Texas | Medicaid

Texas Provider Orientation

TXWP-CD-050348 | May 2024

Wellpoint

Today’s discussion

- **Doing business with Wellpoint:**
  - Member enrollment
  - Credentialing
  - Reference tools/online resources
  - Prior authorization guidelines
  - Claims submission/payment disputes
  - Coordination of benefits
  - Grievances/medical appeals
- **Improving healthcare together:**
  - Community involvement
  - Fraud, waste, and abuse
  - Cultural competency
  - Translation services
  - Availability standards
  - Disease management
  - Quality management
- **Team/key contacts and additional resources**

Our mission and values

- Wellpoint is a name that has been part of our heritage for more than 30 years, so it may be familiar for some — but more importantly, it is a name that perfectly fits with our vision for our brand to be the most innovative, valuable, and inclusive partner we can be.
- It is the Wellpoint mission to improve lives and the communities in which we serve, simplify healthcare, and expect more by challenging ourselves to improve on our performance.
- Our focus is on serving low-income individuals, families, seniors, and people with disabilities.
- We believe focusing on the whole person is the foundation to living well because health is beyond physical; it's recognizing the behavioral and social drivers that impact it, too.

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Medicaid enrollment

MAXIMUS — State enrollment broker:

- Provides education and enrollment services to Texans in Medicaid managed care programs, CHIP, and children's dental services.
- Conducts outreach and provides information about the Texas Health Steps program.

Enrollment:

- Enrollment kits are sent to clients by MAXIMUS, following receipt of the client's eligibility from the Texas Health and Human Services Commission (HHSC).
- An MCO is automatically assigned if the enrollment process is not completed by the client.

Medicaid enrollment (cont.)

- **Assistance is available with the enrollment process, including:**
  - Personalized assistance at enrollment assistance sites and during enrollment events. Visit www.txmedicaidevents.com.
  - Home visits scheduled through the Enrollment Broker Helpline.
  - Submission of enrollment forms online, by mail, or fax.
- **Effective dates:**
  - Before the 15th of the month — effective the first day of following month (for example, enroll January 10 to effective February 1)
  - After the 15th of the month — effective the first day of next full month (for example, enroll January 20 to effective March 1)
- **Plan changes:**
  - Must contact MAXIMUS for plan changes.
  - Same effective date rules apply.

Medicaid enrollment (cont.)

Those who wish to complete the enrollment on their own may submit their applications by mail, online, or by fax. The contact information is provided below:

- Enrollment Broker Helpline (STAR and CHIP): **800-964-2777**
- Special Populations Helpline (STAR+PLUS and STAR Kids): **877-782-6440**
- Mail: P.O. Box 149023, Austin, TX 78714-9023
- Online: yourtexasbenefits.com
- Fax: **855-671-6038**

Marketing activities

Sanctioned marketing activities:

- Attendance at MAXIMUS-sponsored member enrollment events
- Approved MCO-sponsored health fairs and community events
- Radio, television, and print advertisements

In Texas, the following activities are prohibited:

- Conducting direct-contact marketing except through the HHSC-sponsored enrollment events
- Making any written or oral statement containing material that misrepresents facts or laws relating to Wellpoint or the STAR, STAR+PLUS, STAR Kids, or CHIP programs
- Promoting one MCO over another if contracted with more than one MCO

Community Involvement

Wellpoint also works closely with school, community, government, and faith-based organizations to find new ways to help and give back to our communities.

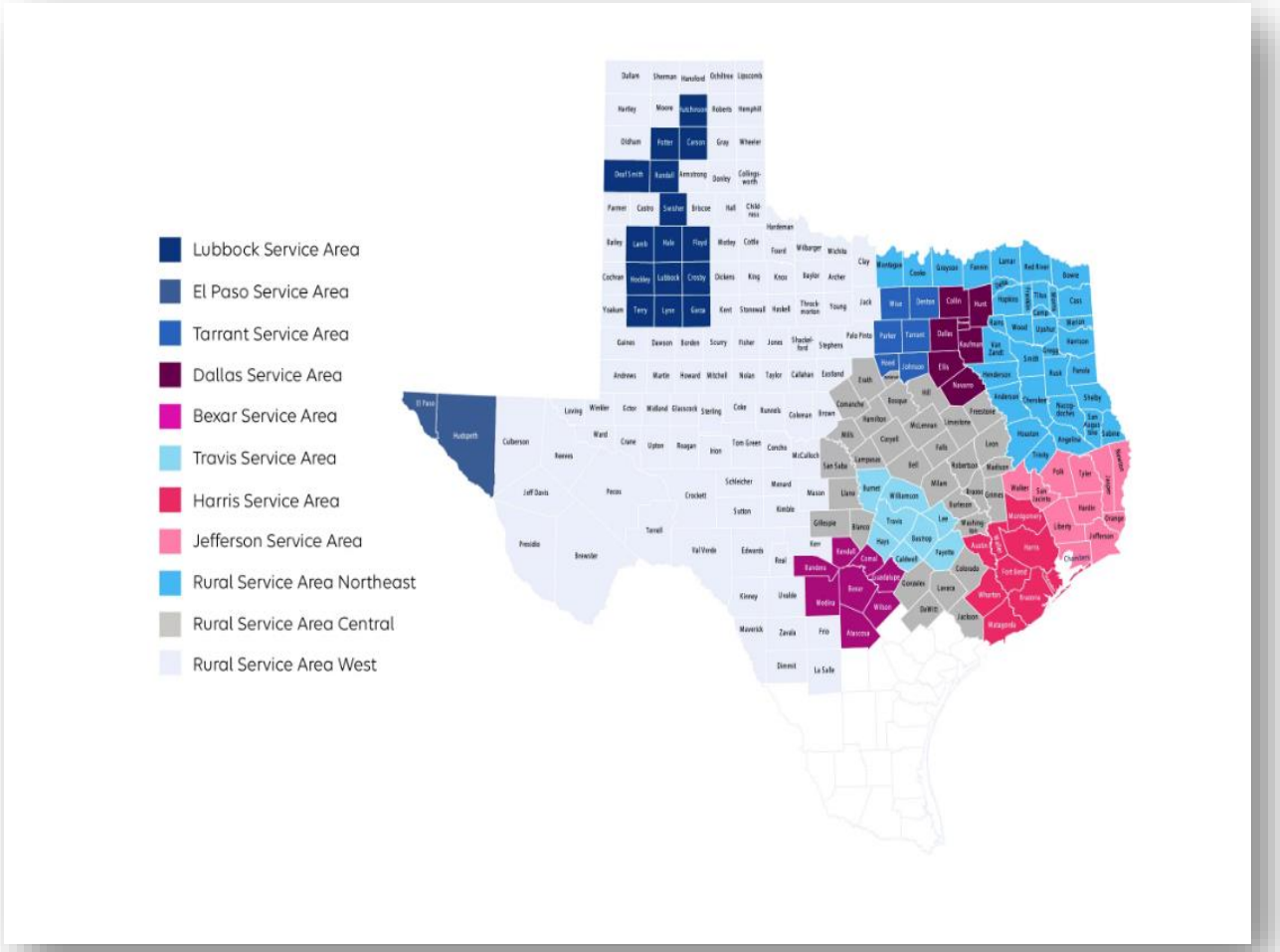
We organize and participate in activities throughout the state like :

- Promoting literacy and self-esteem through the Head Start programs.
- Organizing member advisory groups so parents, guardians, and community advocates can engage with our member advocates to help ensure quality of care for our members.

Eligibility and benefits

	STAR	STAR+PLUS	STAR Kids	CHIP	CHIP Perinatal
Eligibility	Temporary Assistance for Needy Families (TANF), pregnant women, children receiving Medicaid assistance only, AAPCA services	SSI adult population, including dual-eligible clients, non-SSI adults who qualify for home- and community-based service (HCBS) STAR+PLUS waiver services, MBCC services	Children aged 20 and younger who have Medicaid through SSI or 1915(c) waiver programs, AAPCA services	Uninsured children ages 18 and below in families with incomes too high to qualify for Medicaid	Unborn children of pregnant women who do not have health insurance and do not qualify for Medicaid
Covered services	Inpatient and outpatient hospital, emergency, physician services, lab, X-ray, home health, family planning, behavioral health services, pharmacy, Texas Health Steps	Inpatient and outpatient hospital, emergency, physician services, lab, X-ray, home health, family planning, behavioral health services, pharmacy, long-term services and supports (LTSS), service coordination	Inpatient and outpatient hospital, emergency, physician services, lab, X-ray, home health, family planning, behavioral health services, pharmacy, service coordination, LTSS, Texas Health Steps	Inpatient and outpatient hospital, emergency, physician, lab, X-ray, home health, behavioral health services, pharmacy, well-child visits	Care related to pregnancy only, including prenatal visits, labor and delivery, postpartum visits

Medicaid and CHIP by Service Area for Wellpoint



STAR :
Bexar, Dallas, Harris, Jefferson, Lubbock, Tarrant, Rural Service Area – Central, Northeast and West

STAR Kids:
Dallas, El Paso, Harris, Lubbock, Rural Service Area – West

STAR+PLUS:
Bexar, El Paso, Harris, Jefferson, Lubbock, Tarrant, Travis and Rural Service Area– West

CHIP:
Bexar, Dallas, Harris, Jefferson and Tarrant

CHIP Perinatal:
Bexar, Dallas, Harris, Jefferson and Tarrant

Benefits of STAR+PLUS

	Other community — nondual	STAR+PLUS waiver — nondual	Other community — dual	STAR+PLUS waiver — dual
Acute benefits	Covered and coordinated through Wellpoint based on the traditionally defined state Medicaid benefit package	Covered and coordinated through Wellpoint based on the traditionally defined state Medicaid benefit package	Covered through a member's traditional Medicare or Medicare Advantage Plan — Wellpoint will assist members in coordination of care.	Covered through a member's traditional Medicare or Medicare Advantage Plan — Wellpoint will assist members in coordination of care.
Behavioral and mental health benefits	Covered and coordinated through Wellpoint based on the traditionally defined state Medicaid benefit package	Covered and coordinated through Wellpoint based on the traditionally defined state Medicaid benefit package	Covered through a member's traditional Medicare or Medicare Advantage Plan — Wellpoint will assist members in coordination of care.	Covered through a member's traditional Medicare or Medicare Advantage Plan — Wellpoint will assist members in coordination of care.
Pharmacy benefits	Covered and coordinated through Wellpoint based on the traditionally defined state drug formulary	Covered and coordinated through Wellpoint based on the traditionally defined state drug formulary.	Medicare Part D plans — Wellpoint will offer state-defined assistance with copays and doughnut hole coverage.	Medicare Part D Plans— Wellpoint will offer state defined assistance with copays and doughnut hole coverage.
LTSS benefits	Covered and coordinated through Wellpoint, limited to primary home care and day activity health services.	Covered and coordinated through Wellpoint — includes primary home care and day activity health services, as well as all defined 1915(c) or 1115 waiver services	Covered and coordinated through Wellpoint, limited to primary home care and day activity health services	Covered and coordinated through Wellpoint — includes primary home care and day activity health services as well as all defined 1915.c or 1115 waiver services

Texas Health Steps

- Texas Health Steps is for members from 0 to 20 years of age who have Medicaid. Texas Health Steps provides regular medical, dental checkups, and case management services to babies, children, teens, and young adults at no cost to the member.
- Providers must be enrolled in the Texas Health Steps program to administer Texas Health Steps services.
- Providers can enroll through tmhp.com.
- Call Texas Health Steps toll-free at **877-847-8377** (**877-THSTEPS**) Monday to Friday from 8 a.m. to 8 p.m. CT.
- Also, reference tmhp.com for the latest *Texas Health Steps Quick Reference Guide*.

Early childhood intervention

- Early Childhood Intervention (ECI) is a federally mandated program for infants and toddlers under the age of 3 years with or at risk for developmental delays and/or disabilities.
- The federal ECI regulations are found at *34 C.F.R. § 303.1 et seq.*
- The state ECI rules are found within the *Texas Administrative Code, Title 26, Part 1, Chapter 350.*
- Wellpoint must ensure network providers are educated regarding the federal laws on child-find and referral procedures, for example, *20 U.S.C. § 1435(a)(5); 34 C.F.R. § 303.303.*

ECI responsibilities

- Wellpoint must require network providers identify and refer any member under the age of three years suspected of having a developmental delay or disability or otherwise meeting eligibility criteria for ECI services in accordance with *26 Texas Administrative Code, chapter 350* to the designated ECI program for screening and assessment within seven calendar days from the day the provider identifies the member.
- Wellpoint must use written educational materials developed or approved by HHSC for ECI services for these child-find activities. Materials are located at: hhs.texas.gov/services/disability/early-childhood-intervention-services.

ECI responsibilities (cont.)

- The local ECI program will determine eligibility for ECI services using the criteria contained in *26 Texas Administrative Code, Chapter 350*.
- ECI providers must submit claims for all physical, occupational, speech, and language therapy to Wellpoint.
- ECI-targeted case management services and ECI specialized skills training are non capitated services.
- ECI providers are to bill Texas Medicaid & Healthcare Partnership (TMHP) for these services.
- Wellpoint must contract with qualified ECI providers to provide ECI-covered services to members under the age of three who are eligible for ECI services.

ECI responsibilities (cont.)

- Wellpoint must permit members to self-refer to local ECI service providers without requiring a referral from the member's PCP.
- The Individual Family Service Plan (IFSP) is the authorization for the program-provided services (for example, services provided by the ECI contractor) included in the plan.
- Prior authorization is not required for the initial ECI assessment or for the services in the plan after the IFSP is finalized.
- All medically necessary health and behavioral health program-provided services contained in the IFSP must be provided to the member in the amount, duration, scope, and service setting established in the IFSP.

Children of migrant farmworkers

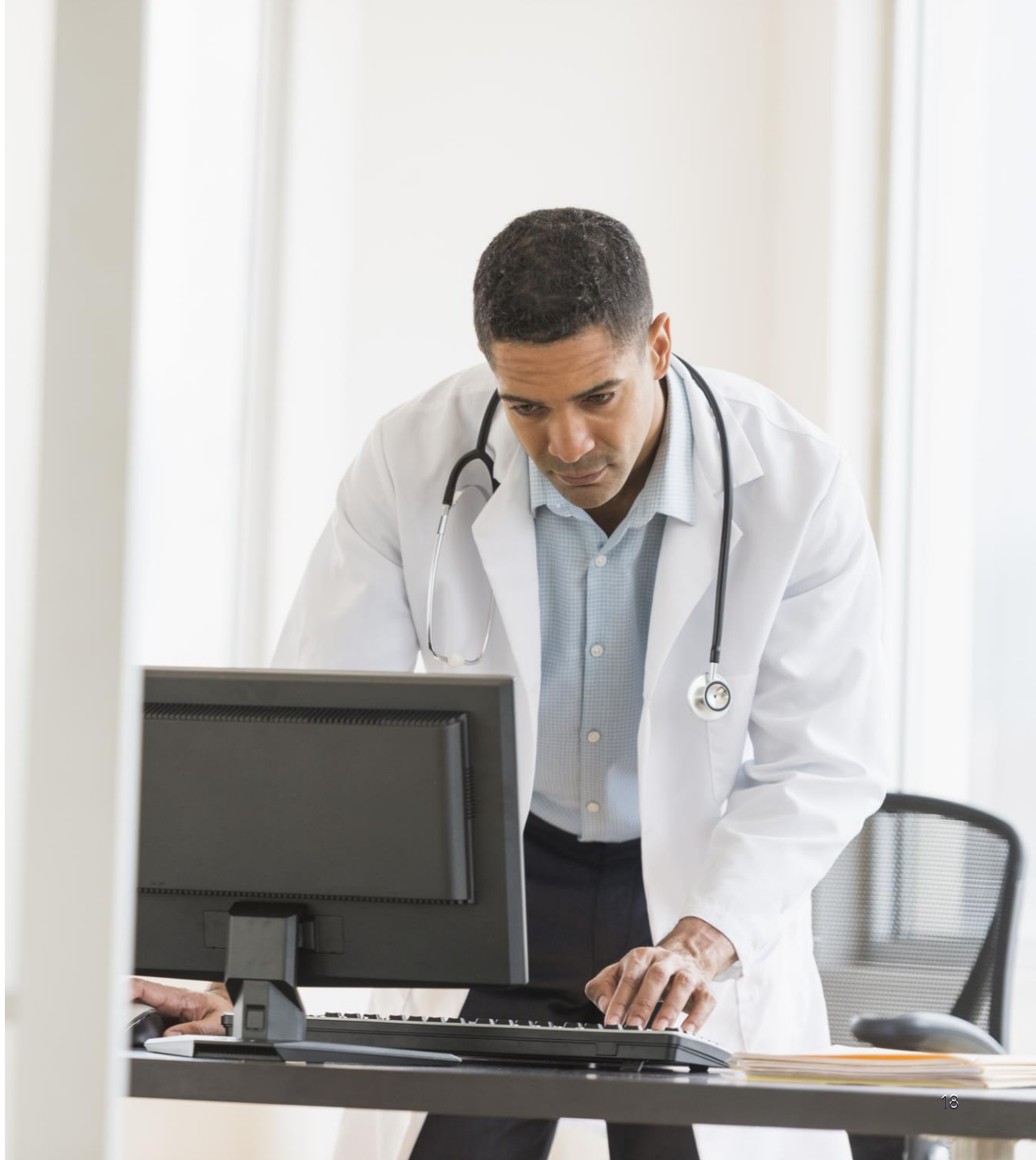
- HHSC defines a migrant farm worker as *a migratory agriculture worker whose principal employment is in agriculture on a seasonal basis, who has been employed in the last 24 months and who establishes for the purpose of such employment a temporary abode.*
- Texas farmworker children face higher proportions of dental, nutritional, and chronic health problems than non-migrant children.
- Wellpoint assists children of migrant farmworkers in receiving accelerated services while they are in the area.
- We ask primary care providers to assist Wellpoint in identifying a child of a migrant farmworker by asking the child or parent during an office visit.
- Previously missed checkup under the periodicity schedule is considered a late checkup and not an exception to periodicity or an accelerated service.
- Call Wellpoint if you identify a child of a migrant farmworker at **833-731-2160 (TTY 711).**

Your responsibilities

Providers should review both provider and member responsibilities detailed in the provider manual found at provider.wellpoint.com/tx.

Providers are also obligated to follow all applicable federal, state, and contractual obligations. You may be selected for a Wellpoint audit on these requirements. Some helpful information is located here:

- Center for Medicare & Medicaid Services
- Texas Health and Human Services
- Texas Administrative Code
- Federal OIG Exclusions
- Texas OIG Exclusions

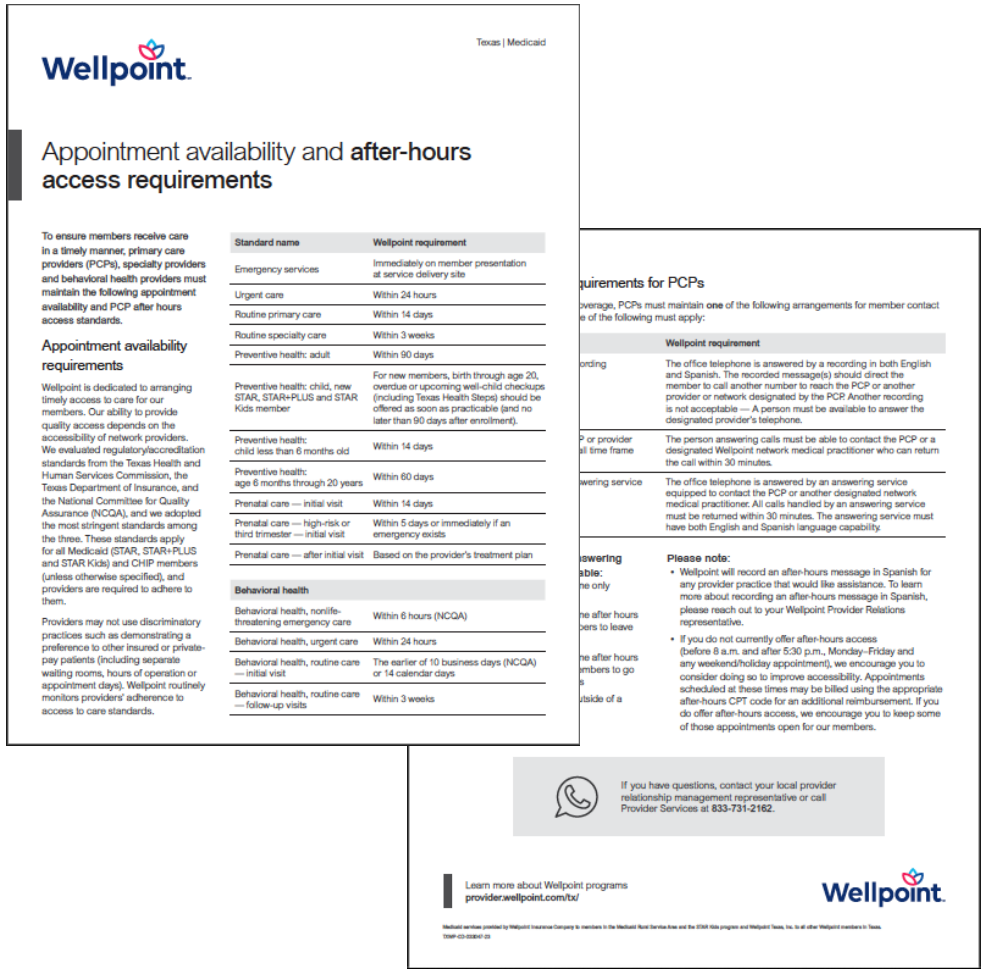


Collaboration and communication

- Collaboration leads to well-informed treatment decisions. Providers work together to develop compatible courses of treatment, increasing the chances for positive health outcomes, and avoiding adverse interaction.
- Communication between the member's PCP or medical home, specialists, hospitals, home health agencies, and therapy providers is key to ensure our members — your patients — receive quality care that is thorough and seamless. Each provider type is responsible to conduct timely provider-to-provider communication as appropriate.
- For additional information related to this requirement please access the Medicaid/CHIP Provider Manual at provider.wellpoint.com/tx> Resources > Provider Manuals and Guides.

Appointment availability and after-hours standards

- We are dedicated to timely access to care for our members. Our ability to provide quality access depends upon the accessibility of network providers. We evaluate HHSC, Texas Department of Insurance, and National Committee for Quality Assurance (NCQA) requirements, and we follow the most stringent standards among the three sources.
- Providers are required to adhere to access standards that apply to both Medicaid and CHIP unless specified. Standards are measured from the date of presentation or request, whichever occurs first.



Wellpoint

Texas | Medicaid

Appointment availability and **after-hours access requirements**

To ensure members receive care in a timely manner, primary care providers (PCPs), specialty providers and behavioral health providers must maintain the following appointment availability and PCP after hours access standards.

Appointment availability requirements

Wellpoint is dedicated to arranging timely access to care for our members. Our ability to provide quality access depends on the accessibility of network providers. We evaluated regulatory/accreditation standards from the Texas Health and Human Services Commission, the Texas Department of Insurance, and the National Committee for Quality Assurance (NCQA), and we adopted the most stringent standards among the three. These standards apply for all Medicaid (STAR, STAR+PLUS and STAR Kids) and CHIP members (unless otherwise specified), and providers are required to adhere to them.

Providers may not use discriminatory practices such as demonstrating a preference to other insured or private-pay patients (including separate waiting rooms, hours of operation or appointment days). Wellpoint routinely monitors providers' adherence to access to care standards.

Standard name	Wellpoint requirement
Emergency services	Immediately on member presentation at service delivery site
Urgent care	Within 24 hours
Routine primary care	Within 14 days
Routine specialty care	Within 3 weeks
Preventive health: adult	Within 90 days
Preventive health: child, new STAR, STAR+PLUS and STAR Kids member	For new members, birth through age 20, overdue or upcoming well-child checkups (including Texas Health Steps) should be offered as soon as practicable (and no later than 90 days after enrollment).
Preventive health: child less than 6 months old	Within 14 days
Preventive health: age 6 months through 20 years	Within 60 days
Prenatal care — initial visit	Within 14 days
Prenatal care — high-risk or third trimester — initial visit	Within 5 days or immediately if an emergency exists
Prenatal care — after initial visit	Based on the provider's treatment plan
Behavioral health	
Behavioral health, nonlife-threatening emergency care	Within 6 hours (NCQA)
Behavioral health, urgent care	Within 24 hours
Behavioral health, routine care — initial visit	The earlier of 10 business days (NCQA) or 14 calendar days
Behavioral health, routine care — follow-up visits	Within 3 weeks

uirements for PCPs

overage, PCPs must maintain **one** of the following arrangements for member contact e of the following must apply:

	Wellpoint requirement
ording	The office telephone is answered by a recording in both English and Spanish. The recorded message(s) should direct the member to call another number to reach the PCP or another provider or network designated by the PCP. Another recording is not acceptable — A person must be available to answer the designated provider's telephone.
P or provider ll time frame	The person answering calls must be able to contact the PCP or a designated Wellpoint network medical practitioner who can return the call within 30 minutes.
wering service	The office telephone is answered by an answering service equipped to contact the PCP or another designated network medical practitioner. All calls handled by an answering service must be returned within 30 minutes. The answering service must have both English and Spanish language capability.

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Please note:

- Wellpoint will record an after-hours message in Spanish for any provider practice that would like assistance. To learn more about recording an after-hours message in Spanish, please reach out to your Wellpoint Provider Relations representative.
- If you do not currently offer after-hours access (before 8 a.m. and after 5:30 p.m., Monday–Friday and any weekend/holiday appointment), we encourage you to consider doing so to improve accessibility. Appointments scheduled at these times may be billed using the appropriate after-hours CPT code for an additional reimbursement. If you do offer after-hours access, we encourage you to keep some of those appointments open for our members.

If you have questions, contact your local provider relationship management representative or call Provider Services at **833-731-2162**.

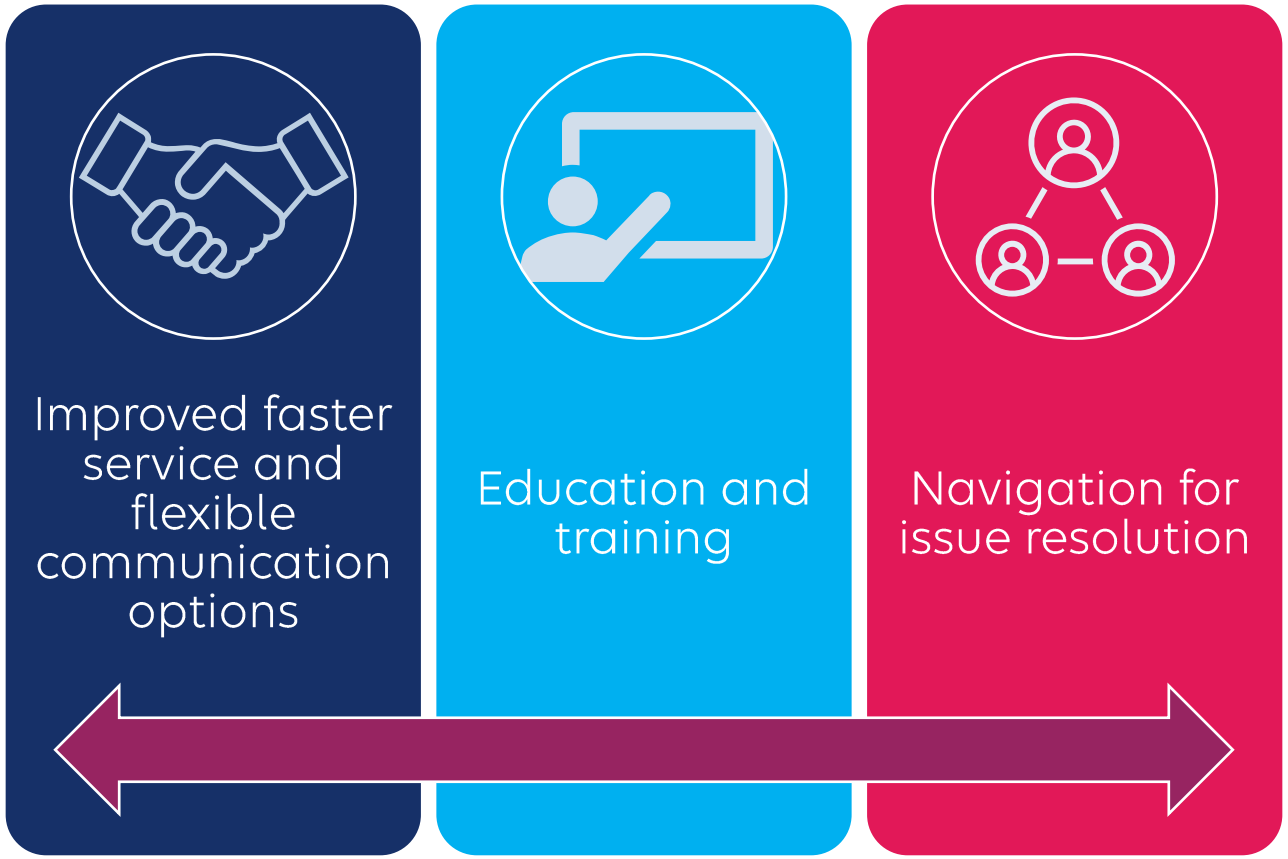
Learn more about Wellpoint programs
provider.wellpoint.com/tx/

Wellpoint

Ongoing credentialing

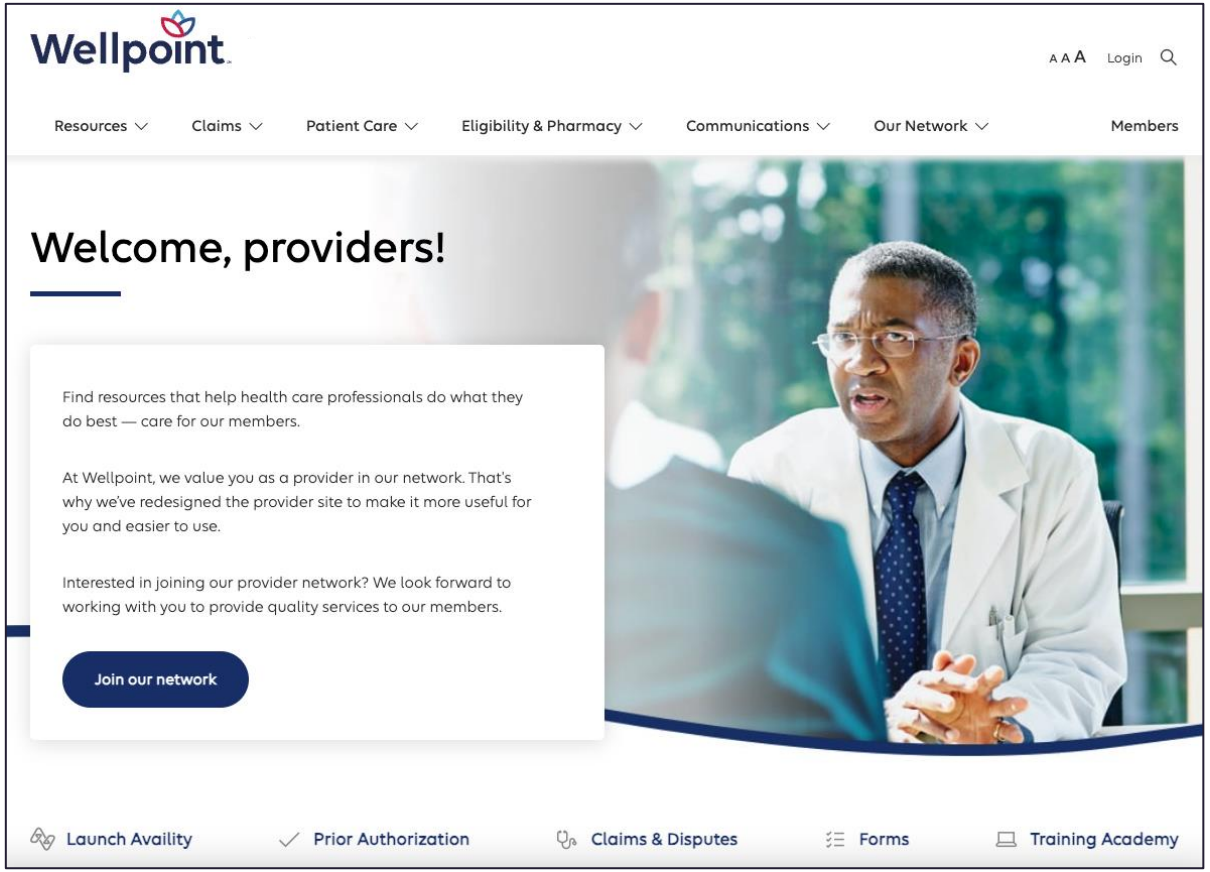
- Credentialing is for a three-year period.
- Recredentialing efforts begin six months prior to the end of the current credentialing period.
- First notice and second notice letters are faxed/mailed to providers.
- Third notice and final notice letters are mailed to providers.
- Providers who do not respond or submit a complete recredentialing packet will be de-credentialed/considered out of network.
- Providers must begin the contracting and credentialing process from the beginning to rejoin the Wellpoint network.
- Notify your provider relationship managment representative with changes in licensure, demographics, or participation status as soon as possible.

Provider Relations Account Management responsibilities



Provider website

- Available to all providers regardless of participation status
- Multiple resources available without login
- Accessible 24/7
- provider.wellpoint.com/tx



Availity Essentials resources

Wellpoint has designated Availity Essentials to operate and service your EDI entry point (EDI Gateway) and other self-service tools. Registration for the secured content on Availity Essentials is easy.

Online claims submission:
Use our free online claim submission tool at Availity.com. You have ability to submit claims, check claims status, dispute claim payment, utilize Clear Claim Connection, etc.

Eligibility verification/authorization:
You have the ability to verify member eligibility and submit authorizations by simple searching with the Wellpoint subscriber or state issued identification number. Submit prior authorization requests online through Availity Essentials, by fax, or by calling Provider Services at **833-731-2162**.

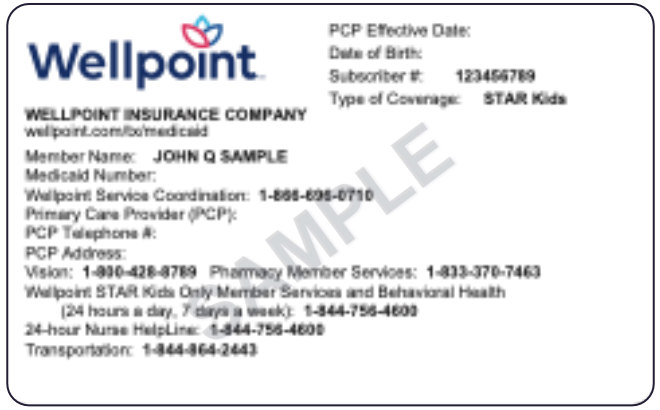
Interactive Care Reviewer (ICR):
Can be accessed by any staff member at any time. ICR allows users to inquire about prior authorization requests submitted via phone, fax, ICR, or other online tools.

Digital provider enrollment: Accessible through Availity, for new enrollment of providers. A demographic change received from outside of the standard independent physician association (IPA) or physician-hospital organization (PHO) process will not be processed separately.

Demographic Changes: Please submit all demographic changes through Availity Provider Data Management (PDM). Also, remember to update your demographic information with Texas Medicaid Health Partnership (**TMHP**.) You can contact TMHP directly at **800-925-9126** for assistance.

Please visit the Availity Essentials website for additional resources. **Support:** Availity Client Services is available at **800-282-4548** (**800-AVAILITY**) Monday to Friday 9 a.m. to 6 p.m. CT.

Member sample ID cards — Medicaid and CHIP



Eligibility

Retro-enrollment:

- Medicaid coverage may be assigned retroactively for a client. For claims for an individual who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the notification of eligibility is received from HHSC and added to the TMHP eligibility file.

Retro-disenrollment:

- If TMHP finds that the member did not meet eligibility guidelines after application or if the member does not complete the necessary paperwork to complete the application, then the member's temporary initial enrollment can be reversed. If this occurs, the state will request funds back from the MCO who will subsequently request those funds back from the provider.

Patient360

- Patient360 is a tool in Availity Essentials that provides an in-depth view of the treatment and care your patient is receiving. This tool allows all providers to view information regarding patient demographic information, pharmacy details, authorizations on file, and claim summaries such as what other providers the patient is seeing. Sharing relevant case information in a timely, useful, and confidential manner is a Wellpoint requirement. Using this tool will allow you to access what providers will need summary of care you are providing.
- Improving provider-to-provider communication will help eliminate barriers when coordinating member care, improve the quality of care a member receives, and improve the member experience.
- To access Patient360, log in to Availity.com, select **Wellpoint** under *Payer Spaces*, and it will appear under the *Applications* tab on the bottom portion of the screen.

Is prior authorization required?

- Determine if specific outpatient procedures and/or services require prior authorization through the Precertification Lookup Tool, which allows you to search by market, member's product, and CPT® code.
- All inpatient stays require prior authorization.
- All out-of-network service requests require prior authorization.
- All nonemergent ambulance transportation requires prior authorization.
- Some services/procedures have Medicaid allowable limits or age restrictions and should be verified through the *Texas Medicaid Provider Procedures Manual (TMPPM)*.
- Resources such as the Wellpoint provider website, your provider manual, Precertification Lookup Tool, and your Quick Reference Guide list services requiring prior authorization and corresponding phone and fax numbers.

Prior authorization required documentation

- A completed prior authorization request is required to eliminate delays in processing, which includes all required essential information, documentation, current clinical information, and a signed authorization form by the requesting provider.

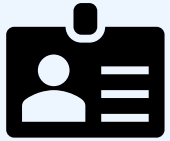
- **Please note:** Obtaining a prior authorization is not a guarantee of payment.

To prevent delays, Wellpoint requests the following information be included with the request to allow for timely processing:

Requesting provider's name, NPI, Tax Identification Number, and signature

Diagnosis code, Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Current Dental Terminology (CDT)

Service request start and end date and Quantity of service units requested based on the CPT, HCPCS, or CDT requested



Member name, date of birth, and the Wellpoint subscriber and state issued identification number

Steps to Process Peer to Peer Review

Office staff may call on the requesting provider's behalf to schedule a peer review with our medical director.

Prior authorization & Important contact information

If you have questions, contact Provider Services at **833-731-2162**. Staff are available Monday through Friday from 8 a.m. to 5 p.m. local time excluding state-observed holidays. You may leave a confidential voicemail after-hours and your call will be returned the next business day.

Inpatient/outpatient surgeries	800-964-3627 (fax), 833-731-2162 (phone)
Inpatient discharge planning (fax only):	• Physical health: **888-708-2599** • Behavioral health: **844-430-6805**
Behavioral health services (digital and fax options):	• Behavioral health (inpatient): **844-430-6805** • Behavioral health (outpatient): **844-442-8010** • Digital submission (preferred method) at Availity.com
Specialized care services (fax only):	• Back and spine procedures: **800-964-3627** • Durable medical equipment (DME): **866-249-1271** • Home health nursing (PDN, SNV, HHA): **866-249-1271** • Medical injectable/infusible drugs: **844-512-8995** (for other services, refer to pharmacy prior authorizations document on provider website) • Pain management injections and wound care: **866-249-1271** • Therapy (physical, occupational, and speech): **844-756-4608**
Carelon Medical Benefits Management, Inc. (formerly AIM)	833-342-1260 (phone); careloninsights.com (online) • Cardiology • Genetic testing • Radiology (high-tech) • Sleep studies • Radiation oncology

Prior authorization & Important contact information (cont.)

Superior Vision (Routine vision/medical/surgical)	**855-313-3106** (fax); ecs@superiorvision.com (email)
Nursing facility	**844-206-3445 (fax)**
Ambulance Transportation (non-emergency)	Physical health (nonurgent): **866-249-1271** (fax) Behavioral health (nonurgent): **844-442-8010** (fax) Urgent: **833-731-2162** (phone)
Long-Term Services and Supports (LTSS)/ Personal Attendant Service for STAR Kids members	**844-756-4604 (fax)**
LTSS/PAS for STAR+PLUS members requests are to be submitted by service area (fax only):	• Austin: 877-744-2334 • El Paso: 888-822-5790 • Houston/Beaumont: 888-220-6828 • Lubbock: 888-822-5761 • San Antonio: 877-820-9014 • Tarrant/West RSA: 888-562-5160
Urgent services	833-731-2162 (phone)
Nurse HelpLine;	833-731-2160 (TTY 711) STAR Kids: 844-756-4600

Referrals

Specialty referrals:

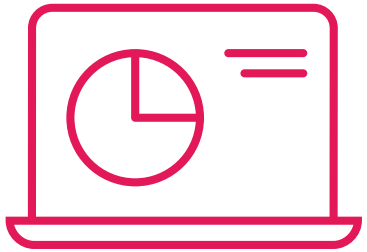
- Providers are not required to call Wellpoint and authorize a referral to a specialist; referrals may be coordinated directly between the PCP and in-network chosen specialist.

Approval of a specialist as a PCP:

- Wellpoint does require authorization for specialist to act as a PCP. Medical necessity of the request is reviewed by the medical director. Please see the provider website for the *Specialist as Primary Care Provider Request Form.*

Claim submission options

- Electronic Data Interchange (EDI)
- Availity Essentials
- Paper
- Timely filing is within 95 days of the service date.



Paper submissions	Electronic submission payers	EDI Hotline
Wellpoint P.O. Box 61010 Virginia Beach, VA 23466-1010	• Availity Essentials: **800-282-4548** • Website: Availity.com • Payer ID: **WLPNT**	• Phone: **800-590-5745**

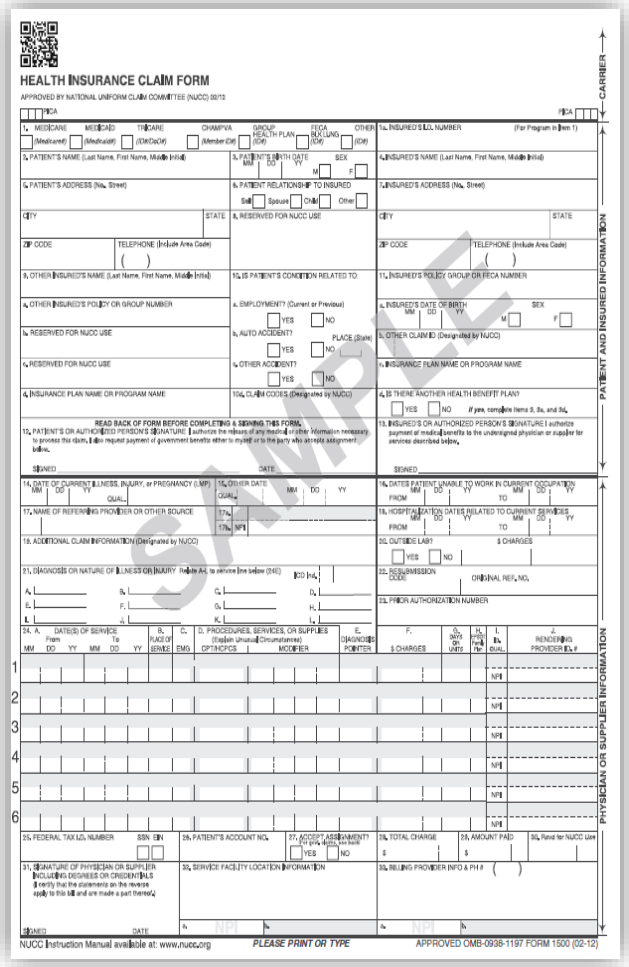
Electronic remittance advice (ERA) and electronic funds transfer (EFT) enrollment

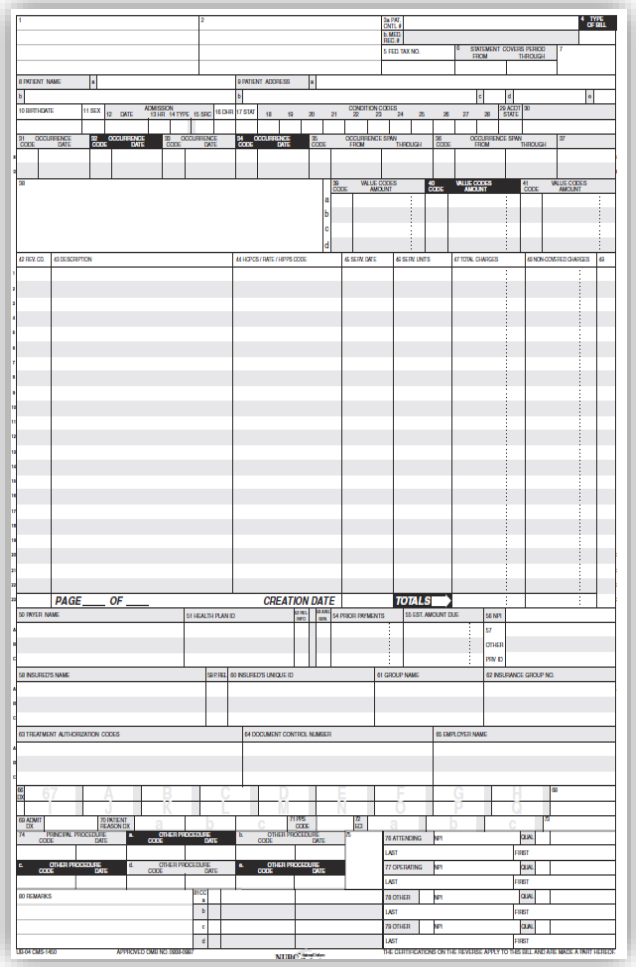
- Electronic remittance advice (835)
- The 835 eliminates the need for paper remittance reconciliation.
- Use Availity to register and manage ERA account changes with these easy steps:
  - Log in to Availity .
  - Select My Providers > Enrollment Center > ERA Enrollment.

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs.

- Electronic funds transfer (EFT):
  - Electronic claims payment through electronic funds transfer (EFT) is a secure and fast way to receive payment, reducing administrative processes. EFT deposits are assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.
  - Use enrollsafe.payeehub.org to register and manage EFT account changes.

Billing format





Paper claims should be submitted on *CMS-1500*, *UB-04*, or successor forms as applicable to the provider contract.

The taxonomy in 24J (shaded) should correspond with the NPI in the unshaded portion and the taxonomy in 33B should match the NPI in 33A respectively.

On the new *UB-04* form, NPI should be in box 56 and taxonomy in box 57. Claims without a verifiable ID number will be denied or rejected.

To ensure timely adjudication of a claim, use the NPI/taxonomy attested with TMHP.

Rejected versus denied claims

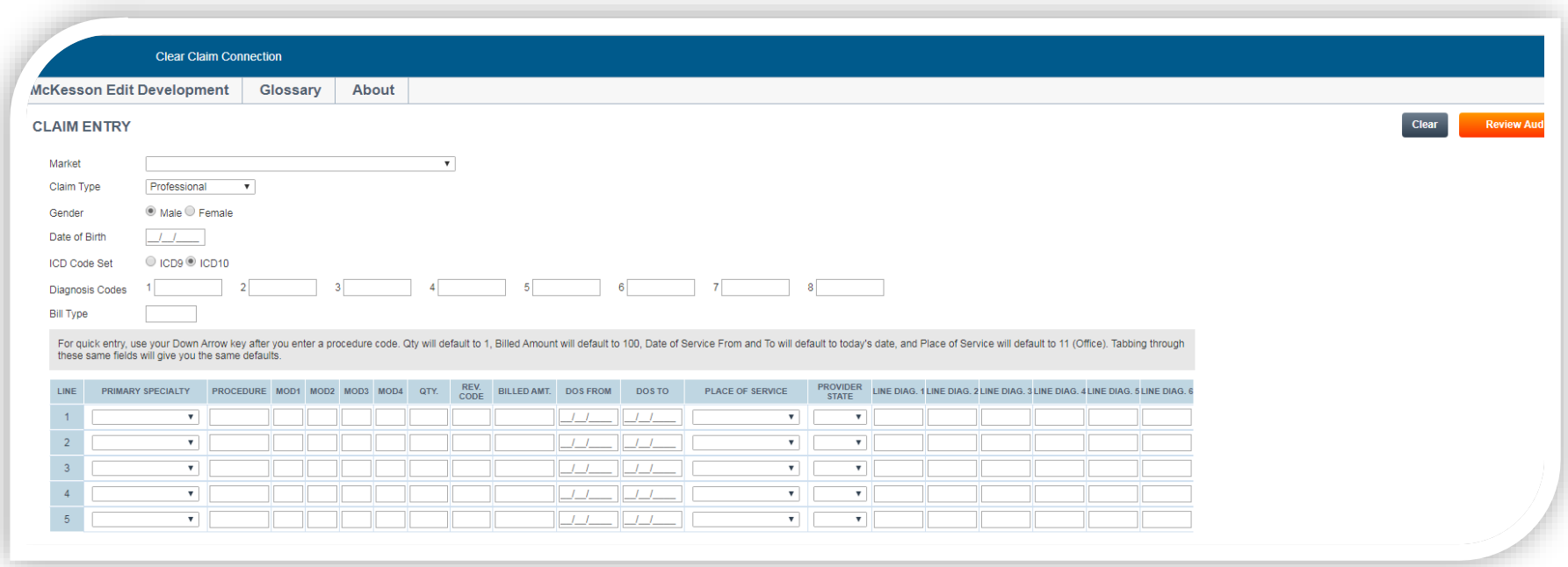
What is the difference between a rejected and a denied claim?

- **Rejected:**
  - Does not enter the adjudication system due to missing or incorrect information
  - Resubmission subject to 95-day timely filing deadline
- **Denied:**
  - Does go through the adjudication process, but is denied for payment
  - Appeal deadline of 120 days from the *Explanation of Payment* (*EOP*) date applies.

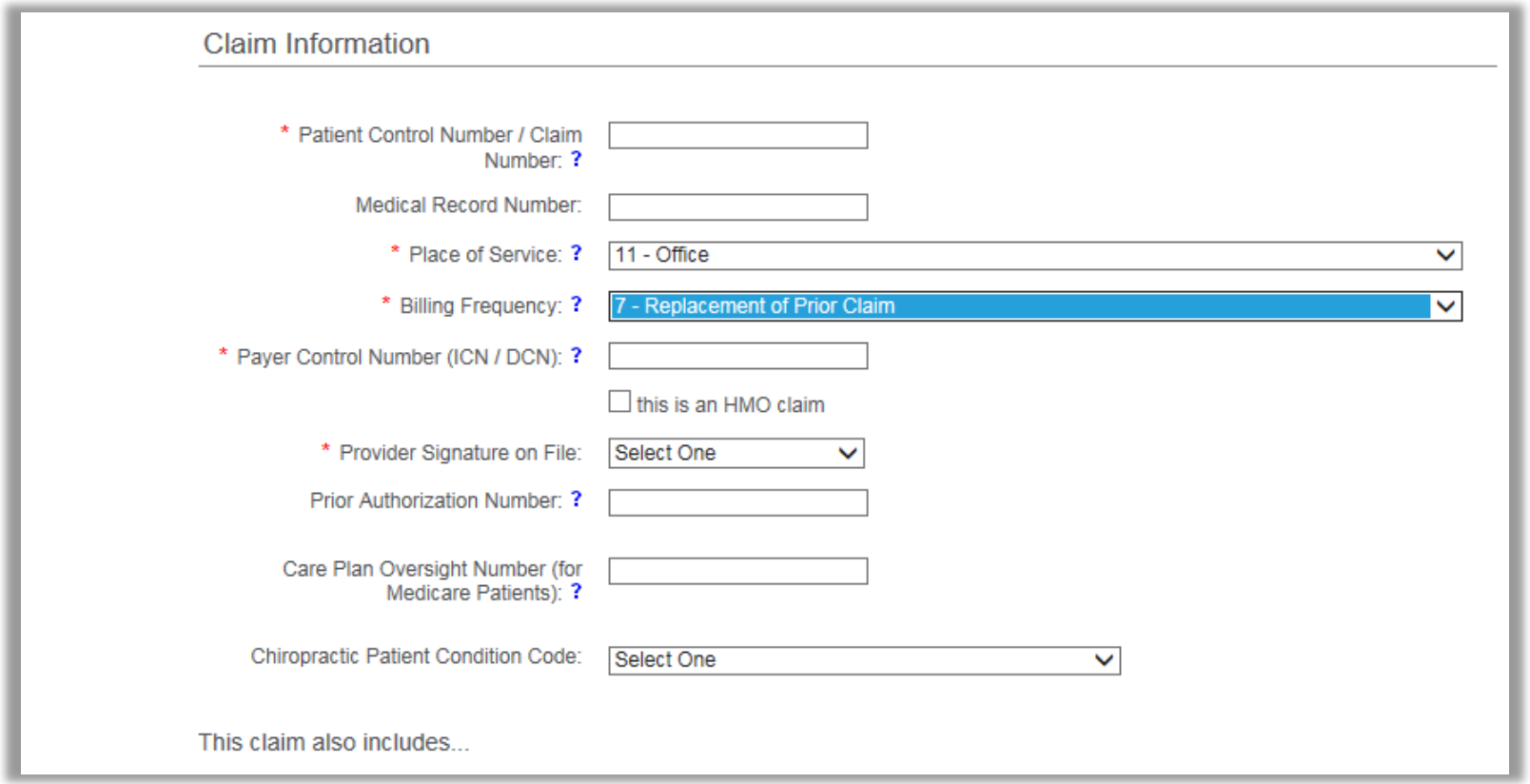
For claims inquiries, please call Provider Services at Call **833-731-2162**

Clear Claim Connection™

- Provides guidance for code combinations and modifiers
- Does not guarantee payment



Submitting a corrected claim



Medicaid member should not be billed

- Our agreement with the state indicates that our members should not be burdened with any non-approved, out-of-pocket expenses for services covered under the Medicaid program.
- Fundamental principal does not change when member has other insurance.
- Members should receive the best benefits available from both coverage plans.
- When claims are denied or reduced for services that are within the amount, duration, and scope of benefits of the Medicaid program.
- For services not submitted for payment, including claims not received.
- When claims are denied for timely filing (95 days).
- When there is failure to submit corrected claims within 120 days.
- When there is failure to appeal claims within the 120-day appeal period.
- When there is failure to appeal a medical denial.
- When submission of unsigned or otherwise incomplete claims such as:
  - Omission of *Hysterectomy Acknowledgement Form.*
  - *Sterilization Consent Form.*

Billing Medicaid members for noncovered services

Before billing members for services not covered, providers must:

- Inform the member in writing of the cost of the service.
- Inform the member that the service is not covered by Wellpoint.
- Inform the member that they can be charged.
- Obtain member's signature on a *Client Acknowledgement* form before providing the service.

Sample *Client Acknowledgment Statement*

I understand my doctor (provider's name), or Wellpoint, has said the services or items I have asked for on (dates of service) are not covered under my health plan. Wellpoint will not pay for these services. Wellpoint has setup the administrative rules and medical necessity standards for the services or items I receive. I may have to pay for them if Wellpoint decides they are not medically necessary or are not a covered benefit, and if I sign an agreement with my provider prior to the service being rendered that I understand I am liable for payment.

Member name (print): _____ **Member signature:** _____ **Date:** _____

Participating providers may bill a member for a service that has been denied as not medically necessary or not a covered benefit only if the following conditions are true:

- The member requests the specific service or item.
- The member was notified by the provider of the financial liability in advance of the service.
- The provider obtains and keeps a written acknowledgement statement signed by the provider and by the member, above, prior to the service being rendered.

Provider name (print): _____ **Provider signature:** _____ **Date:** _____

Above sample found in your provider manual.

Coordination of benefits payment methodology

- Wellpoint is the payer of last resort.
- Coordination of benefits claims are paid up to the Wellpoint allowable, regardless of the primary carrier's allowable:
  - **Example 1:**

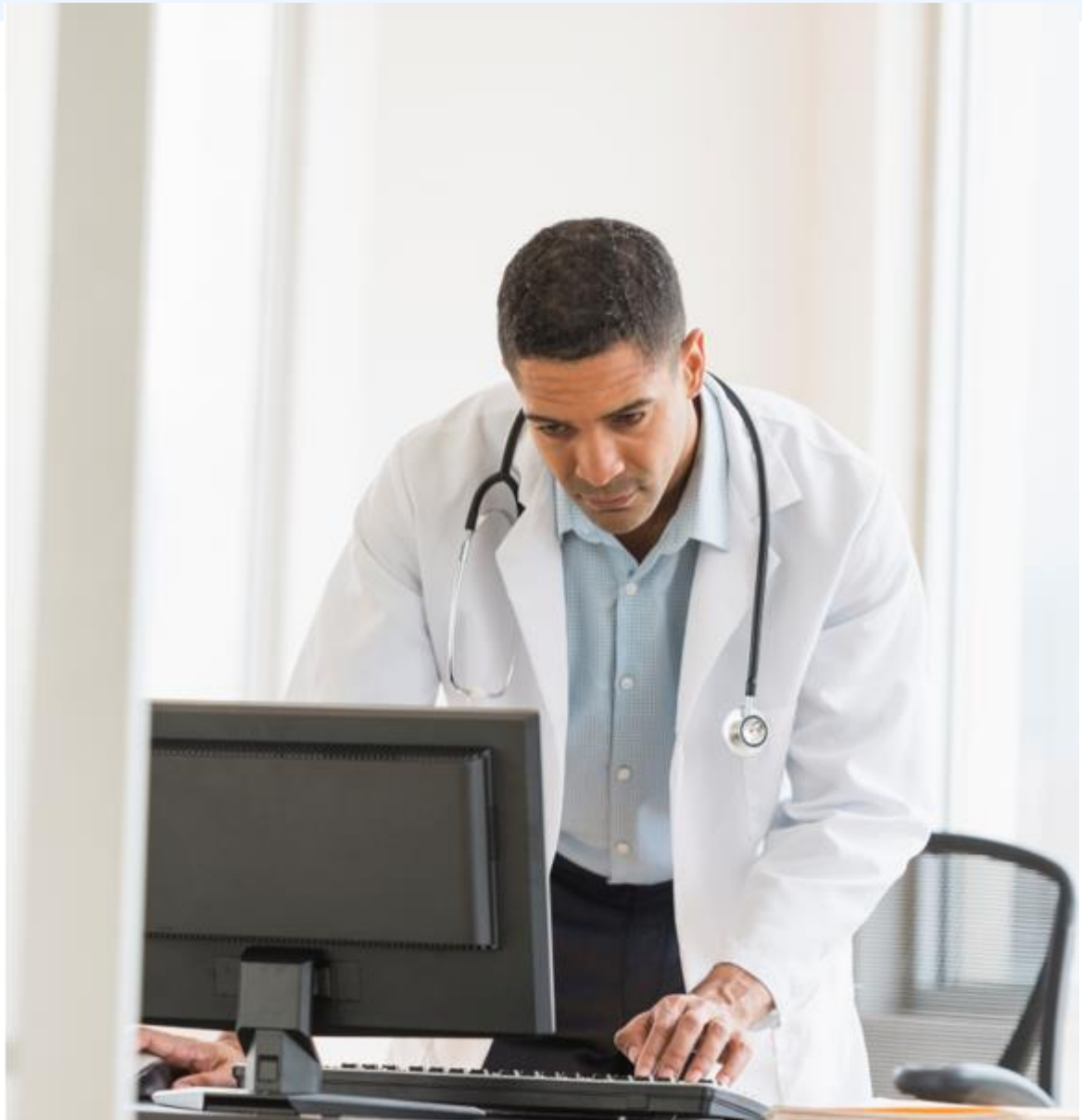
Wellpoint allowable:	$4,000
Minus primary carrier payment:	$2,000
Minus Wellpoint payment:	$2,000
Final balance:	$ 0

When the primary carrier denies your claim

- If the primary carrier does not cover a service because the member or provider did not follow guidelines for the primary payer, then Wellpoint becomes the next payment source.

- At this point, the Wellpoint standard requirements such as authorization rules and timely filing rules are applied.

- Primary *EOPs* must still be submitted within 95 days from the date of the primary *EOP* with some exceptions.



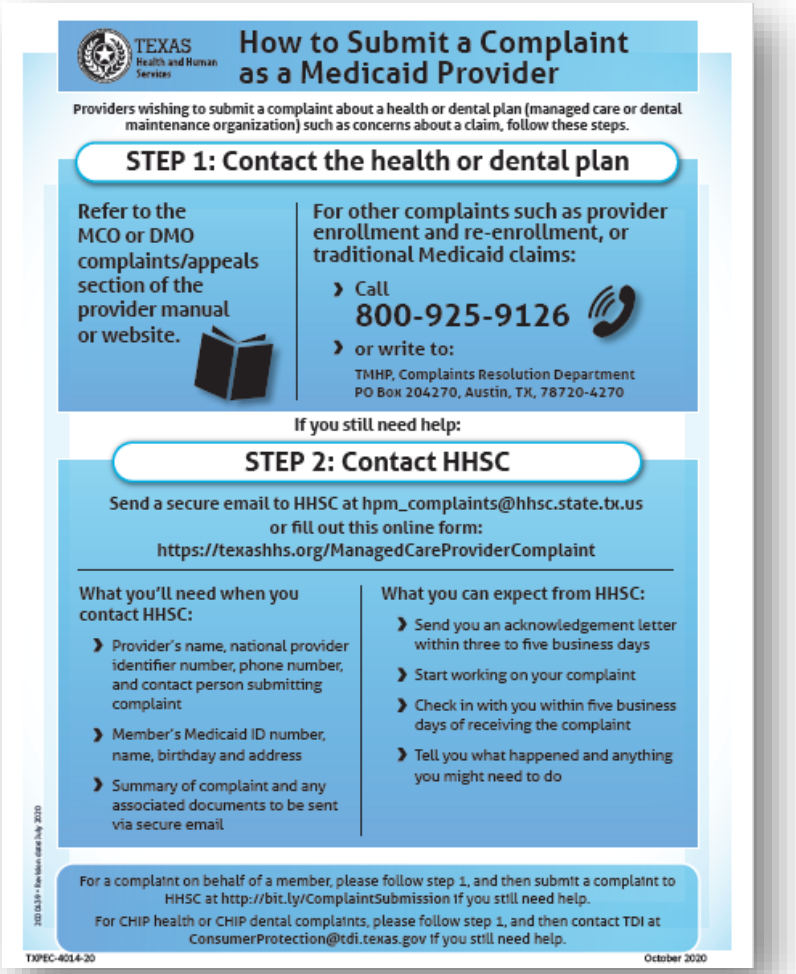
Wellpoint is the payer of last resort

- Some common exceptions include:
  - The Texas Kidney Health Care Program.
  - The Crime Victim's Compensation Program.
  - Adoption agencies.
  - Home- and community-based waiver programs.
- **Wellpoint** will not pay for any expenses that the member would not have a legal obligation to pay if he or she did not have Wellpoint.

Wellpoint provider complaints

- We track all provider grievances until they are resolved.
- The provider manual details filing and escalation processes and contact information.
- Examples of grievances include:
  - Issues with eligibility.
  - Contract disputes.
  - Authorization process difficulties.
  - Member/associate behavior concerns.

Filing a formal HHSC complaint



TEXAS Health and Human Services

How to Submit a Complaint as a Medicaid Provider

Providers wishing to submit a complaint about a health or dental plan (managed care or dental maintenance organization) such as concerns about a claim, follow these steps.

STEP 1: Contact the health or dental plan

Refer to the MCO or DMO complaints/appeals section of the provider manual or website.

For other complaints such as provider enrollment and re-enrollment, or traditional Medicaid claims:

- Call **800-925-9126**
- or write to:

TMHP, Complaints Resolution Department
PO Box 204270, Austin, TX, 78720-4270

If you still need help:

STEP 2: Contact HHSC

Send a secure email to HHSC at hpm_complaints@hhsc.state.tx.us or fill out this online form: https://texashhs.org/ManagedCareProviderComplaint

What you'll need when you contact HHSC:

- Provider's name, national provider identifier number, phone number, and contact person submitting complaint
- Member's Medicaid ID number, name, birthday and address
- Summary of complaint and any associated documents to be sent via secure email

What you can expect from HHSC:

- Send you an acknowledgement letter within three to five business days
- Start working on your complaint
- Check in with you within five business days of receiving the complaint
- Tell you what happened and anything you might need to do

For a complaint on behalf of a member, please follow step 1, and then submit a complaint to HHSC at http://bit.ly/ComplaintSubmission if you still need help.

For CHIP health or CHIP dental complaints, please follow step 1, and then contact TDI at ConsumerProtection@tdi.texas.gov if you still need help.

TXPEC-4014-20 October 2020

Wellpoint is committed to providing quality service to our members and providers that support our network.

To comply with state requirements, the Health and Human Services Commission has requested that managed care organizations notify newly credentialed providers of their process to resolve provider complaints. As a part of this requirement, Wellpoint is sharing this notification.

Member complaints and appeals

- Medicaid and CHIP members or their representatives may contact a member advocate or their service coordinator for assistance with writing or filing a complaint or appeal (including an expedited appeal). Complaints may be filed to dispute financial liability, transportation, failure to provide services timely, etc.
- Member Complaint Resolution:
  - Call us toll free at Member Services at **833-731-2160 (TTY 711),** STAR Kids **844-756-4600 (TTY 711)**
  - The member advocate or Member Services representative can help you or the member file a complaint with us or with the appropriate state program.
  - Complaint will be responded to within 30 days from the date we receive the complaint.
- Send member complaints to:

Member Advocates
Wellpoint
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050

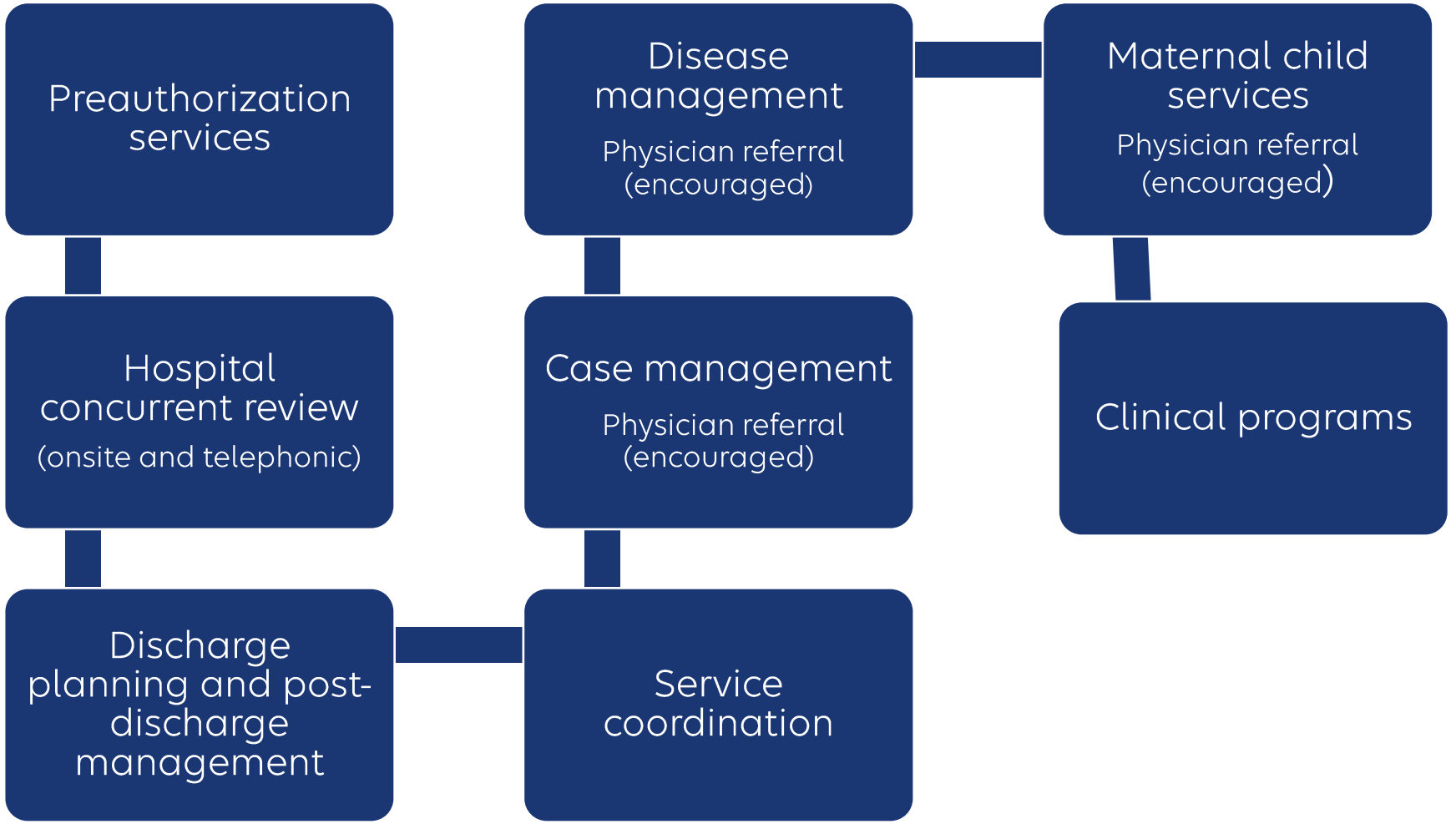
Member medical appeals

- Member medical appeals can be initiated by the member or the provider, on behalf of the member, with the member's signed consent and must be requested within 60 calendar days from the date of an adverse benefit determination. CHIP member appeals do not require signed consent.
- Member medical appeals can be submitted by:
  - Calling Member Services at **833-731-2160 (TTY 711),** STAR Kids **844-756-4600 (TTY 711)**
  - Sending a written request to: P.O. Box 62429, Virginia Beach, VA 23466-2429
- For further details on the medical appeals process, please refer to the Member Medical Appeal Process and Procedures section of the Medicaid/CHIP provider manual.

Payment dispute process

- There is a 120-day filing deadline from the date of the *EOP*.
- Providers may use the payment dispute tool at Availity.com. Supporting documentation can be uploaded using the attachment feature.
- Providers can submit a *Provider Payment Dispute* form and relevant supporting documentation, including the original *EOP*, corrected claim, invoices, medical records, reference materials, etc.:
  - **Fax: 844-756-4607**
  - **Mail:** Wellpoint
    Payment Dispute Unit
    P.O. Box 61599
    Virginia Beach, VA 23466-1599

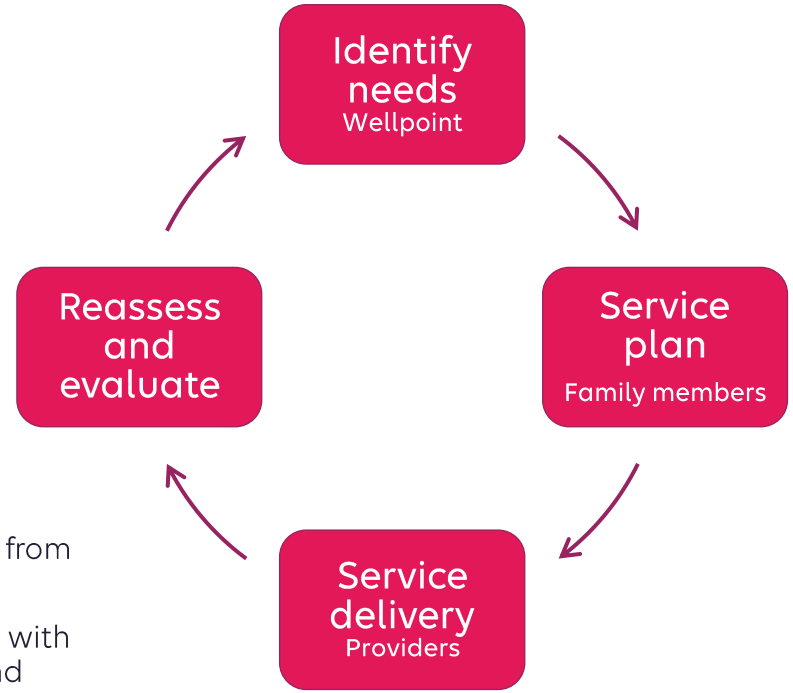
Medical management services



Service coordination model

Reassess and evaluate

- Service coordinator contacts member and reassess the member's needs and functional capabilities.
- Service coordinator and member evaluate and revise the service plan as needed.



Identify needs

- Members contacted in first 30 days and screened for complex needs and high-risk conditions.
- Identify complex and high-risk members for a home visit in next two weeks.

Service plan

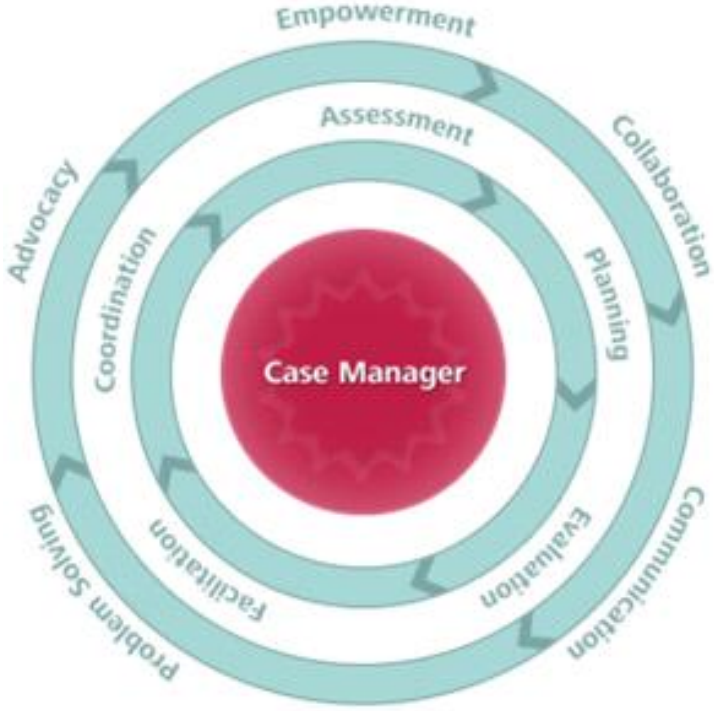
- Service coordinator makes home visit and conducts a comprehensive assessment of all medical, behavioral, social, and long-term care needs.
- Service coordinator works with team of experts to develop a service plan to meet the members needs.
- Service coordinator contact the member's PCP for concurrence.
- Member and member's family reviews and signs the service plan.

Service delivery

- Member selects providers from the network.
- Service coordinator works with care team to authorize and deliver services.
- Service coordinator ensures all appropriate services are authorized and delivered according to the service plan.

Case management program

- Available for members with complex medical conditions
- Focuses on members who have experienced a critical event or diagnosis
- Super utilizer program
- Members with special healthcare needs
- Social workers available



Disease management

- We offer programs for members living with:
  - Asthma
  - Bipolar disorder
  - Congestive heart failure
  - Coronary artery disease
  - Chronic obstructive pulmonary disease
  - Diabetes
  - HIV/AIDS
  - Hypertension
  - Major depressive disorder
  - Schizophrenia
  - Substance use disorder

Continuity of care services

- For members enrolling on the operational start date of an HHSC program or on the start date of a new service area, we will honor existing acute-care authorizations for the earlier of 90 days or the expiration of the current authorization.
- We will honor existing long-term services and supports authorizations for up to six months or until we have completed a new assessment for the member and issued new service authorizations.
- For a full list of the continuity and coordination guidelines for PCPs and behavioral health providers, visit: provider.wellpoint.com/tx > Resources > Provider Manuals and Guides. Continuity of care does not exempt providers from following billing guidelines, such as correct coding and timely filing. Claims can be denied for these errors.

HHSC Primary Health Care Program

- Primary Health Care Services Program works with clinic sites across Texas to ensure eligible Texans can get comprehensive primary health care services to prevent, detect and treat health problems. The PHC Services Program serves men, women and children.
  - Services include:
    - Health education
    - Emergency services
    - Family planning services
    - Diagnosis and treatment
    - Diagnostic testing, such as X-rays and lab services
    - Preventive health services, including immunizations
- For more information, visit hhs.texas.gov/services/health/primary-health-care-services-program.

Maternal child services

- Individualized, one-on-one case management support for identified high-risk pregnancy
- Educational materials and information on community resources
- Care coordination for moms who may need a little extra support
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born

Healthy Texas Women program (HTW)

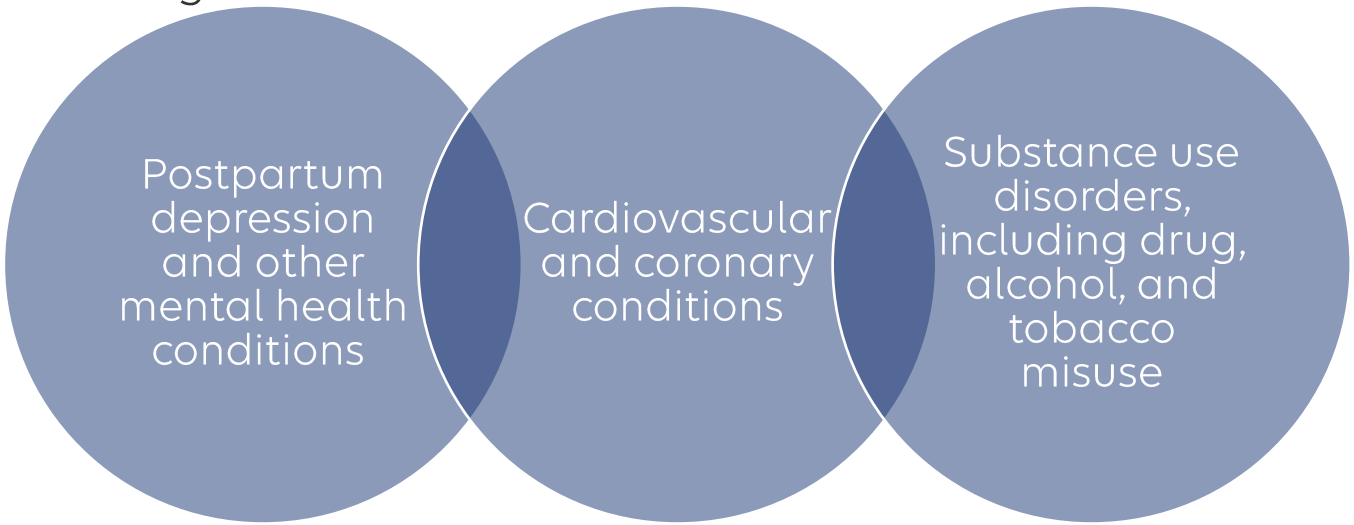
- Health and Human Services launched the Healthy Texas Women program July 1, 2016.
- The program is designed to support women's health and family planning services at no cost to eligible, low-income Texas women.
- Wellpoint will ensure our members have the right to choose any Medicaid family planning provider regardless of network status.
- Wellpoint will reimburse family planning agencies no less than the Medicaid fee-for-service amounts for family planning services, including medically necessary medications, contraceptives, and supplies and will reimburse out-of-network family planning providers in accordance with HHSC's administrative rules.

HTW (cont.)

- HTW is available to Texas women who:
  - Are the ages of 18 to 45 years of age, or between the ages of 15 to 17 years of age and have a parent or legal guardian apply, renew, and report changes on their behalf
  - Are a U.S. citizen or legal immigrant
  - Are a resident of Texas
  - Don't have health insurance
  - Are not pregnant:
    - A pregnant Medicaid or CHIP member will lose eligibility 12 months after delivery.
  - Meet the income requirements

Healthy Texas Women Plus

- Texas Health and Human Services Commission implemented Healthy Texas Women Plus, an enhanced, cost-effective limited postpartum services for women enrolled in the Healthy Texas Women program.
- To qualify for HTW Plus benefits, the applicant must have been pregnant within the last 12 months.
- HTW Plus services focus on treating major health conditions that contribute to maternal morbidity and mortality in Texas, including:



Note: This program pays only for the services listed above. If a health condition such as cancer is found, the patient will be referred to a doctor or clinic that can treat the condition. The patient might have to pay for those extra services.

HHSC Family Planning Program

- The Family Planning Program helps fund clinic sites across the state to provide high-quality, comprehensive, low-cost, accessible family planning, and reproductive healthcare services to women and men in Texas. Family planning services may be provided by a physician or under the direction of a physician, not necessarily personal supervision.
- The benefits of the program include but not limited to:
  - Planning for number and spacing of children.
  - Prevention of unintended pregnancies.
  - Improved future pregnancy and birth outcomes.
- For more information, visit hhs.texas.gov/providers/health-services-providers/family-planning.

Healthy Rewards program

- Increase your HEDIS® quality scores while members earn rewards by ensuring your members receive health screenings, exams, and any needed tests.
- Patients can inquire about the Healthy Rewards program by calling **888-990-8681 (TTY 711)** or logging into their Healthy Rewards account.

Mental health/substance use disorders

Wellpoint will coordinate care for members with mental health needs or substance use disorders.

Authorizations:

- Phone: **833-731-2162**
- Fax (inpatient): **844-430-6805**
- Fax (outpatient): **844-442-8010**

PCPs providing behavioral health services must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

Screening and assessment tools to assist with the detection, treatment and referral of behavioral healthcare services are found on our website at provider.wellpoint.com/tx.

Pharmacy program

- The Texas Vendor Drug Program formulary and *Preferred Drug List* are available on our website: provider.Wellpoint.com/texas-provider/member-eligibility-and-pharmacy/pharmacy-information
- Prior authorization is required for:
  - Nonformulary drug requests.
  - Brand-name medications when generics are available.
  - High-cost injectable and specialty drugs.
  - Any other drugs identified in the formulary as needing prior authorization.

- Online pharmacy prior authorization: covermymeds.com
- Pharmacy prior authorization fax: **844-474-3341**
- *Pharmacy Prior Authorization Form* accessible at provider.wellpoint.com/texas-provider/member-eligibility-and-pharmacy/pharmacy-information/prior-authorization-forms
- Phone: **833-731-2162** (Wellpoint pharmacy)
- Medical injectable/infusible drugs prior authorization fax: **844-512-8995**

Prescribing providers must obtain prior authorization for outpatient drugs based on Medicaid guidelines and for applicable procedures by Wellpoint.

Outpatient information can be found here: txvendordrug.com/resources/manuals

Pharmacy online drug reference information

- Epocrates is a free subscription drug information service that can be downloaded to a computer or handheld device. In addition to listing a drug's preferred status, Epocrates includes drug monographs, dosing information, and warnings. All prescribing providers are eligible to register for Epocrates online. Refer to the Outpatient Drug Services Handbook in the *Texas Medicaid Provider Procedures Manual* to learn more.
- Visit epocrates.com for additional information on the free subscription.

Laboratory services

All clinical and anatomic laboratory services not performed in a physician's office must be sent to Clinical Pathology Laboratories, Inc., Quest Diagnostics, LabCorp, or a participating independent reference laboratory to ensure services are directed to the most appropriate setting. This Wellpoint policy does not apply to laboratory services provided by physicians in their offices, but does apply to all of the following:

- Participating physicians
- Healthcare professionals
- Outpatient clinical laboratories
- Anatomic laboratory services

Translation services

Translation services are available 24/7 in over 170 languages:

- Provider Services: **833-731-2162**
- Member Services: **833-731-2160 (TTY 711)**
- STAR Kids Member Services: **844-756-4600 (TTY 711)**

LiveHealth Online (LHO)

- Members may access a video visit to a doctor, therapist, or psychiatrist 24/7 using a smartphone, tablet, or computer using LiveHealth Online.
- Wellpoint offers video visits at no cost to members.
- If you are interested in joining as an Online Care Network (OCG) provider, please submit an application via this link: providers.amwell.com
- Members eligible to use this service are STAR, STAR+PLUS, CHIP, and STAR Kids members. CHIP Perinate members and members with Medicare are not eligible.
- Please inform your patients that sign up is free by going to livehealthonline.com or by downloading the free LiveHealth Online mobile app. If a member needs assistance with the service, please have them call **888-548-3432 (TTY 711)**.

Telehealth and telemedicine services

- Telemedicine and telehealth services are covered Medicaid benefits. The use of telemedicine and telehealth services is intended to promote and support Patient-Centered Medical Homes™ and care coordination. We encourage our network providers to offer telemedicine and telehealth capabilities to our members.
- Wellpoint follows the guidelines set forth by TMHP regarding telemedicine and telehealth services.
- TMHP publishes the *Texas Medicaid Provider Procedures Manual — Telecommunication Services Handbook* on their website. The handbook offers information regarding telemedicine and telehealth services, provider types, billing guidelines, procedure codes and modifiers, and documentation requirements for the services.
- For additional information, please refer to your Wellpoint *Provider Manual* for Medicaid/CHIP at provider.wellpoint.com/tx and the TMHP handbook can be located at: tmhp.com/resources/provider-manuals/tmppm

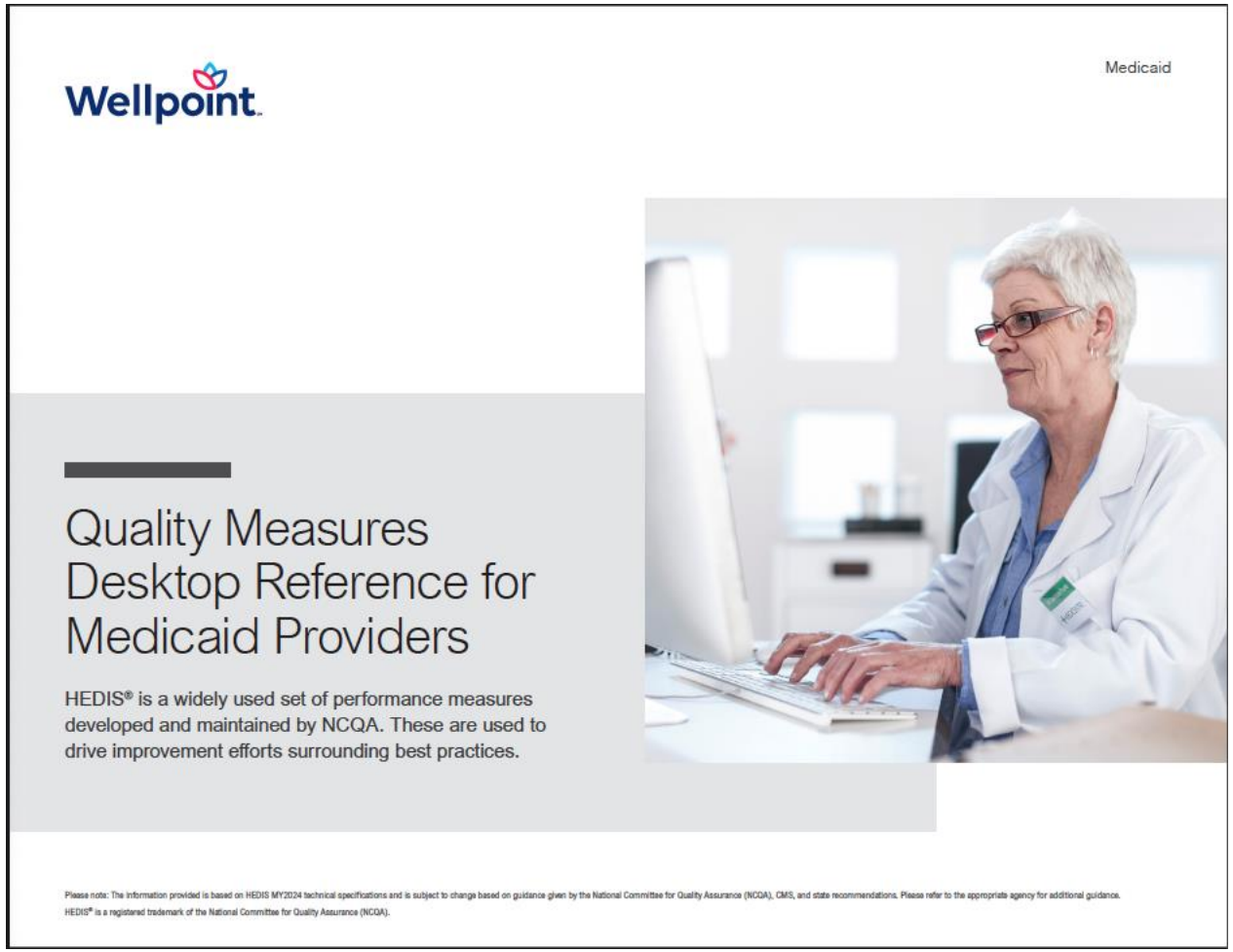
Telehealth and telemedicine notifications to PCPs

- The use of telemedicine and telehealth services is intended to promote and support patient-centered medical homes and care coordination.
- As outlined in *Senate Bill 670* from the 86th Legislature, Medicaid telemedicine and telehealth providers are required to notify the Medicaid member's PCP or provider of the telemedicine or telehealth service, provided the member or their parent/legal guardian consents to the notice. This includes a summary of the telemedicine or telehealth service rendered, exam findings, a list of prescribed or administered medications, and patient instructions.
- Telehealth and telemedicine providers must attest that they are providing notice of all telemedicine/telehealth encounters and outcomes to the member's PCP, providing the parent/legal guardian consents.
- To receive a copy of the attestation form, contact your representative.
- Telemedicine and telehealth providers must keep a record of notifications to primary care physicians and providers in the member's medical records.

Note: ECI providers do not follow these requirements. Behavioral health providers are not required to report telemedicine or telehealth services to PCPs unless the service is provided in the school setting.

Quality management

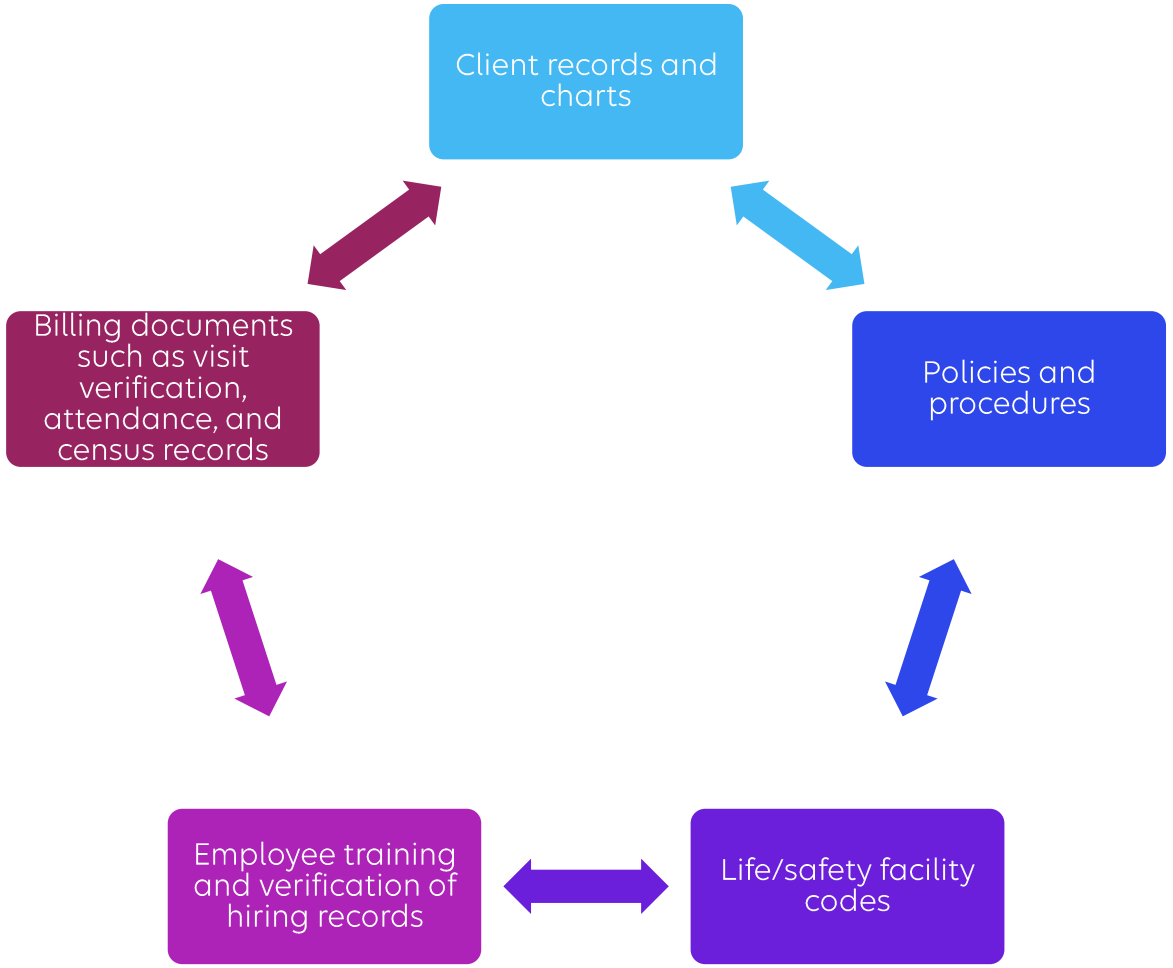
Our Quality Management team continually analyzes provider performance and member outcomes for improvement opportunities.



Quality compliance program

Wellpoint maintains a comprehensive quality management (QM) program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content of the program reflects the demographic and epidemiological needs of the population served. Studies are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

Providers may be contacted and provided with a list of needed documents such as:



Quality compliance program process

Wellpoint notifies providers selected for review and will provide the list of documents needed for the review:

- The assigned reviewer will follow up with contact information to set up a date and time for the review.
- Wellpoint will conduct all onsite reviews during normal business hours or offsite desk review.
- Wellpoint will document the results of the audit with any potential written findings and problem areas identified.
- Wellpoint will send you an initial report of the results and possible corrective procedures within 10 business days of completing the review.
- Wellpoint will work with you to establish a corrective action plan(s) if needed.
- Please note failure to comply with any necessary corrective action plans can affect current and future status as a participating network provider.

Join our advisory committees

- The STAR Kids clinical and administrative advisory committees (CAACs) provide specialized review, expertise, and consultation on a variety of health issues related to the STAR Kids population.
- The purpose of these committees is to monitor, evaluate, and improve performance and quality of healthcare services delivered to STAR Kids members.
- All STAR Kids participating providers are encouraged to join the meetings.
- To participate in a committee, please contact Aron Head at **817-861-7747** or aron.head@Wellpoint.com.

Nonemergency medical transportation (NEMT)

- WellPoint is responsible for coordinating NEMT services for Wellpoint members enrolled in STAR, STAR Kids, STAR+PLUS, and Wellpoint programs.
- The Medical Transportation Program (MTP) will remain available for members in fee-for-service only.
- This new change includes rideshare transportation services such as Lyft.
- Wellpoint will be using Access2Care (A2C) to coordinate travel for all NEMT needs. All NEMT services will be scheduled, completed, and managed by A2C. Members and providers can arrange transportation needs directly with A2C.
- A2C may contact you to validate that the member has an appointment with your office. Please support A2C with validating this information.

Type of Service	Contact by membership type
Access2Care (nonemergent transportation other than ambulance)	Members and providers call the number below for their membership type: • STAR: **833-721-8184** (TTY 711) • STAR+PLUS: **844-867-2837** (TTY 711) • STAR Kids: **844-864-2443 (**TTY 711)

Nonemergency Medical Transportation (NEMT) services (conti.)

- NEMT services provide transportation to covered healthcare services for Medicaid members who have no other means of transportation to health care appointments and to the hospital. NEMT services do NOT include ambulance trips.
- **Services included with NEMT, but not limited to the following:**
  - Passes or tickets for transportation such as mass transit or commercial airline.
  - Demand Response transportation services – curb-to-curb service transport in private buses, van, including wheelchair-accessible vehicles, as necessary.
  - Mileage reimbursement for individual transportation participant (ITP). The ITP can be the member, the member's family member, friend, or neighbor. An ITP will be required to obtain a signature from a provider in order to validate the transportation to a valid provider/visit reason.
  - Members 20 years old or younger may be eligible to receive the cost of meals and lodging associated with a long-distance trip to obtain a covered health-care service.
  - Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

Provider Satisfaction Survey

- Annually, Wellpoint sends out a *Provider Satisfaction Survey* to engage our provider network to give feedback for improving and strengthening our processes and operations.
- We use your survey responses to better understand your experiences and continue to improve our programs. You can complete the survey online by obtaining a unique password/username or you may choose to mail back your response. Please remember to complete the survey!

CAHPS

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS®) is an annual survey to assess consumers' experience with their health and healthcare services from a patient's perspective.

Why focus on patient experience?

- There is a strong correlation between patient experience and healthcare outcomes.
- Patients with chronic conditions demonstrate greater self-management skills and quality of life.
- Patient retention is greater when there is a high-quality relationship with the provider.
- Decreased malpractice risk.
- Efforts to improve patient experience have resulted in decreased employee turnover.

How to improve patient experience:

- Ensure all office staff are courteous and empathetic.
- Respect cultural differences and beliefs.
- Demonstrate active listening by asking questions and making confirmatory statements.
- Spend enough time with the patient to address all their concerns.
- Provide clear explanation of treatments and procedures.
- Obtain and review records from hospitals and other providers.

For a full CAHPS overview, visit provider.wellpoint.com/tx > Resources > Training Academy>Training and Tutorials.

External medical review (EMR) provider training

The EMR training has been developed by Texas Health and Human Services to provide an overview to providers on the participants' role/responsibilities following receipt of an Adverse Benefit Determination from a Managed Care Organization or Dental Contractor.

You may access the entire training on the Wellpoint provider website at provider.wellpoint.com/tx: Go to Resources > Training Academy > Training and Tutorials > Documents

You may watch the recording of the training at attendee.gotowebinar.com/recording/4623254401546558726

For the latest updates, please visit **https://www.hhs.texas.gov/.**

Fraud, waste, and abuse

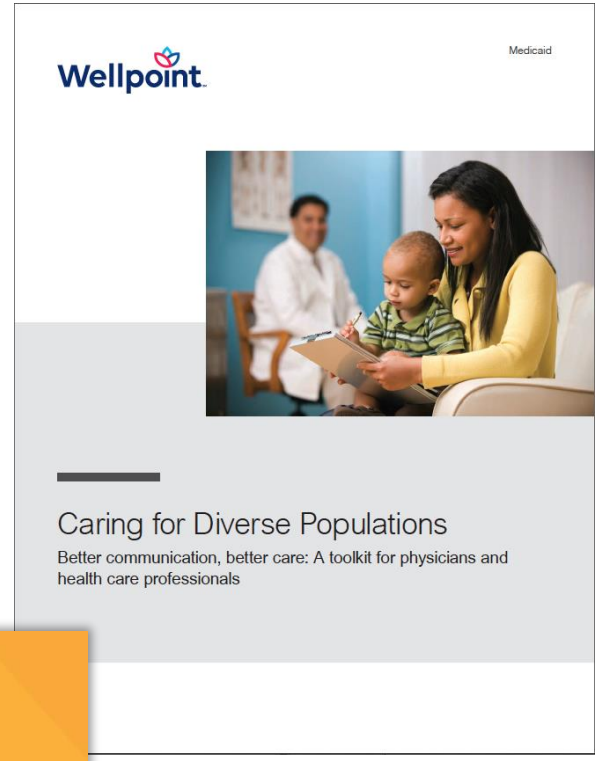
Help us prevent it and tell us if you suspect it!

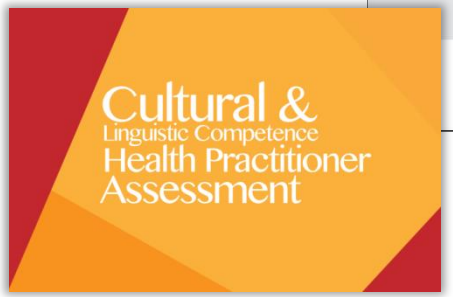
- Verify patient identity.
- Ensure services are medically necessary.
- Document medical records completely.
- Bill accurately.
- Report suspected fraud to **866-847-8247** or Provider Services.

- Call the OIG Hotline at **800-436-6184**.
- Visit oig.hhs.texas.gov
- Report directly to your health plan compliance officer
- Wellpoint Provider Services: **833-731-2162**
- Please visit the Wellpoint website for additional information.

Cultural competency

- Wellpoint believes that we must recognize and thoroughly understand the roles played by culture and ethnicity in the lives of our members to ensure everyone receives equitable and effective healthcare.
- Expectations are that our providers and their staff share our commitment.
- Resources, training material, and information are available online, including:
  - The *Cultural Competency Plan*.
  - Self-Assessment Tool.
  - Cultural Competency Tool Kit.
  - Cultural competency training

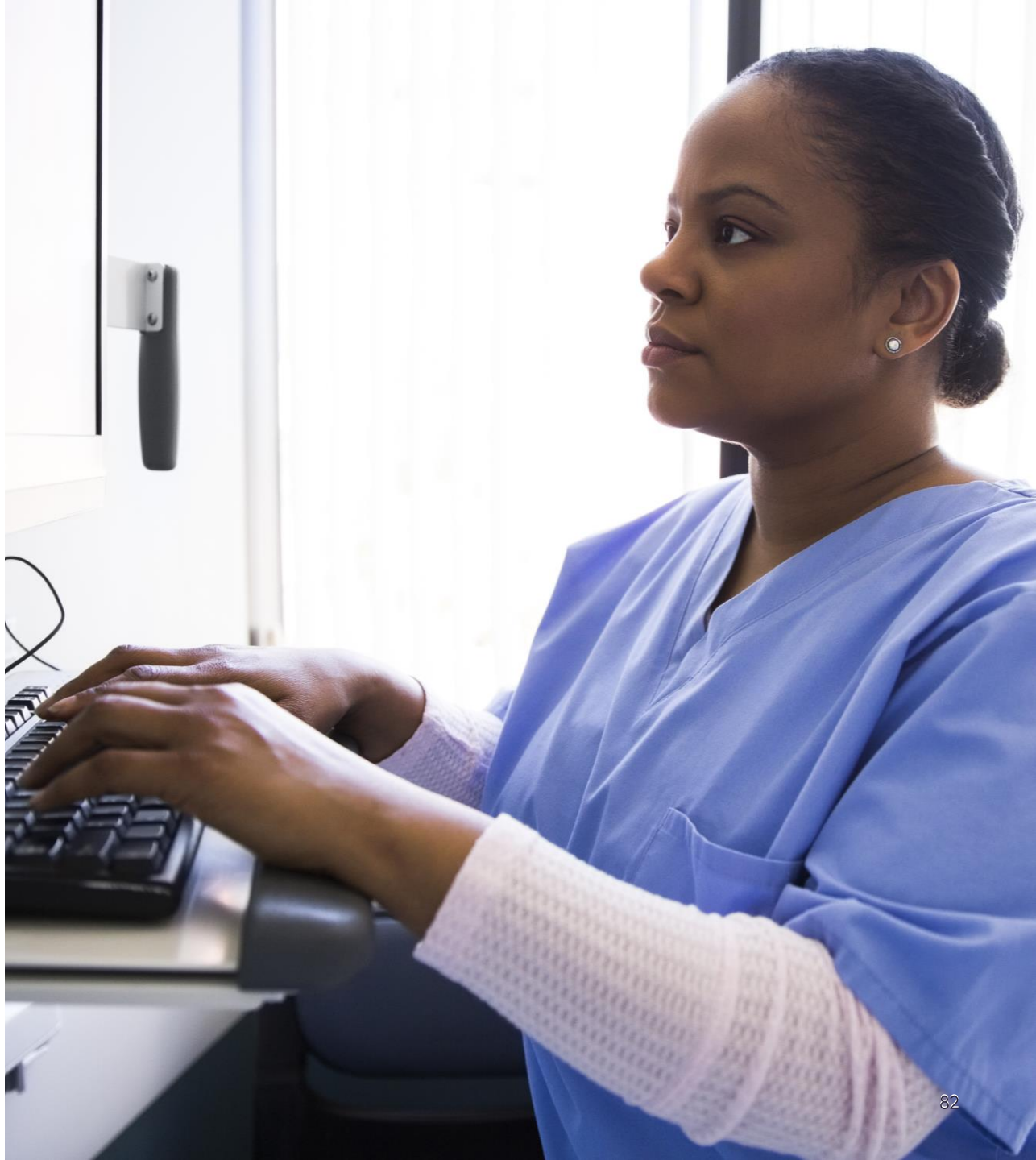




Provider communications/training resources

Wellpoint has curated trainings and provider communications to ensure you and your staff are aware of updates, training, and onboarding resources that every provider — new or experienced — can use to further their education. All training resources are accessible through the Training Academy:

- For more information, visit: provider.Wellpoint.com/texas-provider/resources/training-academy.



Additional resources and information

- CMS: CMS.gov
- National Committee for Quality Assurance: ncqa.com
- Health and Human Services Commission: hhs.texas.gov
- Texas Medicaid Health & Healthcare Partnership: tmhp.com
- Healthy Texas Women: healthytexaswomen.org/about

Next steps

- Complete the *Orientation Feedback Survey*.
- Register for Availity Essentials.
- Register for electronic data interchange.
- Register for EFT services.
- Read your provider manual.

Thank you for working with us!

Carelon Medical Benefits Management, Inc. is an independent company providing some utilization review services on behalf of the health plan.

provider.wellpoint.com/tx/

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.