Wellpoint | Texas

Nursing Facility Provider Manual

Bexar, El Paso, Harris, Jefferson, Lubbock, Tarrant, and Travis Service Areas

Wellpoint Insurance Company | West Rural Service Area

February 2024

Wellpoint℠

TEXAS STAR PLUS
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

833-731-2162
provider.wellpoint.com/tx

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Please note: Material in this provider manual is subject to change. Please visit provider.wellpoint.com/tx for the most up-to-date information.

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1 INTRODUCTION

Welcome to the Wellpoint provider family. We're pleased you are part of our network, which represents some of the finest healthcare providers in the state. As a leader in managed healthcare services for the public sector, we believe nursing facilities, hospitals, physicians, and other providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. This manual is designed to assist you with providing quality care to our members. The information in this manual may be updated periodically and changed as needed.

1.1 Who is Wellpoint?

Wellpoint refers to both Wellpoint Texas, Inc. and Wellpoint Insurance Company. Wellpoint members in the Medicaid Rural Service Area (RSA) and the STAR Kids program are served by Wellpoint Insurance Company. All other Wellpoint members are served by Wellpoint Texas, Inc.

Wellpoint Texas, Inc. is a licensed Health Maintenance Organization (HMO). Wellpoint Insurance Company is a licensed indemnity plan. As a leader in managed healthcare services for the public sector, the Wellpoint health plans provide healthcare coverage exclusively to low-income families, children, pregnant women, and elderly and disabled persons. Wellpoint also offers Medicare Advantage Plans, including Medicare Special Needs Plans, and participates in the Medicare-Medicaid Dual Demonstration program (MMP). Wellpoint administers the following programs in Texas:

Program	Program Objectives
STAR	The STAR program is a Medicaid managed care program for children, pregnant women, and low income families providing clients with acute care medical assistance. The objectives of the program are to: • Improve access to care for clients enrolled in the program. • Increase quality and continuity of care for clients. • Decrease inappropriate use of the healthcare delivery system, such as emergency rooms (ERs) for nonemergencies. • Achieve cost effectiveness and efficiency for the state. • Promote provider and client satisfaction.
STAR+PLUS	The STAR+PLUS program is a Medicaid managed care program providing integrated acute and long-term services and supports in a Medicaid managed care environment for elderly and disabled adults (mainly Supplemental Security Income [SSI]-eligible Medicaid clients). It also covers individuals with intellectual disabilities or related conditions who do not qualify for Medicare and receive services through the ICF-IID program or an IDD Waiver program (acute care and behavioral health services only — long-term services and supports are provided by the Texas Health and Human Services Commission (HHSC). In addition to the objectives of the STAR program, the STAR+PLUS program aims to: • Integrate acute and long-term care services and supports. • Coordinate Medicare services for clients who are dual eligible. • Offer coverage for both home- and community-based services and nursing facility custodial care in order to provide quality care in the best setting to address each member's individual care needs.

Program	Program Objectives
STAR Kids	STAR Kids is a Medicaid managed care program designed specifically for children and young adults with special needs. Most individuals 20 years old and younger who get Supplemental Security Income (SSI) Medicaid or Home- and Community-Based Waiver services will receive some or all of their Medicaid services through STAR Kids. Children and young adults enrolled in STAR Kids will receive comprehensive service coordination. Objectives of the STAR Kids program include the following: • Provide Medicaid benefits customized to meet recipients' healthcare needs through a defined system of care. • Improve recipients' coordination of care, health outcomes and access to health services. • Achieve cost containment and cost efficiency. • Reduce administrative complexity. • Reduce potentially preventable events, including out-of-home residential care, through provision of care management and appropriate services.
CHIP	The Children's Health Insurance Program (CHIP) provides health coverage for children age 18 and younger in families that earn too much to qualify for Medicaid but cannot afford private healthcare coverage. A child must be age 18 or younger, a Texas resident, and a U.S. citizen or legal permanent resident. Objectives of the CHIP program are to: • Increase the number of insured children in Texas. • Ensure children have access to a medical home, a physician or healthcare provider who serves the physical, mental, and developmental healthcare needs of a growing child through a continuous and ongoing relationship. Texas residents who are pregnant, uninsured, and not able to obtain Medicaid may be eligible for CHIP Perinatal benefits. Coverage starts before the child is born and lasts 12 months from the date the unborn child is enrolled. The objectives of CHIP Perinatal are to improve health status and birth outcomes for Texas by ensuring pregnant women who are ineligible for Medicaid due to income or immigration status receive prenatal care.
Medicare Advantage	We contract with the Centers for Medicare & Medicaid Services (CMS) to provide a Medicare Advantage Dual-eligible Special Needs Plan (SNP) as well as traditional Medicare Advantage health plans. All plans offer full Medicare Part D prescription drug coverage as well as extra benefits covering other healthcare services beyond what traditional Fee-For-Service (FFS) Medicare may offer. The Wellpoint Special Needs Plans (SNPs) are for Medicare beneficiaries entitled to Medicare Part A, enrolled in Medicare Part B and Medicaid (either as a full-benefit, dual-eligible or qualified-Medicare beneficiary). There are some copays for prescription drugs. The Wellpoint traditional Medicare Advantage plans are for Medicare beneficiaries who are entitled to Medicare Part A and are enrolled in Medicare Part B. The plans have copays for most services. The objectives of all these plans are to: • Enhance the coordination of a member's primary and acute care, long-term care, and prescription drug benefits through a unified case management program. • Improve the health status and outcomes of members.
STAR+PLUS Medicare-Medicaid Dual Demonstration Program (MMP)	Wellpoint was selected by the Texas Health and Human Services Commission (HHSC) to participate in a program to provide both Medicare and Medicaid benefits to dual eligible members. The goals of this program are to: • Integrate care and improve quality of care for members by consolidating the responsibility for all the covered services into a single plan. • Maximize the member's ability to remain safely in their home and community. • Improve continuity of care across acute care, long-term care, behavioral health, and home- and community-based services using a patient-centered approach.

We offer these programs in the following Service Areas (SAs) across Texas:

Service Area	STAR	STAR+PLUS	STAR Kids	CHIP	Medicare Advantage*	MMP*
Bexar	X	X		X	X	X
Dallas	X		X	X	X	
El Paso		X	X		X	X
Harris	X	X	X	X	X	X
Jefferson	X	X		X	X	
Lubbock	X	X	X		X	
Tarrant	X	X		X	X	X
Travis		X			X	
Central Texas Rural	X				X	
Northeast Texas Rural	X				X	
West Texas Rural	X	X	X		X	

* selected counties

For more information on the programs Wellpoint offers in Texas, please refer to the other provider manuals available on the provider website:

- Medicaid/CHIP Provider Manual
- Medicare Advantage Provider Manual
- Wellpoint STAR+PLUS Medicare-Medicaid Plan (MMP) Provider Manual

You can also call 866-805-4589 for more information about Medicare Advantage or 855-878-1785 for more information about the Medicare-Medicaid Dual Demonstration Program.

1.2 Our Mission and Goals

Our mission is to operate a community-focused managed care company with an emphasis on the public sector healthcare market. We coordinate our members' physical and behavioral healthcare, offering a continuum of education, access, care, and outcome programs, resulting in lower cost, improved quality and better health.

Our goals are to:

- Improve access to preventive primary care services by ensuring the selection of a primary care provider (PCP) who will serve as provider, care manager and coordinator for all basic medical services.
- Improve the health status and outcomes of our members.
- Educate members about their benefits, responsibilities, and the appropriate use of healthcare services.
- Encourage stable, long-term relationships between providers and members.
- Discourage medically inappropriate use of specialists and emergency rooms.
- Commit to community-based enterprises and community outreach.

- Facilitate the integration of physical and behavioral healthcare.
- Foster quality improvement mechanisms that actively involve providers in re-engineering healthcare delivery.
- Encourage a customer service orientation with regular measurement of member and provider satisfaction.

1.3 Legislative Background for STAR+PLUS Nursing Facility Medicaid

Senate Bill 7 of the 83rd Texas Legislature mandates the following:

SECTION 2.02. Subchapter A, Chapter 533. 00251 (c)
Subject to Section 533.0025 and notwithstanding any other law, [HHSC]...shall provide benefits under the medical assistance program to recipients who reside in nursing facilities through the STAR+PLUS Medicaid managed care program.

In accordance with this law, nursing facility services are a covered benefit for qualifying STAR+PLUS members age 21 and older beginning March 1, 2015.

1.4 Role of Nursing Facilities

The role of the nursing facility is to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, as defined by and in accordance with the comprehensive assessment and plan of care.

In addition, nursing facility responsibilities include but are not limited to:

- Verifying member eligibility
- Obtaining prior authorization for services prior to provision of those services
- Coordinating Medicaid/Medicare benefits
- Notifying us of changes in members' physical condition or eligibility within one business day of identification
- Collaborating with the Wellpoint service coordinator in managing members' healthcare
- Managing continuity of care for STAR+PLUS members
- Allowing Wellpoint service coordinators and other key personnel access to Wellpoint members in the facility and requested medical records information

1.5 Role of Primary Care Providers (Medical Home)

The role of the primary care physician or primary care provider (PCP) is to provide a medical home for members. The PCP is also responsible for providing initial and primary care to members, maintaining the continuity of member care, and initiating referral for care.

Members who are eligible for both Medicare and Medicaid will receive primary care from their Medicare plan and will not select a Medicaid primary care provider.

Additional information is available in the Provider Rights and Responsibilities chapter of this manual.

1.6 Role of Specialty Care Providers

The role of the specialty care provider is to meet the medical specialty needs of members and provide all medically necessary covered services. Specialty care providers, including behavioral health providers, coordinate care with the member's medical home provider.

Additional information is available in the Provider Rights and Responsibilities chapter of this manual under Specialty Care Providers' Roles and Responsibilities. Additional information for behavioral health providers is available in the Behavioral Health Program chapter of this manual.

1.7 Role of Long-term Services and Supports Providers

The responsibilities of long-term services and supports (LTSS) providers include but are not limited to:

- Verifying member eligibility
- Obtaining prior authorization for services prior to provision of those services
- Coordinating Medicaid and Medicare benefits
- Notifying us of changes in members' physical condition or eligibility
- Collaborating with the Wellpoint service coordinator in managing members' healthcare
- Managing continuity of care for STAR+PLUS members

Additional responsibilities and information are available in the Long-Term Services and Supports chapter of this manual.

1.8 Role of Wellpoint Service Coordinator

Service coordination means specialized care management services that are performed by a licensed, certified and/or experienced person called a service coordinator. This includes but is not limited to the following activities:

- Identifying a member's needs through an assessment
- Documenting how to meet the member's needs in a care plan
- Arranging for delivery of the needed services
- Establishing a relationship with the member and being an advocate for the member in coordinating care
- Helping with coordination between different types of services, including community transitions
- Making sure the member has a primary care provider

A service coordinator works as a team with the member, member's family, and/or authorized representative, nursing facility clinical and administrative staff, and the primary care provider to arrange all the services the member needs, including services from specialists and behavioral health providers if needed. A service coordinator helps make sure all of the member's different healthcare needs are met.

1.9 Role of Pharmacy

Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations, treatment of short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Members have access to most national pharmacy chains and many independent retail pharmacies as well as pharmacies supported within the member's chosen nursing facility.

Pharmacy providers are responsible for but not limited to the following:

- Filling prescriptions in accordance with the plan benefit design
- Adhering to the Vendor Drug Program (VDP) formulary and Preferred Drug List (PDL)
- Coordinating with the prescribing physician
- Ensuring members receive all necessary medication for which they are eligible
- Coordinating benefits when a member also receives Medicare Part D services or other insurance benefits
- Providing a 72-hour emergency supply of prescribed medication when a prior authorization (PA) cannot be resolved within 24 hours for a medication on the Texas Vendor Drug Program (VDP) formulary that is appropriate for the member's medical condition or if the prescribing provider cannot be reached or is unable to request a PA because it is after the prescriber's office hours. The pharmacy should submit an emergency 72-hour prescription if the dispensing pharmacist determines it is an emergency situation. Emergency situations include cases in which, based on the dispensing pharmacist's judgement, a member may experience a detrimental change in health status within 72 hours from when the pharmacy receives the prescription due to the inability to obtain the medication. Pharmacies should not dispense 72-hour emergency supplies on a routine basis.

1.10 Network Limitations

Providers with the following specialties can apply for enrollment with us as PCPs:

- General practice
- Family practice
- Internal medicine
- Pediatrics
- Obstetrics/gynecology (OB/GYN)
- Advanced practice registered nurses (APRNs) and physician assistants (PAs) when APRNs and PAs are practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics or OB/GYN who also qualifies as a PCP
- Federally qualified health centers (FQHC)
- Rural health clinics (RHCs) and similar community clinics
- Physicians serving members residing in nursing facilities
- Indian Health Care Providers (IHCP) for Indian members

Providers must be enrolled with Texas Medicaid in one of the specialties listed above to serve as a PCP.

Specialist physicians may be willing to provide a medical home to selected members with special needs and conditions. Information regarding the circumstances in which a specialist can be designated as a PCP is available under the Specialist as a PCP section of this manual.

1.11 Nondiscrimination Statement

Wellpoint does not engage in, aid, or perpetuate discrimination against any person by providing significant assistance to any entity or person that discriminates on the basis of race, color, or national origin in providing aid, benefits or services to beneficiaries. Wellpoint does not utilize or administer criteria having the effect of discriminatory practices on the basis of gender or gender identity. Wellpoint does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of gender or gender identity. In addition, in compliance with the Age Act, Wellpoint may not discriminate against any person on the basis of age, or aid or perpetuate age discrimination by providing significant assistance to any agency, organization or person that discriminates on the basis of age. Wellpoint provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, gender identity, race, color, age, religion, national origin, physical or mental disability, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Wellpoint representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so if the member requests assistance. We document, track and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: 800-368-1019 (TTY/TTD: 800-537-7697)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Wellpoint provides free tools and services to people with disabilities to communicate effectively with us. Wellpoint also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages). These services can be obtained by calling the Member Services number on their member ID card.

If you or your patient believe Wellpoint has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our member advocate via:

- Mail: 2505 N. Highway 360, Suite 300, Grand Prairie, TX 75050
- Phone: 833-731-2160 (TTY 711); ask for a member advocate
- Email: <dl-txmemberadvocates@wellpoint.com>

Equal Program Access on the Basis of Gender
Wellpoint provides individuals with equal access to health programs and activities without discriminating on the basis of gender. Wellpoint must also treat individuals in a manner consistent with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (in other words, race, color, national origin, gender, gender identity, age, or disability).

Wellpoint may not deny or limit health services that are ordinarily or exclusively available to individuals of one gender, to a transgender individual based on the fact that a different gender was assigned at birth, or because the gender identity or gender recorded is different from the one in which health services are ordinarily or exclusively available.

2 QUICK REFERENCE INFORMATION

Quick Reference Topic	Description
Provider Services/Inquiry Line	Phone: 833-731-2162 Fax: 800-964-3627
Wellpoint Website	provider.wellpoint.com/tx Availity Essentials at Availity.com These sites feature tools for real-time eligibility inquiry, claims submission/status/appeals, and prior authorization requests/status/appeals. In addition, the sites offer general information and various tools that are helpful to the provider such as: • Preferred Drug List • List of drugs requiring prior authorization • Provider manuals • Referral directories • Provider newsletters • Precertification Lookup Tool • Electronic remittance advice and electronic funds transfer information • Health plan and industry updates • Clinical Practice Guidelines • Downloadable forms

Prior Authorizations	Requests for prior authorizations may be submitted as indicated below:
	• Digital submission (preferred method): Availity.com
	• Nursing facility notification and add-on services: 844-206-3445 (fax)
	• Inpatient/Outpatient surgeries and other general requests:
	  ○ Fax: 800-964-3627
	  ○ Phone: 833-731-2162
	• Inpatient Discharge Planning (fax only):
	  ○ Physical Health: 888-708-2599
	  ○ Behavioral Health: 844-430-6805
	• Specialized Care Services (fax only):
	  ○ Medical injectable/infusible drugs: 844-512-8995 (for additional information, refer to the Pharmacy section of this manual)
	• Behavioral Health Services:
	  ○ Digital submission (preferred method) at Availity.com
	  ○ Behavioral Health – inpatient: 844-430-6805 (fax)
	  ○ Behavioral Health – outpatient: 844-442-8010 (fax)
	• Carelon Medical Benefits Management, Inc. (formerly known as AIM Specialty Health): 833-342-1260 (phone); careloninsights.com (online)
	  ○ Cardiology
	  ○ Genetic testing
	  ○ Radiation oncology
	  ○ Radiology (high-tech)

Quick Reference Topic	Description
	○ Sleep studies ○ Superior Vision of Texas (medical/surgical): ○ Fax: 855-313-3106 ○ Email: ecs@superiorvision.com • Ambulance Transportation (nonemergency): ○ Physical Health (nonurgent): 866-249-1271 (fax) ○ Behavioral Health (nonurgent): 844-442-8010 (fax) ○ Urgent: 833-731-2162 (phone) ○ For additional information, refer to the Nonemergency Transportation section of this manual • Urgent Services (phone only): ○ General: 833-731-2162 ○ Nursing facility: 866-696-0710 Documentation and forms required for prior authorization requests are available on the Wellpoint provider website.
National Provider Identifier (NPI)	The *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* requires the adoption of a standard, unique provider identifier for healthcare providers. All Wellpoint participating providers must have a NPI number. The NPI is a 10-digit, intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about healthcare providers, such as the states in which they practice or their specialties. For more information about the NPI and the application process, please visit https://nppes.cms.hhs.gov. You can 1) complete the application online (estimated time to complete the NPI application is 20 minutes), 2) download a paper application for completion, or 3) call 800-465-3203 to request an application.
Claims Submission	Electronic Data Interchange (EDI): Use your existing software, clearinghouse, or billing company to submit your claims in Availity Essentials. Online claims submission: Submit an online claim submission using Availity Essentials. Navigate to Claims & Payments > select Professional or Institutional claim and complete claim form. Contact Availity Client Services with any questions at 800-Availity (282-4548). Submit paper claims (for providers other than nursing facilities) to: Wellpoint P.O. Box 61010 Virginia Beach, VA 23466-1010 Timely filing for STAR+PLUS nursing facility unit rate or Medicare skilled nursing coinsurance claims is within 365 days from the last date of service represented on the claim. All other STAR+PLUS service claims

Quick Reference Topic	Description
	must be filed within 95 days from the date of service or per the terms of the provider agreement. We provide an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and prior authorization status; visit Availity.com. If you are unable to access the internet, you may receive claims, eligibility, and prior authorization status over the phone at any time by calling our toll-free, automated Provider Inquiry Line at 833-731-2162.
Member Medical Appeal Information	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 submitted within 60 calendar days from the date of an adverse benefit determination. Be sure to include medical charts or other supporting information. Member medical appeals may be submitted in writing to: Wellpoint Appeals P.O. Box 62429 Virginia Beach, VA 23466-2429 Member medical appeals may also be requested by calling Member Services at 833-731-2160 (TTY 711).
Payment Disputes	• A provider has 120 days from the date of an *Explanation of Payment* (*EOP*) to file a payment dispute. Online (for reconsiderations and claim payment appeals): Use the secure provider Availity Appeal application at Availity.com. Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement of your submission. Locate the claim you want to dispute on Availity Essentials using Claim Status from the *Claims & Payments* menu. If available, select Dispute Claim to initiate the dispute. Go to Request to navigate directly to the initiated dispute in the appeals dashboard, add the documentation, and submit. Or fax the dispute request to 844-756-4607 or mail it to: Provider Payment Disputes Wellpoint P.O. Box 61599 Virginia Beach, VA 23466-1599
Complaints	Provider complaints should be faxed to 844-664-7179 or mailed to: Wellpoint P.O. Box 61789 Virginia Beach, VA 23466-1789 Providers can also email complaints at provider.wellpoint.com/tx.

Quick Reference Topic	Description
Case Managers/Service Coordinators	Our case managers/service coordinators are available from 8 a.m. to 5 p.m. local time by calling 833-731-2162 or the local health plan at 866-696-0710. For urgent issues, assistance is available after normal business hours, during weekends and on holidays through Provider Services at 833-731-2162.
Provider Services Representatives	For more information, call Provider Services at 833-731-2162 (fax: 800-964-3627).
Interpreter Services	Telephonic services for those who are deaf or hard of hearing: 711 Non-English telephonic services: 833-731-2162 (language line available) In person interpretation: 833-731-2162
Behavioral Health Services	Phone: 833-731-2162 Prior authorization: Digital submission (preferred method) at Availity.com Fax: • Behavioral Health — inpatient: 844-430-6805 • Behavioral Health — outpatient: 844-442-8010
Emergency Dental Services	Members residing in a nursing facility receive emergency dental services through DentaQuest at 800-516-0165. Other dental services that may be needed or requested by the member residing in a nursing facility should be discussed with the member's assigned service coordinator.
24-hour Nurse HelpLine	833-731-2160 (TTY 711)
Wellpoint Member Services	833-731-2160 (TTY 711)
Carelon Medical Benefits Management (cardiology, genetic testing, hi-tech radiology, radiation oncology, and sleep studies prior authorizations)	Phone: 833-342-1260 Website: careloninsights.com Prior authorization: 833-342-1260 (phone); careloninsights.com (online)
Carelon Behavioral Health, Inc.	National Provider Service Line: 800-397-1630, Monday through Friday, 7 a.m. to 7 p.m. Central time.
Pharmacy Services	Online pharmacy prior authorization via CoverMyMeds: covermymeds.com Pharmacy prior authorization fax: 844-474-3341 Phone: 833-731-2162 (Wellpoint Pharmacy) Medical injectables/infusible drugs prior authorization fax: 844-512-8995
Vision Services (Superior Vision of Texas)	Providers call: 866-819-4298 Members call: 800-428-8789 Medical/surgical prior authorization: 855-313-3106 (fax); ecs@superiorvision.com (email)
Access2Care (nonemergent transportation other than ambulance)	For STAR+PLUS nursing facility residents, transportation benefits are limited to trips for kidney dialysis and discharge to home. Call 844-867-2837 at least two business days in advance to schedule.

Quick Reference Topic	Description
Electronic Data Interchange	Contact Availity Client Services with any questions at 800-Availity (282-4548). If you use a clearinghouse or vendor, please work with them. EDI Payer ID: WLPNT
Availity Essentials (for claim filing, claim status inquiries and disputes, member eligibility and benefits information, prior authorizations, and demographic updates)	Website: Availity.com Phone: 800-Availity (282-4548)
STAR+PLUS Enrollment/Disenrollment HelpLine	877-782-6440

3 MEMBER ELIGIBILITY

Eligibility for STAR+PLUS Medicaid is determined by the Texas Health and Human Services Commission. Once eligible, members select enrollment in a managed care organization in their area through the administrative services contractor.

3.1 Verifying Member Medicaid Eligibility

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the member has current Medicaid coverage. A provider should verify the member's eligibility for the date of service before rendering services. There are multiple ways to do this:

- Call Wellpoint or check Availity.com.
- Use TexMedConnect on the TMHP website at tmhp.com.
- Log into your TMHP user account and access the Medicaid Client Portal for providers.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at 800-925-9126 or
  512-335-5986.
- Your Texas Benefits Medicaid Card
  - Temporary ID (Form 1027-A)
  - Wellpoint ID Card
    - STAR+PLUS Dual Eligible - If the member has Medicare, Medicare is responsible for most primary, acute and behavioral health services. Therefore, the primary care provider's name, address and telephone number are not listed on the member's MCO ID card. The member receives long-term services and supports through Wellpoint.

3.1.1 Temporary ID Verification Form

If the member has lost or does not have access to the Your Texas Benefits Medicaid card and needs a temporary Medicaid ID card, a temporary verification form (*Form 1027-A*) can be obtained by calling the local HHSC benefits office. Providers must accept this form as proof of Medicaid eligibility, but current coverage should be verified as described in the Verifying Member Medicaid Eligibility section of this manual. Members also can go online to yourtexasbenefits.com to order a new card or print a temporary card.

3.2 Wellpoint Member Identification Card

Sample Wellpoint member identification cards are available in Appendix A for the STAR+PLUS nondual and dual program. We now offer members the option of downloading a free digital version of their member ID cards to their Apple iOS or Android-based smartphones and tablets. Members may now show their mobile ID card as proof of coverage. Providers should treat the digital version just the same as the original plastic card.

For STAR+PLUS members who have Medicare, a PCP is not listed on the Wellpoint ID card. Instead, the phrase *Long-term Services and Supports Benefits Only* is listed. Medicare is responsible for primary, acute, and behavioral healthcare services; therefore, the PCP's

name, address, and telephone number are not listed. The member receives long-term services and supports through Wellpoint.

3.2.1 STAR+PLUS Newborns

If a newborn is born to a Medicaid-eligible mother enrolled in STAR+PLUS, the HHSC administrative service contractor will enroll the newborn into the STAR program in the same health plan as the mother (if available in the service area). All rules related to STAR newborn enrollment will apply to the newborn. If the mother's health plan does not offer a STAR plan in the service area, the newborn will be placed in Medicaid FFS until the mother chooses a STAR plan.

3.2.2 STAR+PLUS members in the Medicaid for Breast and Cervical Cancer Program

Women enrolled in the Medicaid for Breast and Cervical Cancer Program are eligible for the STAR+PLUS program. These members are not limited to cancer treatment only; they have full STAR+PLUS benefits.

3.2.3 STAR+PLUS ICF-IID Program and IDD Waiver Services Members

STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program or an IDD Waiver will be covered for acute care services only under STAR+PLUS. Community-based long-term services and supports will be provided through HHSC. The ICF-IID Program is the Medicaid program serving individuals with intellectual disabilities or related conditions who receive care in intermediate care facilities other than a state-supported living center. IDD Waiver means the Community Living Assistance and Support Services Waiver program (CLASS), the Deaf-Blind with Multiple Disabilities Waiver program (DBMD), the Home and Community-Based Services Waiver program (HCS), or the Texas Home Living Waiver program (TxHmL). A personal service coordinator will be assigned to each of these members.

3.3 Service Responsibility

3.3.1 STAR+PLUS Responsibility Table

Type of STAR+PLUS Benefit	Medicaid Coverage Only	Medicaid and Medicare coverage (dual-eligible)
Medicaid nursing facility residential coverage	Wellpoint	Wellpoint or Medicare FFS/ Medicare HMO
Medical and behavioral health coverage	Wellpoint	Medicare FFS or Medicare HMO
Long-term services and supports coverage	Wellpoint and/or waiver program*	Wellpoint or Medicare FFS/Medicare HMO and/or waiver program
Prescription drugs	Wellpoint	Member's chosen Part D prescription drug plan
Transportation coverage	Wellpoint	Wellpoint or Medicare FFS/Medicare HMO
Medicare copays and deductibles	Not applicable	State's fiscal agent (TMHP) for FFS; Medicare HMO
Medicaid wrap-around services	Not applicable	State's fiscal agent (TMHP)

* STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program or an IDD Waiver will be covered for acute care services only under STAR+PLUS. Long-term services and supports will be provided through HHSC.

3.4 Member Enrollment and Disenrollment from Wellpoint

3.4.1 Medicaid Enrollment

STAR+PLUS members may enroll in or disenroll from Wellpoint at any time. If a member asks how to enroll in or disenroll from Wellpoint, the provider can direct the member to either method below:

- Call the state enrollment broker, MAXIMUS, at 877-782-6440
- Write to MAXIMUS at P.O. Box 149219, Austin, TX 78714-9965

The effective date of an enrollment or disenrollment is generally no later than the first day of the second month following the month in which a completed enrollment or disenrollment form was received by MAXIMUS. The examples below illustrate how to determine the effective date of an enrollment or disenrollment:

Example 1:	MAXIMUS receives the enrollment or disenrollment form by January 15; the effective date is February 1.
Example 2:	MAXIMUS receives the enrollment or disenrollment form between January 16 and January 31; the effective date is March 1.

3.4.2 Medicaid Automatic Re-enrollment

Members who are disenrolled because they are temporarily ineligible for Medicaid are automatically re-enrolled in the same HMO. The member may elect to change HMOs at any time. Temporary loss of eligibility is defined as a period of six months or less. We notify our members of this procedure through our member handbooks.

3.4.3 Medicaid Managed Care Program Disenrollment

Members who request disenrollment from the mandated managed care program to move back into FFS require medical documentation from the PCP and/or specialist or documentation that indicates sufficiently compelling circumstances that merit disenrollment. HHSC renders a final decision on these types of requests. Providers cannot take retaliatory action against a member who decides to disenroll from Wellpoint.

3.4.4 Effective Date of SSI Status

The Social Security Administration notifies HHSC of a member's SSI status. HHSC will update their eligibility system within 45 days of receiving notice of SSI status for a member. The member will then be able to prospectively move to STAR+PLUS (if the member is an adult) or to STAR Kids (if the member is a child).

HHSC will not retroactively disenroll a member from the STAR, CHIP or CHIP Perinatal programs.

3.4.5 Enrollment Changes During an Inpatient Stay in a Hospital

The following table outlines payment responsibility for Medicaid enrollment changes occurring during an inpatient stay according to the member's effective date of coverage with the receiving MCO (new MCO) or fee-for-service (FFS).

Scenario	Hospital facility charge	All other covered services
Member retroactively enrolled in MCO program	New MCO	New MCO
Member prospectively moves from FFS to MCO program	FFS	New MCO
Member moves between MCOs in the same program	Former MCO	New MCO
Member moves between MCO programs	Former MCO	New MCO
Member moves from MCO program to FFS	Former MCO	FFS

The responsible party will pay the hospital facility charges until the earliest of:

- The date the member is discharged from the hospital.
- The date the member is transferred.
- The date the member loses Medicaid coverage eligibility.

After the date of discharge, transfer or loss of eligibility, the new payer will be responsible for all charges.

Definitions:

- Discharge: formal release of a member from an inpatient hospital stay when the need for continued care at an inpatient level has concluded:
    - Movement or transfer from one acute care hospital or long term care hospital/facility and readmission to another within 24 hours for continued treatment is not a discharge.
- Transfer: movement of the member from one acute care hospital or long term care hospital/facility and readmission to another acute care hospital or long term care hospital/facility within 24 hours for continued treatment.

3.4.6 Enrollment Changes during a Nursing Facility Stay

The following table describes payment responsibility for Medicaid enrollment changes that occur during a nursing facility stay, beginning on the member's effective date of coverage with the new MCO or FFS.

	Scenario	Nursing facility unit rate and/or Medicare coinsurance	All other covered services
	Member moves from FFS to STAR+PLUS	New MCO	New MCO
	Member moves between STAR+PLUS MCOs	New MCO	New MCO
	Member moves from STAR+PLUS to Dual Demonstration	New MCO	New MCO

	Member moves from Dual Demonstration to STAR+PLUS	New MCO	New MCO
	Member moves from STAR+PLUS to FFS	FFS	FFS

3.4.7 Enrollment Changes with Custom Durable Medical Equipment (DME) and Augmentative Device Prior Authorization

The following table describes payment responsibility for Medicaid enrollment changes that occur when a prior authorization exists for custom DME before the delivery of the product.

	Scenario	Custom DME	All other covered services
	Member moves between STAR+PLUS MCOs	Former MCO	New MCO
	Member moves from FFS to STAR+PLUS MCO	New MCO	New MCO

3.4.8 Enrollment Changes with Home Modification

The following table describes payment responsibility for Medicaid enrollment changes that occur during a minor home modification service provided to an HCBS STAR+PLUS Waiver member before completion of the modification.

	Scenario	Minor home modification	All other covered services
	Member moves between STAR+PLUS MCOs	Former MCO	New MCO

4 COVERED SERVICES AND EXTRA BENEFITS

4.1 Medicaid Covered Services for STAR+PLUS Nursing Facility

Our coverage of STAR+PLUS Medicaid members includes medically necessary services as outlined for the Medicaid FFS program in the *Texas Medicaid Provider Procedures Manual* (TMPPM), enhanced pharmacy and inpatient coverage, and extra benefits. The table below compares covered services of STAR+PLUS to traditional FFS Medicaid.

Covered Services	STAR+PLUS	Traditional Medicaid FFS
Core Medicaid benefits as outlined in the Medicaid FFS program (listed in the Medicaid Services Covered Outside of the Nursing Facility section)	X	X
Waiver of the three-prescription-per-month limit (Unlimited prescriptions for adults is only available for members not covered by Medicare.)	X	
Waiver of the 30-day spell-of-illness limitation under FFS	See notes below	
Extra or value-added benefits	X	

Notes:

- STAR+PLUS dual-eligible members receive their acute care services coverage through Medicare.
- $200,000 annual limit on inpatient services does not apply for STAR+PLUS members.
- For STAR+PLUS, waiver of the 30-day spell-of-illness limitation applies only to non-dual members with a diagnosis from the categories of bipolar disorder(F31), major depressive disorder(F32), recurrent depressive disorder(F33), schizophrenia (F20) or schizoaffective disorder (F25) as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5). Unspecified diagnosis codes are not exempt from the limitation.
- STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program or an IDD Waiver will be covered for acute care services only under STAR+PLUS. Long-term services and supports will be provided through HHSC.

Covered services are subject to change in accordance with Texas Medicaid requirements. Modifications to covered services are communicated through the provider website, mailings, faxes, emails, newsletters and/or provider contractual amendments. Medicaid members do not have deductibles or copays for Medicaid covered services, and providers are prohibited from balance billing for Medicaid covered services.

4.1.1 Nursing Facility Unit Rate

The nursing facility unit rate includes the types of services included in the HHSC vendor payment rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The nursing facility unit rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. Nursing facility unit rates exclude nursing facility add-on services as described below.

4.1.2 Nursing Facility MCO Add-On Services

Ventilator care add-on service: To qualify for supplemental reimbursement, a nursing facility member must require artificial ventilation for at least six consecutive hours daily, and the use must be prescribed by a licensed physician.

Tracheostomy care add-on service: To qualify for supplemental reimbursement, a nursing facility member must be less than 22 years of age; require daily cleansing, dressing and suctioning of a tracheostomy; and be unable to do self-care. The daily care of the tracheostomy must be prescribed by a licensed physician.

PT, ST, OT add-on services: Rehabilitative services are physical therapy, occupational therapy, and speech therapy services (not covered under the NF Unit Rate) for Medicaid nursing facility members who are not eligible for Medicare or other insurance. The cost of therapy services for members with Medicare or other insurance coverage or both must be billed to Medicare or other insurance or both. Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and treatment of functions that have been impaired by illness. Rehabilitative services must be provided with the expectation that the member's functioning will improve measurably in 30 days.

The provider must ensure that rehabilitative services are provided under a written plan of treatment based on the physician's diagnosis and orders, and that services are documented in the member's clinical record.

Customized power wheelchair (CPWC): To be eligible for a CPWC, a member must be:

- Medicaid eligible.
- Age 21 years or older.
- Residing in a licensed and certified NF that has a Medicaid contract with HHSC.
- Eligible for and receiving Medicaid services in an NF.
- Unable to ambulate independently more than 10 feet.
- Unable to use a manual wheelchair.
- Able to safely operate a power wheelchair.
- Able to use the requested equipment safely in the NF.
- Unable to be positioned in a standard power wheelchair.
- Undergoing a mobility status that would be compromised without the requested CPWC.
- Certified by a signed statement from a physician that the CPWC is medically necessary.

Augmentative communication device (ACD): An ACD is a speech-generating device system. A physician and a licensed speech therapist must determine if the ACD is medically necessary.

Note: For NF add-on therapy services, Wellpoint will accept claims received: 1) from the NF on behalf of employed or contracted therapists, and 2) directly from contracted therapists who are contracted with the MCO. All other NF add-on providers must contract directly with and directly bill the MCO.

NF add-on providers (except NF add-on therapy services providers) must refer to the *Medicaid/CHIP Provider Manual* for information, including credentialing and re-credentialing.

4.2 Medicaid Services Covered Outside of the Nursing Facility

The following acute care services are covered by Medicaid for STAR+PLUS nursing facility residents enrolled in Wellpoint, billed by the provider directly and not by the nursing facility:

- Ambulance services — emergency and nonemergency transportation
- Audiology services, including hearing aids
- Behavioral health services, including:
  - Inpatient mental health services
  - Outpatient mental health services
  - Psychiatry services
  - Counseling services
  - Outpatient substance use disorder treatment services, including:
    - Assessment
    - Detoxification services
    - Counseling treatment
    - Medication-assisted therapy
  - Residential substance use disorder treatment services, including detoxification services
  - Mental health rehabilitative services
  - Mental health targeted case management
- Birthing services provided by a physician or certified nurse-midwife in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic and treatment services
- Chiropractic services
- Dialysis
- Emergency services
- Family planning services
- Hospital services including inpatient and outpatient
- Laboratory services
- Mastectomy, breast reconstruction, and external breast prosthesis-related follow-up procedures, including:
  - Inpatient services; outpatient services provided at an outpatient hospital and ambulatory healthcare center as clinically appropriate; physician and professional services provided in an office, inpatient, or outpatient setting for:
    - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed
    - Surgery and reconstruction on the other breast to produce symmetrical appearance
    - Treatment of physical complications from the mastectomy and treatment of lymphedemas
    - Prophylactic mastectomy to prevent the development of breast cancer

    - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; surgery and reconstruction on the other breast to produce symmetrical appearance
- Nonemergency medical transportation services (dialysis and discharge to home)
- Podiatry
- Prenatal care
- Prenatal care provided by a physician, certified nurse midwife, nurse practitioner, clinical nurse specialist or physician assistant in a licensed birthing center
- Prescription drugs, medications and biologicals including pharmacy-dispensed and provider administered outpatient drugs and biologicals
- Primary care services
- Preventive services, including an annual adult well check
- Radiology, imaging and X-rays
- Specialty physician services
- Telemedicine
- Transplantation of organs and tissues
- Vision services — includes optometry and glasses; contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses

4.3 Medicaid Program Exclusions

The following services are not covered by Wellpoint or traditional FFS Medicaid:

- All services not medically necessary
- All services not provided, approved or arranged by a network provider or preauthorized by a nonparticipating provider, with the exception of emergency and family planning services
- Cosmetic surgery, except when medically necessary
- Experimental organ transplants
- Infertility treatments and drugs
- Rest cures, personal comfort and convenience items, and services and supplies not directly related to the care of the patient
- Services provided in federally operated facilities
- Other services listed in the TMPPM as noncovered benefits (located at tmhp.com)

4.4 Coordination with Non-Medicaid Managed Care Covered Services

In addition to MCO coverage, STAR+PLUS nursing facility members are eligible for the services described below. Wellpoint and our network providers are expected to refer to and coordinate with these programs. These services are described in the *Texas Medicaid Provider Procedures Manual* (TMPPM). The TMPPM is located online at tmhp.com/resources/provider-manuals:

- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- HHSC hospice services

- Long-term services and supports for individuals who have intellectual or developmental disabilities provided by HHSC contracted providers
- Case management or service coordination services for individuals who have intellectual or developmental disabilities provided by HHSC contracted providers
- Mental Health Targeted Case Management and Mental Health Rehabilitative Services for STAR+PLUS dual eligible members
- For members who are prospectively enrolled in STAR+PLUS from Medicaid FFS during an inpatient stay, hospital facility charges associated with the inpatient stay are noncapitated services except for a stay in a chemical dependency treatment facility
- Preadmission Screening and Resident Review (PASRR) Level 1 screenings, Level 2 evaluations, and specialized services provided by HHSC-contracted local authority (LA) and DSHS-contracted local mental health authority (LMHA). Specialized services provided by the LA include: service coordination, alternate placement, and vocational training. Specialized services provided by the LMHA include mental health rehabilitative services and targeted case management. Specialized services provided by a nursing facility for individuals identified as IDD include physical therapy, occupational therapy, speech therapy, and customized adaptive aids. All PASRR specialized services are noncapitated, fee-for-service.

4.5 Dental Services

4.5.1 Medicaid Nonemergency Dental Services

Wellpoint is not responsible for paying for routine dental services provided to Medicaid members.

Wellpoint is responsible, however, for paying for treatment and devices for craniofacial anomalies.

4.5.2 Medicaid Emergency Dental Services

Wellpoint is responsible for emergency dental services provided to Medicaid members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (for example, anesthesia and drugs) for covered emergency dental procedures.

Covered emergency dental procedures include, but are not limited to:

- Alleviation of extreme pain in oral cavity associated with serious infection or swelling;
- Repair of damage from loss of tooth due to trauma (acute care only, no restoration);
- Open or closed reduction of fracture of the maxilla or mandible;
- Repair of laceration in or around oral cavity;
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
- Incision and drainage of cellulitis;
- Root canal therapy. Payment is subject to dental necessity review and pre- and post-operative x-rays are required; and

- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

4.5.3 STAR+PLUS Waiver Dental Services

HCBS STAR+PLUS Waiver members living in the community are eligible for services provided by a dentist to preserve teeth and meet the medical needs of the member. Allowable services include the following:

- Emergency dental treatment necessary to control bleeding, relieve pain and eliminate acute infection
- Preventive procedures required to prevent the imminent loss of teeth
- The treatment of injuries to teeth or supporting structures
- Dentures and the cost of preparation and fitting
- Routine procedures necessary to maintain good oral health

Dental services for HCBS STAR+PLUS Waiver members are limited to $5,000 per waiver plan year. This limit may be exceeded upon approval by Wellpoint up to an additional $5,000 per waiver plan year when medically necessary treatment requires the services of an oral surgeon. Wellpoint may also approve other dental services above the $5,000 waiver plan year limit on a case-by-case basis due to medical necessity, functional necessity, or the potential for improved health of the member. Wellpoint must review and approve any treatment in excess of the waiver plan year limit prior to services being rendered.

4.6 Family Planning

Family planning services are a covered benefit of the Medicaid program. We cover family planning services, including medically necessary medications, contraceptives and supplies not covered by the Texas Vendor Drug Program (VDP). We reimburse out-of-network family planning providers in accordance with HHSC administrative rules. Except as otherwise noted, no prior authorization is required for family planning services.

STAR+PLUS members must be allowed:

- The freedom to choose medically appropriate contraceptive methods.
- The freedom to accept or reject services without coercion.
- To receive services without regard to age, marital status, sex, race or ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference.
- To self-refer for family planning services to any Texas Health and Human Services Commission -approved family planning provider listed on the web at healthytexaswomen.org/family-planning-program.

Only members receiving family planning services, not their parents, spouses or any other individual, may consent to the provision of family planning services.

4.7 Pharmacy

Our pharmacy benefit provides coverage for medically necessary prescriptions from any licensed prescriber for legend and nonlegend medications that appear in the latest revision

of the Texas Drug Code Index for Medicaid members. Members have access to most national pharmacy chains and many independent retail pharmacies that are contracted with us. Members may obtain their medications at any network pharmacy unless HHSC has placed the member in the Office of Inspector General (OIG) Lock-in Program.

We have contracted with CarelonRx, Inc. to process prescription drug claims using a computerized point-of-sale (POS) system. This system gives participating pharmacies online, real-time access to beneficiary eligibility, drug coverage (to include prior authorization requirements), prescription limitations, pricing and payment information, and prospective drug utilization review.

Prescription Limits
All prescriptions are limited to a maximum 34-day supply per fill, and all prescriptions for noncontrolled substances are valid only for 11 refills or 12 months from the date the prescription was written, whichever is less.

OIG Lock-in Program
The HHSC OIG Lock-in Program restricts, or locks in, a Medicaid member to a designated pharmacy if HHSC finds that the member used drugs covered by Medicaid at a frequency or in an amount that is duplicative, excessive, contraindicated, or conflicting, or that the member's actions indicate abuse, misuse, or fraud. Some circumstances allow a member to be approved to receive medications from a pharmacy other than the lock-in pharmacy. A pharmacy override occurs when Wellpoint approves a member's request to obtain medication at an alternate pharmacy other than the lock-in pharmacy. In order to request a pharmacy override, the member or pharmacy should call Pharmacy Member Services at 833-235-2022 (TTY 711).

The following are allowable circumstances for pharmacy override approval:

- The member moved out of the geographical area (more than 15 miles from the lock-in pharmacy).
- The lock-in pharmacy does not have the prescribed medication and the medication will not be available for more than 2-3 days.
- The lock-in pharmacy is closed for the day, and the member needs the medication urgently.

Covered Drugs
The Wellpoint Pharmacy program utilizes the Texas Medicaid/CHIP Vendor Drug Program (VDP) formulary and Medicaid Preferred Drug List (PDL) at txvendordrug.com. The PDL is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The PDL is comprised of drug products reviewed and approved by the Texas Drug Utilization Review Board. Over-the-counter (OTC) medications specified in the Texas State Medicaid plan are included in the formulary and are covered if prescribed by a licensed prescriber. To prescribe medications listed as nonpreferred on the PDL, call Wellpoint Pharmacy at 833-731-2162 for prior authorization.

Only those drugs listed in the latest edition of the Texas Drug Code Index (TDCI) are covered. Venosets, catheters and other medical accessories are not covered and are not included when claiming for intravenous and irrigating solutions.

Except for vitamins K and D3, prenatal vitamins, fluoride preparations, and products containing iron in its various salts, we do not reimburse for vitamins and legend and nonlegend multiple-ingredient anti-anemia products. There are some additional exceptions in the VDP formulary based on the age of the member.

We may limit coverage of drugs listed in the TDCI per the VDP. Procedures used to limit utilization may include prior approval, cost containment caps or adherence to specific dosage limitations according to FDA-approved product labeling. Limitations placed on the specific drugs are indicated in the TDCI.

The following are examples of covered items:

- Legend drugs
- Insulin
- Disposable insulin needles/syringes
- Disposable blood/urine glucose/acetone testing agents
- Lancets and lancet devices
- Compounded medication of which at least one ingredient is a legend drug listed on the VDP formulary
- Any other drug, which under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber and is listed on the VDP formulary
- Legend contraceptives. Exception: Injectable contraceptives may be dispensed up to a 90-day supply

Prior Authorization Drugs
Providers are strongly encouraged to write prescriptions for preferred products as listed on the PDL. If for medical reasons a member cannot use a preferred product, providers are required to contact Wellpoint Pharmacy at 833-731-2162 to obtain prior authorization.

Examples of medications that require authorization are listed below (Note: This list is not all-inclusive and is also subject to change):

- Drugs listed as nonpreferred on the PDL or drugs that require clinical prior authorization
- Select self-administered injectable products
- Drugs that exceed certain cost and/or dosing limits (for information on these limits, contact Wellpoint Pharmacy at 833-731-2162)

Obtaining Prior Authorization
To prescribe medications that require prior authorization, submit a request online at https://covermymeds.com, by fax to 844-474-3341, or by phone at 833-731-2162. For requests by fax, submit the applicable pharmacy prior authorization form available under the Eligibility & Pharmacy tab on the provider website at provider.wellpoint.com/tx.

Providers must be prepared to supply relevant clinical information regarding the member's need for a non-PDL product or a medication requiring prior authorization. Only the prescribing physician or one of their staff representatives can request prior authorization. Decisions are based on medical necessity and are determined according to VDP-established

medical criteria. Most approved requests for prior authorization will be valid for one year, although some medications may require review more often.

Emergency Pharmacy Services
A 72-hour emergency supply of a prescribed drug can be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a PA, either because they are nonpreferred drugs on the Preferred Drug List or because they are subject to clinical edits.

A 72-hour emergency supply may be dispensed when a PA cannot be resolved within 24 hours for a medication on the Texas Vendor Drug Program (VDP) formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA because it is after the prescriber's office hours, the pharmacy should submit an emergency 72-hour prescription if the dispensing pharmacist determines it is an emergency situation. Emergency situation includes a case in which, based on the dispensing pharmacist's judgement, a member may experience a detrimental change in health status within 72 hours from when the pharmacy receives the prescription due to the inability to obtain the medication. Pharmacies should not dispense 72 hour emergency supplies on a routine basis.

A pharmacy can dispense a product packaged in a dosage form that is fixed and unbreakable, for example, an albuterol inhaler, as a 72-hour emergency supply.

To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit the following information:

- "8" in "Prior Authorization Type Code" (Field 461-EU)
- "801" in "Prior Authorization Number Submitted" (Field 462-EV)
- "3" in "Days Supply" (in the Claim segment of the billing transaction) (Field 405-D5)
- The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed (for example, an inhaler), it is still permissible to indicate that the emergency prescription is a three-day supply and enter the full quantity dispensed.

Call the CarelonRx Pharmacy Help Desk at 833-252-0329 for more information about the 72-hour emergency prescription supply policy.

Dispensing Limitations
Several drugs have dispensing limitations to ensure appropriate use. The following is an example of some limitations. For a complete list of limitations, please visit the Texas VDP formulary and PDL at txvendordrug.com:

- Prenatal vitamins limitation is for females younger than the age of 50 only.
- Anti-fungal limitation is 180-day supply per calendar year.
- Stadol limitation is 10 ml per calendar month (four bottles).
- Migraine medications limitations are across strengths per calendar month for each drug.

Excluded Drugs
The following drugs are excluded from the pharmacy benefit:

- In accordance with Section 1927 of the Social Security Act, 42 U.S.C. §1396r-8, any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program
- Drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI)
- Drugs excluded from coverage following Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8 such as:
  - Weight control products (except Xenical, which requires prior authorization)
  - Drugs used for cosmetic reasons or hair growth
  - Experimental or investigational drugs
  - Drugs used for experimental or investigational indication
  - Infertility medications
  - Erectile dysfunction drugs to treat impotence

Specialty Drug Program
We cover most specialty drugs under the pharmacy benefit, which may be obtained at any specialty pharmacy in our network. For information on specialty pharmacies, call Wellpoint Pharmacy at 833-731-2162.

The following is a list of conditions typically treated with specialty injectable drugs: growth hormone deficiency, cancer, multiple sclerosis, hemophilia, rheumatoid arthritis, hepatitis and cystic fibrosis.

Texas Prescription Monitoring Program
The Texas Prescription Monitoring Program (PMP) is used to collect and monitor prescription data for all Schedule II, III, IV, and V Controlled Substances dispensed by a pharmacy in Texas or to a Texas resident from a pharmacy located in another state. The PMP also provides a database for monitoring patient prescription history for practitioners and the ordering of Schedule II Texas Official Prescription Forms.

Pharmacists and prescribers are required to check the patient's PMP history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol. The requirement applies to all Schedule II, III, IV, and V controlled substances. The PMP must be utilized to help eliminate duplicate and overprescribing of controlled substances, as well as to obtain critical controlled substance history information.

Information on how to access the Texas PMP, including FAQs and a User Support Manual, is available on the Texas State Board of Pharmacy website at pharmacy.texas.gov/PMP/aware.asp.

Durable Medical Equipment and Other Products Normally Found in a Pharmacy
Wellpoint reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy and not covered under the nursing facility unit rate. DME covered under the NF unit rate includes: medically necessary items, such as nebulizers, ostomy supplies or bed pans, and medical accessories (such as cannulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids, IV equipment, and equipment that can be

used by more than one person, such as wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars, walkers, and oxygen equipment, such as tanks, concentrators, tubing, masks, valves, and regulators).

Preferred Blood Glucose Testing Strips
We have selected the Trividia Health TRUE METRIX® brand as our single preferred line of test strips for blood glucose testing. Pharmacies can provide Trividia Health TRUE METRIX® meters to our members who have prescriptions. Our clinical policy has several standard exceptions to our preferred product, allowing access to other brands. These exceptions include visual or dexterity impairment and use of insulin pumps not compatible with the preferred brand. We evaluate other requests for exceptions on a case-by-case basis for medical necessity. If a member needs a nonpreferred brand of test strips, a prior authorization request should be submitted by faxing a completed prior authorization form to 844-474-3341. If you have questions about prior authorization, call Wellpoint at 833-731-2162. Pharmacies can provide three-day supplies (limited to the smallest package size, typically 25 test strips) of any VDP formulary test strips while a prior authorization review is pending. Blood glucose test strips and monitors are not covered through DME providers.

4.8 Ambulance Transportation Services (Emergent)

Ambulance transportation service is a benefit when the member has an emergency medical condition. See the Emergency Services section for the definition of an emergency medical condition.

Facility-to-facility transport may be considered an emergency if emergency treatment is not available at the first facility and the member still requires emergency care. The transport must be to an appropriate facility, meaning the nearest medical facility equipped in terms of equipment, personnel, and the capacity to provide medical care for the illness or injury of the member.

Transports to out-of-locality providers (one-way transfers of 50 or more miles from the point of pickup to the point of destination) are covered if a local facility is not adequately equipped to treat the condition. Transports may be cut back to the closest appropriate facility.

4.9 Nonemergency Transportation

The nursing facility (NF) is responsible for providing routine nonemergency transportation services except for trips for dialysis services or a discharge of the member to home. The cost of such transportation is included in the NF unit rate. Transports of NF members for rehabilitative treatment (for example, physical therapy), to outpatient departments, or to physician's offices for recertification examinations for NF care are not reimbursable services by Wellpoint.

Wellpoint will provide Nonemergency Medical Transportation (NEMT) services for members who require dialysis services or are being discharged to home. Trips should be scheduled at least two business days in advance by calling 844-867-2837.

Wellpoint is responsible for authorizing nonemergency ambulance transportation for a nondual member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contra-indicated).

A physician, nursing facility, healthcare provider or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency. Requests can be faxed or submitted digitally through Availity Essentials at Availity.com, or called into Wellpoint via the contact numbers shown in the table below. All requests require clinical information to support the need for the member to be transported by nonemergent ambulance transportation. The ambulance provider may not submit an authorization request.

Transports must be limited to those situations where the transportation of the client is less costly than bringing the service to the client.

Some requests for nonemergent ambulance transportation will occur after business hours. Authorizations that meet medical necessity will be authorized retrospectively if the request is received the next business day. The request can be called in or faxed the next business day to the numbers listed in the table below.

Request type	Behavioral health facilities/ behavioral health provider and IDD members	All other members for discharge from facility to NF or from NF to a provider/facility
Urgent same day	Call 833-731-2162	Call 833-731-2162
Nonurgent requests	Fax request to 844-442-8010	Fax request to 866-249-1271

4.10 Vision Services

Coverage for STAR+PLUS nondual members may be obtained by calling Superior Vision of Texas at 866-819-4298. Services are available for member self-referral to a network vision provider for all vision benefits including an ophthalmologist or therapeutic optometrist. Members can call 800-428-8789.

Category	Benefits	Contact
STAR+PLUS nondual adult members (age 21 and older)	One eye exam and medically necessary frames and lenses or contact lenses once every 24 months	Coverage may be obtained by calling Superior Vision of Texas at 866-819-4298 for providers and 800-428-8789 for members.
STAR+PLUS dual adult members (age 21 and older)	Vision services are not covered under Medicaid Managed Care.	Not applicable

4.11 Value-Added Services

We cover extra healthcare benefits for our members. These extra benefits are also called value-added services. You can find a list of these benefits in our member handbooks at wellpoint.com/tx/medicaid. If you have problems accessing the information, please call Provider Services at 833-731-2162.

5 PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT

5.1 Utilization Management Program

Our utilization management (UM) program facilitates the delivery of the most appropriate medically necessary care, benefits, and services to our eligible members in the most appropriate setting while ensuring our members receive clinically appropriate care and services in the most efficient manner possible.

For services that require prior authorization, we make case-by-case determinations that consider the individual's healthcare needs and medical history in conjunction with nationally recognized standards of care and medical necessity criteria.

The UM program includes activities related to inpatient and ambulatory care. Through collaboration with other programs such as care coordination, discharge planning, case management and community programs, we ensure we meet the physical, behavioral and social needs of our members.

We provide medically necessary covered services to all members beginning on the member's date of enrollment, regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior healthcare services. For STAR+PLUS members, we also provide functionally necessary community long-term services and supports beginning on the member's date of enrollment, regardless of health status, pre-existing conditions, prior diagnosis, receipt of any prior healthcare services, confinement in a healthcare facility, and/or previous coverage, if any, or the reason for termination of such coverage. We do not impose any pre-existing condition limitations or exclusions or require evidence of insurability to provide coverage to any member.

Regarding UM issues, staff are available at least eight hours a day Monday through Friday during normal business hours for inbound collect or toll-free calls and can receive inbound communication by fax after normal business hours. Messages will be returned within one business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls. TDD/TTY services and language assistance services are available for members as needed, free of charge.

Medical Policies and UM Criteria can be viewed and downloaded on provider.wellpoint.com/tx by selecting Resources > Medical Policies and Clinical UM Guidelines.

For questions about the UM process, including requesting a free copy of our UM criteria, call Provider Services at 833-731-2162.

5.2 Utilization Management Decision Making Affirmative Statements

As a corporation and as individuals involved in UM decisions, the health plan is governed by the following statements:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- The health plan does not reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

5.3 Medical Policies, Clinical UM Guidelines, and Medical Drug Benefit Clinical Criteria

There are several factors that impact whether a service or procedure is covered under a member's benefit plan. Medical Policies, Clinical UM Guidelines, and Medical Drug Benefit Clinical Criteria are resources that help us determine if a procedure is medically necessary. These guidelines are available to you as a reference through the following websites:

Medical Policies & Clinical UM Guidelines

Medical Drug Benefit Clinical Criteria

In addition, the following criteria/guidelines may be used:

- *Texas Medicaid Provider Procedures Manual* (TMPPM)
- MCG Care Guidelines (based on specific provider contracts, McKesson InterQual® Level of Care criteria) are also used when no specific health plan medical policies exist.
- Carelon Medical Benefits Management (formerly known as AIM Specialty Health) guidelines are utilized for the following types of services:
    - Cardiology
    - Genetic testing
    - Radiation oncology
    - Radiology (high-tech)
    - Sleep studies

  Please refer to their website, careloninsights.com, for additional information.
- Behavioral Health uses the American Society for Addiction Medicine (ASAM) Patient Placement Criteria for substance use disorder treatment authorizations, with the exception of detoxification which uses MCG Care Guidelines.
- Superior Vision of Texas utilizes health plan criteria and guidelines for medical/surgical reviews.

Federal law, state law, contract language, including definitions and specific contract provisions/exclusions, Centers for Medicare & Medicaid (CMS) requirements as well as the *Texas Medicaid Provider Procedures Manual* (TMPPM), tmhp.com/resources/provider-manuals/tmppm, are used when determining eligibility for coverage and supersede any other UM criteria.

5.4 Prior Authorization Process

Determine if specific outpatient procedures and/or services require prior authorization through the Precertification Lookup tool, which can be found on Availity Essentials through Payer Spaces or the health plan provider website through the following link:

Precertification Lookup Tool: https://provider.Wellpoint.com/texas-provider/resources/prior-authorization-requirements/precertification-lookup

A completed prior authorization request is required to eliminate delays in processing, which includes all required documentation, current clinical information, and a signed authorization form by the requesting provider. Documentation and forms required for prior authorization requests are located on our provider website.

Prior authorization requests or notifications can be submitted digitally through Availity Essentials and is the preferred method.

Availity Essentials: Availity.com

Additional information regarding the process to submit prior authorization requests is located in the Quick Reference Information section of this manual.

Information needed for a member that is hospitalized

For services or equipment that will be necessary for the care of the hospitalized member immediately after discharge, ensure all required documentation is submitted with the request along with any required signatures to eliminate delays in processing. For additional information, please refer to the Discharge Planning section of this manual.

Submission Timelines
Initial requests for prior authorization with all supporting documentation are recommended to be submitted a minimum of three business days prior to the start of care.

For timeline exceptions, please refer to the provider website for prior authorization requirements.

Failure to comply with notification rules may result in an administrative denial. Additional information is available in the Administrative Denials section of this manual.

Prior Authorization Review
Upon receipt of a request for prior authorization, an assistant verifies eligibility and benefits prior to forwarding to the nurse or other qualified reviewer. The reviewer examines the request and supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures using criteria/guidelines. When the clinical information received meets medical necessity criteria, we issue a reference number to the requesting provider.

Prior Authorization Not Required
If a request is submitted for a service for which prior authorization is not required, the provider will receive a response stating that prior authorization is not required. This is not an approval or a guarantee of payment. Claims for services are subject to all plan provisions, limitations and patient eligibility at the time services are rendered.

Incomplete Documentation
If the prior authorization documentation is incomplete or inadequate, the reviewer is unable to process the request. In such instances, the health plan will notify the provider and member to submit the additional documentation necessary to make a decision. If no additional information is received within the designated time frame, the medical director will make a determination based on the information previously received.

Additionally, if the request does not meet criteria for approval, the requesting provider will be afforded the opportunity to discuss the case with the medical director prior to issuing the denial. For information on this process, refer to the Peer-to-Peer Review Process section of this manual.

5.5 Prior Authorization Recertification Process

A physician or healthcare provider can submit a medical prior authorization recertification request at least 60 calendar days prior to the expiration of the current authorization of service(s) on file.

Exception: The health plan requires that the following prior authorization recertification requests be received up to 30 calendar days before the expiration of the current authorized service(s):

- Physical, Occupational and Speech Therapy

5.6 Determination Timelines

Utilization review timeliness standards are as follows:

Program	Authorization Type	Decision Timeframe
Medicaid	Routine/Non-Urgent	3 business days
Medicaid	Urgent/Expedited	3 calendar days
Medicaid	Concurrent	1 business day
Medicaid	Post-service	30 calendar days

Within one hour of receiving the request for post-stabilization, life-threatening conditions, except for Emergency Medical conditions and Emergency Behavioral Health conditions where a prior authorization is not required.

Expedited Requests

A member or physician may request to expedite a determination when the member, or member's physician, believes that waiting for a decision under the standard time frame could cause any of the following:

- Serious jeopardy to the life, health, or safety or the member's ability to regain maximum function, based on a prudent layperson's judgement.
- Serious jeopardy to the life, health or safety of the member or others, due to the member's psychological state.
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- In the case of a pregnant woman, serious jeopardy to the life, health, or safety of the fetus.
- In the opinion of a practitioner with knowledge of a member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. The practitioner must be allowed to act as the authorized representative of that member.

The following situations are examples that do not meet criteria for an expedited request:

- The date of service is greater than one week from the request date
- Clinical documentation does not support criteria for an expedited request as defined above
- Any request for therapy (occupational, speech or physical therapy) greater than two days from the request date

5.7 Peer-to-Peer Review Process

If you receive a notification that a case is under review and would like to discuss the case with our medical director, please contact the applicable department shown below.

Contact Numbers:

- Physical Health: 817-861-7768
- Behavioral Health: 844-719-1806

Be prepared to provide the following information:

- Name of person/physician our medical director needs to call
- Contact number
- Convenient time for a return call
- Authorization/reference number for the case
- Member's name, DOB, and the health plan ID number

If you or your office staff reach our voicemail, leave the name of the best contact person and their phone number so we can reach out for additional information. The medical director will make every effort to return calls within one business day.

If the notification received indicates the case was denied, you may contact us within two business days of receipt of the notification to set up a peer-to-peer review for possible reconsideration. After two business days, the case will need to follow the appeal process outlined in the copy of the member denial letter received.

5.8 Administrative Denials

An administrative denial is a denial of services based on reasons other than medical necessity. Administrative denials are made when a contractual requirement is not met, such as late notification of admissions, failure to obtain a prior authorization, or benefit limitations.

If the health plan overturns its administrative decision, the case will be reviewed and, if approved, the claim will be reprocessed or the requestor will be notified of the action that needs to be taken.

5.9 Discharge Planning

Discharge planning is designed to assist the provider in the coordination of the member's discharge when acute care (hospitalization) is no longer necessary to ensure a seamless transition from the inpatient setting to outpatient services and nursing facilities to improve health outcomes for our members. Our UM clinician will help coordinate discharge planning needs with the hospital utilizations review staff and attending physician. The attending physician is expected to coordinate with the member's provider(s) regarding follow-up care after discharge, and the provider is responsible for contacting the member to schedule all necessary follow-up care.

In the case of a behavioral health discharge, the attending facility is also responsible for ensuring that the member has secured an appointment for a follow-up visit with a HEDIS® qualified behavioral health provider. The follow-up visit must occur within seven calendar days of discharge.

When additional/ongoing care is necessary after discharge, we work with the provider to plan the member's discharge to an appropriate setting for extended services. In addition to the nursing facility, these services can often be delivered in a nonhospital facility, such as:

- Hospice facility
- Convalescent facility
- Home health care program (for example, home I.V. antibiotics) or skilled nursing facility

When the provider identifies medically necessary and appropriate services for the member, we will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

For prior authorization requests for a member who is hospitalized at the time of the request, please clearly document at the top of the request to indicate that the member is hospitalized and has discharge planning needs. To eliminate delays in processing, please ensure all required documentation is submitted with the request along with any required signatures to the applicable department shown below.

Contact Numbers (fax):

- Inpatient Discharge Planning – Physical Health: 888-708-2599
- Inpatient Discharge Planning – Behavioral Health: 844-430-6805

Discharge plan authorizations for ongoing outpatient care follow nationally recognized standards of care and medical necessity criteria. Authorizations include, but are not limited to, transportation, durable medical equipment (DME), pharmacy, follow-up visits to practitioners or outpatient procedures.

6 LONG-TERM SERVICES AND SUPPORTS

The STAR+PLUS program provides an integrated approach to healthcare delivery that addresses those services members may require in the acute, behavioral, functional, social, and environmental areas. The program administers acute and long-term services and supports to the eligible populations (persons who are aged and/or persons with disabilities) through a managed care system and includes coverage for both home- and community-based care and nursing facility residential care.

Service coordination is a major feature of STAR+PLUS and involves specialized person-centered service planning for members. Service coordinators provide assistance to members, family members, member representatives and providers to develop a detailed service plan and provide the following services according to the member's needs:

- Nursing facility residential care
- Acute care
- Behavioral health
- Environmental care
- Functional care
- Home- and community-based care

6.1 STAR+PLUS Eligibility

Texas requires enrollment in STAR+PLUS managed care for most nursing facility residents age 21 and older who are enrolled in nursing facility Medicaid (dual or non-dual). Texas also requires enrollment in managed care for the adult Supplemental Security Income (SSI) population, including individuals with Medicaid only, and dually eligible individuals with Medicare and Medicaid. For more information on verifying eligibility, refer to the Verifying Member Medicaid Eligibility section.

Please note it is the provider's responsibility to ensure eligibility is verified before delivering services.

STAR+PLUS members with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program or an IDD Waiver will be covered for acute care services only under STAR+PLUS. Long-term services and supports will be provided through HHSC. A personal service coordinator will be assigned to each of these members.

Women enrolled in STAR+PLUS through eligibility for the Medicaid Breast and Cervical Cancer Program have full STAR+PLUS benefits. These members are not limited to cancer treatment only.

6.2 Member Identification Cards

Sample member identification cards for STAR+PLUS members can be found in Appendix A of this manual.

6.3 Covered Services

The services we cover under STAR+PLUS differ according to a member's eligibility for Medicare. STAR+PLUS LTSS benefits include both custodial nursing home care and community-based services. STAR+PLUS members with Medicare also have coverage for nursing facilities and certain community-based services.

The HCBS STAR+PLUS Waiver provides community-based long-term services and supports to Medicaid-eligible adults with disabilities and elderly persons as a cost-effective alternative to living in a nursing facility. Individuals who reside in a nursing facility must be age 21 or older, enrolled in Medicaid or otherwise financially eligible for waiver services.

All LTSS services must be authorized, except nursing facility custodial care. Coverage of these services is limited to members who need assistance with the activities of daily living. Some services are limited to members who meet the nursing home level of care. If you have a Wellpoint patient who needs these services, please direct them to contact Member Services at 833-731-2160 (TTY 711). Our service coordinators will assess the member's needs and develop a service plan.

6.3.1 Nondual-Eligible Members

STAR+PLUS covers acute care and LTSS benefits for nondual-eligible members (Medicaid-only clients). The Covered Services and Extra Benefits chapter has information on acute care benefits.

6.3.2 Dual-Eligible Members

Acute care for dual-eligible members is covered by Medicare or a Medicare HMO. STAR+PLUS members dually eligible for Medicare will receive most prescription drug services through Medicare rather than Medicaid. Dual-eligible members are eligible to receive coverage for LTSS covered by Wellpoint under the STAR+PLUS program.

6.3.3 STAR+PLUS Coverage Table

STAR+PLUS members get benefits for acute care such as doctor visits, hospitalizations, prescriptions, and behavioral health services, and they can also get long-term services and supports. If a member residing in a nursing facility is able to transition into the community, the types of LTSS benefits that may be available are shown in the table below. If a member does need long-term services and supports benefits, the kind of benefits they can get is based on their category of Medicaid eligibility. There are three Medicaid eligibility levels:

- Other Community Care (OCC): basic coverage
- Community First Choice (CFC): mid-level coverage
- Home- and Community-Based Services (HCBS) STAR+PLUS Waiver (SPW): highest level of coverage for members with complex need

Service types	Nondual (Medicaid only) + OCC	Nondual (Medicaid only) + CFC	Nondual (Medicaid only) + SPW	Dual Eligibles (Medicaid and Medicare) + OCC[2]	Dual Eligibles (Medicaid and Medicare) + CFC[2]	Dual Eligibles (Medicaid and Medicare) + SPW[2]
Medical/acute care (such as: doctor's visits, PT, OT, ST for acute care conditions, and hospital services) and behavioral health services[3]	Wellpoint	Wellpoint	Wellpoint	Medicare or Medicare HMO	Medicare or Medicare HMO	Medicare or Medicare HMO
Prescription drugs	Wellpoint	Wellpoint	Wellpoint	Member's chosen Part D prescription drug vendor	Member's chosen Part D prescription drug vendor	Member's chosen Part D prescription drug vendor
Medicare coinsurance and deductibles	Not applicable	Not applicable	Not applicable	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO	State's fiscal agent (TMHP) for regular Medicare; Medicare HMO)
Transportation assistance	Wellpoint	Wellpoint	Wellpoint	Wellpoint	Wellpoint	Wellpoint
Home and Community Based Long-Term Services and Supports						
Primary home care/Personal assistance services	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]
Day activity and health services (DAHS)	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]
Consumer-directed attendant care (including financial management services)	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]	Wellpoint[1]
Nursing services (in home)	N/A	N/A	Wellpoint[1]	Medicare/ Medicare HMO	Medicare/ Medicare HMO	Wellpoint[1] or Medicare/ Medicare HMO
Habilitation, acquisition, maintenance, and enhancement of skills services	N/A	Wellpoint[1]	Wellpoint[1]	N/A	Wellpoint[1]	Wellpoint[1]

Emergency response services (emergency call button)	N/A	Wellpoint[1]	Wellpoint[1]	N/A	Wellpoint[1]	Wellpoint[1]
Dental services	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Home-delivered meals	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Minor home modifications	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Adaptive aids	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Durable medical equipment	N/A	N/A	Wellpoint[1]	Medicare/ Medicare HMO	Medicare/ Medicare HMO	Wellpoint[1]
Medical supplies	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Physical, occupational and speech therapy	N/A	N/A	Wellpoint[1]	Medicare/ Medicare HMO	Medicare/ Medicare HMO	Wellpoint[1]
Adult foster care/personal home care	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Assisted living	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Transition assistance services (for members leaving a nursing facility) - $2,500 maximum	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Respite (with or without self-directed models)	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Dietitian/ nutritional assistance (for assisted living residents)	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Cognitive rehabilitation therapy	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Support consultation/ management	N/A	Wellpoint[1]	Wellpoint[1]	N/A	Wellpoint[1]	Wellpoint[1]
Employment assistance	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]
Supported employment	N/A	N/A	Wellpoint[1]	N/A	N/A	Wellpoint[1]

1 Members should contact a service coordinator or call Member Services to find out if they qualify for services.

2 Dual-eligible members (Medicaid and Medicare) are not STAR+PLUS Medicare-Medicaid Plan (MMP). MMP members will go through their MCO for Medicare-covered services.
3 For dual-eligible members, mental health targeted case management (MH TCM) and mental health rehabilitative services (MH Rehab) are covered through Fee-for-Service (FFS), but all other behavioral health services are benefits of STAR+PLUS managed care for dual-eligibles. For other behavioral health services, the Medicare plan pays first, and then if the Medicare limit is met, Wellpoint is responsible.

6.3.4 Community-based LTSS Services

STAR+PLUS nursing facility members who wish to transition to the community may qualify for community-based long-term services and supports as described in this section. The following descriptions refer to the STAR+PLUS benefits grid above. Please see the grid for additional information on benefit availability.

Primary home care/personal assistance services (PAS) are available to community-based STAR+PLUS members based on medical and functional necessity and are provided to members living in their own home and community settings. Services include but are not limited to the following:

- Assisting with the activities of daily living, such as feeding, preparing meals, transferring and toileting
- Assisting with personal maintenance, such as grooming, bathing, dressing and routine care of hair and skin
- Assisting with general household activities and chores necessary to maintain the home in a clean, sanitary, and safe environment, such as changing bed linens, housecleaning, laundering, shopping, storing purchased items and washing dishes
- Providing protective supervision
- Providing extension of therapy services
- Providing ambulation and exercise
- Assisting with medications that are normally self-administered
- Performing nursing tasks delegated by registered nurses
- Escorting the member on trips to obtain medical diagnosis, treatment, or both

Day activity and health services (DAHS) — Community-based STAR+PLUS members may receive medically and functionally necessary DAHS. DAHS includes nursing and personal care services, physical rehabilitative services, nutrition services, transportation services and other supportive services. These services are provided at facilities licensed or certified by HHSC.

Habilitation, acquisition, maintenance, and enhancement of skills training is available to CFC and SPW members to enable the member to accomplish activities of daily living, instrumental activities of daily living and other health-related tasks.

Adult foster care (AFC) is a benefit for SPW members that provides a 24-hour living arrangement in an HHSC-contracted foster home for persons who, because of physical, mental, or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, personal care, nursing

tasks, supervision, companion services, activities of daily living assistance and provision of, or arrangement for, transportation.

The SPW AFC member must reside in a SPW AFC home. Providers of AFC must live in the household and share a common living area with the member. Detached living quarters do not constitute a common living area. The individual enrolled to provide AFC must be the primary caregiver. AFC home providers may serve up to three adult residents in a qualified AFC home without being licensed as a personal care home or assisted living facility and may be the AFC home provider's home or the SPW member's home. AFC home providers with four or more residents who are also contracted with HHSC are required to have a Type C Personal Care Home license. AFC homes with four or up to eight more AFC residents who are only contracted with Wellpoint must be licensed as an assisted living facility, with limitations on the number of residents at each level who may reside in one home.

SPW members are required to pay for their own room and board costs and contribute to the cost of their care, if able, through a copay to the AFC provider.

Adaptive aids and medical supplies are covered benefits for SPW members when needs for the member to have optimal function, independence and well-being are identified and approved by the managed care organization in the individual service plan. Adaptive aids and medical supplies are specialized medical equipment and supplies, including devices, controls or appliances specified in the plan of care, that enable individuals to increase their abilities to perform activities of daily living or perceive, control or communicate with the environment in which they live. Adaptive aids and medical supplies are reimbursed with waiver funds, when specified in the individual service plan, with the goal of providing individuals a safe alternative to nursing facility (NF) placement.

This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items; and durable and nondurable medical equipment not available under the Texas State Plan, such as vehicle modifications, service animals and supplies, environmental adaptations, aids for daily living, reachers, adapted utensils, and certain types of lifts.

The annual cost limit of this service is $10,000 per waiver plan year. The $10,000 cost limit may be waived by HHSC upon request from the managed care organization.

The state allows a member to select a relative or legal guardian, other than a legally responsible individual, to be their provider for this service if the relative or legal guardian meets the requirements for this type of service.

Adaptive aids and medical supplies are limited to the most cost-effective items that can:

- Meet the member's needs.
- Directly aid the member to avoid premature NF placement.
- Provide NF residents an opportunity to return to the community.

Wellpoint must provide documentation supporting the medical need for all adaptive aids and medical supplies. The documentation must be provided by the physician, physician assistant, nurse practitioner, registered nurse, physical therapist, occupational therapist, or speech pathologist.

Adaptive aids and medical supplies are approved for purchase as a waiver service by Wellpoint only if the documentation supports the requested item(s) as being necessary and related to the member's disability or medical condition.

The HCBS STAR+PLUS Waiver program is not intended to provide every member with any and all adaptive aids or medical supplies the member may receive as a nursing facility resident. Details of items covered under this category can be found in the HHSC STAR+PLUS Handbook at:
https://hhs.texas.gov/laws-regulations/handbooks/sph/section-6000-specific-starplus-hcbs-program-services

Assisted living is a benefit for SPW members and is a 24-hour living arrangement in licensed personal care facilities in which personal care; home management; escort, social and recreational activities; 24-hour supervision; provision or arrangement of transportation; and supervision of, assistance with and direct administration of medications are provided.

Cognitive rehabilitation therapy is a service available to SPW members that assists a member in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry to enable the member to compensate for the lost cognitive functions. Cognitive rehabilitation therapy is provided when an appropriate professional assesses the member and determines it is medically necessary. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems.

Dental services for SPW members are services provided by a dentist to preserve teeth and meet the medical needs of the member. Allowable services include:

- Emergency dental treatment necessary to control bleeding, relieve pain and eliminate acute infection.
- Preventive procedures required to prevent the imminent loss of teeth.
- The treatment of injuries to teeth or supporting structures.
- Dentures and the cost of preparation and fitting.
- Routine procedures necessary to maintain good oral health.

Dental services for SPW members are limited to $5,000 per waiver plan year. This limit may be exceeded upon approval by Wellpoint up to an additional $5,000 per waiver plan year when medically necessary treatment requires the services of an oral surgeon. Wellpoint may also approve other dental services above the $5,000 waiver plan year limit on a case-by-case basis due to medical necessity, functional necessity, or the potential for improved health of the member. Wellpoint must review and approve any treatment in excess of the waiver plan year limit prior to services being rendered.

Emergency response services (emergency call button) is a benefit for SPW and CFC members. It's an electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in the community or at high risk of institutionalization. In an emergency, the member can press a call button to signal for help. The electronic monitoring

system, which has a 24-hour, seven-day-a-week capability, helps ensure the appropriate persons or service provider respond to an alarm call from the member.

Employment assistance means assistance provided to a SPW member to help the member locate paid competitive or self-employment in the community. Employment assistance includes the following:

- Identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions
- Locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements
- Contacting a prospective employer on behalf of a member and negotiating the member's employment

Employment assistance is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

Financial management services (FMS) is assistance provided to members who elect to participate in the Consumer Directed Services (CDS) option to manage funds associated with services elected for self-direction. The assistance is provided by the Financial Management Services Agency (FMSA). This includes initial orientation and ongoing training related to the responsibilities of being an employer and adhering to legal requirements for employers. A monthly administrative fee is authorized on the individual service plan and paid to the FMSA for FMS.

Home-delivered meals is a benefit for SPW members that provides nutritionally sound meals delivered to the member’s home.

Minor home modifications is a benefit for SPW members that assesses the need for, arranges for, and provides modifications and/or improvements to an individual's residence to enable the individual to reside in the community and to ensure safety, security and accessibility.

Nursing services (in-home) is a benefit for SPW members and includes but is not limited to assessing and evaluating health problems and the direct delivery of nursing tasks, providing treatments and healthcare procedures ordered by a physician and/or required by standards of professional practice or state law, delegating nursing tasks to unlicensed persons according to state rules promulgated by the Texas Board of Nursing, developing the healthcare plan and teaching individuals about proper health maintenance.

Physical therapy, occupational therapy, speech therapy are benefits for SPW members and include the full range of activities provided by an occupational therapist or a licensed occupational therapy assistant under the direction of a licensed occupational therapist, physical therapist, or a licensed physical therapy assistant under the direction of a licensed physical therapist, or by speech and language pathologists within the scope of the therapist’s state licensure.

Respite care is a benefit for SPW members and is temporary relief to persons caring for functionally impaired adults in community settings other than adult foster care homes or

assisted living facilities. Respite services are provided in-home and out-of-home and are limited to 30 days per individual service plan year.

Supported employment means assistance provided to a SPW member to sustain paid employment to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform in a work setting at which members without disabilities are employed. Supported employment includes employment adaptations, supervision and training related to a member's assessed needs and earning at least minimum wage (if not self-employed).

Supported employment is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

Support consultation services are available to SPW members participating in the CDS option. It is an optional service. A member's service planning team may recommend the service when the employer (the individual or legally authorized representative [LAR]) or the designated representative (DR) would benefit from additional support with employer responsibilities. Support consultation services must not duplicate or replace services to be delivered through a case manager, a service coordinator, the Financial Management Services Agency (FMSA) or other sources. A support advisor provides skills-specific training, assistance and supports to the employer or the employer's designated representative (DR) to meet responsibilities of the CDS option.

Examples of services a support advisor may provide include training related to recruiting and screening applicants for employment and verifying employment eligibility, assistance with developing job descriptions, coaching on problem solving and coordinating employee management activities, training on developing and implementing service backup and corrective action plans, and coaching on handling other employer responsibilities.

Support management benefits are available to Community First Choice members. Voluntary training may be received on how to select, manage, and dismiss attendants.

Transition assistance services living is a benefit for SPW members that assists members with nonrecurring set-up expenses for transitioning from nursing homes to the community. Services may include assistance with security deposits for leases on apartments or homes, essential household furnishings, set-up fees for utilities, moving expenses, pest eradication or one-time cleaning.

6.3.5 Settings for Provision of Long-Term Services and Supports Benefits

Community-based long-term services and supports (LTSS) means services provided to members in their home or other community-based settings necessary to provide assistance with activities of daily living, allowing the member to remain in the most integrated setting possible. Community-based LTSS includes services available to all STAR+PLUS members as well as those services available only to STAR+PLUS members who qualify for HCBS STAR+PLUS Waiver services.

The setting for services must ensure the individual’s rights of privacy, dignity and respect and freedom from coercion and restraint. The setting should optimize, but not regiment, individual initiative, autonomy, and independence in making life choices including but not

limited to daily activities, physical environment, and the choice of with whom to interact. The setting must facilitate individual choice regarding services and supports and who provides them.

Community-based LTSS for HCBS STAR+PLUS Waiver (SPW) and CFC must be provided in settings that allow the member an opportunity to:

- Seek employment and work in competitive integrated settings.
- Engage in community life.
- Control personal resources.
- Receive services in the community to the same degree of access as individuals not receiving Medicaid LTSS.

HCBS STAR+PLUS Waiver members should be advised about and assisted with accessing the most appropriate and least restrictive home and community-based services as alternatives to institutional care. The member must be given an opportunity to make an informed choice among the options for care settings including non-disability specific settings and an option for a private unit in a residential setting. The setting options must be:

- Identified and documented in the member's service plan.
- Based on the member's individual needs and preferences, and for residential settings, resources available for room and board.

In a provider-owned or controlled setting, the following additional rights must be given to individuals:

- The same responsibilities and protections from eviction that tenants have under state and local law
- Privacy in their sleeping or living unit, including locking doors, choice of roommates, and freedom to furnish and decorate sleeping and living areas
- Freedom and support to control schedules and activities including access to food at any time and having visitors at any time

Settings for community-based LTSS do not include:

- A nursing facility.
- An institution for mental diseases.
- An intermediate care facility for individuals with intellectual disabilities.
- A hospital.
- Any other location that has the quality of an institutional setting

6.4 Service Coordination

6.4.1 Service Coordination for STAR+PLUS Nursing Facility Residents

We provide a single identified person as a service coordinator to all STAR+PLUS members residing in a nursing facility. We assign the same service coordinator to each Wellpoint member residing at a single nursing facility based on the number of Wellpoint members residing in that facility.

Service coordinators work with the member, the member's family and/or authorized representative, nursing facility staff and providers to coordinate all STAR+PLUS covered

services and any other applicable services. Service coordinators also provide education to members and families about STAR+PLUS program resources and about their rights and responsibilities within STAR+PLUS. Service coordinators are responsible for making at least four face-to-face visits per calendar year to all STAR+PLUS members residing in a nursing facility in order to provide additional monitoring of member care needs.

The face-to-face assessment includes the following elements:

- The service coordinator shall wear their Wellpoint identification badge at all times.
- The service coordinator completes a visual check of the member's functional capacity at this time.
- The service coordinator explains the assessment process and forms to the member and/or representative.
- During the facility visit, the service coordinator assesses the member's social/environmental supports and resources. The service coordinator inquires if the member is interested in returning to the community.
- The service coordinator discusses the member's needs and whether those needs are currently being met. The service coordinator also discusses the member's current level of independence and to what level the member is able to actively participate in their own care.

At the end of the assessment process, the service coordinator closes the visit by educating the member on their role in the facility and their frequency of future visits.

We will help ensure each STAR+PLUS member has access to a PCP or physician who is responsible for overall clinical direction. The PCP/physician, in conjunction with the service coordinator, serves as a central point of integration and coordination of covered services.

Our service coordinators collaborate with the member's PCP/physician regardless of network status. To speak with a service coordinator, call Provider Services at 833-731-2162.

6.4.2 Transition Planning for STAR+PLUS Members

We will provide transition planning for STAR+PLUS members residing in a nursing facility who need or desire to return to a community-based setting. For members newly enrolled to STAR+PLUS or changing MCOs during transition planning, HHSC or the previous STAR+PLUS MCO will give us information such as detailed care plans and names of current providers. We will ensure current providers are paid for medically necessary and functionally necessary covered services that are delivered in accordance with the member's existing care plan beginning with the member's date of enrollment with Wellpoint until the transition plan is developed and implemented.

The transition planning process will include the following:

- Review of existing care plans prepared by a state agency or another STAR+PLUS MCO
- Preparation of a transition plan that ensures continuous care under the member's existing care plan during the transfer to the Wellpoint network while we conduct an appropriate assessment and development of a new plan, if needed
- If durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the date of enrollment, we will coordinate and follow

through to ensure the member receives the necessary supportive equipment and supplies without undue delay
- Payment to the existing provider of service under any existing authorization for up to six months until we have completed the assessment and service plan and issued a new authorization

We will review any existing care plan for a new member and develop a transition plan within 30 days of receiving notice of the member's enrollment. The transition plan will remain in place until we contact the member or the member's representative, and we coordinate modifications to the member's current care plan. We will ensure existing services continue and there is no break in services. For members enrolling in the STAR+PLUS program on the start date of a new service area, we will review the existing care plan and develop the transition plan within 120 days of enrollment, and we will honor existing LTSS authorizations for up to six months or until we have evaluated and assessed the member and issued new authorizations.

A transition plan will include the following:
- The member's history
- A summary of current medical, behavioral health, and social needs and concerns
- Short-term and long-term needs and goals
- A list of services required and their frequency
- A description of who will provide the services

The transition plan may include information about services outside the scope of covered services such as how to access affordable, integrated housing. We will ensure the member or the member's representative is involved in the assessment process and fully informed about options, is included in the development of the transition plan, and is in agreement with the plan when completed.

Service Coordination for STAR+PLUS Community-Based Members
For STAR+PLUS members residing in home- and community-based settings, we provide a single identified person as a service coordinator to all members who qualify as Level 1 or Level 2 under HHSC guidelines, when we determine one is required based on our assessment of the member's health and support needs, and to any member who requests service coordination services. Level 1 members include HCBS STAR+PLUS Waiver recipients, individuals with severe and persistent mental illness (SPMI), and other members with complex medical needs. Level 2 members include those members receiving LTSS for personal assistance services or day activity and health services (PAS and DAHS), members with non-SPMI behavioral health issues, Medicaid Breast and Cervical Cancer Program members, and Medicare and Medicaid dual-eligibles who do not qualify as Level 1. Level 3 members are those members who do not qualify as Level 1 or Level 2. Level 3 members are not required to have a single identified person as a service coordinator unless the member requests service coordination services.

We will help ensure each STAR+PLUS member has access to a PCP or physician who is responsible for overall clinical direction. The PCP/physician, in conjunction with the service coordinator, serves as a central point of integration and coordination of covered services.

Service coordinators work with members and providers to coordinate all STAR+PLUS covered services and any other applicable services. Our service coordinators collaborate with the member's PCP/physician regardless of network status. Members who have a Wellpoint personal service coordinator will be sent a letter to inform them of the name and contact information of their service coordinator. Providers can call 866-696-0710 (TTY 711) to get information about service coordination.

6.4.3 Discharge Planning

We will promptly assess the needs of a member discharged from a hospital, nursing facility, ICF/IID, inpatient psychiatric facility, or other care or treatment facility. Both physical and behavioral health needs, including substance use disorder treatment, will be assessed. A service coordinator will work with the member's PCP, the attending physician, the hospital, inpatient psychiatric facility, nursing facility or ICF/IID discharge planner, the member, and the member's family to assess and plan for the member's discharge, including appropriate service authorizations.

Upon receipt of notice of a member's discharge from an inpatient psychiatric facility, a service coordinator will contact the member within one business day. When long-term services and supports are needed, we will ensure the member's discharge plan includes arrangements for receiving appropriate community-based care. The service coordinator will provide information to the member, the member's family, and the member's PCP regarding all service options available to meet the member's needs in the community. For members being discharged from a nursing facility or ICF/IID to the community, we will provide timely access to service coordination and arrange for medically or functionally necessary personal care services (PCS) or nursing services.

6.4.4 Continuity of Care Transition Plan for New STAR+PLUS Members

We will provide a transition plan for a member newly enrolled with Wellpoint in the STAR+PLUS program who is already receiving long-term services and supports, including nursing facility or ICF/IID services. Either HHSC or the previous STAR+PLUS MCO will give us information, such as detailed care plans and names of current providers. We will ensure current providers are paid for medically necessary and functionally necessary covered services that are delivered in accordance with the member's existing care plan beginning with the member's date of enrollment with Wellpoint until the transition plan is developed and implemented.

The transition planning process will include the following:

- Review of existing care plans prepared by a state agency or another STAR+PLUS MCO
- Preparation of a transition plan that ensures continuous care under the member's existing care plan during the transfer to the Wellpoint network while we conduct an appropriate assessment and development of a new plan, if needed
- If durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the date of enrollment, coordination and follow-through to ensure the member receives the necessary supportive equipment and supplies without undue delay

- Payment to the existing provider of service under any existing authorization or care plan for up to six months, until we have completed an assessment and service plan and issued a new authorization.

A transition plan will include:

- The member's history.
- A summary of current medical, behavioral health, and social needs and concerns.
- Immediate, short-term and long-term needs and goals.
- A list of services required and their frequency.
- A description of who will provide the services.

The transition plan may include information about services outside the scope of covered services, such as how to access affordable, integrated housing. We will ensure the member or the member's representative is involved in the assessment process and fully informed about options, is included in the development of the transition plan and is in agreement with the plan when completed.

We will review any existing care plan for a new member and develop a transition plan within 30 days of receiving notice of the member's enrollment. The transition plan will remain in place until we contact the member or the member's representative, and we coordinate modifications to the member's current care plan. We will ensure existing services continue and there is no break in services.

For members enrolling in the STAR+PLUS program on the start date of a new service area, we will review the existing care plan and develop the transition plan within 120 days of enrollment and honor existing long-term services and supports authorizations for up to six months or until we have evaluated and assessed the member and issued new authorizations.

For members enrolling in the STAR+PLUS program in an existing service area, we will honor existing long-term services and supports authorizations for up to 90 days or until we have evaluated and assessed the member and issued new authorizations.

6.5 Applied Income

The nursing facility must make reasonable efforts to collect applied income from residents and document those efforts. The nursing facility should notify the Wellpoint service coordinator when it has made two unsuccessful attempts to collect applied income in a month. Wellpoint cannot enforce the payment of applied income by members. However, the service coordination team will provide member education and/or convene interdisciplinary team (IDT) meetings with the member or member's family/authorized representative to address the causes and risks associated with failure to pay applied income to the facility.

7 BEHAVIORAL HEALTH PROGRAM

7.1 Overview

Behavioral health services are covered services for the treatment of mental, emotional, or chemical dependency disorders. We provide coverage of medically necessary behavioral health services as indicated below.

Behavioral health-related healthcare services that:

- Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain or prevent deterioration of functioning resulting from such a disorder.
- Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral healthcare.
- Are furnished in the most appropriate and least restrictive setting in which services can be safely provided.
- Are the most appropriate level or supply of service that can safely be provided.
- Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered.
- Are not experimental or investigative.
- Are not primarily for the convenience of the member or provider.

We do not cover behavioral health services that are experimental or investigative. Covered services are not intended primarily for the convenience of the member or the provider. For more information about behavioral health services, providers should call 833-731-2162 and members should call 833-731-2160 (TTY 711).

7.2 Covered Behavioral Health Services

Medicaid-covered behavioral health services are not subject to the quantitative treatment limitations that apply under traditional, Fee-For-Service (FFS) Medicaid coverage. The services may be subject to the HMO's nonquantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 behavioral health services, including the following:

- Inpatient mental health services
- Outpatient mental health services
- Psychiatry services
- Counseling services
- Outpatient substance use disorder treatment services, including:
  - Assessment
  - Detoxification services
  - Counseling treatment
  - Medication-assisted therapy
- Residential substance use disorder treatment services, including:
  - Detoxification services
  - Room and Board
- Mental health rehabilitative services

- Mental health targeted case management

Note: Behavioral health services and supports provided as follow-up to the PASRR evaluation are not a STAR+PLUS benefit and are covered under FFS Medicaid.

7.2.1 Mental Health Rehabilitative Services and Targeted Case Management

Mental health rehabilitative services and mental health targeted case management must be available to eligible STAR+PLUS members who require these services based on the standardized Adult Needs and Strengths Assessment (ANSA).

Severe and persistent mental illness (SPMI) means a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), accompanied by:

- Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder.
- Impaired emotional or behavioral functioning that interferes substantially with the member's capacity to remain in the community without supportive treatment or services.

Mental health rehabilitative services (MHR) are those age-appropriate services determined by HHSC and federally-approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness for adults and to restore the member to their best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a member achieve a rehabilitation goal as defined in the member's rehabilitation plan.

MHR services include training and services that help the member maintain independence in the home and community, such as the following:

- Medication training and support — curriculum-based training and guidance that serves as an initial orientation for the member in understanding the nature of their mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and the increased tenure in the community
- Psychosocial rehabilitative services — social, educational, vocational, behavioral, or cognitive interventions to improve the member's potential for social relationships, occupational or educational achievement, and living skills development
- Skills training and development — skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers
- Crisis intervention — intensive, community-based one-to-one service provided to members who require services in order to control acute symptoms that place the member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting
- Day program for acute needs — short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to

stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting

Mental health targeted case management (TCM) means services designed to assist members with gaining access to needed medical, social, educational, and other services and supports. TCM services include case management for members who have SPMI (adult, 18 years of age or older).

MHR services and TCM services including any limitations to these services are described in the most current TMPPM, including the Behavioral Health, Rehabilitation, and Case Management Services Handbook. We will authorize these services using the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG), but Wellpoint is not responsible for providing any services listed in the RRUMG that are not covered services.

Texas Resilience and Recovery Utilization Management Guidelines for Adult Mental Health Services can be found at https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf.

Providers of MHR services and TCM services must use and be trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) tool to assess a member's need for services and recommend a level of care. Providers must use these tools to recommend a level of care to Wellpoint by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system. Providers must also complete the Mental Health Rehabilitative and Mental Health Targeted Case Management Services Request Form and submit the completed form to Wellpoint. A provider entity must attest to Wellpoint that the organization has the ability to provide, either directly or through subcontract, the full array of RRUMG services to members.

HHSC has established qualifications and supervisory protocols for providers of MHR and TCM services. This criteria is located in Chapter 15.1 of the *HHSC Uniform Managed Care Manual*.

Claims for MHR and TCM services do not require a denial from Medicare or other third-party insurance as a condition of payment.

7.3 Primary and Specialty Services

STAR+PLUS members have access to the following primary and specialty services:

- Behavioral health clinicians available 24 hours a day, 7 days a week to assist with identifying the most appropriate and nearest behavioral health service
- Routine or regular laboratory and ancillary medical tests or procedures to monitor behavioral health conditions of members:
    - These services are furnished by the ordering provider at a lab located at or near the provider's office; in most cases, our network of reference labs is conveniently located at or near the provider's office.

- Behavioral health case managers to coordinate with the hospital discharge planner and member to ensure appropriate outpatient services are available
- Support and assistance for network behavioral healthcare providers in contacting members within 24 hours to reschedule missed appointments

7.4 Behavioral Healthcare Provider Responsibilities

We maintain a behavioral health provider network, including psychiatrists, psychologists and other behavioral health providers experienced in serving children, adolescents, and adults. The network provides accessibility to qualified providers for all eligible individuals in the service area. Our members can self-refer to any participating behavioral health provider.

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 at provider.wellpoint.com/tx.

We will review prescribing patterns for psychotropic medications. For treatment of adults, we will base our parameters on a peer-reviewed, industry standard such as the *HHSC Psychiatric Drug Formulary* at hhs.texas.gov/providers/health-care-facilities-regulation/psychiatric-drug-formulary.

Providers who furnish routine outpatient behavioral health services must schedule appointments within the earlier of 10 business days or 14 calendar days of a request. Routine care after the initial visit must be scheduled within three weeks of a request. Providers who furnish inpatient psychiatric services must schedule outpatient follow-up and/or continuing treatment prior to a patient's discharge. The outpatient treatment must occur within seven days from the date of discharge. Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments.

PCPs should:

- Educate members with behavioral health conditions about the nature of the condition and its treatment.
- Educate members about the relationship between physical and behavioral health conditions.
- Contact a behavioral health clinician when behavioral health needs go beyond their scope of practice.

PCPs can offer behavioral health services when:

- Clinically appropriate and within the scope of their practice.
- The member's current condition is not so severe, confounding, or complex as to warrant a referral to a behavioral health provider.
- The member is willing to be treated by the PCP.

- The services rendered are within the scope of the benefit plan (for members who have Medicare, most behavioral health services are covered under the member's Medicare plan).

Behavioral health providers must:

- Refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment.
- Utilize the most current DSM multi-axial classification when assessing members; the Health and Human Services Commission (HHSC) may require the use of other assessment instruments/outcome measures in addition to the DSM; network providers must document DSM and assessment/outcome information in the member's medical record.
- Be licensed for physical healthcare services if they are provided.
- Send initial and quarterly summary reports of a member's behavioral health status to the PCP with the member's consent.

7.5 Care Continuity and Coordination Guidelines

PCPs and behavioral healthcare providers are responsible for actively coordinating and communicating continuity of care. Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. The exchange of information facilitates behavioral and medical healthcare strategies.

Our care continuity and coordination guidelines for PCPs and behavioral health providers include:

- Coordinating medical and behavioral health services with the local mental health authority (LMHA) and state psychiatric facilities regarding admission and discharge planning for members with serious emotional disorders (SED) and serious mental illness (SMI), if applicable.
- Completing and sending the member's consent for information release to the collaborating provider.
- Using the release as necessary for the administration and provision of care.
- Noting contacts and collaboration in the member's chart.
- Responding to requests for collaboration within one week or immediately if an emergency is indicated.
- Sending a copy of a completed Coordination of Care/Treatment Summary form to us and the member's PCP when the member has seen a behavioral health provider; the form can be found at provider.wellpoint.com/tx.
- Sending initial and quarterly (or more frequently, if clinically indicated) summary reports of a member's behavioral health status from the behavioral health provider to the member's PCP.
- Contacting the PCP when a behavioral health provider changes the behavioral health treatment plan.
- Contacting the behavioral health provider when the PCP determines the member's medical condition could reasonably be expected to affect the member's mental health treatment planning or outcome and documenting the information on the coordination of care/treatment summary.

7.6 Emergency Behavioral Health Services

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention and/or medical attention. And in an emergency and without immediate intervention and/or medical attention, the member would present an immediate danger to themself or others or would be rendered incapable of controlling, knowing or understanding the consequences of his or her actions.

Emergency behavioral health conditions include Emergency Detentions as defined under Chapter 573, Subchapter A, of the Texas Health and Safety Code and under Chapter 462, Subchapter C, of the Texas Health and Safety Code.

In the event of a behavioral health emergency, the safety of the member and others is paramount. The nursing facility should arrange for emergency transportation for the member to receive immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 911 should be contacted if the member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the member is any of the following:

- Suicidal.
- Homicidal.
- Violent towards others.
- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living.
- Alcohol or drug dependent with signs of severe withdrawal.

We do not require prior authorization or notification of emergency services, including emergency room and ambulance services.

7.7 Urgent Behavioral Services

An urgent behavioral health situation is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the member is not an immediate danger to himself or herself or others and is able to cooperate with treatment.

Care for non-life-threatening emergencies should be within six hours.

7.8 Prior Authorization and Referrals for Behavioral Health

Members may self-refer to any Wellpoint network behavioral health services provider. No prior authorization or referral is required from the PCP.

Providers may request prior authorization or refer members for services by:

- Visiting Availity Essentials at Availity.com. From the Availity Essentials home page, select Patient Registration, then select Authorizations & Referrals.

- Faxing information to our dedicated behavioral health fax lines at 844-430-6805 for inpatient services or 844-442-8010 for outpatient services.
- Calling Provider Services at 833-731-2162.

Our staff is available 24 hours a day, 7 days a week, 365 days a year for crisis or emergency calls and authorization requests. We are responsible for authorizing inpatient hospital services, including freestanding psychiatric facilities.

7.9 Court-ordered Services

We provide benefits for Medicaid covered services ordered by a court pursuant to the statutory citations listed in the sections below. Wellpoint will:

- Not deny, reduce, or controvert a court order for Medicaid inpatient mental health covered services for members ages 65 and older including services ordered as a condition of probation.
- Not deny, reduce, or controvert a court order for Medicaid inpatient mental health covered services for members of any age if the court-ordered services are delivered in an acute care hospital.
- Not limit substance use disorder treatment or outpatient mental health services for members of any age that are provided pursuant to a court order or required as a condition of probation.
- Not apply Wellpoint utilization management criteria through prior authorizations, concurrent reviews or retrospective reviews for services required to be covered under a court order or as a condition of probation as detailed in the sections below.
- Accept court order documents from providers at the time of an authorization request.

Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. A member who has been ordered to receive treatment pursuant to a court order can only appeal the court order through the court system.

7.9.1 Court-Ordered Psychiatric Services

We provide benefits for Medicaid covered inpatient psychiatric services to members ages 65 and older, who have been ordered to receive the services:

- By a court of competent jurisdiction including services ordered pursuant to the Texas Health and Safety Code Chapter 573, Subchapters B and C; Texas Health and Safety Code Chapter 574, Subchapters A through G; Texas Family Code Chapter 55, Subchapter D; or
- As a condition of probation.

These requirements do not apply to members who are considered incarcerated as defined by UMCM *Chapter 16.1*, *Section 16.1.15.2*.

7.9.2 Court-Ordered Substance Use Disorder Treatment Services

We provide benefits for Medicaid covered substance use disorder treatment services, including residential treatment, required as a:

- Court order consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code, or
- Condition of probation.

These requirements do not apply to members who are considered incarcerated as defined by UMCM *Chapter 16.1*, *Section 16.1.15.2*.

8 MEMBER RIGHTS AND RESPONSIBILITIES

8.1 Member's Right to Designate an OB/GYN

Wellpoint allows the member to pick any Wellpoint OB/GYN, whether that doctor is in the same network as the member's primary care provider or not.

The following language or similar information is included in member handbooks:

ATTENTION FEMALE MEMBERS
Members have the right to pick an OB/GYN without a referral from their primary care provider. An OB/GYN can give the member:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- A referral to a specialist doctor within the network.

For members who also have Medicare, an OB/GYN is selected from Medicare plan providers.

8.2 Member Rights and Responsibilities

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change your health plan and your primary care provider.
    b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
    c. Change your primary care provider.
    d. Change your health plan without penalty.
    e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
    a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
    b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with your provider in deciding what health care is best for you.

    b. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, external medical reviews, and state fair hearings. That includes the right to:
    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
    b. Get a timely answer to your complaint.
    c. Use the plan's appeal process and be told how to use it.
    d. Ask for an external medical review and state fair hearing from the state Medicaid program and get information about how that process works.
    e. Ask for a state fair hearing without an external medical review from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    b. Get medical care in a timely manner.
    c. Be able to get in and out of a health care provider's office. This includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
    e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

MEMBER RESPONSIBILITIES:

A. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
    c. Learn what choices of health plans are available in your area.
B. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
    a. Learn and follow your health plan's rules and Medicaid rules.
    b. Choose your health plan and a primary care provider quickly.

    c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your primary care provider first for your nonemergency medical needs.
    g. Understand when you should and should not go to the emergency room.

C. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
    a. Tell your primary care provider about your health.
    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    c. Help your providers get your medical records.

D. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
    a. Work as a team with your provider in deciding what health care is best for you.
    b. Understand how the things you do can affect your health.
    c. Do the best you can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to your provider about all of your medications.

Additional member responsibilities while using NEMT services:

1. When requesting NEMT services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT services to travel to and from your medical appointments.
7. If you have arranged for an NEMT service but something changes and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

9 COMPLAINTS, APPEALS AND PROVIDER DISPUTES

We offer five distinct complaint and appeal processes:

- Member complaints
- Member appeals
- Provider complaints
- Provider payment disputes
- Provider medical appeals

9.1 Member Complaints and Appeals

Medicaid 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). Each of these resources also works with the member to monitor the process through resolution.

9.1.1 Member Complaints and Appeals Definitions

Adverse benefit determination:

1) The denial or limited authorization of a member or provider requested service, including: the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit
2) Reduction, suspension, or termination of a previously authorized service
3) Denial, in whole or in part, of payment of service
4) Failure to provide services in a timely manner, as defined and determined by the State
5) Failure of an MCO to act within the timeframes provided in the State contract and 42 CFR §438.408(b);
6) For a resident of a rural area with only one MCO, the denial of a Medicaid member's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network
7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities

Appeal: means the formal process by which a member or their authorized representative requests a review of the health plan's adverse benefit determination as defined above

Complainant: any member (family member or caregiver of a member), provider, or other person or agency designated to act on behalf of the member (including the state's Medicaid Managed Care Division or the State's Ombudsman Program) who files a complaint

Complaint: An expression of dissatisfaction (orally or in writing) to the health plan by a complainant about any matter related to the health plan other than an adverse benefit determination as defined in this section. Possible subjects for complaints include:

- Quality of care or services provided.
- Aspects of interpersonal relationships, such as rudeness of a provider or employee.
- Failure of a provider or employee(s) to respect a member's rights regardless of whether remedial action is requested.

Complaint includes the member's right to dispute an extension of time proposed by the health plan to make an authorization decision. A complainant's oral or written dissatisfaction with an adverse benefit determination is considered a request for an appeal.

Designated (authorized) representative: Any person or entity acting on behalf of the member and with the member's written consent.

9.1.2 Member Complaint Resolution

The following language or similar information appears in our member handbook:

What should I do if I have a complaint? Who do I call?
We want to help. If you have a complaint, please call us toll free at 833-731-2160 (TTY 711) to tell us about your problem. A Wellpoint Member Services representative or a member advocate can help you file a complaint. Just call 833-731-2160. Most of the time, we can help you right away or at the most within a few days. Wellpoint cannot take any action against you as a result of you filing a complaint.

Can someone from Wellpoint help me file a complaint?
Yes, a member advocate or a Member Services representative can help you file a complaint with us or with the appropriate state program. Please call Member Services at 833-731-2160 (TTY 711).

How long will it take to process my complaint?
Wellpoint will answer your complaint within 30 days from the date we get it.

If your complaint is about an ongoing emergency or hospital stay, it will be resolved as quickly as needed for the urgency of your case and no later than one business day from when we receive your complaint.

What are the requirements and time frames for filing a complaint?
You can tell us about your complaint by calling us or writing us. We will send you a letter within five business days of getting your complaint. This means that we have your complaint and have started to look at it. We will include a complaint form with our letter if your complaint was made by telephone. You must fill out this form and mail it back to us. If you need help filling out the complaint form, please call Member Services.

How do I file a complaint with the Health and Human Services Commission once I have gone through the Wellpoint complaint process?
Once you have gone through the Wellpoint complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free 866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-32474

If you can get on the internet, you can submit your complaint at hhs.texas.gov/managed-care-help.

You can also file a complaint with the state's long-term care ombudsman at ltc.ombudsman@hhs.texas.gov or 800-252-2412. For more information about filing a complaint with the state's long-term care ombudsman, go to https://apps.hhs.texas.gov/news_info/ombudsman.

If you file a complaint, Wellpoint will not hold it against you. We will still be here to help you get quality health care.

Do I have the right to meet with a complaint appeal panel?
Yes. If you're not happy with the answer to your complaint, you can ask us to look at it again. You must ask for a complaint appeal panel in writing. Write to us at:

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

When we get your request, we'll send you a letter within five business days. This means we have your request and started to work on it. You can also call us at 833-731-2160 (TTY 711) to ask for a complaint appeal panel request form. You must complete the form and return it to us.

We'll have a meeting with Wellpoint staff, providers in the health plan and other Wellpoint members to look at your complaint. We'll try to find a day and time for the meeting so you can be there. You can bring someone to the meeting if you want to. You don't have to come to the meeting. We'll send you a letter at least five business days before the complaint appeal panel meeting. The letter will have the date, time, and place of the meeting. We'll send you all of the information the panel will look at during the meeting.

We'll send you a letter within 30 days of getting your written request. The letter will tell you the complaint appeal panel's final decision. This letter will also give you the information the panel used to make its decision.

9.1.3 Member Medical Appeal Process and Procedures

Wellpoint has established and maintains a system for resolving dissatisfaction with actions regarding the denial or limitation of coverage of healthcare services filed by a member or a provider acting on behalf of a member. This process is called a member appeal.

Note: Medical appeals do not apply to nonmedical issues. Nonmedical concerns are classified as complaints.

What can I do if the MCO denies or limits my member's request for a covered service?

Medicaid Appeal Process — the following language or similar information describing the appeals process appears in our member handbook:

What can I do if my doctor asks for a service or medicine for me that's covered but Wellpoint denies it or limits it?

There may be times when Wellpoint says we will not pay for all or part of the care that has been recommended. You have the right to ask for an appeal. An appeal is when you or your designated representative asks Wellpoint to look again at the care your doctor asked for and we said we will not pay for. A designated representative can be a family member, your provider, an attorney, a friend, or any person you choose.

If you ask someone (a designated representative) to file an appeal for you, you must also send a letter to Wellpoint to let us know you have chosen a person to represent you. Wellpoint must have this written letter to be able to consider this person as your representative. We do this for your privacy and security.

You can appeal our decision orally or in writing:

- You can call Member Services at 833-731-2160 (TTY 711).
- You can send us a letter or the request form included with our decision letter to:
  Wellpoint Appeals
  P.O. Box 62429
  Virginia Beach, VA 23466-2429

How will I find out if services are denied?
If we deny services, we will send you a letter at the same time the denial is made.

What are the time frames for the appeals process?
You or a designated representative can file an appeal. You must do this within 60 days of the date of the first letter from Wellpoint saying we will not pay for or cover all or part of the recommended care.

When we get your letter or call, we will send you a letter within five business days. This letter will let you know we got your appeal. We will also let you know if we need any other information to process your appeal. Wellpoint will contact your doctor if we need medical information about the service.

A doctor who has not seen the case before will look at your appeal. They will decide how we should handle the appeal.

We will send you a letter with the answer to your appeal. We will do this within 30 calendar days from when we get your appeal unless we need more information from you or the person you asked to file the appeal for you. If we need more information, we may extend the appeals process for 14 days if the delay is in your best interest. If we extend the appeals process, we will let you know in writing the reason for the delay. You may also ask us to extend the process if you know more information that we should consider.

How can I continue receiving services that were already approved?
You have 60 days to file an appeal from the date of the decision letter. To continue receiving services that have already been approved by Wellpoint but may be part of the reason for your appeal, you must file a request for continuation of benefits on or before the later of:

- Ten days after we send the notice to you to let you know we will not pay for or cover all or part of the care.
- The date the notice says the service will end.

If the decision on your appeal upholds our first decision, you may be asked to pay for the services you received during the appeals process.

If the decision on your appeal reverses our first decision, Wellpoint will pay for the services you received while your appeal was pending.

Can someone from Wellpoint help me file an appeal?
Yes, a member advocate or Member Services representative can help you file an appeal with Wellpoint or with the appropriate state program. Please call Member Services toll-free at 833-731-2160 (TTY 711).

Can members request an external medical review and state fair hearing?
Yes, you can ask for an external medical review and state fair hearing after the Wellpoint internal appeal process is complete. Your request must be made within 120 days of the date of our appeal decision letter. An external medical review cannot be requested without a state fair hearing but you can withdraw your request for the hearing after you get the external medical review decision.

Can members request a state fair hearing only?
Yes, you can ask for a state fair hearing without an external medical review after the Wellpoint internal appeal process is complete. Your request must be made within 120 days of the date of our appeal decision letter.

9.1.4 Emergency Medical Appeals

An emergency medical appeal will be performed when appropriate. A member can request an emergency medical appeal in cases where time expended in the standard resolution could jeopardize the member's life, health, or ability to attain, maintain or regain maximum function. An emergency medical appeal concerns a decision or action by Wellpoint that relates to:

- Healthcare services including but not limited to procedures or treatments for a member with an ongoing course of treatment ordered by a healthcare provider, the denial of which, in the provider's opinion, could significantly increase the risk to a member's health or life.
- A treatment referral, services, procedure, or other healthcare service that if denied could significantly increase risk to a member's health or life.

The following language or similar information appears in our member handbooks:

What is an emergency appeal?
An emergency appeal is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for an emergency appeal? Does my request have to be in writing?
You or the person you ask to file an appeal for you can request an emergency appeal. You can request an emergency appeal orally or in writing.

- You can call Member Services at 833-731-2160 (TTY 711).
- You can send us a letter or the request form included with our decision letter to:

Wellpoint Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

What are the time frames for an emergency appeal?
After we get your letter or call and agree your request for an appeal should be expedited, we will call and send you a letter with the answer to your appeal. We will do this within 72 hours from receipt of your appeal request.

If your appeal relates to an ongoing emergency or hospital stay, we will call you with an answer within one business day or 72 hours, whichever is shorter. We will also send you a letter with the answer to your appeal within 72 hours.

What happens if Wellpoint denies the request for an emergency appeal?
If we do not agree that your request for an appeal should be expedited, we will call you right away. We will send you a letter within two calendar days to let you know how the decision was made and that your appeal will be reviewed through the standard review process.

Who can help me file an emergency appeal?
A member advocate or Member Services representative can help you file an emergency appeal. Please call Member Services toll-free at 833-731-2160 (TTY 711).

9.1.5 State Fair Hearing and External Medical Review Information

Can a member ask for a state fair hearing?
If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the member has the right to ask for a state fair hearing. The member may name someone to represent them by contacting the health plan in writing and giving the name of the person the member wants to represent him or her. A provider may be the member's representative. The member or the member's representative must ask for the state fair hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the member does not ask for the state fair hearing within 120 days, the member may lose his or her right to a state fair hearing. To ask for a state fair hearing, the member or the member's representative should send a letter to the health plan at:

Wellpoint State Fair Hearing/EMR Coordinator
P.O. Box 62429
Virginia Beach, VA 23466-2429

Or call Member Services at 833-731-2160 (TTY 711).

If the member asks for a state fair hearing within 10 days from the time the health plan mails the appeal decision letter, the member has the right to keep getting any service the health plan denied at least until the final hearing decision is made. If the member does not request a state fair hearing within 10 days from the time the health plan mails the appeal decision letter, the service the health plan denied will be stopped.

If the member asks for a state fair hearing, the member will get a packet of information letting the member know the date, time, and location of the hearing. Most state fair hearings are held by telephone. At that time, the member or the member's representative can tell why the member needs the service the health plan denied.

HHSC will give the member a final decision within 90 days from the date the member asked for the hearing.

Can a member ask for an external medical review?
If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the member has the right to ask for an external medical review. An external medical review is an optional, extra step the member can take to get the case reviewed for free before the state fair hearing. The member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the member wants to represent him or her. A provider may be the member's representative if the provider is named as the member's authorized representative. The member or the member's representative must ask for the external medical review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the member does not ask for the external medical review within 120 days, the member may lose their right to an external medical review. To ask for an external medical review, the member or the member's representative should either:

- Fill out the *State Fair Hearing and External Medical Review Request Form* provided as an attachment to the member notice of MCO internal appeal decision letter and mail or fax it to Wellpoint by using the address or fax number at the top of the form;
- Call Wellpoint at 833-731-2160 (TTY 711).

If the member asks for an external medical review within 10 days from the time the health plan mails the appeal decision letter, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final state fair hearing decision is made. If the member does not request an external medical review within 10 days from the time the health plan mails the appeal decision letter, the service the health plan denied will be stopped.

The member, the member's authorized representative, or the member's LAR may withdraw the member's request for an external medical review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the external medical review request. The member, the member's authorized representative, or the member's LAR must submit the request to withdraw the external medical review using one of the following methods: 1) in writing, via United States mail, email, or fax; or 2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an external medical review based on functional necessity or medical necessity. An external medical review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the external medical review decision is received, the member has the right to withdraw the state fair hearing request. The member may withdraw a state fair hearing

request orally or in writing by contacting the hearings officer listed on *Form 4803, Notice of Hearing*.

If the member continues with a state fair hearing and the state fair hearing decision is different from the Independent Review Organization decision, it is the state fair hearing decision that is final. The state fair hearing decision can only uphold or increase member benefits from the Independent Review Organization decision.

Can a member ask for an emergency external medical review?
If a member believes that waiting for a standard external medical review will seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function, the member or member's representative may ask for an emergency external medical review and emergency state fair hearing by writing or calling Wellpoint. To qualify for an emergency external medical review and emergency state fair hearing, the member must first complete the Wellpoint internal appeals process.

9.1.6 Medicaid Continuation of Benefits

Wellpoint members may request a continuation of their benefits during the medical appeal process by contacting Wellpoint Member Services at 833-731-2160 (TTY 711). To ensure continuation of currently authorized services, the member (or person acting on behalf of the member) must file an appeal with continuation of benefits request by the later of:

- Ten days following the date Wellpoint sends the notice of adverse benefit determination.
- The intended effective date of the adverse benefit determination as stated in the letter.

Wellpoint will continue the member's coverage of benefits if all the following conditions are met:

- The member or the member's representative files the appeal timely (within 60 days of the date of the initial notice of adverse benefit determination).
- The appeal involves the termination, suspension, or reduction of previously authorized services.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The member or the member's representative timely requests continuation of benefits as defined in the previous paragraph.

If, at the member's request, Wellpoint continues or reinstates the benefits while the appeal is pending, the benefits will be continued until one of the following occurs:

- The member withdraws the appeal or request for the state fair hearing.
- Ten days pass after Wellpoint mails the appeal determination letter unless the member has, within the 10 days, requested a state fair hearing with continuation of benefits either with or without an external medical review.
- A State Fair Hearing Officer issues a hearing decision adverse to the member.

The member may be responsible for the continued benefits if the final determination of the appeal or state fair hearing is not in their favor. If the final determination of the appeal or

state fair hearing is in the member's favor, Wellpoint will authorize coverage of and arrange for disputed services as expeditiously as the member's health condition requires but no later than 72 hours after receipt of notice reversing the determination. If the final determination is in the member's favor and the member received the disputed services, Wellpoint will pay for those services.

9.1.7 Appealing Nursing Facility Level of Care Determinations

Medicaid nursing facility residents have the right to appeal level of care determinations issued by TMHP as part of the minimum data set (MDS) medical necessity level of care determination. The appeal request must be filed within 10 business days of receiving written notification of the medical necessity denial in order to continue nursing facility coverage. The appeal request must be filed within 90 calendar days of the medical necessity denial in order to maintain the right to a state fair hearing. Wellpoint is not responsible for issuing MDS level of care determinations, but we will assist members in the process of filing an appeal with HHSC if the resident contests the denial of medical necessity for nursing facility care. Wellpoint will coordinate with HHSC and with TMHP to continue coverage and reimbursement for nursing facility unit rate services as appropriate during appeal and fair hearing processes.

9.2 Provider Complaints, Payment Disputes and Medical Appeals

9.2.1 Provider Complaint Resolution

Wellpoint maintains a system for tracking and resolving provider complaints pertaining to administrative issues and nonpayment-related matters within 30 calendar days of receipt. Wellpoint accepts provider complaints verbally through Provider Services at 833-731-2162 or through local health plan Provider Relations representatives. Written provider complaints should be submitted to:

Wellpoint
P.O. Box 61789
Virginia Beach, VA 23466-1789

Written complaints may also be sent to the attention of the Provider Relations department of the local health plan or faxed to 844-664-7179. Complaints may be sent by email to TXProviderRelations@Wellpoint.com or via the provider website at provider.wellpoint.com/tx. When submitting complaint information, we recommend providers retain all documentation including fax cover pages, email correspondence and logs of telephone communications at least until the complaint is resolved.

Wellpoint will contact the complainant by telephone, email or in writing within 30 calendar days of receipt of the complaint with the resolution.

Wellpoint will not cease coverage of care pending a complaint investigation. If a provider is not satisfied with the resolution of the complaint by Wellpoint, the provider may complain to the state. A complaint to the state should contain a written explanation of the provider's position on the issue and be accompanied by all materials related to the complaint including medical records and the written response from Wellpoint. Medicaid complaints may be sent to:

Texas Health and Human Services Commission
MCCO Research and Resolution
P.O. Box 149030, MC:0210
Austin, TX 78714-9030
ATTN: Resolution Services

9.2.2 Provider Claim Payment Disputes

Provider Claim Payment Dispute Process
If you disagree with the outcome of a claim, you may utilize the Wellpoint provider payment dispute process. The simplest way to define a claim payment dispute is when a claim is finalized, but you disagree with the outcome.

Please be aware there are four common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, we've defined them briefly here:

- Claim inquiry: a question about a claim but not a request to change a claim payment
- Claims correspondence: when Wellpoint requests further information to finalize a claim; typically includes medical records, itemized bills, or information about other insurance a member may have
- Member medical necessity appeals: a pre-service appeal for a denied service
- Provider medical appeals: a post-service medical appeal for a denied service

For more information on each of these, please refer to the appropriate section in this chapter of the provider manual.

The Wellpoint provider claim payment dispute process consists of two internal options. You will not be penalized for filing a claim payment dispute, and no action is required by the member.

1. Claim payment reconsideration: This is a convenient option in the Wellpoint provider claim payment dispute process. The reconsideration is an initial request for an investigation into the outcome of the claim. Most issues are resolved with a claim payment reconsideration.
2. Claim payment appeal: This is an additional option in the Wellpoint provider claim payment dispute process. If you disagree with the outcome of a reconsideration or you choose not to ask for a reconsideration, you may request a claim payment appeal. Please note: If you did not ask for a claim payment reconsideration first, this will be the only internal appeal option available for your dispute.

For a claim payment appeal decision in which the denial is upheld, the provider should review the *Participating Provider Agreement* for any other available methods of dispute resolution. The provider may also file a complaint with HHSC.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment.
- Disagreements over reduced or zero-paid claims.
- Other health insurance denial.
- Claim code editing.

- Duplicate claim.
- Retro-eligibility.
- Experimental/investigational procedure.
- Claim data.
- Timely filing.*

* We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

Claim Payment Reconsideration: The first available option in the Wellpoint claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally, or online through Availity Essentials at Availity.com within 120 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). Reconsiderations filed more than 120 calendar days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect.

Wellpoint will resolve the claim payment reconsideration within 30 calendar days of receipt. We will send you a decision in a determination letter, which will include:

- A statement of the provider's reconsideration request.
- A statement of what action Wellpoint intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.
- An explanation of the provider's right to request a claim payment appeal within 30 calendar days of the date of the reconsideration determination letter or 120 calendar days from the original *EOP* if later.
- How to submit a claim payment appeal.

If the decision results in a claim adjustment, any payment and the *EOP* will be sent separately.

Claim Payment Appeal
If you are dissatisfied with the outcome of a reconsideration determination or if you wish to bypass the reconsideration process altogether, you may submit a claim payment appeal.

We accept claim payment appeals online through Availity Essentials at Availity.com or in writing within the later of either:

- 30 calendar days from the date on the reconsideration determination letter or
- 120 calendar days from the date of the original *EOP*

Claim payment appeals received later than these time frames will be considered untimely and upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the original denial or reconsideration determination was in error.

Wellpoint will resolve the claim payment appeal within 30 calendar days of receipt. We will send you a decision in a determination letter, which will include:

- A statement of the provider's claim payment appeal request.
- A statement of what action Wellpoint intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, claims, codes, or provider manual references.

If the decision results in a claim adjustment, any payment and the *EOP* will be sent separately.

How to Submit a Claim Payment Dispute
We have several options to file a claim payment dispute:

- Online (for reconsiderations and claim payment appeals): Use the secure Availity Provider Payment Appeal Tool at Availity.com. Through Availity Essentials, you can upload supporting documentation and will receive immediate acknowledgement of your submission. Locate the claim you want to dispute on Availity Essentials using Claim Status from the *Claims & Payments* menu. If available, select Dispute Claim to initiate the dispute. Go to Request to navigate directly to the initiated dispute in the appeals dashboard to add the documentation and submit.
- Verbally (for reconsiderations only): Call Provider Services at 833-731-2162.
- Written (for reconsiderations and claim payment appeals): Mail all required documentation (see below for more details), including the *Provider Payment Dispute and Claim Correspondence Submission Form* to:
  Payment Dispute Unit
  Wellpoint
  P.O. Box 61599
  Virginia Beach, VA 23466-1599
- Fax (for reconsiderations and claim payment appeals) all required documentation to 844-756-4607

9.3 Required Documentation for Claim Payment Disputes

Wellpoint requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their Wellpoint or Medicaid ID number
- A listing of disputed claims, which should include the Wellpoint claim number and the date(s) of service(s)
- All supporting statements and documentation

When submitting a payment dispute, we recommend providers retain all documentation including fax cover pages, email correspondence and logs of telephone communications at least until the dispute is resolved.

Claim Inquiries
A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of a claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Relations program helps you with claim inquiries. Just call 833-731-2162 and select the *Claims* prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence
Claim correspondence is different from a payment dispute. Correspondence is when Wellpoint requires more information to finalize a claim. Typically, Wellpoint makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Wellpoint will use it to reprocess the claim.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of issue	What do i need to do?
EDI rejected claim(s)	Contact Availity Client Services with any questions at 800-Availity (282-4548)
EOP Requests for supporting documentation (*Sterilization/ Hysterectomy/Abortion Consent Forms*, itemized bills, and invoices)	Submit a Provider Payment Dispute and Claim Correspondence Submission Form, a copy of your EOP and the supporting documentation to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP requests for medical records	Submit a Provider Payment Dispute and Claim Correspondence Submission Form, a copy of your EOP and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to submit a corrected claim due to errors or changes on original submission	Submit a Provider Payment Dispute and Claim Correspondence Submission Form and your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Type of issue	What do i need to do?
	Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 120 calendar days of the *EOP*. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Wellpoint to adjust the other health insurance (OHI) payment information, the 95-day timely filing period starts with the date of the most recent OHI *EOB*.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a Provider Payment Dispute and Claim Correspondence Submission Form, a copy of your EOP and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency room payment review	Submit a Provider Payment Dispute and Claim Correspondence Submission Form, a copy of your EOP and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Member Medical Necessity Appeals
A member medical necessity appeal refers to a situation in which an authorization for a service was denied prior to the service. Member medical necessity appeals/prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the Member Medical Appeal Process and Procedures section of this chapter.

Provider Medical Appeals
This type of appeal is available to providers with respect to a denial of services that have already been provided to the member and determined to be not medically necessary or appropriate. These appeals do not include member medical necessity appeals as described in the Member Medical Appeal Process and Procedures section of this chapter.

Provider medical appeals should be submitted in writing to:
Wellpoint
Appeals Team
P.O. Box 61599
Virginia Beach, VA 23466-1599

A provider must file a medical appeal within 120 calendar days of the date of the denial letter or *EOP* (the earlier date if both apply). The appeal must include an explanation of what is being appealed and why. Appropriate supporting documentation must be attached to the appeal request.

The appeals team will research and determine the current status of a medical appeal. A determination will be made based on the available documentation submitted with the appeal and a review of Wellpoint systems, policies, and contracts. Appeals received with supporting clinical documentation will be retrospectively reviewed by a registered/licensed nurse. Established clinical criteria will be applied to the appeal. After retrospective review,

the appeal may be approved or forwarded to the plan medical director for further review and resolution.

The results of the review will be communicated in a written decision to the provider within 30 calendar days of our receipt of the appeal. If the appeal is approved, the provider will receive a denial overturn letter. An upheld denial of services decision receives an appeal determination letter. The determination letter includes the following:

- A statement of the provider's appeal
- The reviewer's decision, along with a detailed explanation of the contractual and/or medical basis for such decision
- A description of the evidence or documentation that supports the decision
- A description of the method to obtain a second level internal review

If a provider is dissatisfied with the appeal resolution, they may file a second-level appeal. This must be a written appeal submitted within 30 calendar days of the date of the first-level determination letter. The case is handled by reviewers not involved in the first-level review. The results of the review are communicated in a written decision to the provider within 30 calendar days of receipt of the appeal. If the appeal is approved, the provider will receive a denial overturn letter. An upheld denial of services decision receives an appeal determination letter. For a decision in which the denial was upheld, the provider should review the *Participating Provider Agreement* for any other available methods of dispute resolution. The provider may also file a complaint with HHSC.

9.4 Provider Appeal Process to HHSC (Related to Claim Recoupment due to Member Disenrollment)

A provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating the appeal is related to a managed care disenrollment/recoupment and the provider is requesting an Exception Request.
- The Explanation of Benefits (EOB) showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- The EOB showing the recoupment and/or the plan's "demand" letter for recoupment. If sending the demand letter, it must identify the client name, identification number, DOS and recoupment amount. The information should match the payment EOB.
- Completed clean claim. All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, TX 78720-4077

10 PROVIDER RIGHTS AND RESPONSIBILITIES

10.1 Providers' Bill of Rights

Each healthcare provider who contracts with HHSC or subcontracts with Wellpoint to furnish services to members will be assured of the following rights:

- To not be prohibited (when acting within the lawful scope of practice) from advising or advocating on behalf of a member who is their patient for the following:
  - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
  - Any information the member needs in order to decide among all relevant treatment options
  - The risks, benefits, and consequences of treatment or nontreatment
  - The member's right to participate in decisions regarding their healthcare, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the complaint, appeal, external medical review, and state fair hearing procedures
- To have access to Wellpoint policies and procedures covering the authorization of services
- To be notified of any decision by Wellpoint to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of a Medicaid member, the denial of coverage of or payment for medical assistance
- To be assured that Wellpoint provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of their license or certification under applicable state law solely on the basis of that license or certification

10.2 Network Provider General Responsibilities

Each healthcare provider contracted with Wellpoint has the following general responsibilities:

- Provide Wellpoint members with a professionally recognized level of care and efficacy consistent with community standards, compliant with Wellpoint clinical and nonclinical guidelines and within the practice of your professional license
- Treat all Wellpoint members in a fair and nondiscriminatory manner and with respect and consideration
- Abide by the terms of your Wellpoint Participating Provider Agreement
- Comply with all Wellpoint policies and procedures including those found in this provider manual and any future updates or supplements
- Facilitate inpatient and ambulatory care services at in-network facilities
- Arrange referrals for care and service within the Wellpoint network

- Verify member eligibility and obtain prior authorization for services as required by Wellpoint
- Notify Wellpoint immediately if unable to render authorized services to the full extent authorized
- Ensure members understand the right to obtain medication from any network pharmacy
- Maintain confidential medical records consistent with Wellpoint medical records guidelines, as outlined in the Member Record Standards section of this manual and applicable *HIPAA* regulations
- Maintain a facility that promotes patient safety
- Participate in the Wellpoint Quality Improvement Program initiatives
- Participate in provider orientations and continuing education
- Abide by the ethical principles of your profession
- Notify Wellpoint if you are undergoing any type of legal or regulatory investigation or if you have agreed to a written order issued by the state licensing agency for your profession
- Notify Wellpoint if a member has a change in eligibility status by contacting Provider Services
- Maintain professional liability insurance in an amount that meets Wellpoint credentialing requirements and/or state mandated requirements
- Notify promptly both Wellpoint and the HHSC administrative services contractor of any changes to the provider's physical address or remittance address, telephone number, tax identification number, group affiliation, or any other change that affects provider directory information
- Immediately notify the HHSC administrative services contractor of demographic changes when requested by Wellpoint

10.2.1 Update enrollment and demographic information with TMHP

Texas Medicaid & Healthcare Partnership (TMHP) is the provider enrollment administrator for HHSC and serves as the authoritative source for HHSC providers' enrollment and demographic information. Once you update your enrollment and demographic information with TMHP, your data will be reconciled with the demographic information on file with the managed care organizations (MCOs).

You can also contact TMHP directly at 800-925-9126 for assistance.

10.2.2 Reporting abuse, neglect, or exploitation (ANE) — Medicaid managed care

Report Suspected Abuse, Neglect and Exploitation:
MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to the Health and Human Services Commission (HHSC) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities
- Assisted living facilities
- Home and Community Support Services Agencies (HCSSAs) — Providers are required to report allegations of ANE to both DFPS and HHSC
- Adult day care centers, or
- Licensed adult foster care providers

Contact HHSC at 800-458-9858.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
  - Home and Community Support Services Agencies (HCSSAs) — also required to report any HCSSA allegation to HHSC
  - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
  - Local intellectual and developmental disability authority (LIDDA), Local mental health authority (LMHAs), community center, or mental health facility operated by the Department of State Health Services
  - A person who contracts with a Medicaid managed care organization to provide behavioral health services;
  - A managed care organization;
  - An officer, employee, agent, contractor or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at 800-252-5400 or, in nonemergency situations, online at txabusehotline.org.

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHSC or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHSC or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.053; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).

- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

10.3 Nursing Facility Responsibilities

It is the responsibility of the nursing facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the member as defined by and in accordance with the comprehensive assessment and plan of care.

In addition, nursing facilities are responsible for but not limited to the following:

- Contacting us to verify member eligibility
- Obtaining prior authorization for services requiring prior authorization
- Coordinating Medicaid/Medicare benefits
- Notifying us of changes in members' physical condition or eligibility within one business day of identification
- Collaborating with the Wellpoint service coordinator in managing members' healthcare
- Managing continuity of care for members
- Documenting coordination of referrals and services provided between primary care providers and specialists
- Allowing Wellpoint service coordinators and other key personnel access to Wellpoint members and complete medical records information:
    - Medical records documentation must comply with the timelines, definitions, formats, and instructions specified by HHSC.
    - Medical records must be made available within three business days of request by Wellpoint.
    - If at the time of request for access to medical records HHSC or OIG or another state or federal agency believes records are about to be altered or destroyed, the nursing facility must provide records at the time of request or in less than 24 hours.
- Allowing Wellpoint service coordinators to participate in plan of care (POC) development and interdisciplinary team (IDT) meetings involving Wellpoint members
- Ensuring 24-hour availability of clinical staff to identify and respond to member needs
- Coordinating with the member's primary care provider
- Providing notice to the Wellpoint designated service coordinator via phone, fax, email, or other electronic means no later than one business day after the following events:
    - A significant, adverse change in the member's physical or mental condition or environment that could potentially lead to hospitalization
    - An admission to or discharge from the nursing facility, including admission or discharge to a hospital or other acute facility, skilled bed, long-term services and supports provider, noncontracted bed, another nursing or long-term care facility
    - An emergency room visit
    - Nursing facility-initiated, involuntary discharge of a member from a facility

- Submitting Form 3618 or Form 3619, as applicable, to HHSC's administrative services contractor
- Submitting MDS assessments, as required to federal CMS, and associated MDS Long Term Care Medicaid Information Section to HHSC's administrative services contractor
- Completing and submitting PASRR level I screening information to HHSC's administrative services contractor
- Coordinating with local authorities (LAs) and local mental health authorities (LMHAs) to complete a PASRR Level 2 Evaluation when an individual has been identified through the PASRR level 1 screen as potentially eligible for PASRR specialized services
- Informing members of covered services and the costs for noncovered services prior to rendering these services by obtaining a signed private pay form from the member
- Informing members on how to report abuse, neglect, or exploitation
- Training staff on how to recognize and report abuse, neglect, or exploitation
- Informing both Wellpoint and the Health and Human Services Commission (HHSC) of any changes to the provider's address, telephone number, group affiliation, or other key demographic or licensing information.

10.4 Advance Directives

We adhere to the Patient Self-Determination Act and maintain written policies and procedures regarding advance directives. Advance directives are documents signed by a competent person giving direction to healthcare providers about treatment choices in certain circumstances. There are two types of advance directives. A durable power of attorney for healthcare (durable power) allows the member to name a patient advocate to act on behalf of the member. A living will allows the member to state his or her wishes in writing but does not name a patient advocate. We encourage members to request education about advance directives and ask for an advance directive form from their PCP at their first appointment.

Members age 18 and over and emancipated minors are able to make an advance directive. Their response is to be documented in the medical record. Wellpoint will not discriminate or retaliate based on whether a member has or has not executed an advance directive.

While each member has the right without condition to formulate an advance directive within certain limited circumstances, a facility or an individual physician may conscientiously object to an advance directive.

We will assist members with questions about advance directives. However, no associate of Wellpoint may serve as witness to an advance directive or as a member's designated agent or representative. Wellpoint notes the presence of advance directives in the medical records when conducting medical chart audits.

10.5 Americans with Disabilities Act Requirements

All providers are expected to meet federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Healthcare services provided through us must be accessible to all members.

Our policies and procedures are designed to promote compliance with the *Americans with Disabilities Act of 1990* (42 U.S.C. §12101 et seq). Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:

- Street-level access
- Elevator or accessible ramp into facilities
- Access to lavatory that accommodates a wheelchair
- Access to examination room that accommodates a wheelchair
- Handicap parking clearly marked unless there is street-side parking

10.6 Appointments

Routine care
Healthcare for covered preventive and medically necessary healthcare services that are nonemergent or nonurgent is considered routine care.

Urgent care
A health condition (including an urgent behavioral health situation) that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe their condition requires medical treatment evaluation or treatment by the member's PCP or PCP designee within 24 hours to prevent serious deterioration of the member's condition or health.

Emergency care
Emergency care is defined as any medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in any of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- Serious jeopardy to the health of a woman or her unborn child (in the case of a pregnant woman)

Appointment and access standards
We are dedicated to arranging access to care for our members. Our ability to provide quality access depends upon the accessibility of network providers. We evaluate HHSC, TDI and National Committee for Quality Assurance (NCQA) requirements and follow the most stringent standards among the three sources. Providers are required to adhere to the following access standards. Standards are measured from the date of presentation or request, whichever occurs first.

Standard Name	Wellpoint
Emergency services	Immediately upon member presentation at the service delivery site
Urgent care	Within 24 hours

Standard Name	Wellpoint
Post-emergency room or hospital discharge (nonbehavioral health)	Within 14 days of discharge
Primary routine care	Within 14 days
Specialty routine care	Within 3 weeks
Preventive health	Within 90 days
Prenatal care: initial visit	Within 14 days
Prenatal care: high-risk/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: nonlife-threatening emergency	Within 6 hours (NCQA)
Behavioral health: urgent care	Within 24 hours
Post-hospital discharge (behavioral health)	Within 7 days of discharge (For missed appointments, provider must contact member within 24 hours to reschedule appointment.)
Behavioral health: routine care — initial visit	The earlier of 10 business days or 14 calendar days
Behavioral health: routine care — follow-up visits	Within 3 weeks
After-hours care	For PCPs: practitioners must be accessible 24/7 directly or through answering service: • Answering service or recording assistance in English and Spanish • Member reaches on-call physician or medical staff within 30 minutes

Providers may not use discriminatory practices such as preference to other insured or private-pay patients, including separate waiting rooms, hours of operation or appointment days. We routinely monitor providers' adherence to the access to care standards.

10.7 Continuity of Care

The care of newly enrolled members may not be disrupted or interrupted. This is true for care that falls within the scope of benefits. We will work to provide continuity in the care of newly enrolled members whose health or behavioral health conditions have been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted.

For acute care and add-on services:
We will honor existing service authorizations for new members in the same amount, duration, and scope until the shorter of:

- 90 calendar days.
- The end of the current authorization period.
- The time it takes for us to evaluate and assess the member and issue or deny a new authorization.

In the case of a newly enrolled member who is receiving a service that did not require authorization from the prior plan, we will authorize services in the same amount, duration, and scope until the shorter of:

- 90 calendar days.
- The time it takes for us to evaluate and assess the member and issue or deny a new authorization.

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.

Pregnant Wellpoint members past the 24th week of pregnancy are allowed to remain under the care of their current OB/GYNs through their postpartum check within six weeks of delivery. This applies even if the providers are out-of-network. If a member wants to change her OB/GYN to one who is in the network, she will be allowed to do so if the provider to whom she wishes to transfer agrees to accept her.

For new members who have been diagnosed with a terminal illness, we will approve out-of-network care by existing providers for up to nine months while enrolled with Wellpoint.

We pay a new member's existing out-of-network providers for medically necessary covered services, including inpatient and nursing facility services, until the member's records, clinical information and care can be transferred to a network provider or until the member is no longer enrolled with us, whichever is shorter.

Member Moves Out of Service Area
We provide or pay out-of-network providers for medically necessary covered services to members who move out of the service area. Members are covered through the end of the period for which they are enrolled in Wellpoint.

When a member's nursing facility address is not located in the member's enrolled service area, we will pay out-of-network providers for medically necessary covered services while working with the member, his or her legal guardian, HHSC and the nursing facility to determine on a case-by-case basis if updates are needed to the member's plan enrollment or if transfer to an in-network facility is necessary.

Nursing Facility Transfers
Residential nursing facility stays are not preauthorized by Wellpoint for STAR+PLUS nursing facility members. As such, nursing facilities are not required to obtain prior authorization or approval from Wellpoint for the transfer of Wellpoint residents between facilities, regardless of whether the sending or receiving nursing facility is a participating Wellpoint provider. Nursing facilities are required to notify Wellpoint within one business day of admission, discharge, or transfer of Wellpoint members in their facilities. Continuity of care, the authorization waiver period and standard prior authorization rules apply to acute, LTSS and add-on services for members transferring between nursing facilities.

Hospitalizations
There is no prior authorization requirement for Wellpoint STAR+PLUS nursing facility residents admitted or readmitted to nursing facilities for residential care following hospitalization. Emergency services, including emergency transportation, do not require prior authorization from Wellpoint.

Skilled Nursing Facility Admission and Discharge
Prior authorization from Wellpoint is always required for admission to a skilled nursing facility (SNF) for non-dual members. SNF stays for non-dual members are excluded from the authorization waiver period for acute care services. Admissions or readmissions to residential nursing facility care following discharge from an SNF do not require prior authorization from Wellpoint.

Pre-existing Condition not Imposed
We do not impose any pre-existing condition limitations or exclusions. We do not require evidence of insurability to provide coverage to any member.

10.8 Covering Physicians

During a provider's absence or unavailability, they need to arrange for coverage for their members. The provider will either:

- Make arrangements with one or more network providers to provide care for their patients.
- Make arrangements with another similarly licensed and qualified provider with appropriate medical staff privileges at the same network hospital or medical group as applicable to provide care to the members in question.

The covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing, and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider's behalf.

10.9 Credentialing and Re-credentialing

To be reimbursed for services rendered to Medicaid managed care members, providers must be enrolled in Texas Medicaid. Providers are not considered participating with us until they have enrolled in Texas Medicaid and have been credentialed with a duly executed contract with us.

We adhere to NCQA standards and state requirements for credentialing and re-credentialing. In accordance with these standards, providers must submit all requested information necessary to complete the credentialing or re-credentialing process. Each provider must cooperate with us as necessary to conduct credentialing and re-credentialing pursuant to our policies and procedures.

We will complete the initial credentialing process, and our claims system will be able to recognize a newly contracted provider no later than 90 calendar days after receipt of a

complete application. Wellpoint follows the nursing facility credentialing standards outlined in Chapter 8.6 of the HHSC Uniform Managed Care Manual.

A provider has the right to inquire about the status of an application by the following methods:

- Email: TXCredentialing@Wellpoint.com

Wellpoint uses the credentialing verification organization (CVO) as part of our credentialing and re-credentialing process. The CVO, Aperture Credentialing, LLC, is responsible for receiving completed applications, attestations, and primary source verification documents. If an application does not include required information, Aperture will send the applicant written notice of all missing information no later than five business days after receipt of the application.

If a provider qualifies for expedited credentialing under Texas Insurance Code 1452, Subchapters C, D and E, regarding providers joining established medical groups or professional practices that are already contracted with us, our claims system will be able to process claims from the provider as if the provider was a network provider, no later than 30 days after receipt of a complete application, even if the credentialing process has not yet been completed.

Wellpoint will provide expedited credentialing for certain provider types and allow services to members on a provisional basis as required by Texas Government Code §533.0064 and our state contract with HHSC. Provider types included are dentists, dental specialists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, and psychologists. To qualify for expedited credentialing, the provider must meet the following criteria:

- Be a member of a provider group that has a current contract in place with Wellpoint
- Be Medicaid-enrolled
- Agree to comply with the terms of the existing provider group contract
- Timely submit all documentation and other information required to begin the credentialing process

Wellpoint will provide expedited credentialing for nursing facilities that successfully underwent a change of ownership (CHOW). To qualify, the nursing facility must be a Medicaid-enrolled provider, submit all documentation and information timely, and agree to comply with the terms of the contract.

Providers are required to notify us of a change in address or practice status within 10 days of the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a re-credentialing application is not an acceptable form of notification. The Provider Data Management (PDM) tool in Availity Essentials at Availity.com should be used to submit demographic change requests for all professional and facility providers. The HHSC administrative services contractor must also be notified of all demographic changes. A notice of termination must adhere to the advance notice timelines stated in the provider's agreement and be sent to:

Provider Configuration
Wellpoint
P.O. Box 62509
Virginia Beach, VA 23466-2509

10.9.1 Wellpoint Discretion

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Wellpoint discretion in any way to amend, change or suspend any aspect of the Wellpoint credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or Health Delivery Organizations (HDOs) who seek to provide healthcare services to members. Wellpoint further retains the right to approve, suspend, or terminate individual physicians and healthcare professionals, and sites in those instances where it has delegated credentialing decision making.

10.9.2 Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the appropriate state agency to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Wellpoint:

- An independent relationship exists when Wellpoint directs its members to see a specific practitioner or group of practitioners, including all practitioners whom a member can select as primary care practitioners; and

3. Practitioners who provide care to members under Wellpoint medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
   - That are part of the Wellpoint primary network and include Wellpoint members who reside in the rental network area.
   - That are specifically for out-of-area care and members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Wellpoint credentials the following licensed/state certified independent healthcare practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing health services covered under the health benefit plan
- Doctors of dentistry providing health services covered under the health benefit plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training

- Other behavioral healthcare specialists who provide treatment services under the health benefit plan
- Telemedicine practitioners who provide treatment services under the health benefit plan
- Medical therapists (for example, physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Wellpoint credentials the following Health Delivery Organizations:

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
    - Adult Family Care/Foster Care Homes
    - Ambulatory Detox
    - Community Mental Health Centers (CMHC)
    - Crisis Stabilization Units
    - Intensive Family Intervention Services
    - Intensive Outpatient – Mental Health and/or Substance Use Disorder
    - Methadone Maintenance Clinics
    - Outpatient Mental Health Clinics
    - Outpatient Substance Use Disorder Clinics
    - Partial Hospitalization — Mental Health and/or Substance Use Disorder
    - Residential Treatment Centers (RTC) — Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

10.9.3 Credentials Committee

The decision to accept, retain, deny, or terminate a practitioner's or HDO's participation in one or more of the Wellpoint networks or plan programs is conducted by a peer review body, known as the Wellpoint Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where a Wellpoint affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or a Wellpoint medical director designee and the vice-chair must be a lead medical officer or a Wellpoint medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (for example, nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (for example, Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct

economic competition with the practitioner; or (ii) feels their judgment might otherwise be compromised. A committee member will also disclose if they have been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more networks or plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Wellpoint credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Wellpoint may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

10.9.4 Nondiscrimination Policy

Wellpoint will not discriminate against any applicant for participation in its plan programs or provider networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Wellpoint will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not

required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Wellpoint will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Wellpoint will take appropriate action to track and eliminate those practices.

10.9.5 Initial Credentialing

Wellpoint will verify those elements related to an applicant's legal authority to practice, relevant training, experience, and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Wellpoint will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating members.
Hospital admitting privileges at a TJC, NIAHO, CIHQ or HFAP accredited hospital, or a network hospital previously approved by the committee.
DEA/CDS and state-controlled substance registrations: • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating members. Practitioners who see members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable

Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

10.9.6 Re-credentialing

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Wellpoint credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

10.9.7 Health Delivery Organizations

New HDO applicants will submit a standardized application to Wellpoint for review. If the candidate meets Wellpoint screening criteria, the credentialing process will commence. To assess whether network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Wellpoint Credentialing Program Standards" section, all network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Wellpoint may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

10.9.8 Ongoing Sanction Monitoring

To support certain Credentialing Standards between the re-credentialing cycles, Wellpoint has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments

- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Wellpoint departments
- Any other information received from sources deemed reliable by Wellpoint

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

10.9.9 Appeals Process

Wellpoint has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of the Wellpoint networks or plan programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Wellpoint may wish to terminate practitioners or HDOs. Wellpoint also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in the Wellpoint networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Wellpoint will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Wellpoint's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of the Wellpoint networks or plan programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation, or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Wellpoint's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

10.9.10 Reporting Requirements

When Wellpoint takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its networks or plan programs, Wellpoint may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

10.9.11 Wellpoint Credentialing Program Standards

Eligibility Criteria

A. Healthcare practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where they provide services to members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to their specialty in which they will treat members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who see members in more than one state must have a DEA/CDS registration for each state; and
4. Meet the education, training and certification criteria as required by Wellpoint.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine (ABPM), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement:
    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training, and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant

professor or higher at an academic medical center and teaching facility in the Wellpoint network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Wellpoint education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Wellpoint review and approval. Reports submitted by delegates to Wellpoint must contain sufficient documentation to support the above alternatives, as determined by Wellpoint.

5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Healthcare Facilities Accreditation Program (HFAP) accredited hospital, or a network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.
6. For Genetic Counselors, the applicant must be licensed by the appropriate state agency to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Criteria for Selecting Practitioners

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to their specialty in which they will treat members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members. Practitioners who treat members in more than one state must have a valid DEA/CDS registration for each applicable state.

10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that they have applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. Wellpoint is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Wellpoint upon receipt of the required DEA/CDS registration.
    d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources:
        i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the network.

    Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Wellpoint members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration, the credentialing process may proceed if all the following criteria are met:
        a. It can be verified that the applicant's application is pending; and
        b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
        c. The applicant agrees to notify Wellpoint upon receipt of the required DEA registration; and
        d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources; and
        e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

    Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:
        a. Controlled substances are not prescribed within their scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
        b. Must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. Wellpoint is not required to arrange an alternative prescriber; and
        c. DEA/CDS registration is or was not suspended, revoked, surrendered, or encumbered for reasons other than those aforementioned.
11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists

a defined referral arrangement with a participating practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.

12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard professional conduct and competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in the Wellpoint network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. A NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Participation Criteria and Exceptions for Non-Physician Credentialing

The following participation criteria and exceptions are for non-MD practitioners. They are not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types are to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
    a. Master or doctoral degree in social work.
    b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.
    c. Licensure to practice independently.

2. Licensed professional counselor (LPC), marriage and family therapist (MFT), licensed mental health counselor (LMHC) or other master level license type:
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
    b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
    c. Practitioners with PhD training as a clinical psychologist can be reviewed.
    d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
    e. Licensure to practice independently or in states without licensure or certification:
        i. Marriage & Family Therapists with a master's degree or higher:
            a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
        ii. Mental Health Counselors with a master's degree or higher:
            a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:
    a. Master's or doctoral degree in a mental health discipline.
    b. Licensed as another recognized behavioral health provider type (for example, MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.

c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
    a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
    b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
    c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
    d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating members.

5. Clinical Psychologists:
    a. Valid state clinical psychologist license.
    b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
    c. Master's level therapists in good standing in the network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the network and will not be subject to the above education criteria.

6. Clinical Neuropsychologist:
    a. Must meet all the criteria for a clinical psychologist listed in section 4 above and be board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
    b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
    c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
        i. Transcript of applicable pre-doctoral training;
        ii. Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
        iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
        iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

7. Licensed Psychoanalysts:
    a. Applies only to practitioners in states that license psychoanalysts.
    b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Wellpoint Credentialing Policy (for example, psychiatrist, clinical psychologist, licensed clinical social worker).
    c. Practitioner must possess a valid psychoanalysis state license:
        a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
        b) Meet examination requirements for licensure as determined by the licensing state.

8. Process, Requirements and Verification — Nurse Practitioners:
    a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
    e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
        i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
        ii. American Academy of Nurse Practitioners – Certification Program;
        iii. National Certification Corporation;
        iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
        v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or

vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

f. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review.
g. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the CC. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
h. The NP applicant will undergo the standard credentialing processes outlined in Wellpoint Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for CC review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
i. Upon completion of the credentialing process, the NP may be listed in the Wellpoint provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
j. NPs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

9. Process, Requirements and Verifications — Certified Nurse Midwives:
    a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training, and board certification.
    b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms, or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority

information will be requested and primary source verified via normal Wellpoint procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.

e. All CNM applicants will be certified by either:
    i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
    ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.
    iii. This certification must be active and primary source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.
f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the CC or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
g. The CNM applicant will undergo the standard credentialing process outlined in Wellpoint Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the CNM may be listed in Wellpoint provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. CNMs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

10. Process, Requirements and Verifications — Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.

c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted, and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Wellpoint health plan and submitted for individual review by the CC.
f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the CC. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
g. The PA applicant will undergo the standard credentialing process outlined in Wellpoint Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the PA may be listed in Wellpoint provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. PAs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date within 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Wellpoint plan programs or provider networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for

participation in the applicable government programs or provider networks as well as Wellpoint other credentialed provider networks.

4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a network practitioner of similar specialty at a network HDO who provides inpatient care to members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. A NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Wellpoint standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Wellpoint may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Wellpoint may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for member access need only when the CC review indicates compliance with Wellpoint standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Wellpoint standards.

1. General Criteria for HDOs:
    a. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to members. The license must be in good standing with no sanctions.
    b. Valid and current Medicare certification.
    c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Wellpoint plan programs or provider networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider networks as well as Wellpoint other credentialed provider networks.
    d. Liability insurance acceptable to Wellpoint.
    e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Wellpoint quality and certification criteria standards have been met.

2. Additional Participation Criteria for HDO by Provider Type:

10.9.12 HDO Type and Wellpoint Approved Accrediting Agent(s)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC

Home Health Care Agencies (HHA)	ACHC, CHAP, DNV/NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Facility Type (Behavioral Healthcare)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV/NIAHO, HFAP, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, HFAP
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV/NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV/NIAHO, HFAP, TJC

Facility Type (Behavioral Health Care -Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

10.10 Culturally and Linguistically Appropriate Services

Patient panels are increasingly diverse and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Wellpoint wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety

Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Wellpoint ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. We encourage providers to access and utilize MyDiversePatients.com.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- Caring for Children with ADHD: Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- My Inclusive Practice — Improving Care for LGBTQIA+ Patients: Helps providers understand the fears and anxieties LGBTQIA patients often feel about seeking medical care, learn key health concerns of LGBTQIA patients, and develop strategies for providing effective healthcare to LGBTQIA patients.
- Improving the Patient Experience: Helps providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
- Medication Adherence: Helps providers identify contributing factors to medication adherence disparities for diverse populations and learn techniques to improve patient-centered communication to support needs of diverse patients.

- Moving Toward Equity in Asthma Care: Helps providers understand issues often faced by diverse patients with asthma and develop strategies for communicating to enhance patient understanding.
- Reducing Health Care Stereotype Threat (HCST): Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and healthcare needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Cultural competency training and other resource materials are available at provider.wellpoint.com/tx. See the Interpreter Services section of this manual for information on language supports.

Wellpoint appreciates the shared commitment to ensuring members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

10.11 Eligibility Verification

PCPs can obtain listings of members assigned to their panels from our Provider Online Reporting tool assessed via Payer Spaces located on Availity Essentials at Availity.com. If a member calls Wellpoint to change their PCP, the change will be effective the same business day. The PCP should verify that each Wellpoint member receiving treatment in their office is on the membership listing. For questions regarding a member's eligibility, providers may visit Availity.com (select Patient Registration > Eligibility & Benefits Inquiry), or call the automated Provider Inquiry Line at 833-731-2162.

10.12 Emergency Services

We provide a 24-hour Nurse Helpline service with clinical staff to provide triage advice, referral (if necessary) and make arrangements for treatment of the member. The service is available 24 hours a day, 7 days a week. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

We encourage members to contact their PCP in situations where urgent, unscheduled care is necessary. If you are unable to see the member, you can refer them to one of our participating urgent care centers. If the member needs care during nonbusiness hours, they can be seen by a provider who participates in our after-hours care program. Prior authorization by Wellpoint is not required for a member to access a participating urgent care center or a provider participating in our after-hours care program.

We do not discourage members from using the 911 emergency system, and we do not deny access to emergency services. Emergency services are provided to members without requiring prior authorization. Any hospital or provider calling for an authorization for

emergency services will be granted one immediately upon request. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- Serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child).
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.

An emergency behavioral health condition is defined as any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing average knowledge of medicine and health:

- Requires immediate intervention and/or medical attention without which the member would present an immediate danger to themselves or others.
- Renders the member incapable of controlling, knowing, or understanding the consequences of their actions.

Emergency response is coordinated with community services, including the following (if applicable):

- Police, fire, and EMS departments
- Juvenile probation
- The judicial system
- Child protective services
- Chemical dependency agencies
- Emergency services
- Local mental health authorities

When a member is sent by a nursing facility for emergency services at a hospital, we request immediate notification by the network hospital of emergent admissions. Our Medical Management staff will verify eligibility and determine benefit coverage. The determination as to whether the need for those services exists will be made for purposes of treatment. The determination is made by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of, or in collaboration with, a physician licensed to practice medicine. The physician or other appropriate personnel will indicate the results of the emergency medical screening examination in the member's chart. We will compensate the provider for the screenings, evaluations and examinations that are reasonable and calculated to assist the healthcare provider in determining whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (in other words, whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable

transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the patient at the treating facility prevails and is binding on Wellpoint. If the emergency department is unable to stabilize and release the member, we will assist in coordination of the inpatient admission, regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care. The transferring facility should make all attempts to transfer our members to a network facility. If the member is admitted, the Wellpoint concurrent review nurse will implement the concurrent review process to ensure coordination of care.

Post-stabilization care services are covered services related to an emergency condition provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient's condition. We will adjudicate emergency and post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

10.13 Fraud, Waste and Abuse

General Obligation to Prevent, Detect and Deter Fraud, Waste and Abuse
As recipients of funds from state and federally sponsored healthcare programs, we each have a duty to help prevent, detect, and deter fraud, waste and abuse. Our commitment to detecting, mitigating, and preventing fraud, waste and abuse is outlined in our corporate compliance program. As part of the requirements of the federal Deficit Reduction Act, each Wellpoint provider is required to adopt our policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state-funded healthcare programs in which we participate. Electronic copies of this policy are available at our website, provider.wellpoint.com/tx.

To meet the Deficit Reduction Act requirements, providers must adopt our fraud, waste and abuse policies. Additionally, providers must distribute the policies to any staff members or contractors who work with us. If you have questions or would like to have more details concerning our fraud, waste and abuse detection, prevention and mitigation program, please contact our chief compliance officer.

If a network provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), the network provider must:

- Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider; the policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims and whistleblower protections under such laws as described in Section 1902(a)(68)(A) of the Social Security Act.
- Include as part of such written policies detailed provisions regarding the network provider's policies and procedures for detecting and preventing fraud, waste and abuse.
- Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing fraud, waste and abuse.

False Claims Act
We are committed to complying with all applicable federal and state laws, including the federal *False Claims Act* (*FCA*). The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The *FCA* also contains Qui Tam or whistleblower provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

First Line of Defense Against Fraud
We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting, and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness:

- Fraud — Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. It includes any act that constitutes Fraud under applicable Federal or State law.
- Waste — includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- Abuse — Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to benefit programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare; it also includes beneficiary practices that result in unnecessary cost to the benefit program.

Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse
Healthcare fraud costs taxpayers increasingly more money every year. There are state and federal laws designed to crack down on these crimes and impose strict penalties. Fraud, waste and abuse in the healthcare industry may be perpetuated by every party involved in the healthcare process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation, and reporting. In this section, we educate providers on how to help prevent member and provider fraud by identifying the different types.

Examples of Provider Fraud, Waste and Abuse:

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering, or receiving kickbacks or bribes

- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code.
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

Providers can help prevent fraud, waste and abuse by ensuring the services rendered are medically necessary, accurately documented (in medical records) and billed according to American Medical Association guidelines.

Examples of Member Fraud, Waste and Abuse:

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID (identification) card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service plan area
- Using someone else's ID card

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is simply reviewing our member identification card. It is the first line of defense against fraud. We may not accept responsibility for the costs incurred by providers rendering services to a patient who is not a member even if that patient presents a Wellpoint member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage members to protect their Wellpoint member ID card as they would a credit card or cash. Members should carry their ID card at all times and report any lost or stolen cards to us as soon as possible. Members can also utilize a digital ID card available in their secure member website account or in the Sydney Health app instead of a physical card. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. If you or a patient suspect ID theft due to the loss of their ID card, call Provider Services at 833-731-2162.

10.13.1 Fraud Information

Reporting Waste, Abuse or Fraud by a Provider or Member

Medicaid Managed Care

Do you want to report waste, abuse or fraud?
Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare providers or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid.
- Using someone else's Medicaid.

- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at 800-436-6184;
- Visit https://oig.hhs.texas.gov and click the red Report Fraud box to complete the online form.
- You can report directly to your health plan:
  Compliance Officer
  Wellpoint
  2505 N. Highway 360, Suite 300
  Grand Prairie, TX 75050
  800-839-6275

Other reporting options include:

- Wellpoint Provider Services: 833-731-2162
- Special Investigations Fraud Hotline: 866-847-8247 (reporting can be anonymous)
- Visit our fighthealthcarefraud.com education site; at the top of the page click Report it and complete the *Report Waste, Fraud and Abuse* form

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.), include:
  - Name, address and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse or fraud

10.13.2 Fraud Investigation Process of Providers and Member Allegations

Our Special Investigations Unit (SIU) investigates all reports of provider and member fraud, abuse and waste for all services provided under the contract. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries, or may advise of further action.
- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.

- *Prepayment review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment within the required time may result in reduced payment of future claims or further legal action.

If you are working with the SIU, all checks and correspondence should be sent to:
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and/or claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and/or supporting medical records electronically is an option if you register for Availity Essentials. Contact Availity Client Services at 800-Availity (282-4548) for more information.

10.13.3 About Prepayment Review

One method we use to detect fraud, waste or abuse (FWA) is through claim prepayment review. Through a variety of means, certain providers (facilities or professionals), or certain claims submitted by providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or claims activity that indicates the provider is an outlier compared to the provider's peers.

Once a claim, or a provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the provider's action(s) may involve FWA, unless exigent circumstances exist, the provider is notified of their placement on prepayment review and given an opportunity to respond.

When a provider is on prepayment review, the provider will be required to submit medical records and any other supporting documentation with each claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the claim under review. The provider will be given the opportunity to request a discussion of the prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of claims submitted by the provider, even if those guidelines are not used for all providers delivering services to health plan members.

The provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been

corrected. If the inappropriate activity is not corrected, the provider could face corrective measures, up to and including termination from the network at the direction of the State Medicaid agency.

Providers are prohibited from billing a member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose claims are determined to be not payable may make appropriate corrections and resubmit such claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

10.13.4 Acting on Investigative Findings

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, waste, or abuse, the provider:

- Will be referred to the Special Investigations Unit.
- May be presented to the Credentials Committee and/or peer review committee for disciplinary action, including provider termination.

Failure to comply with program policy or procedures, or any violation of the provider contract, may result in termination from our plan.

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health plan, with state approval.

10.14 Laboratory Services (Outpatient)

All outpatient laboratory tests should be performed at a Wellpoint-preferred network lab (LabCorp, Clinical Pathology Laboratories (CPL) or Quest Diagnostics) or a network facility outpatient lab. The exception to this requirement is when the service being performed is a Clinical Laboratory Improvement Amendments (CLIA)-approved office test. Visit the CMS website at cms.gov for a complete list of CLIA-approved tests.

CLIA requires all laboratories serving Medicaid clients to maintain a certificate of registration or a certificate of waiver. Those laboratories with a certificate of waiver may only provide the following nine tests:

1. Dipstick or tablet reagent urinalysis for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity and urobilinogen
2. Fecal occult blood
3. Ovulation tests
4. Urine pregnancy tests
5. Erythrocyte sedimentation rate, nonautomated
6. Hemoglobin-copper sulfate, nonautomated
7. Blood glucose by glucose monitoring devices cleared by the FDA specifically for home use

8. Spun microhematocrit
9. Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout

If a laboratory test cannot be directed to or provided by a network provider, prior authorization is required for coverage.

10.15 Locum Tenens

We allow reimbursement of locum tenens physicians in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines, subject to benefit design, medical necessity and authorization guidelines.

We will reimburse the member's regular physician or medical group for all services (including emergency visits) of a locum tenens physician during the absence of the regular physician. This applies in cases where the regular physician pays the locum tenens physician on a per diem or similar fee-for-time basis. Reimbursement to the regular physician or medical group is based on the applicable fee schedule or contracted rate. The locum tenens physician may not provide services to a member for more than a period of 60 continuous days.

A member's regular physician or medical group should bill the appropriate procedure code(s) identifying the service(s) provided by the locum tenens physician. A Modifier Q6 must be appended to each procedure code.

If a locum tenens physician only performs postoperative services furnished during the period covered by the global fee, these services are not identified on the claim as substitution services. Additionally, these services do not require Modifier Q6.

10.16 Member Missed Appointments

Wellpoint members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. We require providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone, allowing the provider to educate the member about the importance of keeping appointments. It's also a good time for the provider to encourage the member to reschedule the appointment.

Wellpoint members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, providers can call Provider Services at 833-731-2162 or the local health plan member advocate to address the situation. Our staff will contact the member and provide more extensive education and/or case management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and adhering to the PCP's recommended plan of care. Providers may not bill us or our members for missed appointments.

10.17 Member Record Standards

Our providers are required to maintain medical records that conform to good professional medical practice and appropriate health management. A permanent medical record is maintained at the primary care site for every member and is available to the PCP and other providers. Medical records must be kept in accordance with Wellpoint and state standards as outlined below:

The records reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of the *Health Insurance Portability and Accountability Act (HIPAA)* and other federal and state laws.

Documentation of each visit must include the following:

1. Date of service
2. Complaint or purpose of visit
3. Diagnosis or medical impression
4. Objective finding
5. Assessment of patient's findings
6. Plan of treatment, diagnostic tests, therapies, and other prescribed regimens
7. Medications prescribed
8. Health education provided
9. Signature or initials and title of the provider rendering the service

Note: If more than one person documents in the medical record, there must be a record on file as to which signature is represented by which initials.

These standards will, at a minimum, meet the following medical record requirements:

1. Patient identification information. Each page or electronic file in the record must contain the patient's name or patient ID number.
2. Personal/biographical data. The record must include the patient's age, sex, address, employer, home and work telephone numbers, and marital status.
3. Date and corroboration. All entries must be dated and author-identified.
4. Legibility. Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
5. Allergies. Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (no known allergies – NKA) must be noted in an easily recognizable location.
6. Past medical history for patients seen three or more times. Past medical history must be easily identified, including serious accidents, operations, and illnesses. For children, the history must include prenatal care of the mother and birth.
7. Physical examination: A record of physical examination(s) appropriate to the presenting complaint or condition must be noted.
8. Diagnostic information. Documentation of clinical findings and evaluation for each visit should be noted.
9. Medication information. This notation includes medication information/instruction(s) to the patient.
10. Identification of current problems. Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record. A current problem list must be included in each patient record.

11. Instructions. The record must include evidence that the patient was provided with basic teaching/instructions regarding physical and/or behavioral health condition.
12. Smoking/alcohol/substance use disorder. A notation concerning cigarettes and alcohol use and substance use disorder must be stated if present for patients age 12 and older. Abbreviations and symbols may be appropriate.
13. Preventive services/risk screening. The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.
14. Consultations, referrals, and specialist reports. Notes from any referrals and consultations must be in the record. Consultation, lab, and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
15. Emergencies. All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP's panel must be noted.
16. Hospital discharge summaries. Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient's current medical condition.
17. Advance directive. Medical records of adult patients must document whether or not the individual has executed an advance directive. An advance directive is a written instruction, such as a living will or durable power of attorney, which directs healthcare decision making for individuals who are incapacitated.
18. Security. Providers must maintain a written policy to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. Physical safeguards require records to be stored in a secure manner that allows access for easy retrieval by authorized personnel only. Staff receives periodic training in member information confidentiality.
19. Release of information. Written procedures are required for the release of information and obtaining consent for treatment.
20. Documentation. Documentation is required setting forth the results of medical, preventive, and behavioral health screening and of all treatment provided and results of such treatment.
21. Multidisciplinary teams. Documentation of the team members involved in the multidisciplinary team of a patient needing specialty care is required.
22. Integration of clinical care. Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include the following:
    - Notation of screening for behavioral health conditions (including those which may be affecting physical healthcare and vice versa) and referral to behavioral health providers when problems are indicated
    - Notation of screening and referral by behavioral health providers to PCPs when appropriate
    - Notation of receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals
    - A summary (at least quarterly or more often if clinically indicated) of the status/progress from the behavioral health provider to the PCP

- A written release of information that will permit specific information sharing between providers
- Documentation that behavioral health professionals are included in primary and specialty care service teams when a patient with disabilities, or chronic or complex physical or developmental conditions, has a co-occurring behavioral disorder
- Documentation of the member's power of attorney (POA), durable power of attorney (DPOA) or guardianship paperwork as applicable.

10.18 Noncompliant Wellpoint Members

Call Provider Services at 833-731-2162 if you need help working with a member regarding:

- Behavior.
- Treatment cooperation and/or completion.
- Appointment compliance.

A member advocate will contact the member to address the situation with education and counseling. The outcome of the counseling efforts will be reported back to you.

To remove a member from your panel after efforts with the member have been unsuccessful, you must:

- Not make a removal decision based on the member's health status or utilization of services that are medically necessary for treatment of the member's condition.
- Send a certified letter to the member or head of household stating the member must select a new PCP within 30 days of the notice.
- Send a copy of the letter to:
  Member Advocates
  Wellpoint
  2505 N. Highway 360, Suite 300
  Grand Prairie, TX 75050
- Continue to provide care to the member until the effective date of the assignment to a new PCP.
- Not take any retaliatory action against a noncompliant member.

In extreme situations where a member consistently refuses to cooperate with us and our providers, misuses or loans their member ID card to another person to obtain services, or refuses to comply with managed care restrictions, we may request that HHSC disenroll the member from Wellpoint. If the member disagrees with the disenrollment, they may utilize our member complaint process and the HHSC state fair hearing process.

10.19 Patient Visit Data

Documentation of individual encounters must provide adequate evidence of (at a minimum):

1. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints.

2. Behavioral health treatment that includes at-risk factors (danger to self/others, ability to care for self, affect/perceptual disorders, cognitive functioning, and significant social health) for behavioral health patients.
3. An admission or initial assessment that must include current support systems or lack of support systems.
4. An assessment for behavioral health patients (performed at each visit) of client status/symptoms regarding the treatment process; assessment may indicate initial symptoms of the behavioral health condition as decreased, increased, or unchanged during the treatment period.
5. A plan of treatment that includes activities/therapies and goals to be carried out.
6. Diagnostic tests.
7. Therapies and other prescribed regimens for patients who receive behavioral health treatment, including evidence of:
    - Family involvement, as applicable.
    - Family inclusion in therapy sessions when appropriate.
8. Follow-up care encounter forms or notes indicating when follow-up care, a call, or a visit (noted in weeks, months or PRN) should occur; notes should include the specific time to return with unresolved problems from any previous visits.
9. Referrals and results including all other aspects of patient care, such as ancillary services.

We will systematically review medical records to ensure compliance with these standards. To be considered compliant with medical record performance standards, your medical record score must be 80%, including six clinical elements that must be met. We will institute actions for improvement when standards are not met.

We maintain an appropriate record-keeping system for services to members. This system will collect all pertinent information relating to the medical management of each member and make that information readily available to appropriate health professionals and appropriate state agencies. All records will be retained in compliance with applicable federal and state laws and contract requirements.

10.20 Primary Care Providers

Members who are eligible for both Medicare and Medicaid will receive primary care from their Medicare plan and will not select a Medicaid primary care provider.

10.20.1 Medical Home

The PCP is the foundation of the medical home, responsible for providing, managing, and coordinating all aspects of the member's medical care. The PCP must provide all care that is within the scope of their practice. Additionally, the PCP is responsible for coordinating member care with specialists and conferring and collaborating with the specialists, using a collaborative concept known as a medical home.

We promote the medical home concept to all of our members. The PCP is the member's and family's initial contact point when accessing healthcare. The PCP has an ongoing and collaborative contractual relationship with:

- The member and family.

- The healthcare providers within the medical home.
- The extended network of consultants and specialists with whom the medical home works.

The providers in the medical home are knowledgeable about the member's and family's special, health-related social and educational needs. The medical home providers are connected to community resources that will assist the family in meeting those needs. When a PCP refers a member for a consultation, specialty/hospital services, or health and health-related services through the medical home, the medical home provider maintains the primary relationship with the member and family. They keep abreast of the current status of the member and family through the PCP.

10.20.2 PCP Provider Types (Network Limitations)

Physicians with the following specialties can apply for enrollment with us as PCPs:

- Family practitioners
- General practitioners
- General pediatricians
- General internists
- Advanced practice registered nurses (APRNs) and physician assistants (PAs), when practicing under the supervision of a physician specializing in family practice, internal medicine, pediatrics, or obstetrics/gynecology who also qualifies as a PCP
- Nurse practitioners certified as specialists in family practice or pediatrics
- FQHCs, RHCs and similar clinics
- Obstetricians/gynecologists
- Specialist physicians who are willing to provide a medical home to selected members with special needs and conditions
- Indian Health Care Providers (IHCP) for Indian members

The provider must be enrolled in the Medicaid program at the service location where they wish to practice as a PCP before contracting with us for STAR+PLUS.

10.20.3 PCP Responsibilities

The PCP is a network physician who has the responsibility for the complete care of their patients, whether providing it himself or herself or by referral to the appropriate provider of care within the network. FQHCs and RHCs may be included as PCPs. The PCP shall:

- Manage the medical and healthcare needs of members, including monitoring and following up on care provided by other providers (both in- and out-of-network); providing coordination necessary for referrals to specialists (both in- and out-of-network); and maintaining a medical record of all services rendered by the PCP and other providers.
- Make referrals for specialty care for members on a timely basis, based on the urgency of the member's medical condition, but within no later than 30 calendar days from the date the need is identified or requested.
- Provide 24-hour-a-day, 7-day-a-week coverage in accordance with the After-Hours Coverage section of this manual; regular hours of operation should be clearly defined and communicated to members.

- Be available to provide medically necessary services.
- Ensure covering physicians follow the referral/prior authorization guidelines.
- Provide services ethically and legally in a culturally competent manner; meet the unique needs of members with special healthcare needs.
- Participate in any process established by Wellpoint to facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements.
- Make provisions to communicate in the language or fashion primarily used by their patients.
- Participate and cooperate with Wellpoint in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Wellpoint.
- Participate in and cooperate with the Wellpoint complaint procedures; we will notify the PCP of any member complaint.
- Not bill members for any outstanding balance; Medicaid members do not have an out-of-pocket expense for covered services.
- Continue care in progress during and after termination of their contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan, in compliance with Occupational Safety and Health Administration standards, regarding blood-borne pathogens.
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act.
- Support, cooperate and comply with the Wellpoint Quality Improvement Program initiatives and any related policies and procedures.
- Provide quality care in a cost-effective and reasonable manner.
- Inform Wellpoint if a member objects to provision of any counseling, treatments, or referral services for religious reasons.
- Treat all members with respect and dignity; provide members with appropriate privacy and treat member disclosures and records confidentially, giving the member the opportunity to approve or refuse their release.
- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis; give members the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons.
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program.
- Advise members on treatments which may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies, such as local police, social services agencies, and poison control centers to provide high-quality patient care.

- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research shall be clearly contrasted with entries regarding the provision of nonresearch-related care.
- Report any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002, and Texas Family Code §261.101.

Note: We do not cover the use of any experimental procedures or experimental medications except under certain circumstances.

10.20.4 After-hours Coverage

We encourage PCPs to offer extended office hours to include nights and weekends.

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements after normal business hours:

- Have the office telephone answered after hours by an answering service that can contact the PCP or another designated network medical practitioner; all calls answered by an answering service must be returned within 30 minutes. The answering service must have both English and Spanish language capability.
- Have the office telephone answered after normal business hours by a recording in both English and Spanish; the recorded message should direct the member to call another number to reach the PCP or another provider designated by the PCP; someone must be available to answer the designated provider's telephone; another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone; the person answering the calls must be able to contact the PCP or a designated Wellpoint network medical practitioner who can return the call within 30 minutes.

The following telephone answering procedures are NOT acceptable:

- Answering office telephone only during office hours
- Answering office telephone after hours by a recording that tells members to leave a message
- Answering office telephone after hours by a recording that directs members to go to an emergency room for any services needed
- Returning after-hours calls outside of 30 minutes

10.20.5 New Members

We encourage enrollees to select a PCP for preventive and primary medical care. PCPs also ensure authorization and coordination of all medically necessary specialty services. Dual-eligible STAR+PLUS members will not be assigned to a Wellpoint PCP but will select a PCP through their primary coverage through Medicare.

10.20.6 PCP Changes and Transfers

We encourage members to remain with their PCPs to maintain continuity of care. However, members may request to change a PCP for any reason by contacting Member Services at

833-731-2160 (TTY 711). The member's name will be provided to the PCP on the membership roster.

PCP change requests will be processed generally on the same day or by the next business day. Members will receive a new ID card within 10 days. Members who have Medicare and Medicaid should call their Medicare plan to make a PCP change.

10.20.7 Specialist as a PCP

Under certain circumstances, a member may require the regular care of the specialist. We may approve that specialist to serve as a member's PCP. The criteria for a specialist to serve as a member's PCP include the member having a disability, special healthcare needs, or a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists.
- The majority of care needs to be given by a specialist.
- The administrative requirements arranging for care exceed the capacity of the nonspecialist PCP; this would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.

A member who resides in a nursing facility may designate a specialist as their PCP.

Note: Providers who follow NF residents should adhere to Texas Administrative Code guidelines for frequency of visits and documentation in the resident medical record.

The specialist must:

- Agree to serve as the member's primary care provider.
- Meet the requirements for PCP participation (including contractual obligations and credentialing).
- Provide access to care 24 hours a day, 7 days a week.
- Coordinate the member's healthcare, including preventive care.

When such a need is identified, the member or specialist must contact the Wellpoint Case Management department and complete a Specialist as PCP Request form. A case manager will review the request and submit it to our medical director. We will notify the member and the provider of our determination in writing within 30 days of receiving the request.

The designation cannot be retroactive. If the request is approved, we will not reduce the compensation that is owed to the original PCP before the date of the new designation of the specialist as PCP. If we deny the request, however, the member may appeal the decision through our member complaint process. Under that process, we must respond to the member's complaint in writing within 30 days. For further information, call Provider Services at 833-731-2162.

Members who are eligible for both Medicare and Medicaid will receive primary care from their Medicare plan and will not select a Medicaid primary care provider.

10.21 Provider Disenrollment Process

Providers may cease participating with us for either mandatory or voluntary reasons. Mandatory disenrollment occurs when a provider becomes unavailable due to immediate, unforeseen reasons. Examples of this include death or loss of license. Members are assigned to another PCP to ensure continued access to our covered services as appropriate. We will notify members of any termination of PCPs or other providers from whom they receive ongoing care.

We will provide notice to affected members when a provider disenrolls for voluntary reasons, such as retirement. Providers must furnish written notice to us within the time frames specified in the *Participating Provider Agreement*. Members linked to a PCP who disenrolled for voluntary reasons will be notified to select a new PCP. We are responsible for submitting notification of all provider disenrollments to the Texas Health and Human Services Commission (HHSC).

10.22 Provider Marketing

Providers are prohibited from engaging in direct marketing to members to increase enrollment in a particular health plan. The prohibition should not constrain network providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

Providers must comply with the HHSC marketing policies and procedures as set forth in Chapter 4.3 of the HHSC Uniform Managed Care Manual, available at https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-contracts-manuals

10.23 Provider Quality Incentive Programs

We have several provider quality incentive programs to reward various facility and provider types for the provision of quality, medically appropriate healthcare services to our members. The programs vary by the provider's panel size and use of predefined measures, such as HEDIS and access measures. Providers must be in good standing and meet the eligibility criteria of the given program to participate. For additional information regarding the programs, call your Provider Relations representative.

10.24 Radiology

When both a physician and a radiologist read an X-ray, only the radiologist can submit a claim for reading the film. If the physician feels there is a problem with the reading diagnosis, they should contact the radiological facility to discuss the concern.

10.25 Referrals

Providers shall refer patients to participating providers and facilities when available. We will provide members with timely and adequate access to out-of-network services if those services are necessary and covered but not available within the network.

10.26 Self-Referrals

We do not require members to seek a referral from their PCP prior to accessing services from other providers in the Wellpoint network. HHSC specifically requires the services in the table below to be available to members through self-referral.

Service	Authorization for services
Obstetric/gynecological services (nonparticipating providers must seek prior approval from Wellpoint)	• One well-woman checkup each year • Care related to pregnancy • Care for any female medical condition • Referral to specialist doctor within the network
Behavioral Health - (nonparticipating providers must seek prior approval from Wellpoint)	Members may self-refer to any Wellpoint network behavioral health services provider. No prior approval from the PCP is required. Providers may refer members for services by: • Calling Provider Services at 833-731-2162. • Faxing referral information to our dedicated behavioral health faxes at 844-430-6805 for inpatient and 844-442-8010 for outpatient. Our staff is available to callers 24 hours a day, 7 days a week, 365 days a year for routine, crisis or emergency calls and authorization requests.
Emergent care	No prior authorization or notification is required, regardless of network status with Wellpoint
Family planning/sexually transmitted disease (STD)	No prior authorization or notification is required, regardless of network status with Wellpoint
Sterilization	• No prior authorization or notification is required for sterilization procedures, including tubal ligation and vasectomy • A Sterilization Consent Form is required for claims submission.
Tuberculosis, sexually transmitted diseases, HIV/AIDS testing, and counseling services	No prior authorization or notification is required for these services, regardless of network status with Wellpoint

10.26 Reporting Involvement in Legal or Administrative Proceedings, Changes in Address and Practice Status

Within 30 days of occurrence, a provider shall give written notice to us if they are named as a party in any civil, criminal or administrative proceeding. Failure to provide such timely notice to us constitutes grounds for termination of the provider's contract with us.

Providers are required to notify us of a change in address or practice status within 10 days of the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a re-credentialing application is not an acceptable form of notification. The Provider Data Management (PDM) tool in Availity Essentials at Availity.com should be used to submit demographic change requests for all professional and facility providers. The HHSC administrative services contractor must also

be notified of all demographic changes. A notice of termination must adhere to the advance notice timelines stated in the provider's agreement and be sent to:

Provider Configuration
Wellpoint
P.O. Box 62509
Virginia Beach, VA 23466-2509

10.27 Second Opinions

A member, parent, and/or legally appointed representative (LAR) or the member's PCP may request a second opinion. A second opinion may be requested in any situation where there is a question concerning a diagnosis, the options for surgery or other treatment of a health condition. The second opinion shall be provided at no cost to the member.

The second opinion must be obtained from a network provider or a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When we request a second opinion, we will make the necessary arrangements for the appointment, payment, and reporting. We will inform the member and the PCP of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

10.28 Specialty Care Providers

To participate in the Medicaid managed care model, the provider must have applied for enrollment in the Texas Medicaid program. The provider must be licensed by the state before signing a contract with us.

We contract with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network physician who has the responsibility for providing specialized care for members, usually upon appropriate referral from a PCP, within the network. See the Specialty Care Providers' Roles and Responsibilities section of this manual for more information. In addition to sharing many of the same responsibilities as the PCP (see PCP Responsibilities), the specialty care provider furnishes services that can include any of the following or others:

- Allergy and immunology services
- Burn services
- Community behavioral health (for example, mental health and substance use disorder) services
- Cardiology services
- Clinical nurse specialists, psychologists, clinical social workers (behavioral health)
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Hematology/oncology services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- Oncology services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Pediatric services
- Perinatal services
- Psychiatry assessment services
- Trauma services
- Urology services

10.28.1 Specialty Care Providers' Roles and Responsibilities

Responsibilities of specialists contracted with Wellpoint include:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program.
- Accepting all members referred to them.
- Submitting required claims information, including source of referral to Wellpoint.
- Arranging for coverage with network providers while off-duty or on vacation.
- Verifying member eligibility and prior authorization of services (if required) at each visit.
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis; following a referral or routinely scheduled consultative visit.
- Notifying the member's PCP when scheduling a hospital admission.
- Coordinating care (as appropriate) with other providers involved in rendering care for members, especially in cases involving medical and behavioral health comorbidities, or co-occurring mental health and substance use disorders.

The specialist shall:

- Manage the medical and healthcare needs of members to encompass:
  - Monitoring and following up on care provided by other providers.
  - Coordinating referrals to other specialists and providers (both in- and out-of-network).
  - Maintaining a medical record of all services rendered by the specialist and other providers.
- Maintain regular hours of operation that are clearly defined and communicated to members.
- Provide services ethically and legally and in a culturally competent manner that meets the unique needs of members with special healthcare requirements.
- Participate in Wellpoint systems that facilitate record sharing (subject to applicable confidentiality and HIPAA requirements).
- Participate in and cooperate with Wellpoint in any reasonable internal or external quality assurance, utilization review, continuing education or other similar programs established by Wellpoint.
- Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers (including behavioral health providers) involved in delivering care and services to members.
- Participate in and cooperate with the Wellpoint complaint processes and procedures; we will notify the specialist of any member complaint brought against the specialist.
- Not balance-bill members; Medicaid members do not have an out-of-pocket expense for covered services.
- Continue care in progress during and after termination of his or her contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members; this is to occur in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration standards.
- Make best efforts to fulfill the obligations under the Americans with Disabilities Act applicable to their practice location.
- Support, cooperate and comply with Wellpoint Quality Improvement program initiatives, and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
- Inform Wellpoint if a member objects for religious reasons to the provision of any counseling, treatment, or referral services.
- Treat all members with respect, dignity, and appropriate privacy; treating member disclosures and records confidentially, giving members the opportunity to approve or refuse their release as allowed under applicable laws and regulations.
- Provide members complete information concerning diagnosis, evaluation, treatment, and prognosis; giving members the opportunity to participate in decisions involving healthcare, except when contraindicated for medical reasons.
- Advise members about their health status, medical care, or treatment options regardless of whether benefits for such care are provided under the program.

- Advise members on treatments that may be self-administered.
- Contact members (when clinically indicated) as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Establish and maintain a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies, such as local police, social services agencies, and poison control centers to provide quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch-related care.
- Within 30 days of occurrence, provide written notice to Wellpoint if the specialist is named as a party in any civil, criminal, or administrative proceeding; failure to provide timely notice to Wellpoint constitutes grounds for termination of the specialist's contract with Wellpoint.
- Report any suspicion or allegation of member abuse, neglect, or exploitation in accordance with Texas Human Resources Code §48.051, Texas Health and Safety Code §260A.002, and Texas Family Code §261.101.

Note: We do not cover the use of any experimental procedures or experimental medications except under certain preauthorized circumstances.

10.29 Cancellation of Product Orders

If a network provider offers delivery services for covered products, such as durable medical equipment (DME), home health supplies, or outpatient drugs or biological products, then the provider must reduce, cancel, or stop delivery at the member's or the member's authorized representative's written or oral request. The provider must maintain records documenting the request.

10.30 Reading/Grade Level Consideration

Millions of Americans are functionally illiterate and many millions more are only marginally literate. Many of our members may have limited ability to understand and read instructions, but most people with literacy problems are ashamed and will try to hide their problem from providers. Low literacy may mean that your patient may not be able to comply with your medical advice and course of treatment because they do not understand your instructions. Materials provided to members should be written at a fourth to sixth grade reading level. Be sensitive to the fact that the member may not be able to read instructions for taking medicine or for treatment and may feel embarrassment about limited literacy. If interpreter services are needed, call Provider Services at 833-731-2162.

10.31 Health Insurance Portability and Accountability Act

The *Health Insurance Portability and Accountability Act (HIPAA)*, also known as the Kennedy-Kassebaum bill, was signed into law in August 1996. The legislation improves the

portability and continuity of health benefits, ensures greater accountability in the area of healthcare fraud and simplifies the administration of health insurance.

We strive to ensure that both Wellpoint and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted providers must implement procedures that demonstrate compliance with the *HIPAA* privacy regulations. This requirement is described in the following paragraphs.

We recognize our responsibility under the *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us. However, please note that the privacy regulations allow the transfer or sharing of member information, which we may request to conduct business and make decisions about care, such as a member's medical record, to make an authorization determination or resolve a payment dispute. Such requests are considered part of the *HIPAA* definition of treatment, payment, or healthcare operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify that the receiving fax number is correct, notify the appropriate staff at Wellpoint and verify that the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing member information to us (for example, Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box or department at Wellpoint.

Our voicemail system is secure and password-protected. When leaving messages for our associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose. When contacting us, be prepared to verify the provider's name, address and tax identification number or Wellpoint provider number.

Medical records standards require that medical records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of the *HIPAA* and other federal and state laws.

10.32 Misrouted Protected Health Information

Providers and facilities are required to review all member information received from Wellpoint to ensure no misrouted Protected Health Information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email, or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the

PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please call our Provider Services team at 833-731-2162 for help.

11 MEMBER MANAGEMENT SUPPORT

11.1 Appointment Scheduling

Through our participating providers, we ensure members have access to primary care services for routine, urgent and emergency services as well as specialty care services for chronic and complex care. Providers will respond to a Wellpoint member's needs and requests in a timely manner and must schedule our members for appointments using the guidelines outlined in the Appointments section of this manual.

11.2 Interpreter Services

We can provide interpreter services in many different languages and dialects for members who do not speak English. We will set up and pay for a sign language interpreter to assist members who are deaf or hard of hearing. These services are available at no cost to providers or members. Interpreter services should be requested at least 24 hours before the appointment. Services can be arranged by calling Provider Services at 833-731-2162.

11.3 Case Management

Our case management program is part of a comprehensive healthcare management services program offering a continuum of services that include case management, condition care (formerly disease management), care coordination, hospital discharge case management and utilization management. These programs help reduce barriers by identifying the unmet needs of members and assisting them in meeting those needs. This may involve coordinating care, assisting members to access community resources, providing disease-specific education or any number of interventions designed to improve the quality of life and functionality of members. The programs are designed to make more efficient use of limited healthcare resources. Participation in case management is voluntary and member consent must be obtained prior to enrollment. All members have the option to opt out of case management at any time.

Scope of the Case Management Program:

- Member identification and screening
- Initial and ongoing assessment
- Problem-based, comprehensive care planning that includes measurable goals and interventions tailored to the acuity level of the member as determined by the initial assessment
- Coordination of care with PCPs and specialty providers
- Member education
- Effective member and provider communication
- Program monitoring and evaluation using quantitative and qualitative analysis of data
- Satisfaction and quality of life measurement

Objectives of the Case Management Program:

- Maintain a cost-effective case management system to manage the needs of members with increased case management needs in one or more domains (physical, behavioral, or social)
- Empower members and their families by providing information and education that promote condition specific self-care management to facilitate member behavior change
- Identify barriers that may impede members from achieving optimal health
- Implement agreed-upon interventions to increase the likelihood of improved health outcomes, improving quality of life
- Reach out to effectively engage members and their families as partners in the case management process
- Reduce unnecessary, duplicated and/or fragmented utilization of healthcare resources
- Promote collaboration and coordination (at all levels of the healthcare delivery system) between physical health, behavioral health, the pharmacy program, and community-based social programs
- Provide members with connection and coordination of community resources to address member needs including social determinants of health throughout the case management process but especially when benefits end and the member still needs care
- Foster improved coordination and communication among providers and with Wellpoint staff
- Improve member and provider satisfaction and retention
- Comply with applicable contractual and regulatory requirements related to case management
- Identify opportunities to transition members to more appropriate federal/state programs (for example, STAR to STAR+PLUS)
- Serve as advocates for members
- Assist members to match available benefits to their healthcare needs
- Promote effective strategies to prevent or delay relapse or recurrence through interventions, such as member education and improved member self-management
- Coordinate case management interventions with ongoing health promotion initiatives, such as dissemination of member education literature
- Help members and their families mobilize internal and external resources and strengths to improve their health outcomes and manage the costs of care
- Provide culturally competent case management services to members, families, and providers
- Maintain the highest quality of ethical standards, including maintenance of confidentiality, in all dealings with members
- Conduct quality management and improvement activities to ensure the highest possible level of service to members and their families
- Monitor outcomes of interventions to assist in evaluating and improving programs

Eligibility for Case Management
Any Wellpoint member is eligible for case management. Members are identified through continuous case-finding methods that include, but are not limited to, prior authorization, admission review, and/or provider referrals or member requests.

For STAR+PLUS members who receive services through the ICF-IID Program or an IDD Waiver, primary case management responsibilities will remain with the state for development of the service plan and the coordination of services:

- For individuals who live in ICF-IID facilities, the qualified intellectual disabilities professional (QIDP)
- For CLASS and DBMD Waiver members, a case manager
- For HCS and TxHmL Waiver members, a local authority service coordinator

We will also assign these members a Wellpoint personal service coordinator.

Comprehensive Member Assessment
A case manager will conduct a comprehensive assessment to further determine a member's needs. The assessment will include a range of questions identifying and evaluating the member's:

- Medical condition.
- Functional status.
- Social determinants of health.
- Goals.
- Life environment.
- Support systems.
- Emotional status.
- Capability for self-care.
- Current treatment plan.

Using the structured assessment tool, a case manager will conduct a telephone interview or home visit to collect and assess information from the member or their representative. To complete the assessment, the case manager will obtain information from the primary care provider and specialists, our continuous case-finding information, and other sources to coordinate and determine current medical needs and needed nonmedical services. This information is used to develop a comprehensive individualized plan of care.

Hours of Operation
Our case managers are licensed nurses and social workers, available Monday through Friday from 8 a.m. to 5 p.m. local time. Confidential voicemail is available 24 hours a day.

Contact Information
To contact a case manager, please call 833-731-2162 or your local health plan.

11.4 Members with Special Health Care Needs (MSHCN)

MSHCN means a member who both:

- Has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted (or is anticipated to last) for a significant period of time.

- Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained healthcare personnel.

All STAR+PLUS members qualify as MSHCN.

For MSHCN, we develop a service plan to provide care and services to meet your special needs. We also provide access to treatment by a multidisciplinary team when needed. MSHCN members may have a specialist designated to serve as a PCP (see the Specialist as a PCP section of this manual).

11.5 Communicable Disease Services

We cover communicable disease services to members. Communicable disease services help control and prevent diseases such as tuberculosis (TB), sexually transmitted diseases (STDs) and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) infection. Members can receive TB, STD, and HIV/AIDS services outside of our provider network through the Texas Department of Health and Environmental Control clinics without any restrictions. Providers should encourage members to receive TB, STD, and HIV/AIDS services through Wellpoint to ensure continuity and coordination of a member's total care.

Providers must report all known cases of TB, STD, and HIV/AIDS infection to the state public health agency within 24 hours. Providers must report all diseases reportable by healthcare workers, regardless of whether the case is also reportable by laboratories.

Control and Prevention of Communicable Diseases
We will coordinate with public health entities in each service area regarding the provision of essential public healthcare services. We must meet the following requirements:

- Report to public health entities regarding communicable diseases and/or diseases that are preventable by immunization as defined by state law
- Notify the local public health entity, as defined by state law, of communicable disease outbreaks involving members
- Coordinate with local public health entities that have a child lead program, or with DSHS regional staff when the local public health entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure

11.6 Health Promotion

We strive to improve healthy behaviors, reduce illness, and improve the quality of life for our members through comprehensive programs. Educational materials are disseminated to our members, and health education classes are coordinated with community organizations and network providers.

We offer our members education and information regarding their health. Ongoing projects include:

- Annual member newsletter
- Health education publications developed to inform members of condition-specific information and health promotion issues
- Health Tips on Hold (educational telephone messages while the member is on hold)

- Relationship development with community-based organizations to enhance opportunities for members

11.7 24-Hour Nurse HelpLine

The Wellpoint 24-Hour Nurse HelpLine is a telephonic, 24-hour service Wellpoint members can call to speak with a registered nurse who can:

- Give advice about needed care and how to get it
- Find doctors after-hours or on weekends.
- Schedule appointments with network doctors.

Members can reach the 24-Hour Nurse HelpLine at 833-731-2160. TTY services are available for members who are deaf or hard of hearing by calling 711. Language interpretation services are also available.

11.8 Telemedicine, Telehealth and Telemonitoring Access

We encourage our network providers to offer telemedicine, telehealth and telemonitoring capabilities to our members. Information will be included in our provider directories as to which providers have these services available. For specific details concerning provision and requirements of these services, refer to the *Medicaid/CHIP Provider Manual* at provider.wellpoint.com/tx under the *Resources* tab.

11.9 Patient360

The Patient360 application is an interactive dashboard available through Payer Spaces on Availity Essentials at Availity.com that gives instant access to detailed information about your Wellpoint patients. By selecting each tab in the Member Summary dashboard, you can drill down to specific items in a patient's medical record:

- Demographic information — member eligibility, other health insurance, assigned PCP and assigned case managers
- Care summaries — emergency department visit history, lab results, immunization history, and due or overdue preventive care screenings
- Claims details — status, assigned diagnoses and services rendered
- Authorization details — status, assigned diagnoses and assigned services
- Pharmacy information — prescription history, prescriber, pharmacy, and quantity
- Care management-related activities — assessment, care plans and care goals

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. Note: Your organization's Availity Administrator must assign you the P360 role for the application to be accessible.

11.10 Confidentiality of Information

Utilization management, case management, disease management, discharge planning, quality management and claims payment activities are designed to ensure that patient-specific information, particularly protected health information (PHI) obtained during review, is kept confidential in accordance with applicable laws, including *HIPAA*. Information is

shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and other activities and processes listed above.

12 BILLING AND CLAIMS ADMINISTRATION

Overview
Wellpoint strives to ensure providers can submit and receive reimbursement for claims efficiently and timely. In the following sections, we outline our general guidelines for nursing facilities.

Nursing facilities (NFs) may bill Wellpoint at any frequency they wish. We provide several electronic vehicles to facilitate your submissions. Please note the important information below:

- Clean claims for NF unit rate and NF Medicare Coinsurance submitted for Medicaid members are adjudicated within 10 days from the date the provider submits a clean claim. Clean claims not adjudicated within 10 days of submission by us are subject to interest payments. Claims must be filed within 365 days of the date of service.
- Clean claims for NF add-on services or other services negotiated into the provider's contract and submitted for Medicaid members are adjudicated within 30 days from the date we receive a clean claim. Clean claims not adjudicated within 30 days of receipt by us are subject to interest payments. Claims must be filed within 95 days of the date of service.
- Adjudication edits are based on the member's eligibility, benefit plan, authorization status, *HIPAA* coding compliance and our claim processing guidelines. Claim coding is subject to review using code-editing software.
- Claim reimbursement is based on the provider's contract. We are responsible for paying qualified providers their liability insurance and an enhanced fee to NF providers who are part of the HHSC Direct Care Staff Rate Enhancement Payment program. The fees will be built into the provider's unit rate payment fee schedule.
- Claims submitted by a NF must meet the HHSC criteria for clean claims submission as described in UMCM Chapter 2.3, Nursing Facility Claims Manual.

12.1 Nursing Facility Carved-in Services

The following services are reimbursable by Wellpoint for STAR+PLUS members.

12.1.1 Nursing Facility Unit Rate

Daily unit rate services include services traditionally provided by NFs as defined by HHSC Vendor Payment services. The following service categories are included in the NF unit rate and are not reimbursable separately:

- Computation of the NF daily unit rate = direct care staff + other resident care + dietary + general & administration costs + fixed capital
- Full or partial ventilator services
- Child tracheostomy for adults ages 21-22
- Liability insurance
- Direct care staff rate enhancement

Individual NF rates are established by HHSC and supplied to Wellpoint regularly from TMHP.

Claims submitted for the daily unit rate will continue to be authorized by TMHP. Wellpoint will not reassess or authorize services resulting from the MDS and covered under the daily unit rate.

12.1.2 Add-On Services

The following add-on services are covered benefits for STAR+PLUS members residing in the nursing facility:

- Tracheostomy care for members age 21
- Ventilator care
- Physician-ordered rehabilitative therapy services (including assessments) provided by therapists who are either employed by the nursing facility or subcontracted by the facility:
    - Rehabilitative therapy services should be billed by the nursing facility when authorized by Wellpoint and provided in the nursing facility.

The following add-on services are covered benefits that must be billed by the rendering provider of the service and not by the nursing facility:

- Emergency dental services
- Augmentative communication devices
- Customized power wheelchairs

12.1.3 Medicare SNF Coinsurance

Medicare SNF coinsurance amounts should be billed by the nursing facility to Wellpoint.

12.1.4 Other Negotiated Services

Other negotiated services contained in the nursing facility provider's contract should be billed to Wellpoint.

12.1.5 Carved-Out Services

The following list of services is carved out of our responsibility and should be billed to fee-for-service Medicaid:

- PASSR specialized services
- Hospice services
- Nursing facility daily care for a veterans' home
- Hospice care for a veterans' home

Questions related to the services included can be addressed to the nursing facility's assigned Network Relations representative by calling 833-731-2162.

12.2 Cost Reporting to HHSC

The nursing facility provider must submit cost reports to HHSC or its designee in the manner and format required by HHSC. If the provider fails to comply with this requirement, Wellpoint will hold payments to the provider as directed by HHSC until HHSC instructs Wellpoint to release payments.

12.3 Direct Care Staff Rate Enhancement Payment Program

The Direct Care Staff Rate Enhancement Payments is a legislatively mandated program providing additional compensation to long-term care direct care providers. We administer the enhanced payments for direct-care providers rendering services to our members.

12.4 Direct Care Staff Rate Enhancement Payment Program (DCREAP) Reporting

We require each contracted provider participating in the enhancement program to supply a detailed report describing the amount spent and payment distribution. Each provider must submit the required report in the format and by the date required each year by HHSC or its designee. Each report submitted by the provider will be reviewed by HHSC or its designee to ensure funds were distributed in accordance with state and federal guidelines.

If a provider fails to distribute the funds appropriately, HHSC will instruct us how to address the noncompliance, which can include but is not limited to:

- Retracting the funds.
- Reporting inappropriate use of funds by the provider to HHSC.
- Suspending or terminating the provider's participation in the enhancement program.
- Terminating the Wellpoint Provider Participation Agreement.

12.5 Claims Submission

Providers have three options for submitting claims to us:

- Electronic Data Interchange (EDI) using the Availity EDI Gateway
- Availity Essentials
- TMHP website claim portal
- Paper (for claims filed by providers other than a nursing facility)

12.6 Timely Filing

Providers must adhere to the following guidelines and time limits for nursing facility unit rate claims to be considered for payment:

- Submit clean claims for nursing facility unit rate claims within 365 calendar days from the date of service.
- In the case of other insurance or coordination of benefits/subrogation, submit clean claims within 365 calendar days of receiving a response from the third-party payer.
- In the case of retroactive member eligibility, submit clean claims within 365 calendar days from the date of service for members whose eligibility has not been added to the state's eligibility system.
- Corrected claims must be submitted within 120 days from the date of the Explanation of Payment (EOP).
- Wellpoint will pay providers interest at a rate of 18 percent per annum on all clean claims that are not adjudicated within the 10-day requirement.

Providers must adhere to the following guidelines and time limits for nursing facility add-on service claims or other negotiated services claims to be considered for payment:

- Submit clean claims for nursing facility add-on service claims or other negotiated services within 95 calendar days from the date of service or date of discharge.
- In the case of other insurance or coordination of benefits/subrogation, submit clean claims within 95 calendar days of receiving a response from the third-party payer.
- In the case of retroactive member eligibility, submit clean claims within 95 calendar days from the date the member is added to the state's eligibility system but no later than 365 days from the date of service or the inpatient date of discharge.
- For a provider who has a new or changed enrollment in Texas Medicaid, clean claims must be submitted within 95 days of the effective date of the Texas Medicaid enrollment or change but no later than 365 days from the date of service.
- If a provider first submits a claim to the wrong health plan within the 95-day period and produces documentation of the filing, the provider may resubmit the claim to the correct health plan within 95 calendar days of the date of the denial from the wrong health plan.
- Corrected claims must be submitted within 120 days from the date of the Explanation of Payment (EOP).
- Wellpoint will pay providers interest at a rate of 18 percent per annum on all clean claims that are not adjudicated within the 30-day requirement.

Note: We will make adjustments to previously adjudicated claims within 30 days from the date of receipt of an adjustment from the state using an automated process to reflect changes to such things as: nursing facility daily rates, provider contracts, service authorizations, applied income, and level of service (RUG).

Claims submitted after the filing timelines outlined above will be denied. We must receive claims from out-of-network providers rendering services outside of Texas within one year of the date of service and/or date of discharge.

12.7 Coding

Providers must use *HIPAA*-compliant codes when billing us for electronic, online and paper claim submissions. When billing codes are updated, the provider is required to use appropriate replacement codes. We will not accept claims submitted with noncompliant codes. We edit claims using SNIP Level One through and Six edits.

HHSC has defined the allowable codes to be billed for nursing facility unit rate services and add-on services. The *Nursing Facility Billing Matrix* is located in the *STAR+PLUS Handbook* at hhs.texas.gov/laws-regulations/handbooks/sph/appendices/appendix-xx-starplus-nursing-facility-billing-matrix.

All claims submitted are processed using generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by sources that include the National Correct Coding Initiative, the uniform billing editor, CPT-4 and ICD-10 manuals, and successor documents. In addition, we reserve the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. Our clinical policies/bulletins are posted on our provider website at provider.wellpoint.com/tx.

12.8 Clean Claim

A clean claim is one submitted for medical care or healthcare services rendered to a member with the data necessary for the MCO or its subcontracted claims processor to adjudicate and accurately report the claim. A clean claim other than a nursing facility unit rate clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837 (claim type) encounter guides as follows:

- 837 Institutional Combined Implementation Guide
- 837 Professional Combined Implementation Guide
- 837 Institutional Companion Guide
- 837 Professional Companion Guide

Claims submitted by a nursing facility for nursing facility unit rate or Medicare coinsurance must meet the HHSC criteria for clean claims submission as described in UMCM Chapter 2.3, *Nursing Facility Claims Manual*.

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted timely.
- Is accurate.
- Is submitted in a *HIPAA*-compliant format or using the standard claim form, including a *CMS1450* (UB-04), *CMS-1500* (02-12) or successor forms thereto, or the electronic equivalent of such claim form.
- Requires no further information, adjustment, or alteration by the provider or by a third party to be processed and paid by us.
- For a nursing facility unit rate or Medicare coinsurance claim, is submitted including all data as defined in the HHSC criteria for clean claims submission as described in UMCM Chapter 2.3, *Nursing Facility Claims Manual*.

CMS-1450 (*UB-04*) and *CMS-1500* (02-12) forms must include the following information (*HIPAA*-compliant where applicable):

- Patient's ID number
- Patient's name
- Patient's date of birth
- ICD-10 diagnosis code/revenue codes
- Date of service
- Place of service
- CPT-4 codes/HCPCS procedure codes
- Modifiers
- Diagnosis pointers
- Itemized charges
- Days or units
- Provider's tax ID number
- Total charge
- Provider's name according to the contract
- NPI of billing provider
- Billing provider's taxonomy codes

- NPI of rendering provider
- Rendering provider taxonomy codes
- State Medicaid ID number (optional)
- COB/other insurance information
- Authorization number or copy of authorization
- Name of referring physician
- NPI of ordering/referring/supervising provider when applicable
- Any other state-required data
- National drug codes (NDCs)

A claim that is deemed unclean is returned to the provider or submitter along with the reason for rejection.

For STAR+PLUS nursing facility daily unit rate and Medicare Coinsurance claims, clean claims are adjudicated within 10 calendar days of initial clean claim submission.

All other clean claims are adjudicated within 30 calendar days of receipt (18 days for electronic pharmacy claims submission, 21 days for nonelectronic pharmacy claims). If we do not adjudicate the clean claim within the time frames specified above, we will pay all applicable interest as required by law.

We produce and distribute *Explanation of Payments* (*EOP*s) on a daily basis except Sundays for our nursing facility providers. *EOP*s for other provider claims are produced on a biweekly basis. The EOP delineates the status of each claim that has been adjudicated during the payment cycle. EOPs are available in a format of the provider's choice, paper or electronic, and are available for printing and/or download.

12.9 Deficient Claim

Also known as an unclean claim, a deficient claim is one submitted for medical care or healthcare services rendered to a member that does not contain the data necessary for the MCO or its subcontracted claims processor to adjudicate and accurately report the claim.

12.10 Methods of Submission

12.10.1 Electronic Data Interchange Submission

Nursing facility claims may only be filed via electronic submission of claims through Availity Essentials, the TMHP Claim Portal or by an Electronic Data Interchange (EDI) vendor.

Availity is our exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business.

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)

- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity EDI submission options

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit Availity.com > Provider Solutions > EDI Clearinghouse.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway).

EDI Response Reports
Claims submitted electronically will return response reports that may contain rejections. If using a clearinghouse or billing vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports, contact your clearinghouse or billing vendor or Availity at 800-Availity (282-4548).

Availity Payer ID:
WLPNT

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Contact Availity
Please contact Availity Client Services with any questions at 800-Availity (282-4548).

Useful EDI Documentation
Availity EDI Connection Service Startup Guide — This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.

Availity EDI Companion Guide — This Availity EDI Guide supplements the *HIPAA* TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.

Availity Registration Page — Availity Register page for users new to Availity.

X12 Code Sets — X12 code descriptions used on EDI transactions.

12.10.2 Online Claims Submission

We offer a free digital claim submission application for all providers at Availity.com. This application submits claims directly to us without the use of a clearinghouse. Submission via this website requires provider registration. More information about claims submission can be found at provider.wellpoint.com/tx under the *Claims* tab.

12.10.3 Paper Claims Submission

Paper claims will not be accepted for claims submitted by a nursing facility.

For claims submitted by providers other than a nursing facility, we accept paper claim submissions on the following forms:

- *CMS-1450* (*UB-04*) claim form for institutional or facility claim submissions
- *CMS-1500* (02-12) claim form for professional claim submissions

The forms and instructions are available at the CMS website at cms.gov.

We use optical character recognition (OCR) technology as part of our front-end claims processing procedures. Claims must be submitted on original red claim forms (not black and white or photocopied forms) with laser printed or typed (not handwritten) information in a large, dark font. We cannot accept claims with alterations to billing information. Altered claims will be returned to the provider with an explanation of the reason for the return. We will not accept handwritten claims.

Submit paper claims to:
Texas Claims
Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-1010

12.11 Claim Status

We offer two methods for accessing claim status 24 hours a day, 365 days a year:

- Provider website: Availity.com:
    - You can check the status of a claim anytime by logging in to Availity Essentials at Availity.com and selecting Claims & Payments > Claim Status
    - When viewing the status of a claim on Availity Essentials, there may be options available to submit medical records or an itemized bill or dispute the claim.
- Provider Inquiry Line: 833-731-2162

12.12 Participating, In-Network Provider Reimbursement

Claim reimbursement is based on the provider's contract.

We cannot pay providers or assign Medicaid members to providers for Medicaid services unless they are included on the state master file as provided by the Texas Medicaid & Healthcare Partnership (TMHP), which includes the state master file for nursing facilities. State master files are updated weekly.

Federal regulations require state Medicaid agencies to revalidate provider enrollment information every 3 to 5 years. If a provider's re-enrollment is not complete by the required date, the provider will not be able to receive payments for Medicaid services. Compliance with the re-enrollment process is solely the responsibility of the provider. Additional information is available through HHSC and the administrative services contractor.

Wellpoint will automatically adjust previously adjudicated daily care claims within 30 days from the date of receipt of a change in data from the state to reflect adjustments to such items as nursing facility daily rates, provider contracts, service authorizations, applied income and level of service (resource utilization group [RUG]). Any adjustments, besides the ones listed previously and some denials, may require a corrected claim by the nursing facility provider.

12.13 Electronic Funds Transfer and Electronic Remittance Advice

Electronic Remittance Advice (ERA) (835)
The 835 eliminates the need for paper remittance reconciliation. Use Availity Essentials to register and manage ERA account changes with these three easy steps:

1. Log in to Availity.com
2. Select My Providers
3. Select Enrollments Center and select Transaction Enrollment

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

Contact Availity
For help with ERA questions, contact Availity Client Services at 800-Availity (282-4548).

Electronic Funds Transfer (EFT)
Electronic claims payment through electronic funds transfer (EFT) is a secure and fast way to receive payment and reduce administrative processes. EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use EnrollSafe (https://enrollsafe.payeehub.org/) to register and manage EFT account changes.

12.14 Reimbursement Policies

Reimbursement policies serve as a guide to assist you with accurate claim submissions and outline the basis for reimbursement if services are covered by the member's Wellpoint benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claims submissions. Services should be billed with appropriate CPT codes, HCPCS codes and/or revenue codes. The codes denote the service and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Wellpoint may:

- Reject or deny the claim

- Recover and/or recoup claim payment

Wellpoint reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by provider or state contract language or state, federal requirements, or mandates. System logic or set-up may prevent the loading of policies into the claims platforms in the same manner as described; however, Wellpoint strives to minimize these variations.

Reimbursement Hierarchy
Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review Schedules and Updates to Reimbursement Policies
Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Wellpoint business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical Coding
The Medical Coding department ensures that correct coding guidelines have been applied consistently through Wellpoint. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition
Wellpoint allows reimbursement for covered services based on their procedure code definitions or descriptor, as opposed to their appearance under particular CPT categories or sections, or descriptors unless otherwise noted by state or provider contracts or state, federal or CMS contracts and/or requirements. There are eight CPT sections:

1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

12.15 Provider Claims Payment Disputes

Information on the payment dispute process (including acute care claims) is located in the Complaints, Appeals and Provider Disputes chapter of this manual.

12.16 Overpayments & Payment Withhold

We are entitled to offset an amount equal to any overpayments made by us to a provider against any payments due and payable by us. Overpayments may be identified by our Cost Containment Unit (CCU), a Wellpoint vendor or the provider. When an overpayment is identified by the CCU or a Wellpoint vendor, the provider will receive written notification. The notification will include an *Overpayment Refund Notification Form* specifying the reason for the return, to be completed by the provider and returned along with the refund check. The submission of the *Overpayment Refund Notification Form* allows us to process and reconcile the overpayment in a timely manner.

HHSC requires that providers must report identified overpayments and submit a refund to Wellpoint within 60 days from the time of identification. HHSC defines identification as when the provider has or should have, through reasonable diligence, determined that the provider has received an overpayment and quantified the overpayment amount. Overpayments should be reported and refunds submitted using the *Overpayment Refund Notification Form*. This form can be found on our provider website at provider.wellpoint.com/tx under Resources > Forms.

Wellpoint will withhold or reject all or part of payment for a claim submitted by the provider if:

- The provider has been excluded or suspended from the Medicare, Medicaid or CHIP programs for fraud, waste, or abuse.
- The provider is on full or partial payment hold under the authority of HHSC or its authorized agent(s).
- The provider has debts, settlements, or pending payments due to HHSC or the state or federal government.
- A claim for nursing facility unit rates does not comply with the HHSC criteria for clean claims.
- A claim for Medicare-covered services for dual-eligible members is not first submitted to the Medicare payer.

12.17 Claim Audits

Except as specified in this section or by future changes in our contract with the state of Texas, we must complete all audits of a provider claim no later than two years after receipt of a clean claim, regardless of whether the provider participates in our network. This limitation does not apply in cases of provider fraud, waste or abuse that we did not discover within the two-year period following receipt of the claim. In addition, the two-year limitation does not apply when an examination, audit, or inspection of a provider, by an official or entity that we are required to allow access to records by our contract with the state of Texas, is concluded more than two years after we received the claim. Also, the two-year limitation does not apply when HHSC has recovered a capitation from us based on a

member's ineligibility. If any exception to the two-year limitation applies, we may recoup related payments from providers.

If an additional payment is due to a provider as a result of an audit, we must make the payment no later than 30 days after the audit is completed. If the audit indicates we are due a refund from the provider, we must send the provider written notice of the basis and specific reasons for the recovery no later than 30 days after the audit is completed. If the provider disagrees with the refund request, we must give the provider an opportunity to appeal and may not attempt to recover the payment until the provider has exhausted all appeal rights.

12.18 Coordination of Benefits

Federal and state laws require Medicaid, including the STAR+PLUS programs, to be the payer of last resort. All other available third-party resources (including Medicare) must meet their legal obligation to pay claims before Medicaid funds are used to pay for the care of an individual eligible for Medicaid. Providers must submit claims to other health insurers for consideration prior to billing us. A copy of the other health insurer's *EOB/EOP* or rejection letter should be submitted with the claim to us. If we are aware of other third-party resources at the time of claim submission, we will deny the claim and redirect the provider to bill the appropriate insurance carrier. If we become aware of the resource after payment for the service was rendered, we will pursue postpayment recovery.

We will process claim payments on potential subrogation cases for third-party resources other than health insurance. These cases will be referred to the HHSC administrator to pursue recovery. Any recoveries received on these subrogation cases will be remitted to the HHSC administrator.

12.19 Billing Members

Our members must not be balance-billed for the amount above that which is paid by us for covered services.

In addition, providers may not bill a member if any of the following occurs:

- Failure to timely submit a claim, including claims not received by us
- Failure to submit a claim to us for initial processing within the 365-day filing deadline for nursing facility unit rate claims or 95-day filing deadline for nursing facility add-on services and other claims
- Failure to submit a corrected claim within the 120-day filing resubmission period
- Failure to appeal a claim within the 120-day payment dispute period
- Failure to submit a member appeal for a pre-service utilization review determination within 60 calendar days of the date of coverage denial
- Submission of an incomplete claim
- Errors made in claims preparation, claims submission or the appeal process

A member cannot be billed for failing to show for an appointment. Providers may not bill Wellpoint members for a third-party insurance copay. Medicaid members do not have any out-of-pocket expense for covered services.

Before rendering services, providers should always inform members they will be charged for the cost of services not covered by us. A provider who chooses to deliver services not covered by us must:

- Understand we only reimburse for services that are medically necessary, including hospital admissions and other services.
- Obtain the member's signature on the *Client Acknowledgment Statement* prior to the provision of the services, specifying the member will be held responsible for payment of services.
- Understand they may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

12.20 Private Pay Agreement

Providers:

- Must advise members at the time the service is rendered that they are accepted as private-pay patients, and as such, are financially responsible for all services received.
- May bill for any service that is not a benefit of a Wellpoint program (like personal care items) without obtaining a signed *Client Acknowledgment Statement*.
- May bill a member as a private pay patient if retroactive eligibility is not granted.
- Must have private pay members agree in writing (see sample documentation shown below) to avoid being asked questions about how the member was accepted; without written, signed documentation that the member has been properly notified of the private pay status, the provider should not seek payment from an eligible program member.

Sample Private Pay Agreement

"I understand [provider's name] is accepting me as a private pay patient for the period of _____, and I am responsible for paying for any services I receive. The provider will not file a claim to Medicaid or Wellpoint for services provided to me."

_____

Signed Date

12.21 Client Acknowledgment Statement

Providers may bill a Wellpoint member for a service denied as not medically necessary or not a covered benefit only if all of the following conditions are met:

- 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 acknowledgment statement signed by the member and the provider (as shown on the following page); the signed statement must be obtained prior to the provision of the service in question.

Client Acknowledgment Statement Form

I understand my doctor, _____, or Wellpoint has said the services
Provider name
or items I have asked for on _____ are not covered under my
Dates of service
Wellpoint plan. Wellpoint will not pay for these services. Wellpoint has set up the administrative rules and medical necessity standards for the services or items I get. 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.

_____ Date: _____
Member name (print)

_____
Member signature

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 acknowledgment statement signed by the provider and by the member, above, prior to the service being rendered.

_____ Date: _____
Provider name (print)

_____
Provider signature

12.22 Cost Sharing

12.22.1 Medicaid Cost Sharing

Medicaid members do not have copays.

12.22.2 Medicare Coinsurance

Wellpoint will pay the state's Medicare coinsurance obligation for a qualified dual-eligible member's Medicare-covered stay in a nursing facility. Wellpoint is not responsible for the state's Medicare cost-sharing obligation for a dual-eligible member's Medicare-covered nursing facility add-on services, which are adjudicated by either the state's fee-for-service claims administrator or the dual-eligible member's Medicare plan as applicable to the member. The nursing facility provider must submit an electronic version of the Medicare Remittances and Advice form.

If the provider files a claim for Medicare coinsurance with a third-party insurance resource, the wrong health plan or with the wrong HHSC portal and produces documentation verifying the initial filing met the timeliness standards described in the Timely Filing section of this manual, Wellpoint will process the claim without denying the resubmission for failure to timely file. The provider must file the claim with Wellpoint by the later of: 1) 365 days after the date of service, or 2) 95 days after the date on the remittance and status report or Explanation of Payment from the other carrier or contractor.

12.22.3 Applied Income (AI) and Incurred Medical Expenses (IME)

We will include the application of AI and IME at the time of claim adjudication and based on the amounts reported to us from HHSC/TMHP for each member during the period in which the AI or IME applies. Providers are required to place the expected AI or IME amounts in the appropriate location on the claim submission.

Collection of Applied Income
The provider must make reasonable efforts to collect AI, document those efforts, and notify the service coordinator or the Wellpoint designated representative when it has made two unsuccessful attempts to collect applied income in a month. This provision in no way subrogates the provider's existing regulatory and licensing responsibilities related to the collection of AI, including the requirements of 26 TAC §554.2316.

We will provide each nursing facility the name and contact information of a service coordinator or other designated representative who will assist with the collection of applied income from members. Wellpoint must notify the provider within 10 days of any change to the assigned service coordinator or representative.

12.23 Emergency Services

Prior authorization is not required for coverage of emergency services. Any hospital or provider request for authorization of emergency services is granted immediately. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are

consistent with the prudent layperson standard and comply with federal and state requirements.

12.24 Hospital emergency room claim processing

Hospital emergency room claims will be processed as emergent and reimbursed at the applicable contracted rate or valid out-of-network fee-for-service rate when a diagnosis from our designated auto-pay list is billed as the primary diagnosis on the claim. If the primary diagnosis is not on the auto-pay list, the provider must submit medical records with the claim. Upon receipt, the claim and records will be reviewed by a prudent layperson standard to determine if the presenting symptoms qualify the patient's condition as emergent. If the reviewer confirms the visit was emergent, according to the prudent layperson criteria, the claim will pay at the applicable contracted rate or valid out-of-network fee-for-service rate. If it is determined to be nonemergent, the claim will pay a triage fee.

In the event a claim from a hospital is submitted without a diagnosis from the auto-pay list as the primary diagnosis and no medical records are attached, the claim for the ER visit will automatically pay a triage fee.

A copy of the current ER diagnosis auto-pay list is available on our provider website at provider.wellpoint.com/tx on the *Claims Submissions and Disputes* page. The list of diagnoses is updated as needed.

12.25 Network Relations Consultants

Wellpoint will designate a Network Relations Consultant to support each contracted nursing facility with coverage questions, payment and billing support, education and training needs, and overall contract management. Questions and inquiries can be directed to the assigned Network Relations Consultant by calling 833-731-2162, referencing the [*Network Relations Consultants by Facility*] list at provider.wellpoint.com/tx > Resources > STAR+PLUS > Nursing Facility Resources or using the individual contact information provided to each nursing facility by their designated Wellpoint representative.

13 QUALITY MANAGEMENT

13.1 Overview

We maintain a comprehensive Quality Management 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. Members and providers have opportunities to make recommendations for areas of improvement. The Quality Management program goals and outcomes are available to both providers and members upon request. Studies are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program. If you would like more information about our Quality Management program goals, processes and outcomes, call Provider Services at 833-731-2162.

The initial program development was based on a review of the needs of the population served. Systematic re-evaluation of the needs of the plan's specific population occurs on an annual basis. This includes not only age and gender distribution but also a review of utilization data — inpatient, emergent and urgent care and office visits by type, cost, and volume. This information is used to define high-volume or problem-prone areas.

HEDIS performance is evaluated annually and compared against national benchmarks. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) evaluates member satisfaction and experience annually. Performance is analyzed for barriers and best practices, and interventions are developed to improve performance.

We maintain a quality committee structure that includes a medical advisory committee (MAC), a credentialing committee (with participation from network physicians and practitioners), and a peer review committee. These committees are overseen by the quality management committee structure.

13.2 Quality Management Committee

The purpose of the Quality Management Committee (QMC) is to maintain quality as a cornerstone of our culture. The committee serves as an instrument of change through demonstrable improvement in care and service. The QMC's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the quality management program.
- Establish processes and structure that ensure NCQA, HHSC and Texas Department of Insurance (TDI) compliance.
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies.
- Coordinate communication of quality management activities throughout the health plans.
- Review HEDIS data and action plans for improvement.
- Review and approve the annual Quality Management Program Description.
- Review and approve the annual work plans for each service delivery area.
- Provide oversight and review of delegated services.

- Provide oversight and review of subordinate committees.
- Receive and review reports of utilization review decisions and take action when appropriate.
- Analyze member and provider satisfaction survey responses.
- Monitor the plan's operational indicators through the plan's senior staff.

13.3 Medical Advisory Committee

The Medical Advisory Committee (MAC) assesses levels and quality of care provided to members and recommends, evaluates, and monitors standards of care. It oversees the peer-review process that provides a systematic approach for monitoring the quality and appropriateness of care. The MAC conducts a systematic process for network maintenance through the credentialing and re-credentialing process. The MAC advises the health plan administration in any aspect of its policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer-review process, the Quality Management program, and the Health Care Management Services program.

The MAC's responsibilities are to:

- Utilize an ongoing peer-review system to monitor practice patterns, identify appropriateness of care and improve risk prevention- activities.
- Review clinical study design and results.
- Develop action plans and recommendations regarding clinical quality improvement studies.
- Consider and act in response to provider sanctions.
- Provide oversight of credentialing committee decisions to credential and recredential providers for participation in the plan.
- Approve credentialing and re-credentialing policies and procedures.
- Oversee member access to care.
- Review and provide feedback regarding new technologies.
- Approve recommendations from subordinate committees.

13.4 Use of Performance Data

All providers must allow Wellpoint to use performance data in cooperation with our Quality Management program and activities.

13.5 Credentialing Committee

The Credentialing Committee's purpose is to credential and recredential all participating providers according to plan, state, and federal accreditation standards.

Committee responsibilities include:

- Conducting reviews for all providers who apply for participation in the network.
- Reviewing all participating providers for re-credentialing purposes, including the review of any quality or utilization data/reports.
- Approving or denying providers submitted by a delegated credentialing entity.
- Reviewing and updating credentialing policies and procedures.

- Reporting physician corrective actions and sanctions imposed based upon re-credentialing activity to the MAC.
- Approving or denying providers for participation in the network and report decisions to the MAC.
- Overseeing delegated credentialing relationships.

13.6 Peer Review

The peer review process provides a systematic approach for monitoring the quality and appropriateness of care.

Peer review responsibilities are to:

- Participate in the implementation of the established peer review system.
- Review and make recommendations regarding individual provider peer-review cases.
- Work in accordance with the executive medical director.

Should investigation of a member complaint result in concern regarding a physician's compliance with community standards of care or service, all elements of peer review will be followed.

Dissatisfaction severity codes and levels of severity are applied to quality issues. The medical director assigns a level of severity to the complaint. Peer review includes investigation of physician actions by or at the discretion of the medical director. The medical director takes action based on the quality issue and the level of severity, invites the cooperation of the physician, and consults and informs the MAC and peer review committee. The medical director informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken. Outcomes are reported to the appropriate internal and external entities, which include the quality management committee. The peer review process is a major component of the MAC monthly agenda. The peer review policy is available upon request.

13.7 Clinical Practice Guidelines

Using nationally recognized, scientific, evidence-based standards of care, we work with providers to develop clinical policies and guidelines for the care of members. The super MAC oversees and directs us in formulating, adopting, and monitoring guidelines.

Clinical Practice Guidelines are located on our website at provider.wellpoint.com/tx on the *Provider Manuals & Guides* page in the Resources menu. A copy of the guidelines can be printed from the website, or you may call Provider Services at 833-731-2162 to receive a printed copy.

We select at least four evidence-based Clinical Practice Guidelines that are relevant to the member population. We measure performance against at least two important aspects of each of the four Clinical Practice Guidelines annually. The guidelines must be reviewed and revised at least every two years or whenever the guidelines change.

13.8 Focus Studies and Utilization Management Reporting Requirements

Quality management is involved in conducting clinical and service utilization studies that may or may not require medical record review. We conduct gap analysis of the data and share opportunities for improvement with our network providers.

13.9 New Technology

Our medical director and participating providers review and evaluate new medical advances in technology (or the new application of existing technology) in medical procedures, behavioral health procedures, pharmaceuticals, and devices to determine their appropriateness for covered benefits. Scientific literature and government approval are reviewed for determining if the treatment is safe and effective. The new medical advance or treatment (or new application of existing technology) must provide equal or better outcomes than the existing covered benefit treatment or therapy for it to be considered for coverage by Wellpoint.

14 OUT-OF-NETWORK PROVIDERS

14.1 Claims Submission

Nonparticipating nursing facility providers must submit clean claims to us within 365 days of service for daily unit rate services and within 95 days of service for add-on services. Nonparticipating providers located outside of Texas must submit clean claims for nursing facility unit rate services or add-on services to us within 365 days of the date of service. Refer to the definition of clean claim in the Billing and Claims Administration chapter of this manual. To submit claims for services provided to STAR+PLUS members, providers must be enrolled with Texas Medicaid.

14.2 Prior authorization

Nursing facility residential services included in the nursing facility daily unit rate and Medicare coinsurance do not require prior authorization by Wellpoint.

Nonparticipating providers must obtain prior authorization for all other nonemergent services except as prohibited under federal or state law for in-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated delivery by Cesarean section. We require prior authorization of maternity inpatient stays for any portion in excess of these time frames.

14.3 Reimbursement

Nonparticipating providers are reimbursed in accordance with a negotiated case rate or, in absence of a negotiated rate, as follows:

For STAR+PLUS, we reimburse:

- Out-of-network, in-area service providers at no less than the prevailing Medicaid FFS rate, less five percent.
- Out-of-network, out-of-area service providers at no less than 100 percent of the Medicaid FFS rate.

APPENDIX A – ID CARDS

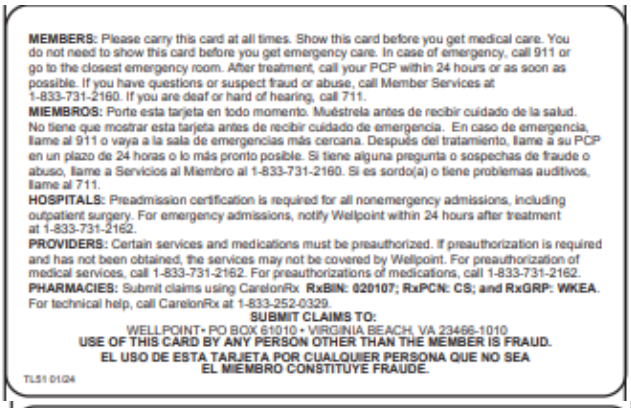
Below are sample ID cards for: 1) members who have Medicaid only and 2) members who have both Medicaid and Medicare.


Wellpoint

PCP Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR+PLUS

WELLPOINT TEXAS, INC.
wellpoint.com/tx/medicaid

Member Name: JOHN Q SAMPLE
Medicaid Number:
Wellpoint Service Coordination: 1-833-731-2160
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:
Vision: 1-800-428-8789 Pharmacy Member Services: 1-833-235-2022
Wellpoint Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-833-731-2160
24-hour Nurse HelpLine: 1-833-731-2160
Transportation: 1-844-867-2837


MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. If you have questions or suspect fraud or abuse, call Member Services at 1-833-731-2160. If you are deaf or hard of hearing, call 711.
MIEMBROS: Porte esta tarjeta en todo momento. Muéstrela antes de recibir cuidado de la salud. No tiene que mostrar esta tarjeta antes de recibir cuidado de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP en un plazo de 24 horas o lo más pronto posible. Si tiene alguna pregunta o sospechas de fraude o abuso, llame a Servicios al Miembro al 1-833-731-2160. Si es sordo(a) o tiene problemas auditivos, llame al 711.
HOSPITALS: Preadmission certification is required for all nonemergency admissions, including outpatient surgery. For emergency admissions, notify Wellpoint within 24 hours after treatment at 1-833-731-2162.
PROVIDERS: Certain services and medications must be preauthorized. If preauthorization is required and has not been obtained, the services may not be covered by Wellpoint. For preauthorization of medical services, call 1-833-731-2162. For preauthorizations of medications, call 1-833-731-2162.
PHARMACIES: Submit claims using CarelonRx **RxBIN: 020107; RxPCN: CS; and RxGRP: WKEA.** For technical help, call CarelonRx at 1-833-252-0329.
SUBMIT CLAIMS TO:
WELLPOINT• PO BOX 61010 • VIRGINIA BEACH, VA 23466-1010
USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.
EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.
TL51 01/24

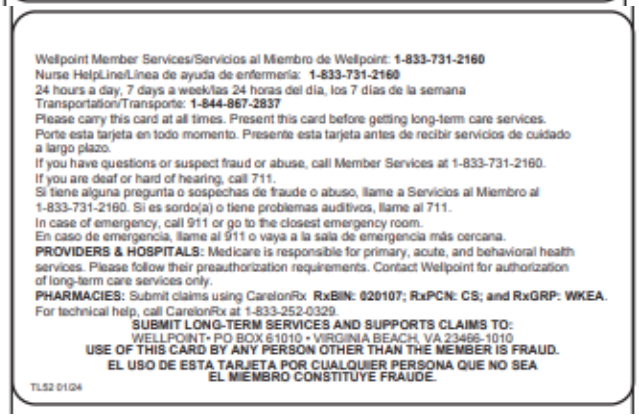

Wellpoint

Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR+PLUS

WELLPOINT TEXAS, INC.
wellpoint.com/tx/medicaid

Member Name: JOHN Q SAMPLE
Medicaid Number:
Wellpoint Service Coordination: 1-833-731-2160
Pharmacy Member Services: 1-833-235-2022

LONG-TERM SERVICES AND SUPPORTS BENEFITS ONLY
You receive primary, acute, and behavioral health services through Medicare.
You receive only long-term services and supports through Wellpoint.
SOLO BENEFICIOS DE SERVICIOS Y APOYOS A LARGO PLAZO
Usted recibe servicios de cuidado primario, aguda y del comportamiento a través de Medicare. Solo recibe servicios y apoyos a largo plazo a través de Wellpoint.


Wellpoint Member Services/Servicios al Miembro de Wellpoint: **1-833-731-2160**
Nurse HelpLine/Linea de ayuda de enfermería: **1-833-731-2160**
24 hours a day, 7 days a week/las 24 horas del día, los 7 días de la semana
Transportation/Transporte: **1-844-867-2837**
Please carry this card at all times. Present this card before getting long-term care services.
Porte esta tarjeta en todo momento. Presente esta tarjeta antes de recibir servicios de cuidado a largo plazo.
If you have questions or suspect fraud or abuse, call Member Services at 1-833-731-2160.
If you are deaf or hard of hearing, call 711.
Si tiene alguna pregunta o sospechas de fraude o abuso, llame a Servicios al Miembro al 1-833-731-2160. Si es sordo(a) o tiene problemas auditivos, llame al 711.
In case of emergency, call 911 or go to the closest emergency room.
En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana.
PROVIDERS & HOSPITALS: Medicare is responsible for primary, acute, and behavioral health services. Please follow their preauthorization requirements. Contact Wellpoint for authorization of long-term care services only.
PHARMACIES: Submit claims using CarelonRx **RxBIN: 020107; RxPCN: CS; and RxGRP: WKEA.** For technical help, call CarelonRx at 1-833-252-0329.
SUBMIT LONG-TERM SERVICES AND SUPPORTS CLAIMS TO:
WELLPOINT• PO BOX 61010 • VIRGINIA BEACH, VA 23466-1010
USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.
EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.
TL52 01/24

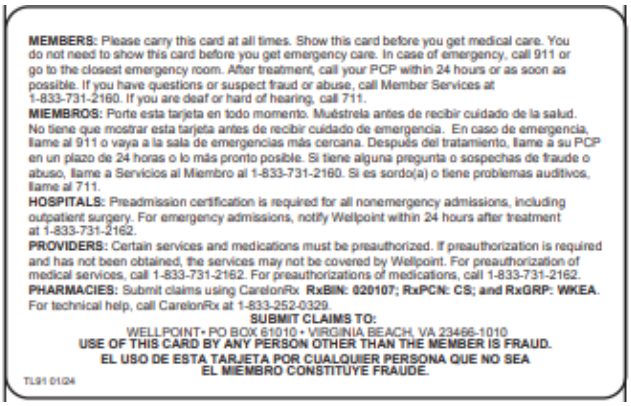
Sample ID cards for Wellpoint members in the Medicaid Rural Service Area for: 1) members who have Medicaid only and 2) members who have both Medicaid and Medicare:

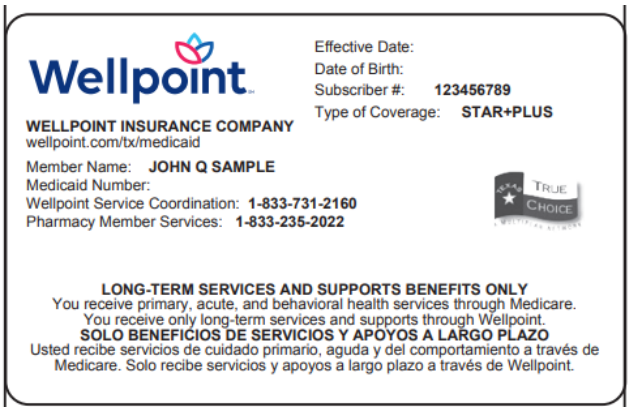

Wellpoint

PCP Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR+PLUS

WELLPOINT INSURANCE COMPANY
wellpoint.com/tx/medicaid

Member Name: JOHN Q SAMPLE
Medicaid Number:
Wellpoint Service Coordination: 1-833-731-2160
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:
Vision: 1-800-428-8789 Pharmacy Member Services: 1-833-235-2022
Wellpoint Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-833-731-2160
24-hour Nurse HelpLine: 1-833-731-2160
Transportation: 1-844-867-2837


MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. If you have questions or suspect fraud or abuse, call Member Services at 1-833-731-2160. If you are deaf or hard of hearing, call 711.
MIEMBROS: Porte esta tarjeta en todo momento. Muéstrela antes de recibir cuidado de la salud. No tiene que mostrar esta tarjeta antes de recibir cuidado de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP en un plazo de 24 horas o lo más pronto posible. Si tiene alguna pregunta o sospechas de fraude o abuso, llame a Servicios al Miembro al 1-833-731-2160. Si es sordo(a) o tiene problemas auditivos, llame al 711.
HOSPITALS: Preadmission certification is required for all nonemergency admissions, including outpatient surgery. For emergency admissions, notify Wellpoint within 24 hours after treatment at 1-833-731-2162.
PROVIDERS: Certain services and medications must be preauthorized. If preauthorization is required and has not been obtained, the services may not be covered by Wellpoint. For preauthorization of medical services, call 1-833-731-2162. For preauthorizations of medications, call 1-833-731-2162.
PHARMACIES: Submit claims using CarelonRx **RxBIN: 020107; RxPCN: CS; and RxGRP: WKEA.** For technical help, call CarelonRx at 1-833-252-0329.
SUBMIT CLAIMS TO:
WELLPOINT• PO BOX 61010 • VIRGINIA BEACH, VA 23466-1010
USE OF THIS CARD BY ANY PERSON OTHER THAN THE MEMBER IS FRAUD.
EL USO DE ESTA TARJETA POR CUALQUIER PERSONA QUE NO SEA EL MIEMBRO CONSTITUYE FRAUDE.
TL91 01/24



Wellpoint

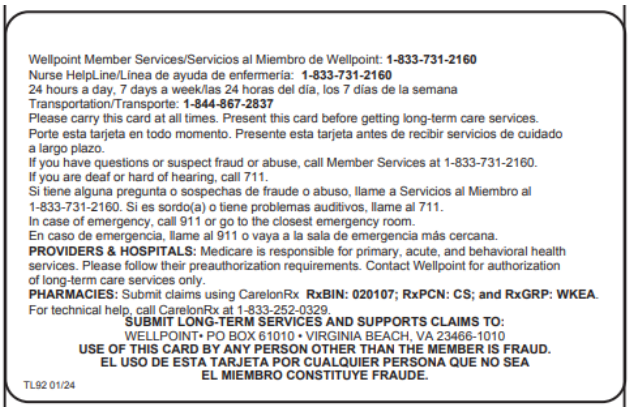
Effective Date:
Date of Birth:
Subscriber #: **123456789**
Type of Coverage: **STAR+PLUS**

WELLPOINT INSURANCE COMPANY
wellpoint.com/tx/medicaid

Member Name: **JOHN Q SAMPLE**
Medicaid Number:
Wellpoint Service Coordination: **1-833-731-2160**
Pharmacy Member Services: **1-833-235-2022**

TRUE CHOICE

LONG-TERM SERVICES AND SUPPORTS BENEFITS ONLY
You receive primary, acute, and behavioral health services through Medicare.
You receive only long-term services and supports through Wellpoint.
SOLO BENEFICIOS DE SERVICIOS Y APOYOS A LARGO PLAZO
Usted recibe servicios de cuidado primario, aguda y del comportamiento a través de Medicare. Solo recibe servicios y apoyos a largo plazo a través de Wellpoint.



Wellpoint Member Services/Servicios al Miembro de Wellpoint: **1-833-731-2160**
Nurse HelpLine/Línea de ayuda de enfermería: **1-833-731-2160**
24 hours a day, 7 days a week/las 24 horas del día, los 7 días de la semana
Transportation/Transporte: **1-844-867-2837**
Please carry this card at all times. Present this card before getting long-term care services.
Porte esta tarjeta en todo momento. Presente esta tarjeta antes de recibir servicios de cuidado a largo plazo.
If you have questions or suspect fraud or abuse, call Member Services at 1-833-731-2160.
If you are deaf or hard of hearing, call 711.
Si tiene alguna pregunta o sospechas de fraude o abuso, llame a Servicios al Miembro al 1-833-731-2160. Si es sordo(a) o tiene problemas auditivos, llame al 711.
In case of emergency, call 911 or go to the closest emergency room.
En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana.
PROVIDERS & HOSPITALS: Medicare is responsible for primary, acute, and behavioral health services. Please follow their preauthorization requirements. Contact Wellpoint for authorization of long-term care services only.
PHARMACIES: Submit claims using CarelonRx **RxBIN: 020107; RxPCN: CS; and RxGRP: WKEA**.
For technical help, call CarelonRx at 1-833-252-0329.
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TL92 01/24

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan. Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan. CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan.


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