



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>1 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

### DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	2.0	January 15, 2016	Initial version of Uniform Managed Care Manual Chapter 16.1, "Medicaid and CHIP Contract Operational Guidance."  Chapter 16.1 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042, 529-13-0071, and 529-15-0001; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.

<sup>1</sup> Status is represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.

<sup>2</sup> Revisions are numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

<sup>3</sup> Brief description of the changes to the document made in the revision.



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	<b>16.1</b>	<b>2 of 48</b>
CHAPTER TITLE	EFFECTIVE DATE	
<b>Medicaid and CHIP Contract Operational Guidance</b>	<b>January 15, 2016</b>	
	<b>Version 2.0</b>	

### **I. Applicability**

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS (including the Medicare-Medicaid Dual Demonstration (MMDD)), CHIP, STAR Kids, and STAR Health Programs, and Dental Contractors providing Children’s Medicaid and CHIP Dental Services to Members through dental health plans. In this chapter, references to “CHIP” or the “CHIP Managed Care Program(s)” apply to the CHIP Program and the CHIP Dental Contractors. References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR, STAR+PLUS, and STAR Health Programs, and the Medicaid Dental Contractors. The term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Dental Contractors, Medicare-Medicaid Plans (MMPs), and any other entities licensed or approved by the Texas Department of Insurance.

### **II. Background**

This chapter provides operational guidance regarding contractual requirements of Managed Care Organizations (MCOs). The formatting of this chapter is based on Section 8 of the Uniform Managed Care Contract, which focuses on specific requirements and guidelines for MCOs. Note that all operational guidance is currently effective. If the effective date is not applicable then the policy clarification is just a reminder.

### **III. Purpose**

This chapter includes policy clarifications and operational guidance released since January 2013 for Medicaid and CHIP MCOs.



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	<b>16.1</b>	<b>3 of 48</b>
CHAPTER TITLE	EFFECTIVE DATE	
<b>Medicaid and CHIP Contract Operational Guidance</b>	<b>January 15, 2016</b>	
	<b>Version 2.0</b>	

## Contents

ACRONYMS .....	7
16.1 GENERAL SCOPE OF WORK .....	9
16.1.1 Administration and Contract Management .....	9
16.1.2 Covered Services .....	9
16.1.2.1 Ambulance Services.....	9
16.1.2.1.1 Prior Authorization for Non-Emergency Transportation by Ambulance .....	9
16.1.2.2 Reserved - 16.1.2.5.....	11
16.1.2.6 Durable Medical Equipment (DME), Medical Supplies, and Nutritional Products.....	12
16.1.2.6.1 Breast Pumps.....	12
16.1.2.6.2 Accessories, Modifications, Adjustments and Repairs for Mobility Aids.....	13
16.1.2.7 Reserved [Emergency Services].....	13
16.1.2.8 Gynecological, Reproductive Health, and Family Planning Services.....	13
16.1.2.8.1 Long Acting Reversible Contraception (LARC) .....	13
16.1.2.9 Home Health Care Services .....	15
16.1.2.9.1 Home Health Therapy Provider Rates .....	15
16.1.2.9.2 Homebound Policy .....	16
16.1.2.10 Hospital (Inpatient and Outpatient) Services .....	17
16.1.2.10.1 Spell of Illness Guidance for STAR+PLUS Members .....	17
16.1.2.11 Reserved -16.1.2.20.....	20
16.1.3 Access to Care.....	21
16.1.3.1 Reserved [Waiting Times for Appointments] .....	21
16.1.3.2 Access to Network Providers.....	21
16.1.3.2.1 Reserved – 16.1.3.2.5 .....	21
16.1.3.2.6 Nursing Facility Access.....	21
16.1.3.2.6.1 STAR Clients Admitted to Nursing Facilities.....	21
16.1.3.2.7 Reserved [All Other Covered Services] .....	22
16.1.4 Provider Network.....	22
16.1.4.1 Reserved [Provider Contract Requirements].....	22
16.1.4.2 Primary Care Providers.....	22
16.1.4.2.1 Use of Advanced Nurses and Physician Assistants .....	22
16.1.4.2.2 Prescription Regulations for Advanced Nurses and Physician Assistants.....	23
16.1.4.3 - 16.1.4.14 Reserved.....	24
16.1.4.15 Ambulance Providers .....	24
16.1.4.15.1 Ambulance Provider Network Agreement .....	24
16.1.5 Member Services.....	24
16.1.5.1 Cultural Competency Plan .....	24
16.1.6 Reserved [Marketing and Prohibited Practices] .....	27
16.1.7 Reserved [Quality Assessment and Performance Improvement].....	27
16.1.8 Utilization Management.....	27



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>4 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

16.1.8.1	CHIP Notice for Approved Services.....	27
16.1.9	<i>Early Childhood Intervention (ECI)</i> .....	27
16.1.9.1	Service Designations for Early Childhood Intervention (ECI) Individual Family Service Plan Form 27	
16.1.10	<i>Reserved [Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)- Specific Requirements]</i> .....	32
16.1.11	<i>Reserved [Coordination with Texas Department of Family and Protective Services]</i> .....	32
16.1.12	<i>Reserved [Services for People with Special Health Care Needs]</i> .....	32
16.1.13	<i>Reserved</i>	32
16.1.14	<i>Reserved [Disease Management (DM)]</i> .....	32
16.1.15	<i>Reserved [Behavioral Health (BH) Network and Services]</i> .....	32
16.1.16	<i>Reserved [Financial Requirements for Covered Service]</i> .....	32
16.1.17	<i>Accounting and Financial Reporting Requirements</i> .....	32
16.1.17.1	HMO Deliverables related to MIS Requirements .....	32
16.1.18	<i>Management Information System Requirements</i> .....	33
16.1.18.1	Services Provided During the Retroactive or Restorative Enrollment Period.....	33
16.1.19	<i>Reserved [Fraud and Abuse]</i> .....	34
16.1.20	<i>Reserved [General Reporting Requirements]</i> .....	34
16.1.21	<i>Pharmacy Services</i> .....	34
16.1.21.1	Specialty Pharmacy and Mail-order Requirements .....	34
16.1.22	<i>Reserved [Federally Qualified Health Centers (FQHCS) and Rural Health Clinics (RHCS)]</i> .....	34
16.1.23	<i>Reserved [Payment by Members]</i> .....	34
16.1.24	<i>Reserved [Immunizations]</i> .....	35
16.1.25	<i>Dental Coverage</i> .....	35
16.1.25.1	Dental Fluoride Varnish .....	35
16.1.26	<i>Reserved [Health Home Services]</i> .....	35
16.1.27	<i>Reserved [Cancellation of Product Orders]</i> .....	35
16.1.28	<i>Reserved [Preadmission Screening and Resident Review (PASRR) Referring Entity Requirements]</i> ...	35
16.2	ADDITIONAL MEDICAID MCO SCOPE OF WORK .....	36
16.2.1	<i>Reserved [Continuity of Care and Out-of-Network Providers]</i> .....	36
16.2.2	<i>Reserved [Provisions Related to Covered Services for Medicaid Members]</i> .....	36
16.2.3	<i>Reserved [Medicaid Significant Traditional Providers]</i> .....	36
16.2.4	<i>Reserved [Provider Complaints and Appeals]</i> .....	36



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	<b>16.1</b>	<b>5 of 48</b>
CHAPTER TITLE	EFFECTIVE DATE	
<b>Medicaid and CHIP Contract Operational Guidance</b>	<b>January 15, 2016</b>	
	<b>Version 2.0</b>	

16.2.5	<i>Reserved [Member Rights and Responsibilities]</i> .....	36
16.2.6	<i>Reserved [Medicaid Member Complaint and Appeal System]</i> .....	36
16.2.7	<i>Additional Medicaid Behavioral Health Provisions</i> .....	36
16.2.7.1	Substance Use Disorder Benefit .....	36
16.2.7.1.1	Substance Use Disorder Benefit for Dual Eligibles .....	38
16.2.8	<i>Reserved [Third Party Liability and Recovery and Coordination of Benefits]</i> .....	40
16.2.9	<i>Reserved [Coordination with Public Health Entities]</i> .....	41
16.2.10	<i>Reserved [Coordination with Other State Health and Human Services (HHS) Programs]</i> .....	41
16.2.11	<i>Reserved [Advance Directives]</i> .....	41
16.2.12	<i>Reserved [SSI Members]</i> .....	41
16.2.13	<i>Reserved [Medicaid Wrap-Around Services]</i> .....	41
16.2.14	<i>Reserved [Medical Transportation]</i> .....	41
16.2.15	<i>Reserved [Blank]</i> .....	41
16.2.16	<i>Reserved [Supplemental Payments for Qualified Providers]</i> .....	41
16.2.17	<i>Electronic Visit Verification</i> .....	41
16.3	ADDITIONAL STAR+PLUS SCOPE OF WORK .....	42
16.4	ADDITIONAL STAR HEALTH SCOPE OF WORK .....	43
16.4.1	<i>Reserved [STAR Health Disease Management]</i> .....	43
16.4.2	<i>Reserved [Additional Behavioral Health Provisions]</i> .....	43
16.4.3	<i>Reserved [STAR Health Member Records and Enrollment]</i> .....	43
16.4.4	<i>Reserved [Urgent Services]</i> .....	43
16.4.5	<i>Reserved [Payments for Providers]</i> .....	43
16.5	RESERVED [ADDITIONAL STAR KIDS SCOPE OF WORK].....	44
16.6	RESERVED [ADDITIONAL SCOPE OF WORK FOR MEDICARE/MEDICAID PLANS IN THE DUAL DEMONSTRATION] .....	45
16.7	ADDITIONAL CHIP SCOPE OF WORK .....	46
16.7.1	<i>Reserved [CHIP Provider Complaint and Appeals]</i> .....	46
16.7.2	<i>Reserved [CHIP Member Complaint and Appeal Process]</i> .....	46
16.7.3	<i>Reserved [Third Party Liability and Recovery, and Coordination of Benefits]</i> .....	46
16.7.4	<i>Reserved [Perinatal Services for Traditional CHIP Members]</i> .....	46
16.7.5	<i>Reserved [Covered Benefits]</i> .....	46



MANUAL <b>HHSC UNIFORM MANAGED CARE MANUAL</b>	Chapter <b>16.1</b>	PAGE <b>6 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

16.8	ADDITIONAL SCOPE OF WORK FOR DENTAL MAINTENANCE ORGANIZATIONS.....	48
16.8.1	<i>Reserved [Scope of Work].....</i>	48
16.8.2	<i>Reserved [Additional Medicaid Scope of Work].....</i>	48
16.8.3	<i>Reserved [Additional CHIP Scope of Work].....</i>	48



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	<b>16.1</b>	<b>7 of 48</b>
CHAPTER TITLE	EFFECTIVE DATE	
<b>Medicaid and CHIP Contract Operational Guidance</b>	<b>January 15, 2016</b>	
	<b>Version 2.0</b>	

## Acronyms

AAP	American Academy of Pediatricians
ACOG	American Congress of Obstetricians and Gynecologists
APRNs	Advance Practice Registered Nurses
CCP	Comprehensive Care Program
CDTF	Chemical Dependency Treatment Facility
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DARS	Department of Aging and Rehabilitative Services
DM	Disease Management
DME	Durable Medical Equipment
DMO	Dental Maintenance Organization
DRG	Diagnosis Related Group
ECI	Early Childhood Intervention
EVV	Electronic Visitor Verification
FFS	Fee For Service
FQHC	Federally Qualified Health Center
HRC	Human Resources Code
HHSC	Health and Human Services Commission
IFSP	Individual Family Service Plan
LAR	Legally Authorized Representative
LARC	Long Acting Reversible Contraceptive
MCO	Managed Care Organization
MQMB	Medicaid Qualified Medicare Beneficiaries
NF	Nursing Facility
NPI	National Provider Identifier
OIG	Office of the Inspector General
PA	Prior Authorization
PA	Physician Assistant
PCP	Primary Care Provider
QDWI	Qualified Disabled and Working Individuals
QI	Medicare Qualified Individuals
QMB	Qualified Medicare Beneficiaries
SB	Senate Bill
SOI	Spell of Illness
SLMB	Specified Low-Income Medicare Beneficiaries
SSI	Supplemental Social Security Income
SUD	Substance Use Disorder
TAC	Texas Administrative Code
TDI	Texas Department of Insurance
TMPPM	Texas Medicaid Provider Procedures Manual



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>8 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

TMHP      Texas Medicaid and Healthcare Partnership  
UMCC      Uniform Managed Care Contract  
UMCM      Uniform Managed Care Manual  
WIC        Women, Infants, and Children Program



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>9 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

## 16.1 General Scope of Work

### 16.1.1 Administration and Contract Management

### 16.1.2 Covered Services

This section includes operational guidance for health care services the MCO must arrange to provide to members, including all services required by the contract and state and federal law, and all value-added services negotiated by the parties.

#### 16.1.2.1 Ambulance Services

##### 16.1.2.1.1 Prior Authorization for Non-Emergency Transportation by Ambulance

Release Date            September 18, 2015  
 Effective Date         April 1, 2016

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	Yes	Yes	No	No	No

Medicaid managed care organizations (MCOs) are required to cover emergency and medically necessary non-emergency ambulance services. Nonemergency ambulance transport is defined as ambulance transport provided for a Medicaid client to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the client's home after discharge when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation. Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition, as defined in 1 Texas Administrative Code (TAC) §353.2 (relating to Definitions), is not available at the first facility and the MCO has not included payment for such transports in the hospital reimbursement.

#### *Prior-Authorizations for Non-Emergency Ambulance Transportation*

According to Human Resources Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health-care 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. Other responsible parties include staff working with a health care service provider submitting prior authorizations on behalf of the provider or facility. Please note that



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>10 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

administrative staff will still be required to submit physician or physician extender orders with the prior authorization unless the physician or physician extender sign the prior authorization form. An ambulance provider may not request a prior authorization for non-emergent ambulance transports. This section of HRC applies to both fee-for-service and managed care, inclusive of managed care for nursing facility members. Prior authorizations by MCOs must be approved in the timeframe prescribed in the managed care contracts and/or or the Uniform Managed Care Manual (UMCM).

*Coverage Determinations and Appeals Processes*

Requirements for prior authorizations, coverage determinations and appeals processes for services provided through Medicaid managed care are included in Government Code 533 and managed care contracts. MCOs use utilization management criteria to review non-emergency ambulance transportation. Appeals for denials of medical necessity follow standard provider appeals provisions of the MCO contracts. If the individual has fee-for-service (FFS) Medicaid coverage, then the provider must follow the process outlined in the Texas Medicaid Provider Procedures Manual (TMPPM).

*OPERATIONAL GUIDANCE FOR MCOs*

*Prior Authorizations for Medicaid Members Not Residing in a Nursing Facility (NF)*

For non-emergency transportation services rendered to a member, ambulance providers may coordinate the prior-authorization (PA) request between the Medicaid-enrolled physician, health-care provider, or other responsible party and the MCO. Ambulance providers may assist in providing necessary information such as NPI number, fax, and business address. The prior-authorization request must be signed and submitted by the Medicaid-enrolled physician, health-care provider, or other responsible party to the MCO. The MCO should provide an approval or denial for the prior authorization to the requesting entity, as well as the ambulance provider. The ambulance provider is ultimately responsible for ensuring that a prior authorization has been obtained prior to transport; non-payment may result for services provided without a prior authorization or when the authorization request is denied by the MCO.

*Prior Authorizations for STAR+PLUS and STAR Kids Members Residing in a NF*

Nursing facility providers must follow the steps below to obtain prior authorizations for non-emergency ambulance transportation for STAR+PLUS and STAR Kids members:

1. A physician or physician extender writes an order for non-emergency transport.



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>11 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

2. NF staff should contact the member's MCO member services line, utilization management department, or service coordinator to find an ambulance company that is in-network.
3. NF staff contacts the ambulance company to get their necessary information to complete the prior authorization form. Necessary information supplied by the ambulance company is limited to company name, fax number, national provider identifier (NPI), and other business information.
4. The ambulance provider will document the request was initiated by NF staff and include name, time, and date.
5. The NF must sign and submit the form to the MCO for approval, along with documentation to support medical necessity. The MCO will provide notice of approval/denial to the NF and ambulance provider. If a request for recurring transports is approved, the MCO will include the number of one way transports in the approval.
6. The ambulance company and NF will coordinate the scheduling of the appointment.

Please note that all MCOs will accept the Texas Department of Insurance (TDI) Standard Prior Authorization form; however, each MCO may have its own forms and methods for submission for prior authorizations, but the steps should remain the same for communication between NF and ambulance providers.

#### References

1. Human Resources Code 32.024(t). Available at:  
<http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.32.htm>.
2. 1 TAC § 354.1111. Available at:  
[http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=T&app=9&p\\_dir=P&p\\_rloc=131389&p\\_tloc=&p\\_ploc=1&pg=4&p\\_tac=&ti=1&pt=15&ch=354&rl=1113](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=P&p_rloc=131389&p_tloc=&p_ploc=1&pg=4&p_tac=&ti=1&pt=15&ch=354&rl=1113)
3. TMPPM. 5.1.8. Prior Authorization for Nonemergency Ambulance Transport. Available at:  
[http://www.tmhp.com/pages/medicaid/Medicaid\\_Publications\\_Provider\\_Manual.aspx](http://www.tmhp.com/pages/medicaid/Medicaid_Publications_Provider_Manual.aspx)
4. Medicaid Managed Care Contracts. Available at:  
<http://www.hhsc.state.tx.us/medicaid/managed-care/forms.shtml>

#### **16.1.2.2      Reserved - 16.1.2.5**

- |          |                                                      |            |
|----------|------------------------------------------------------|------------|
| 16.1.2.2 | Audiology and Hearing Services                       | (Reserved) |
| 16.1.2.3 | Cancer screening, diagnostic, and treatment services | (Reserved) |



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>12 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

16.1.2.4      Chiropractic Services      (Reserved)  
 16.1.2.5      Dialysis      (Reserved)

**16.1.2.6      Durable Medical Equipment (DME), Medical Supplies, and Nutritional Products**

**16.1.2.6.1      Breast Pumps**

Release Date      August 18, 2014  
 Effective Date      September 1, 2014

Impacted Programs	STAR	STAR Health	STAR+PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	-	Yes	No	No	No

Beginning September 1, 2014, the Women, Infants, and Children (WIC) Program will begin referring members in Medicaid managed care to their MCO to request information on how to obtain a breast pump and inquire about other available breastfeeding support services.

Breast pumps are covered benefits for STAR, STAR Health, STAR+PLUS, STAR Kids, and CHIP. The breast pump benefit may include the following:

- A manual or electrical (AC or DC) breast pump may be considered for purchase only or;
- a hospital-grade breast pump may be considered for rental only.

The following billing codes are appropriate for breast pumps:

- Manual Breast Pump purchase, CPT Code J-E0602
- Hospital Grade Electric Breast Pump rental, CPT Code L-E0604
- Individual Electric Breast Pump purchase, CPT Code J-E0603
- Replacement parts for a breast pump device owned by the client, CPT E0602 or E0603.

The Medicaid policy regarding pumps can be found in the TMPPM Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook Chapter 2.2.8 Breast Pumps.

References

1. TMPPM. 2.2.8 Breast Pumps



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>13 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

---

**16.1.2.6.2 Accessories, Modifications, Adjustments and Repairs for Mobility Aids**

---

Release Date            September 18, 2015  
 Effective Date        N/A

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	-	Yes	No	No	No

HHSC would like to remind all MCOs accessories, modifications, adjustments, and repairs of mobility aids are benefits of Texas Medicaid. Equipment replacement is a benefit within five years of the equipment purchase when one of the following occurs:

- There has been a significant change in the member’s condition such that the current equipment no longer meets their needs
- The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair.
- Loss or irreparable damage has occurred.

Additional information is available in the TMPPM, Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook Section 2.2.15.24.

References

1. TMPPM. Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook Section 2.2.15.24

**16.1.2.7 Reserved [Emergency Services]**

**16.1.2.8 Gynecological, Reproductive Health, and Family Planning Services**

---

**16.1.2.8.1 Long Acting Reversible Contraception (LARC)**

---

Notice:            October 13, 2015  
 Effective:        January 1, 2016

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	-	Yes	No	No	No



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>14 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

Effective January 1, 2016, HHSC will implement Medicaid benefit changes in an effort to increase access to and utilization of LARCs in Texas Medicaid. MCOs must implement the necessary changes in order to reimburse hospitals and Federally Qualified Health Centers (FQHCs) appropriately for providing Medicaid covered LARC devices in the same amount, duration, and scope as the Medicaid benefit requires.

#### *Hospital Reimbursement for Immediate Postpartum LARC*

Effective January 1, 2016, hospitals may receive reimbursement for the following procedure codes in addition to the hospital diagnosis related group (DRG) payment when a LARC device is inserted immediately postpartum:

- J7300
- J7301
- J7302
- J7307

HHSC requires pharmacies of eligible entities participating in the 340B Drug Pricing Program to identify all outpatient pharmacy claims filled with 340B stock for 340B-eligible patients by submitting a value of "2Ø" (defined as "34ØB / Disproportionate Share Pricing/Public Health Service") in the "Submission Clarification Code" claims submission field (42Ø-DK). For 340B clinician-administered claims, providers must use modifier "U8." These requirements apply to submission of claims for LARC devices purchased through the 340B Drug Pricing Program in managed care. HHSC will propose rates for LARC device procedure codes billed with the U8 modifier at the November 2015 rate hearing.

Medicaid MCOs must adopt claim processing procedures to implement add-on hospital reimbursement for immediate postpartum LARC devices.

NOTE: For claims submitted to the Texas Medicaid and Healthcare Partnership (TMHP) for processing, hospital providers will be required to submit an outpatient claim with the appropriate procedure code for the LARC device in addition to the inpatient claim for the delivery services.

#### *FQHC Reimbursement for LARC*

Effective January 1, 2016, FQHCs may receive reimbursement for the following procedure codes in addition to the FQHC encounter payment:

- J7300
- J7301
- J7302
- J7307



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>15 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

HHSC requires pharmacies of eligible entities participating in the 340B Drug Pricing Program to identify all outpatient pharmacy claims filled with 340B stock for 340B-eligible patients by submitting a value of “20” (defined as “340B / Disproportionate Share Pricing/Public Health Service”) in the “Submission Clarification Code” claims submission field (420-DK). For 340B clinician-administered claims, providers must use modifier “U8.” These requirements apply to submission of claims for LARC devices purchased through the 340B Drug Pricing Program in managed care. HHSC will propose rates for LARC device procedure codes billed with the U8 modifier at the November 2015 rate hearing.

Medicaid MCOs must adopt claim processing procedures to implement add-on FQHC reimbursement for LARC devices.

NOTE: For claims submitted to TMHP for processing, the FQHC provider will be required to submit a claim with the appropriate procedure codes for both the family planning services provided and for the LARC device, which will no longer be subject to FQHC limitations.

References

1. American Congress of Obstetricians and Gynecologists (ACOG) LARC Program. Available at: <http://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception>
2. ASTHO LARC Learning Community. Available at: <http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-ReversibleContraception-LARC/>
3. Clinical Guidance on Implants and IUDs, Association of Reproductive Health Professionals. Available at: <http://larc.arhp.org/evidence-based-guidance.aspx>
4. Long-Acting Reversible Contraception Products, Medicaid/CHIP Vendor Drug Program. Available at: <http://www.txvendordrug.com/formulary/larc.shtml>

**16.1.2.9 Home Health Care Services**

**16.1.2.9.1 Home Health Therapy Provider Rates**

Notice: October 4, 2013  
Effective: N/A

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	-	Yes	No	No	No

MCOs that have agreed to pay Texas Medicaid fee-for-service (FFS) rates to therapy providers should pay close attention to the acute care FFS rates versus the Comprehensive Care



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>16 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

Program therapy services rates. Home health agency providers performing Comprehensive Care Program (CCP) therapy services should be paid at the CCP rate rather than the acute care rate. For reference, in the FFS system, if the provider bills a service for a child (ages 0-20) without the AT modifier to indicate acute care services, the rate paid is type of service (TOS) 1 and is treated as CCP.

References

1. TMHP. Home Health Fee Schedule and Online Fee Lookup. February 19, 2010. Available at: [http://www.tmhp.com/News\\_Items/2010/02-19-10%20Home%20Health%20Fee%20Schedule%20and%20Online%20Fee%20Lookup.pdf](http://www.tmhp.com/News_Items/2010/02-19-10%20Home%20Health%20Fee%20Schedule%20and%20Online%20Fee%20Lookup.pdf)

**16.1.2.9.2 Homebound Policy**

Release Date August 14, 2013  
Effective Not applicable

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	-	Yes	No	No	No

Federal regulations prohibit the arbitrary denial or reduction of the amount, duration, and scope of a required service on the basis of a beneficiary's diagnosis, type of illness, or condition. States must offer mandatory home health services to Medicaid beneficiaries who are entitled to nursing home care, but States may not condition receipt of services on the need for institutional care.

The U.S. Department of Health & Human Services' (HHS) Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS) interpret federal law and regulation to prohibit improperly restricting a request for home health services based on a member's homebound status.

MCOs should refer to the Home Health Services sections of the TMPPM.<sup>1</sup>  
Client Eligibility Home health clients do not have to be homebound to qualify for services.

To qualify for home health services, the Medicaid client must be eligible on the date of service (DOS) and must:

- Have a medical need for home health professional services, DME, or supplies that is documented in the client's plan of care (POC) and considered a benefit under home health services, and
- Receive services that meet the client's existing medical needs and can be



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>17 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

safely provided in the client's home.

### References

<sup>1</sup> TMPPM. Volume 2: Durable Medical Equipment (DME), Medical Supplies, and Nutritional Products Handbook, 2.2.1.1

<sup>2</sup> TMHP. Home Health Fee Schedule and Online Fee Lookup. February 19, 2010. Available at: [http://www.tmhp.com/News\\_Items/2010/02-19-10%20Home%20Health%20Fee%20Schedule%20and%20Online%20Fee%20Lookup.pdf](http://www.tmhp.com/News_Items/2010/02-19-10%20Home%20Health%20Fee%20Schedule%20and%20Online%20Fee%20Lookup.pdf)

### 16.1.2.10 Hospital (Inpatient and Outpatient) Services

#### 16.1.2.10.1 Spell of Illness Guidance for STAR+PLUS Members

Release Date            September 21, 2015  
Effective                 October 1, 2015

Impacted Programs	STAR	STAR Health	STAR+PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	No	No	Yes	-	No	No	No	No

Effective October 1, 2015, the spell of illness (SOI) limitation will be removed for STAR+PLUS members who have diagnoses of severe and persistent mental illness as outlined below. MCOs are required to ensure the SOI limitation will not apply if the member has any of the exempting diagnoses communicated to the MCO through a pre-authorization (if applicable), through a submitted claim, or upon appeal with appropriate documentation. This requirement has been appropriately accounted for in MCO capitation rates.

### Background

In STAR+PLUS, adult members are subject to a SOI limitation. The policy places a 30-day limit on inpatient hospital stays for adults 21 years and older. SOI is defined as 30 days of inpatient hospital care, which may be consecutive or cumulative. After 30 days of inpatient care is provided, coverage for additional inpatient care is not covered until the member has been out of an acute care facility for 60 consecutive days.

### Exempting Diagnoses

Applicable diagnoses exempt from the spell of illness limitation include the following as described in the DSM-V (parenthetical codes are corresponding ICD-10 codes): Schizophrenia (F20), Schizoaffective disorders (F25), Bipolar Disorders (F31) with any severity or status, Major Depressive Disorder (F32) and Recurrent Depressive Disorder (F33) with any variation or



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>18 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

subtype. MCOs are not required to exempt "unspecified" diagnoses. The following unspecified diagnoses are not exempt from SOI: F20.9 Schizophrenia, unspecified; F25.9 Schizoaffective disorder, unspecified; F31.9 Bipolar disorder, unspecified; F32.9 Major Depressive Disorder, single episode, unspecified; F33.9 Recurrent Depressive Disorder, unspecified.

*Determining Eligibility for Spell of Illness Limitation Exemption*

The SOI exemption will be applied for any member that has an exempting diagnosis listed as one of the top 5 diagnoses on any inpatient preauthorization request, any submitted claim for an inpatient hospital admission, or upon appeal with appropriate documentation. These diagnoses will remove the SOI limitation for the entire inpatient hospital stay. If the member is transferred from one inpatient hospital directly to another inpatient hospital, the SOI exemption would transfer to the second hospital. Upon discharge to the community, a member is eligible for unlimited subsequent SOI exemptions if all criteria outlined in this policy guidance is met for the subsequent stay.

Any inpatient hospitalizations that were exempted from the SOI limitation must be tracked by the MCO so that those stays are not counted towards any subsequent SOI calculation. For example, a member has an inpatient stay of 10 days in April 2016 that were determined to be exempt from SOI calculation (Bipolar II Disorder was listed as one of the top five diagnoses on a claim form during the stay). In May 2016, the member is readmitted to a hospital for a non-exempt stay (there is no exempting diagnosis on the preauthorization form or a claim). MCOs must ensure that the April 2016 stay does not factor into the spell of illness calculation for the June 2016 stay, because the April 2016 stay was exempt.

An inpatient hospitalization that is exempt from the SOI limitation may have an admission date before October 1<sup>st</sup>, 2015 if the stay continues through October 1<sup>st</sup>, 2015 and exemption criteria outlined in this policy guidance are met on or after that date. For example, a member who is admitted to an inpatient hospital on September 15<sup>th</sup>, 2015 and who has an established a SOI exemption consistent with this policy on October 7<sup>th</sup>, 2015 will have the entire inpatient stay exempted.

This policy guidance does not require an MCO to approve an inpatient stay that is not medically necessary as outlined in MCO contracts. Inpatient hospital days are eligible for SOI exemption only if those days would have otherwise been denied due to the SOI limitation.

*Reason for Inpatient Admission*

Any inpatient admission for a member with an exempted diagnosis should not be counted towards the SOI limitation, regardless of whether the primary reason for admission is related to a behavioral or physical health. For example, a member is admitted to a general acute care hospital for congestive heart failure. This condition is listed on diagnosis line 1 of a claim submitted to an MCO for payment. Line 4 details that the member has a diagnosis of Schizophrenia (F20). Although the primary reason for the inpatient admission is congestive



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	<b>16.1</b>	<b>19 of 48</b>
CHAPTER TITLE	EFFECTIVE DATE	
<b>Medicaid and CHIP Contract Operational Guidance</b>	<b>January 15, 2016</b>	
	<b>Version 2.0</b>	

heart failure (and not Schizophrenia), the member is still exempt from the spell of illness limitation because Schizophrenia is listed as a top 5 diagnosis.

*Example Scenarios*

The below scenarios provide guidance related to applying the SOI limitation exemption.

1. In May 2016, a member is admitted to a general acute care hospital for injuries resulting from a car accident. The hospital includes the member diagnoses as required by the MCO as part of the claim submission process. The first three diagnoses include injuries related to the car accident. The fourth diagnosis lists Bipolar Disorder (F31). The hospital bills for and is approved for 44 days of medically necessary services in the hospital.

Analysis: The MCO appropriately applied the exclusion to the SOI limitation for the hospital stay for this member. The criteria for exemption from the SOI calculation is a diagnosis of Schizophrenia (F20), Schizoaffective disorders (F25), Bipolar Disorders (F31) with any severity or status, Major Depressive Disorder (F32) and Recurrent Depressive Disorder (F33) with any variation or subtype listed as a top five diagnosis on the preauthorization request or a submitted claim form. Because the member had Bipolar Disorder (F31) listed as a diagnosis #4 on the claim form, the member is exempt from the SOI limitation and may stay as many days as is medically necessary.

2. The member described in scenario #1 is readmitted to a different hospital the following month (June 2016) for complications related to diabetes. The hospital does not include any mental health disorder on a submitted claim for the inpatient stay. The MCO authorizes the hospital for services for days 1 through 30 and denies authorization for services past 30 days due to the spell of illness limitation.

Analysis: The MCO appropriately applied the SOI limitation to this member. An exempting diagnosis must be noted as a top 5 diagnosis on either the preauthorization request or a submitted claim for the hospital stay. Because no exempting diagnosis was included, the MCO denied the stay past the 30<sup>th</sup> day, consistent with the SOI limitation outlined in the Texas Medicaid Provider Procedure Manual. The MCO also appropriately excluded the May 2016 stay noted in scenario #1 above from the SOI calculation. Because the May 2016 stay was exempted from SOI calculation, it was not considered when determining the availability of days for the June 2016 stay.

3. A member who has a diagnosis of Schizophrenia (F20) is admitted to Austin State Hospital (an institution for mental disease) under the "in-lieu-of" contractual provision in the Uniform Managed Care Contract. During the pre-authorization process, the state hospital notes that the member has a diagnosis of Schizophrenia. Three days before this stay, the member discharged from a general acute care hospital for the treatment of complications related to chronic obstructive pulmonary disease where the member



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	<b>16.1</b>	<b>20 of 48</b>
CHAPTER TITLE	EFFECTIVE DATE	
<b>Medicaid and CHIP Contract Operational Guidance</b>	<b>January 15, 2016</b>	
	<b>Version 2.0</b>	

stayed for 28 days before being discharged and the preauthorization form and claims did not include any exempting diagnoses. The MCO denies any stay past 2 days at the Austin State Hospital and communicates to state hospital utilization management staff that the member has met the 30 day SOI limitation.

Analysis: Because the member had a diagnosis of Schizophrenia that was noted in the pre-authorization form, the MCO should have approved additional medically necessary days in the state hospital, if all conditions of the "in-lieu-of" contractual provision were met. The diagnosis noted on the pre-authorization form exempted the member from the SOI limitation.

4. A member is admitted to a general acute care hospital for injuries resulting from a car accident. The hospital does not include an exempting diagnosis on a claim submitted to an MCO for the inpatient stay. The MCO authorizes the hospital for services for days 1 through 30 and denies authorization for services past 30 days due to the spell of illness limitation. The hospital provides a total of 37 days of inpatient care, after which the member is discharged. After the member is discharged, the hospital realizes the original pre-authorization request and claim forms did not include the member's exempting diagnosis of Bipolar Disorder (F31), which was noted in the inpatient hospitalization medical records. The hospital submits an appeal to the MCO for coverage for days 31-37, which are subsequently authorized and reimbursed by the MCO.

Analysis: The MCO appropriately applied the exemption to the SOI limitation for this member. While the original pre-authorization request and claim forms did not include an exempting diagnosis, a subsequent appeal noted that the member did have an exempting diagnosis (F31) which removed the spell of illness limitation. This diagnosis resulted in the stay for days 31-37 being eligible for Medicaid reimbursement.

**16.1.2.11      Reserved -16.1.2.20**

16.1.2.11	Laboratory Services	(Reserved)
16.1.2.12	Nursing Services	(Reserved)
16.1.2.13	Organ Transplant	(Reserved)
16.1.2.14	Radiology, Imaging and X-rays	(Reserved)
16.1.2.15	Specialty Physician Services	(Reserved)
16.1.2.16	Therapy (PT, OT, and Speech) Services	(Reserved)
16.1.2.17	Telemedicine, Telehealth, and Telemonitoring	(Reserved)
16.1.2.18	THSteps Checkups and CCP Services	(Reserved)
16.1.2.19	Transplants	(Reserved)
16.1.2.20	Vision	(Reserved)



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>21 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

### 16.1.3 Access to Care

#### 16.1.3.1 Reserved [Waiting Times for Appointments]

#### 16.1.3.2 Access to Network Providers

##### 16.1.3.2.1 Reserved – 16.1.3.2.5

16.1.3.2.1	OB/Gyn Access	(Reserved)
16.1.3.2.2	Outpatient Behavioral Health Service Provider Access	(Reserved)
16.1.3.2.3	Other Specialist Physician Access	(Reserved)
16.1.3.2.4	Hospital Access	(Reserved)
16.1.3.2.5	Pharmacy Access	(Reserved)

##### 16.1.3.2.6 Nursing Facility Access

##### 16.1.3.2.6.1 STAR Clients Admitted to Nursing Facilities

Release Date: May 23, 2013  
 Effective Date: Not applicable

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	No	No	No	No	No	No	No

HHSC is providing clarification to STAR MCOs regarding members admitted to nursing facilities. STAR members admitted to nursing facilities are disenrolled prospectively. Nursing facilities are required to provide the State with a notification of a STAR member's admission to a nursing facility. However, to ensure HHSC receives expeditious notification of a STAR member's nursing facility admission, MCOs should also notify HHSC of the member's admission. MCOs should send the nursing facility admission notification to the following mailbox:  
[HPO\\_STAR\\_Plus@hhsc.state.tx.us](mailto:HPO_STAR_Plus@hhsc.state.tx.us).

After receiving and entering the information in the system, HHSC terminates the member's enrollment prospectively at the end of the month in which HHSC receives notification of the client's admission to a nursing facility.

During the member's stay in the nursing facility before the member is disenrolled from STAR, MCOs are responsible for all covered services they normally provide, including pharmacy, for the month(s) they receive capitation.



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>22 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

**16.1.3.2.7 Reserved [All Other Covered Services]**

**16.1.4 Provider Network**

**16.1.4.1 Reserved [Provider Contract Requirements]**

**16.1.4.2 Primary Care Providers**

**16.1.4.2.1 Use of Advanced Nurses and Physician Assistants**

Notice: December 3, 2013  
Effective: September 1, 2013

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	Yes	Yes	No	No	No

In accordance with Texas law<sup>1</sup> and HHSC contract requirements<sup>2</sup> Texas Medicaid and CHIP managed care organizations are required to use advanced practice registered nurses (APRNs) and physician assistants (PAs) as primary care providers (PCPs) to increase the availability of primary care providers in the organization's provider network. APRNs and PAs practicing as PCPs serve an important role in expanding access to health services for Medicaid clients. MCOs therefore encourage and facilitate the use of APRNs and PAs as PCPs, in accordance with this goal and applicable state law.

APRNs and PAs who serve as PCPs in an MCO network must be listed in the same manner as other primary care provider types in the MCO's provider network. Additionally, MCOs may not refuse a request by an APRN or PA to be listed as a PCP if the APRN or PA meets the relevant standards, as described below.<sup>3</sup>

In order to serve as a PCP, an APRN or PA must meet the MCO's credentialing standards and be practicing under the supervision of a physician acting as a PCP in the MCO's provider network. The supervising physician must be practicing as a specialist in family medicine, internal medicine, pediatrics, or obstetrics/gynecology.<sup>4</sup> Advanced practice nurses should be enrolled with Medicaid or CHIP and designated as either a clinical nurse specialist or a nurse practitioner in order to be properly recognized by Texas Medicaid and CHIP systems.

In accordance with federal regulation, guidance from the Centers for Medicare and Medicaid Services (CMS), and state law, APRNs and PAs are prohibited from prescribing for any durable medical equipment (including home health supplies) and outpatient schedule II controlled substances for Medicaid and CHIP clients.<sup>5</sup> See Section 157.0511 of the Occupations Code for



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>23 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

more information about the specific in-patient settings where APRNs and PAs may prescribe schedule II controlled substances.

### References

<sup>1</sup> Section 533.005(a)(13) of the Government Code as amended by S.B. 406, 83rd Legislature, Regular Session, 2013; see also Section 62.1551 of the Health and Safety Code, as added by S.B. 406, 83<sup>rd</sup> Legislature, Regular Session, 2013.

<sup>2</sup> Section 8.1.4.2, Attachment B-1, Uniform Managed Care Contract; Section 8.1.4.2, Attachment B-1, STAR+PLUS Expansion Contract; Section 8.1.4.2, Attachment B-1, CHIP RSA Contract; Section 4.1.4.5, Attachment B-1, STAR Health Contract.

<sup>3</sup> Section 843.312 of the Texas Insurance Code

<sup>4</sup> See Section 8.1.4.2 of the Texas Medicaid Uniform Managed Care Contract

<sup>5</sup> 42 C.F.R. § 440.70

### **16.1.4.2.2 Prescription Regulations for Advanced Nurses and Physician Assistants**

Notice: August 30 ,2013

Effective: N/A

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	Yes	Yes	No	No	No

In accordance with federal regulation (42 C.F.R. 440.70), guidance from the Centers for Medicare and Medicaid Services (CMS), and state law, advanced practice registered nurses (APRNs) and physician assistants (PAs) are prohibited from prescribing any durable medical equipment (including home health supplies) and outpatient schedule II controlled substances for Medicaid and CHIP clients. See S.B. 406, 83rd Legislature, 2013, Section 157.0511 of the Occupations Code for more information about the specific in-patient settings where APRNs and PAs may prescribe schedule II controlled substances. HHSC will reject pharmacy encounters submitted for durable medical equipment (including home health supplies) and outpatient schedule II controlled substances when prescribed by APRNs and PAs.

### References

<sup>1</sup> 42 C.F.R. 440.70

<sup>2</sup> S.B. 406, 83rd Legislature, 2013

<sup>3</sup> Section 157.0511 of the Occupations Code



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>24 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

**16.1.4.3 - 16.1.4.14 Reserved**

16.1.4.3	Inpatient Hospital and Medical Services	(Reserved)
16.1.4.4	Children’s Hospitals/Hospitals with Specialized Pediatric Services	(Reserved)
16.1.4.5	Trauma	(Reserved)
16.1.4.6	Physician Services	(Reserved)
16.1.4.7	Urgent Care Clinics	(Reserved)
16.1.4.8	Laboratory Services	(Reserved)
16.1.4.9	Pharmacy Providers	(Reserved)
16.1.4.10	Diagnostic Imaging	(Reserved)
16.1.4.11	Home Health Services	(Reserved)
16.1.4.12	Community Long Term Services and Supports	(Reserved)
16.1.4.13	Nursing Facility Services	(Reserved)
16.1.4.14	Hospice Services	(Reserved)

**16.1.4.15 Ambulance Providers**

---

**16.1.4.15.1 Ambulance Provider Network Agreement**

---

Notice: May 13, 2013  
 Effective: May 13, 2013

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	Yes	Yes	No	No	No

The MCO must enter into a Network Provider Agreement with any willing ambulance provider that meets the MCO’s credentialing requirements and agrees to the MCO’s contract rates and terms. The MCO cannot use network adequacy as a reason to deny offering a contract to an ambulance provider. If the ambulance provider meets credentialing requirements and agrees to the contract rates and terms, the MCO must extend a contract. This contractual requirement does not have a time limit.

16.1.4.16 Mental Health Rehabilitative Services (Reserved)

**16.1.5 Member Services**

---

**16.1.5.1 Cultural Competency Plan**

---



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>25 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

Notice: June 27, 2014  
Effective: N/A

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

All Medicaid and CHIP MCOs must provide and pay for necessary language interpreter services to Members in conjunction with Covered Services and as required by the MCO's Cultural Competency Plan.

The TMPPM, Medicaid Managed Care Handbook, Section 2.5.1 states that MCOs are responsible for providing interpreter services. HHSC incorporates these interpreter service costs into the rates paid to the MCOs.<sup>1</sup>

As required by federal law and regulation and under their relevant Contract, MCOs must promote the delivery of Covered Services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.<sup>2</sup>

MCOs must:

- provide information on how to obtain interpreter services in the MCO's Member handbook.<sup>3</sup>
- include languages spoken by Providers in the MCO's Provider directories.<sup>4</sup>
- inform Members of their right to an interpreter.
- arrange and pay for Members' access to interpreter services.
- have a Cultural Competency Plan.<sup>5</sup>

The MCO's Cultural Competency Plan must include how the MCO will provide Linguistic Access and Disability-Related Access, including appropriate hotline access and sign language interpretation services during Provider appointments. The Plan must also describe how the MCO effectively provides Covered Services to members from varying cultures, races, ethnic backgrounds, and religions to ensure those characteristics do not pose barriers to gaining access to needed services. This includes providing interpreter services as necessary during appointments with Providers to ensure effective communication.

### References

<sup>1</sup> TMPPM. Medicaid Managed Care Handbook. 2.5.1. Limited English Proficiency. [http://www.tmhp.com/TMPPM/TMPPM\\_Living\\_Manual\\_Current/Vol2\\_Medicaid\\_Managed\\_Care\\_Handbook.pdf](http://www.tmhp.com/TMPPM/TMPPM_Living_Manual_Current/Vol2_Medicaid_Managed_Care_Handbook.pdf)

<sup>2</sup> 42 C.F.R. § 438.206(c)(2); See also Uniform Managed Care Contract, Attachment A, Section 7.05(a)(1); STAR+PLUS Expansion Contract, Attachment A, Section 7.05(a)(1); STAR Health



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>26 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

Contract, Attachment A, Section 7.05(a)(1); Dental Services Contract, Attachment A, Section 7.05(a)(1); CHIP RSA Contract, Attachment A, Section 7.05(a)(1)

<sup>3</sup> Uniform Managed Care Manual Chapter 3.4, MMC Member Handbook; Chapter 3.5, CHIP Member Handbook

<sup>4</sup> 42 C.F.R. § 438.10(f)(6)(i)

<sup>5</sup> 1 Tex. Admin. Code § 353.411; See also Uniform Managed Care Contract, Attachment B-1, Section 8.1.5.8; STAR+PLUS Expansion Contract, Attachment B-1, Section 8.1.5.8; STAR Health Contract, Attachment B-1, Section 4.1.5.8; Dental Services Contract, Attachment B-1, Section 8.1.6.8; CHIP RSA Contract, Attachment B-1, Section 8.1.5.8



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>27 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

**16.1.6 Reserved [Marketing and Prohibited Practices]**

**16.1.7 Reserved [Quality Assessment and Performance Improvement]**

**16.1.8 Utilization Management**

---

**16.1.8.1 CHIP Notice for Approved Services**

---

Notice: April 24, 2013  
 Effective: May 21, 2013

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	No	No	No	No	No	No	Yes	Yes

The Texas Department of Insurance (TDI) has adopted new rules, 28 Texas Administrative Code (TAC), Part I, Chapter 19, Subchapter R, on utilization reviews for health care providers under a health benefit plan. The new rules affect CHIP, including dental and pharmacy services, but not Medicaid. These new rules will require CHIP plans to provide notification to their membership on services that are approved, not just those that are denied.

References

1. Texas Administrative Code § 19.1709. Notice of Determinations Made in Utilization Review. Available at: [http://info.sos.state.tx.us/pls/pub/readtac\\$ext.TacPage?sl=R&app=9&p\\_dir=&p\\_rloc=&p\\_tloc=&p\\_ploc=&pg=1&p\\_tac=&ti=28&pt=1&ch=19&rl=1709](http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=19&rl=1709)
2. UMCC. 8.1.8. Utilization Management.

**16.1.9 Early Childhood Intervention (ECI)**

---

**16.1.9.1 Service Designations for Early Childhood Intervention (ECI) Individual Family Service Plan Form**

---

Notice: August 25, 2015



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>28 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

Effective: November 15, 2015

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	No	Yes	No	Yes	No

### *Background*

ECI is a statewide service system for families with children, birth up to age three, with disabilities or developmental delays. They provide a full range of developmental services that support families to help their children reach their potential. To be a provider of ECI services, an entity must have a contract with the Texas Department of Assistive and Rehabilitative Services (DARS) for the provision of ECI services. ECI contractors include public (e.g., local community centers, independent school districts) and private non-profit agencies.

### *Description of the ECI Service System*

A key component of the ECI service system is the use of interdisciplinary teams consisting of professionals, family members, and other persons as requested by the parent/legally authorized representative (LAR). Each child's team develops an Individualized Family Service Plan (IFSP) to identify and address the unique needs of the child and family. As stated in section 8.1.9.4 of Attachment B-1 of the Uniform Managed Care Contract, the IFSP identifies the services to be provided to the child to meet the needs of the child and the family, and identifies the person or persons responsible for each service required by the plan. The IFSP is a contract between the ECI contractor and child's parent/ LAR. Section 8.1.9.5 indicates the IFSP serves as authorization for services provided by the ECI contractor.

### *Form*

DARS has modified the required IFSP form to clarify the state's expectations and improve oversight of the ECI contractors. Contractors began using the updated IFSP on April 22, 2015. Contractors are expected to convert to the new form at the child's next IFSP review. This will result in 100% use of the updated IFSP by November 1, 2015. The change to the IFSP form is the removal of "Parent Arranged" and the addition of "Services Designation." There are four services designations: Program Provided (PP), Parent Choice (PC), Program Arranged (PA), and Not Part C (NP). The table below compares the four service designations.

### *ECI Contractors and Other Service Providers*

Section 1905(r)(5) of the Social Security Act requires that a Medicaid recipient under the age of 21 must receive the health care services listed in the Act for which she/he has medical need (Social Security Act section 1905(r)). There is no prohibition to ECI contractors and non-ECI providers from providing services to the same child. If a child has Medicaid, they are entitled to receive all medically necessary services. The IFSP is the authorizing document for ECI



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>29 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

services, but if the family of a child with Medicaid wants more therapy services than what the IFSP requires, the family would be able to receive the additional therapy if authorized by a physician, APRN, or PA (in accordance with HHSC medical policy). Given the MCOs' obligation to ensure the child receives all medically necessary services, it is important that the IFSP accurately reflect the developmental needs identified by the IFSP team regardless of the service provider. Similarly, the ECI contractor is expected to keep the MCO informed with regard to needed auditory and vision evaluations. ECI contractors are expected to put forth good faith effort to obtain the necessary release of information from the parent/LAR to allow the ECI contractor and the MCO to exchange information regarding needed evaluations.

### Service Designations

	Program Provided (PP)	Parent Choice (PC)	Program Arranged (PA)	Not Part C (NP)
<b>IFSP</b>	IFSP team documents their service recommendations on the IFSP <ul style="list-style-type: none"> <li>The parent is a member of the team</li> <li>A copy of the signed IFSP is given to the parent</li> </ul>			
<b>Providers</b>	ECI contractor has necessary personnel (employee or contractor) to provide the service, and family agrees to services.	Parent declines ECI provider, and selects outside provider.	<ul style="list-style-type: none"> <li>ECI contractor <b>does not</b> have necessary personnel (employee or contractor) to provide the service.</li> <li>ECI contractor must assist the family in locating a provider.</li> </ul>	<ul style="list-style-type: none"> <li>ECI contractor <b>does not</b> have necessary personnel (employee or contractor) to provide the service.</li> <li>ECI contractor must assist the family in locating a provider.</li> </ul>
<b>Personnel Requirements</b>	ECI personnel meets <b>all three</b> of the following:	Selected provider chooses <b>not</b> to contract with ECI or does not meet at least one of the following:	ECI contractor locates a provider who meets <b>all three</b> of the following:	ECI contractor locates a provider who <b>does not meet at least one</b> of the following:
	<ol style="list-style-type: none"> <li>ECI trained per 40TAC, Part 2, Chapter 108, Subchapter C, §108.309</li> <li>Member of the IFSP (signs the IFSP)</li> <li>Provides progress notes after providing services to the child/family</li> </ol>			



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>30 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

	Program Provided (PP)	Parent Choice (PC)	Program Arranged (PA)	Not Part C (NP)
<b>Prior Authorizations (PA)</b>	IFSP serves as service authorization (prior authorization). MCO may not require referral or PA.	IFSP <b>does not</b> serve as service authorization (prior authorization).  MCO may require referral or PA.		
<b>Claims Processing</b>	ECI contractor submits claims for the services provided.	ECI contractor <b>does not</b> submit claims for the services provided.		
<b>Reimbursement</b>	An MCO <b>is</b> responsible for payment.	An MCO is <b>not</b> responsible for payment for unauthorized non-emergency services.		

*Example*

Service Information									
Service	Discipline of Provider	Expected Frequency	Expected Intensity	Total Authorized Visits	Location*	Method	Start Date	End Date	Services Designation **
CM	Service Coordinator's Name: Sally Worth	Ongoing	As Needed	Not Applicable	<input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/> Community <input type="checkbox"/> Other Specify other: _____	Not Applicable	9/1/15	9/1/16	PP
SST	EIS	3 x per month	45 minutes	36	<input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/> Community <input type="checkbox"/> Other Specify other: _____	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Group	9/1/15	9/1/16	PP
OT	OT	1 x per month	60 minutes	12	<input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/> Community <input type="checkbox"/> Other Specify other: _____	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Group	9/1/15	9/1/16	PP
PT	PT	4 x per month	45 minutes	48	<input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/> Community <input type="checkbox"/> Other Specify other: _____	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Group	9/1/15	9/1/16	PA
ST	SLP	1 x per month	60 minutes	12	<input type="checkbox"/> Home <input type="checkbox"/> Community <input checked="" type="checkbox"/> Other Specify other: SLP Office	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Group	9/1/15	9/1/16	PC
AI	TASC	4 x per month	30 minutes	48	<input checked="" type="checkbox"/> Home <input checked="" type="checkbox"/> Community <input type="checkbox"/> Other Specify other: _____	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Group	9/1/15	9/1/16	PP

This serves as an example only. Any individual IFSP may include as few as one, or as many as all four service designations, depending on the circumstance of the individual child. The implications to the MCO in this specific example are as follows:



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>31 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

- Both case management (CM) and specialized skills training (SST) are carved out of managed care and the Texas Medicaid & Healthcare Partnership (TMHP) is the payor.
- The IFSP authorizes payment to the ECI contractor not to exceed 60 minutes of OT once a month for 12 months.
- Neither the physical therapy (PT) or speech therapy (ST) will be provided by the ECI contractor. The designation of PA (or NP) indicates the ECI contractor will work with the MCO to assist the family in locating an in-network provider for the PT. The designation of PC indicates that the parent has selected a non-ECI provider for the provision of ST. The providers of the PT and ST must seek service authorization and payment independent of the ECI contractor.
- The auditory services (AI) are provided by the local educational agency (LEA) and are considered (for ECI contract purposes) as program provided (PP). This is also the case for visual services (VI). AI and VI services provided by the LEA are funded with IDEA Part B funds and the ECI contractor cannot receive Medicaid reimbursement for these services.

#### *ECI Contractors and Other Service Providers*

Section 1905(r)(5) of the Social Security Act requires that a Medicaid recipient under the age of 21 must receive the health care services listed in the Act for which she/he has medical need ([Social Security Act section 1905\(r\)](#)). There is no prohibition to ECI contractors and non-ECI providers from providing services to the same child. If a child has Medicaid, they are entitled to receive all medically necessary services. The IFSP is the authorizing document for ECI services, but if the family of a child with Medicaid wants more therapy services than what the IFSP requires, the family would be able to receive the additional therapy if authorized by a physician, APRN, or PA (in accordance with HHSC medical policy).

Given the MCOs' obligation to ensure the child receives all medically necessary services, it is important that the IFSP accurately reflect the developmental needs identified by the IFSP team regardless of the service provider. Similarly, the ECI contractor is expected to keep the MCO informed with regard to needed auditory and vision evaluations. ECI contractors are expected to put forth good faith effort to obtain the necessary release of information from the parent/LAR to allow the ECI contractor and the MCO to exchange information regarding needed evaluations.

#### References

1. UMCC. 8.1.9.4 Individual Family Service Plan.



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>32 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

- 16.1.10 Reserved [Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)- Specific Requirements]**
- 16.1.11 Reserved [Coordination with Texas Department of Family and Protective Services]**
- 16.1.12 Reserved [Services for People with Special Health Care Needs]**
- 16.1.13 Reserved**
- 16.1.14 Reserved [Disease Management (DM)]**
- 16.1.15 Reserved [Behavioral Health (BH) Network and Services]**
- 16.1.16 Reserved [Financial Requirements for Covered Service]**
- 16.1.17 Accounting and Financial Reporting Requirements**

---

**16.1.17.1 HMO Deliverables related to MIS Requirements**

---

Notice: May 15, 2013  
 Effective: Not applicable

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

HHSC is providing clarification to Section 8.1.18.2 HMO Deliverables related to MIS Requirements of the Uniform Managed Care Contract. At the beginning of each state fiscal year (SFY), the MCO must submit the following documents and corresponding checklists for HHSC's review and approval:

1. Disaster Recovery Plan\*
2. Business Continuity Plan\*
3. Security Plan



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>33 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

\*The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.

Additionally, at the beginning of each SFY, if the MCO modifies the following documents, it must submit the revised documents and corresponding checklists for HHSC's review and approval:

1. Joint Interface Plan
2. Risk Management Plan
3. Systems Quality Assurance Plan

### 16.1.18 Management Information System Requirements

#### 16.1.18.1 Services Provided During the Retroactive or Restorative Enrollment Period

Effective: May 2015

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Dental Medicaid	CHIP	Dental CHIP
	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

In May 2015, the Health and Human Services Commission clarified that Medicaid and CHIP MCOs are required to process claims for services delivered to retroactively-enrolled members for whom they have received a capitation payment. MCOs are required to process claims from providers upon notification that a member was retroactively or restoratively enrolled as the MCO's member for services provided within the retroactive or restorative enrollment period. MCOs can find information about the retroactive or restorative enrollment on the capitation adjustment file. If the MCO's claims system does not automatically adjudicate the claim for a member who was retroactively or restoratively enrolled, the MCO must process the claims on appeal from providers who document that the MCO's retroactively or restoratively enrolled member was in FFS at the time services were rendered. The MCOs must override any prior authorization requirements for services provided without a prior authorization. Standard timely filing and clean claims requirements apply. Claims received from non-network providers should be processed according to out-of-network standards.

#### *For CHIP MCOs Only*

In order to comply with this requirement, CHIP MCOs must contact the member either by phone, letter, or other means of communication to inquire about and request information regarding covered services provided on or after the retroactive or restorative enrollment date through the end of the retroactive or restorative enrollment period. This will ensure the provider



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>34 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

or member is reimbursed, as needed, and that any claims are processed according to claims processing deadlines.

**16.1.19 Reserved [Fraud and Abuse]**

**16.1.20 Reserved [General Reporting Requirements]**

**16.1.21 Pharmacy Services**

**16.1.21.1 Specialty Pharmacy and Mail-order Requirements**

Notice: July 18, 2013  
Effective: September 1, 2013

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

TAC 353.911 prohibits MCOs from requiring members to use mail-order pharmacies. Also, 1 TAC 353.905(e)(3) specifies that a MCO cannot require a member to obtain a specialty drug from a mail-order pharmacy. The only drugs that may be exclusively provided through the MCO's specialty pharmacy network are the drugs listed on HHSC's Specialty Drug List. If a drug is not on the list, a member may choose any network pharmacy to obtain medications. Furthermore, if a drug on the HHSC Specialty Drug List is available at a retail pharmacy and a member chooses to receive the drug through that retail pharmacy, the MCO is prohibited from limiting the member to the MCO's specialty pharmacy network.

References

1. Government Code 533.005(a)(23)(I)
2. 1 TAC 353.905(e)(3)

**16.1.22 Reserved [Federally Qualified Health Centers (FQHCS) and Rural Health Clinics (RHCS)]**

**16.1.23 Reserved [Payment by Members]**



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>35 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

**16.1.24 Reserved [Immunizations]**

**16.1.25 Dental Coverage**

---

**16.1.25.1 Dental Fluoride Varnish**

---

Notice: October 13, 2015  
Effective: September 1, 2015

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	Yes	Yes	No	Yes	No

The American Academy of Pediatrics (AAP) recommended well-child exams and preventive health are covered benefits of Medicaid and CHIP. The AAP recently revised its recommendations for preventive pediatric health care to include fluoride varnish. Effective September 1, 2015, AAP recommend the application of topical fluoride by physicians for children ages 6 months to 5 years.

References

1. AAP. Recommendations for Preventive Pediatric Health Care. Available at: [https://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule\\_FINAL.pdf](https://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf)

**16.1.26 Reserved [Health Home Services]**

**16.1.27 Reserved [Cancellation of Product Orders]**

**16.1.28 Reserved [Preadmission Screening and Resident Review (PASRR) Referring Entity Requirements]**



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>36 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

## **16.2 Additional Medicaid MCO Scope of Work**

**16.2.1 Reserved [Continuity of Care and Out-of-Network Providers]**

**16.2.2 Reserved [Provisions Related to Covered Services for Medicaid Members]**

**16.2.3 Reserved [Medicaid Significant Traditional Providers]**

**16.2.4 Reserved [Provider Complaints and Appeals]**

**16.2.5 Reserved [Member Rights and Responsibilities]**

**16.2.6 Reserved [Medicaid Member Complaint and Appeal System]**

**16.2.7 Additional Medicaid Behavioral Health Provisions**

---

### **16.2.7.1 Substance Use Disorder Benefit**

---

Notice: June 6, 2014  
Effective: N/A

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	Yes	Yes	Yes	Yes	Yes	No	No	No

An overview of the substance use disorder (SUD) benefit follows, along with guidance for SUD billing for dual eligibles, and clarification on the MCOs' obligations related to SUD as a condition of probation.



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>37 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

*Background and Overview of SUD Benefits in Medicaid*

Effective September 1, 2010, substance abuse treatment benefits in a chemical dependency treatment facility (CDTF) were implemented. Covered services, Medicaid fee-for-service (FFS) billing codes, FFS prior authorization requirements, and service limitations are as follows:

- Clinical assessment. (Billing code: H0001; modifier HF. Does not require prior authorization.)
  - Allowed once per episode of care.
- Ambulatory detoxification. (Billing codes: H0016, H0050, and S9945; modifier HF. Requires prior authorization)
  - Up to 21 days.
- Outpatient individual and group chemical dependency counseling. (H0004, H0005; both with modifier HF. Does not require prior authorization)
  - Up to 26 hours of individual counseling and 135 hours of group counseling.
- Medication-assisted therapy (MAT) (H0020 for methadone; H2010, modifier HG, for opioid addiction treatment using non-methadone medication such as buprenorphine. Use modifier HF with H2010 for non-methadone medication used to treat a non-opioid addiction. Both billing codes require an additional modifier to denote doses provided in person or take-home doses. These codes are: UA for in-person and U1 for take-home doses. MAT does not require prior authorization)
  - Providers must follow federal regulations in 42 C.F.R. Section 8, and TAC 448.902
- Residential detoxification. (H0031, T1007, H0047, H2017, S9445; modifier HF. Requires prior authorization)
  - Up to 21 days.
- Residential treatment. (H2035; H0047; modifier HF. Requires prior authorization.)
  - Up to 35 days.

In FFS, CDTFs are the only provider type that can bill for these services, with the exception of MAT. MAT can be billed by physicians as well as CDTFs.

SUD services do not require a referral from a PCP.

HHSC encourages MCOs to verify that you have adequate numbers of CDTFs in your network and that your claims systems are set up to process claims for these services.

Reference the Behavioral Health, Rehabilitation, and Case Management Services Handbook at [www.tmhp.com](http://www.tmhp.com) for more details.

Note: children can exceed service limitations with medical necessity and prior authorization.



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>38 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

*Substance abuse treatment services for dual-eligible clients*

HHSC recently became aware that some plans are requiring a Medicare denial to process billing for SUD services for dual-eligible clients. Services provided by CDTFs and MAT physician services are not covered Medicare benefits. Therefore, CDTFs or physicians providing MAT services do not have to bill Medicare first.

*Substance abuse treatment services as a condition of probation*

HHSC recently became aware that some plans have interpreted the following statement in Section 8.1.15.7 of the contract to be applicable to substance abuse treatment: “The MCO is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code. These placements are Non-capitated services.” However, the provisions in Section 8.1.15.7 apply to inpatient psychiatric care and are not intended to apply to substance use disorder treatment. Substance abuse treatment is a covered benefit of Medicaid and payable by the health plans.

It is HHSC’s intent to clarify in future contract language that SUD services as a condition of probation are payable by the health plan. In the meantime, HHSC requests that plans cease any recoupment efforts and determine a mechanism to reimburse the provider for any SUD condition-of-probation claims that have been recouped.

---

**16.2.7.1.1 Substance Use Disorder Benefit for Dual Eligibles**

---

Notice: June 6, 2014  
Effective: N/A

Impacted Programs	STAR	STAR Health	STAR+ PLUS	Dual Demo	STAR Kids	Medicaid Dental	CHIP	CHIP Dental
	No	No	Yes	Yes	Yes	No	No	No

*General Overview*

Dual eligible individuals are persons who qualify for both Medicare and Medicaid benefits. Medicare is a federally-paid and administered health insurance benefit. Medicare covers inpatient hospital services (Part A), physician and related health services (Part B), Medicare managed care (Part C), and prescription drugs (part D). For dual eligible individuals, Medicaid may pay for all or a portion of Medicare Part A and B premiums, co-insurance, and deductibles.



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>39 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

Some clients who have full dual eligibility status are referred to as "fully dual eligible individuals," and are eligible to receive "full" Medicaid benefits. Medicaid pays the premiums, deductibles, and co-insurance for Medicare services, so that most acute care services are still paid through Medicare. However, for fully dual eligible individuals, Medicaid may also cover services that are not covered Medicare, including long term care and SUD treatment in a CDTF. CDTFs are not recognized as a payable provider type in Medicare, and these services are therefore not covered by Medicare.

In order to be eligible to enroll in Texas Medicaid, a provider typically must be a Medicare participating provider. Certain types of providers, however, are not required to meet the Medicare participation requirement, including CDTFs. Also, because Medicare does not recognize CDTFs as a payable provider type, CDTFs do not need to bill Medicare first for a dual eligible client.

#### *STAR+PLUS*

Clients eligible for STAR+PLUS who have Medicare and Medicaid are Medicaid Qualified Medicare Beneficiaries (MQMBs). The MQMB status means that Medicaid reimburses for the coinsurance and deductibles as well as Medicaid-only services. MQMBs qualify for Medicaid benefits not covered by Medicare in addition to Medicaid payment of Medicare deductibles and/or coinsurance. Medicaid will pay for their SUD treatment in a CDTF, even if the client normally would have their acute care paid through Medicare. Claims for SUD services rendered to a STAR+PLUS dual eligible should be submitted to TMHP: [www.tmhp.com](http://www.tmhp.com) (Not the STAR+PLUS health plan.)

#### *Dual Eligibles with MQMB status who are not enrolled in STAR+PLUS*

If the client is dual eligible and has MQMB coverage, even if the client is not enrolled in STAR+PLUS, then TMHP will pay claims for CDTF-rendered services.

#### *Dual Eligible Individuals who do not qualify for Medicaid reimbursement for CDTF SUD Services*

When a provider verifies a client's Medicaid eligibility, terms like "QMB" or "MQMB" may appear to indicate dual eligible status. Only full dual eligible individuals qualify for reimbursement of CDTF services.

Medicaid will not reimburse CDTF-rendered services to the following dual eligible individuals: Qualified Medicare Beneficiaries (QMB); Specified Low-Income Medicare Beneficiaries (SLMB), Medicare Qualified Individuals (QI), or Qualified Disabled and Working Individuals (QDWI).

#### *Prior Authorization for Duals*

For MQMB dual eligible individuals, no prior authorization is required for Medicaid CDTF SUD services for clients enrolled in a STAR+PLUS health plan. Clients who have MQMB status and



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>40 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

are not enrolled in a STAR+PLUS health plan must have prior authorization from TMHP for the following SUD services: ambulatory detoxification, residential detoxification, and residential treatment.

### *Dual Demonstration*

The Dual Demonstration began March 1, 2015, and offers a new way to serve people who are dual eligible. The goal of the project is to better coordinate the care dual eligible members receive.

This demonstration project features the provision of both Medicare and Medicaid health services through a single health plan. The goal is to improve coordination of services for dual eligibles, enhance quality of care, and reduce costs for both the state and the federal government.

This project is in six Texas counties, including: Bexar (San Antonio), Dallas, El Paso, Harris (Houston), Hidalgo (McAllen) and Tarrant (Ft. Worth and Arlington).

If a client is enrolled in the Dual Demonstration, claims for Medicaid-covered CDTF services need to be submitted to the client's health plan. Providers will need to check with the client's health plan regarding any potential prior authorization requirements for SUD treatment.

### *Things to Remember when Billing SUD Services to TMHP*

Claims must be received by TMHP within 95 days from the date of service (DOS), or from the date that eligibility is added to the TMHP files (add date). Appeals must be received by TMHP within 120 days of the disposition date on the remittance and status report on which the claim appears. A 95 day claims filing deadline, or 120 day appeal filing deadline that falls on a weekend or holiday is extended to the next business day following the weekend or holiday.

When a service is billed to another insurance resource, the filing deadline is 95 days from the date of disposition by the other resource.

### References

1. TMHP information on claims:  
[http://www.tmhp.com/Pages/Medicaid/Medicaid\\_Publications\\_Provider\\_manual.aspx](http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx).  
 Search the manual for Claims, Volume 1, Chapter 6.

## **16.2.8 Reserved [Third Party Liability and Recovery and Coordination of Benefits]**



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>41 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

- 16.2.9      Reserved [Coordination with Public Health Entities]**
  
- 16.2.10     Reserved [Coordination with Other State Health and Human  
Services (HHS) Programs]**
  
- 16.2.11     Reserved [Advance Directives]**
  
- 16.2.12     Reserved [SSI Members]**
  
- 16.2.13     Reserved [Medicaid Wrap-Around Services]**
  
- 16.2.14     Reserved [Medical Transportation]**
  
- 16.2.15     Reserved [Blank]**
  
- 16.2.16     Reserved [Supplemental Payments for Qualified Providers]**
  
- 16.2.17     Electronic Visit Verification**



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>42 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

## 16.3 Additional STAR+PLUS Scope of Work

The STAR+PLUS Handbook contains HHSC-approved policies and procedures related to the STAR+PLUS Program, including policies and procedures relating to the Home and Community Based Services STAR+PLUS Waiver. The STAR+PLUS Handbook includes additional requirements regarding the STAR+PLUS Program and guidance for the MCOs, the Program Support Units, and HHSC staff for administrating and managing STAR+PLUS Program operations.

Reference:

1. STAR+PLUS Handbook. Available at: <http://www.dads.state.tx.us/handbooks/sph/>



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>43 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

- 16.4 Additional STAR Health Scope of Work**
- 16.4.1 Reserved [STAR Health Disease Management]**
- 16.4.2 Reserved [Additional Behavioral Health Provisions]**
- 16.4.3 Reserved [STAR Health Member Records and Enrollment]**
- 16.4.4 Reserved [Urgent Services]**
- 16.4.5 Reserved [Payments for Providers]**



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>44 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

## **16.5 Reserved [Additional STAR Kids Scope of Work]**



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>45 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

**16.6 Reserved [Additional Scope of Work for  
Medicare/Medicaid Plans in the Dual Demonstration]**



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>46 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

## **16.7 Additional CHIP Scope of Work**

**16.7.1 Reserved [CHIP Provider Complaint and Appeals]**

**16.7.2 Reserved [CHIP Member Complaint and Appeal Process]**

**16.7.3 Reserved [Third Party Liability and Recovery, and Coordination of Benefits]**

**16.7.4 Reserved [Perinatal Services for Traditional CHIP Members ]**

**16.7.5 Reserved [Covered Benefits]**

16.7.5.1- 16.7.5.21 (Reserved)

- 16.7.5.1 Inpatient General Acute and Inpatient Rehabilitation Hospital (Reserved)
- 16.7.5.2 Skilled Nursing Facilities (includes Rehabilitation Hospitals) (Reserved)
- 16.7.5.3 Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center (Reserved)
- 16.7.5.4 Physician/Physician Extender Professional Services (Reserved)
- 16.7.5.5 Prenatal Care and Pre-Pregnancy Family Services and Supplies (Reserved)
- 16.7.5.6 Birthing Center Services (Reserved)
- 16.7.5.7 Services Rendered by a Certified Nurse Midwife of physician in a licensed birthing center (Reserved)
- 16.7.5.8 Durable Medical Equipment, Prosthetic Devices, and Disposable Medical Supplies (Reserved)
- 16.7.5.9 Home and Community Health Services (Reserved)
- 16.7.5.10 Inpatient Mental Health Services (Reserved)
- 16.7.5.11 Outpatient Mental Health Services (Reserved)
- 16.7.5.12 Outpatient Substance Abuse Treatment Services (Reserved)
- 16.7.5.13 Rehabilitation Services (Reserved)
- 16.7.5.14 Hospice Care Services (Reserved)
- 16.7.5.15 Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services (Reserved)
- 16.7.5.16 Transplants (Reserved)
- 16.7.5.17 Vision Benefit (Reserved)
- 16.7.5.18 Chiropractic Services (Reserved)
- 16.7.5.19 Tobacco Cessation Program (Reserved)
- 16.7.5.20 Case Management and Care Coordination Services (Reserved)



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>47 of 48</b>
CHAPTER TITLE <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

16.7.5.21

Drug Benefits

(Reserved)



MANUAL HHSC UNIFORM MANAGED CARE MANUAL	Chapter <b>16.1</b>	PAGE <b>48 of 48</b>
CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>January 15, 2016</b>	
	<b>Version 2.0</b>	

## **16.8 Additional Scope of Work for Dental Maintenance Organizations**

### **16.8.1 Reserved [Scope of Work]**

### **16.8.2 Reserved [Additional Medicaid Scope of Work]**

- 16.8.2.1 Reserved [Continuity of Care and Out-of-Network Providers]
- 16.8.2.2 Reserved [Provisions related to Medically Necessary Covered Dental Services for Medicaid Members]
- 16.8.2.3 Reserved [Provider Complaints and Appeals]
- 16.8.2.4 Reserved [Member Rights and Responsibilities]
- 16.8.2.5 Reserved [Medicaid Member Complaints and Appeals Systems]
- 16.8.2.6 Reserved [Third Party Liability and Recovery and Coordination of Benefits]
- 16.8.2.7 Reserved [SSI Members]

### **16.8.3 Reserved [Additional CHIP Scope of Work]**

- 16.8.3.1 Reserved [CHIP Provider Complaints and Appeals]
- 16.8.3.2 Reserved [CHIP Member Complaint and Appeals Process]
- 16.8.3.3 Reserved [Third Party Liability and Recovery and Coordination of Benefits]