary care provider, a primary care provider is selected for the newborn on the basis of claims history.

Once the baby is assigned a primary care provider and a Medicaid number, normal billing and referral procedures will be in effect.

Refer to: “CMS-1500 Instruction Table” on page 5-29 Referring Physician field (boxes 17a and 17b) for specific services that require a referring provider number.

7.7.21.2 Personal Care Services (PCS)
PCS are authorized and reimbursed by TMHP for PCCM.
Refer to: “Personal Care Services (PCS) (CCP)” on page 43-59.

7.7.21.3 Network Hospitals
A network hospital is one that is contracted to provide services to PCCM clients. Individual reimbursement arrangements are negotiated for the HHSC by PCCM Hospital Contracting.
For all SAs, all inpatient services to PCCM clients, including services provided to PCCM clients receiving SSI benefits, are reimbursed at the PCCM rate.

7.7.21.4 Out-of-Network Hospitals
An out-of-network hospital is one that is not contracted to provide services to PCCM clients:
• Out-of-network hospitals are reimbursed only for inpatient services provided to PCCM clients as the result of an emergency admission. Inpatient services are reimbursed at the rate paid by the Texas Medicaid fee-for-service program.
• Reimbursement for emergency treatment will be made at the current Medicaid rates.
Hospitals that are not contracted with PCCM are reimbursed according to Texas Medicaid fee-for-service rates.

7.7.21.5 Emergency Outpatient Services
If the client presents at a hospital emergency outpatient facility, the physician should provide the medically necessary medical screening examination and stabili-
zation services immediately, and the client should be referred back to the primary care provider for follow-up care. Reimbursement for emergency outpatient services requires that the medical record document the medically necessary services.

The hospital should contact the client’s primary care provider within 24 hours or the next business day to advise that emergency treatment has been provided. In addition, if a procedure requiring authorization was performed while in the emergency department, the hospital must contact the PCCM Outpatient Prior Authorization Department within seven calendar days to obtain the authorization. If the condition results in an inpatient admission, the hospital must notify the PCCM Inpatient Prior Authorization Department prior to claim submission. Reimbursement in cases of emergency treatment will be based on the actual services rendered. The hospital will be reimbursed at its current Medicaid reimbursement rate.

Refer to: “PCCM Inpatient Authorization Process” on page 7-47.

7.7.21.6 Nonemergency Outpatient Clinic Services
All hospitals are reimbursed for outpatient clinic services at their current Medicaid outpatient reimbursement rate.

7.7.21.7 PCCM Claims Details
To avoid PCCM claim denials, the primary care provider’s complete and correct name, and provider identifier must be entered in the referring provider field of the appropriate claim form, indicating a referral from the primary care provider if the treating provider is not the client’s primary care provider at the time of service.

If this information is missing or invalid and the treating provider is not the assigned primary care provider on the date of service, the claim will be denied.

For services requiring authorization, enter the authorization number in block number 23, when submitting claims on the CMS 1500 paper claim form. This block is the prior authorization field. The Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form is not required with the claims submission. Online authorization requests submitted on the TMHP website require an NPI.

Refer to: “PCCM Inpatient Authorization Process” on page 7-47.

7.7.21.8 National Drug Code (NDC)
All PCCM providers that submit professional or outpatient claims with physician-administered prescription drug procedure codes will be required to use the associated NDC. Drug claims submitted with procedure codes in the “A” code series will not require an NDC. The NDC is only required on outpatient hospital claims and physician claims.

N4 must be entered before the NDC on claims. The NDC is an 11-digit number on the package or container from which the medication is administered.

The unit of measurement codes for all three forms are:

- F2—International unit
- GR—Gram
- ML—Milliliter
- UN—Unit
Unit quantities must also be provided on the claim. Depending on the claim type, the NDC information must be submitted as indicated below. If submitting on a UB-04 CMS-1450, the NDC information must be submitted as indicated below:

**UB-04 CMS-1450**

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>Revenue codes and description</td>
<td>Enter N4, the 11-digit NDC number (number on package or container from which the medication was administered), the unit of measurement code, and the unit quantity with a floating decimal for fractional units (limited to 3 digits). Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025</td>
</tr>
</tbody>
</table>

If submitting on a CMS-1500 the NDC information must be submitted as indicated below:

**CMS-1500**

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>24A</td>
<td>DOS</td>
<td>In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on package or container from which the medication was administered). Do not enter hyphens or spaces within this number. Example: N400409231231</td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, services, or supplies</td>
<td>In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit.</td>
</tr>
<tr>
<td>24G</td>
<td>Days or units</td>
<td>In the shaded area, enter the NDC unit of measurement code.</td>
</tr>
</tbody>
</table>

### 7.7.21.9 Claims for Specialist Services

Specialists may bill for health-care services provided to PCCM clients if the patient was referred by the client’s primary care provider. Electronic claims submissions by specialists require a referral from the PCCM client’s primary care provider. The specialist can submit claims electronically by including the complete, correct name of the referring provider who is also the PCCM client’s primary care provider, and the referring provider’s NPI number in the NPI required blocks. An NPI only is required for electronic claims submissions. If a TPI is submitted on an electronic claim, the claim will be denied. Paper claims submissions by specialists also require a referral from the PCCM client’s primary care provider. To indicate a referral from the client’s primary care provider, the primary care provider’s name, NPI, and provider identifier must be included in the Referring Physician field (blocks 17 and 17b) on the CMS-1500 claim form. A referral is not required if a specialist is providing a service that does not require a referral from a primary care provider.

Reimbursement for specialists is based on the current Texas Medicaid fee-for-service rates.

Refer to: “Referrals” on page 7-46 and “Self-Referred Services” on page 7-40.

PCS are authorized and reimbursed by TMHP for PCCM.

For claims filing purposes, the PCS provider must bill place of service 2 (home) when submitting claims to TMHP. Texas Medicaid will not reimburse providers for PCS that duplicate services that are the legal responsibility of school districts.