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CHAPTER TITLE  <b>Medicaid and CHIP Contract Operational Guidance</b>	EFFECTIVE DATE <b>December 7, 2018</b>	
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### DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
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Revision	2.1	July 1, 2017	Section 16.1.25.2 "Prior Authorization for Level 4 Deep Sedation and general Anesthesia Provided in Conjunction with Therapeutic Dental services" is added.
Revision	2.2	September 1, 2017	Section 16.1.2.11 "Laboratory Services" is added.  Section 16.1.2.21 "Guidance on amount, duration, and scope of Medicaid benefits delivered through Medicaid managed care" is added.  Section 16.1.4.1 "Preferred Provider Arrangements and Network Access" is added.  Section 16.1.9.2 "Out-of-Network Reimbursement for ECI Services" is added.  Section 16.1.9.3 "Federal Entitlement to Medicaid and ECI Services" is added.  Section 16.2.15 "Prescribed Pediatric Extended Care Centers" is added.  Section 16.8.1.1 "Substitute Dentist" is added.
Revision	2.3	November 15, 2018	Section 16.1.2.6.1 "Breast Pumps" modified to clarify coverage in CHIP and remove information that is more up-to-date in the TMPPM.  Section 16.1.2.8.1 "Long Acting Reversible Contraception (LARC)" modified to streamline guidance and clarify the expectations of the MCO regarding implementation, provider education, and encounter data.



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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
			<p>Section 16.1.2.11.1 “Zika Virus Testing” modified to remove testing codes formerly used.</p> <p>Section 16.1.2.16 “Therapy (PT, OT, and Speech) Services” is added.</p> <p>Section 16.1.15.1 “Behavioral and Physical Health Integration” and its subsections are added in compliance with SB 74, 85R.</p> <p>Section 16.1.15.2 “Mental Health Parity” is added.</p> <p>Section 16.1.25.1 “Dental Fluoride Varnish” is modified to clarify for CHIP MCOs that this benefit must be covered under the AAP periodicity requirements when administered by physicians and to re-emphasize that Medicaid MCOs and Medicaid/CHIP MCOs are required to cover the benefit.</p> <p>Section 16.1.25.2 “Prior Authorization for Level 4 Deep Sedation and General Anesthesia Provided in Conjunction with Therapeutic Dental Services” is modified to reflect updates to dental procedure codes.</p> <p>Section 16.1.25.3 Topical Dental Fluoride Varnish for CHIP Members is added.</p> <p>Section 16.2.5.1 “Dissemination of Practice Guidelines” is added.</p> <p>Section 16.2.5.2 “Dissemination of Medical Necessity Criteria When Issuing An Adverse Determination” is added.</p> <p>Section 16.8.1.1 “Substitute Dentist” is modified to match the updated TAC rules §354.1221 and §354.1121.</p>
<p><sup>1</sup> Status is represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.</p> <p><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.</p> <p><sup>3</sup> Brief description of the changes to the document made in the revision.</p>			



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### **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 CHIP 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. For the purposes of this chapter, 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 MCOs. This chapter is based on Section 8 of the managed care contracts, which focuses on specific requirements and guidelines for the 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.

All capitalized terms in this chapter are defined in Attachment A, Contract Terms and Conditions, to the managed care contracts, as amended.



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## 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





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



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## 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

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 Tex. Admin., Code §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*



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According to Human Resources Code §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 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 the 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 Texas Government Code Chapter 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 FFS Medicaid coverage, then the provider must follow the process outlined in the TMPPM.

*OPERATIONAL GUIDANCE FOR MCOs*

*Prior Authorizations for Medicaid Members Not Residing in a NF*

For non-emergency transportation services rendered to a Member, ambulance providers may coordinate the 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 PA 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 PA to the requesting entity, as well as the ambulance provider. The ambulance provider is ultimately responsible for ensuring that a PA has been obtained prior to transport; non-payment may result for services provided without a PA or when the authorization request is denied by the MCO.

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



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NF providers must follow the steps below to obtain PA 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.
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 PA 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 provider and NF will coordinate the scheduling of the appointment.

Please note that all MCOs will accept the TDI Standard Prior Authorization form; however, each MCO may have its own forms and methods for submission for PAs, 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 Texas Administrative Code § 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>



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**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)
16.1.2.4	Chiropractic Services	(Reserved)
16.1.2.5	Dialysis	(Reserved)

**16.1.2.6 Durable Medical Equipment, Medical Supplies, and Nutritional Products**

**16.1.2.6.1 Breast Pumps**

Release Date August 18, 2014  
Effective Date November 1, 2018

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

The Medicaid policy regarding breastfeeding support services can be found in the Texas Medicaid Provider Procedures Manual.

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

Release Date September 18, 2015

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

All 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:

1. There has been a significant change in the Member's condition such that the current equipment no longer meets their needs;



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2. The equipment is no longer functional and either cannot be repaired or it is not cost-effective to repair; or
3. 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

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**16.1.2.7 Reserved [Emergency Services]**

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

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

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Notice: October 13, 2015  
Effective: November 1, 2018

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

Effective January 1, 2016, HHSC implemented Medicaid benefit changes in an effort to increase access to and utilization of LARCs in Texas Medicaid. MCOs must implement the necessary changes to reimburse Hospitals, FQHCs, and RHCs 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 covered LARC devices in addition to the reimbursement for labor and delivery services when a LARC device is inserted immediately postpartum



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Medicaid MCOs must adopt claim processing procedures to reimburse Hospital providers for immediate postpartum LARC devices in addition to the contracted rate for inpatient labor and delivery services. MCOs must educate Hospital providers on claim submission requirements.

NOTE: For claims submitted to the 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 and RHC Reimbursement for LARC*

FQHCs and RHCs may receive reimbursement for covered LARC devices in addition to the encounter rate paid for the visit:

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

*340B Drug Pricing Program*

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.

*Provider education*

MCOs must educate providers regarding billing and reimbursement procedures, including those for immediate postpartum LARC. LARC billing and reimbursement guidelines must be posted on the MCO's website, and MCOs must notify family planning providers, hospitals, FQHCs, RHCs, and other providers who may bill for LARC.

*MCOs Not Providing Family Planning Services*

MCOs that do not provide family planning services must adopt claims processing procedures for immediate postpartum LARC that will facilitate provider reimbursement from TMHP in accordance with Texas Medicaid Provider Procedures Manual: Medicaid Managed Care Handbook, Section 9.1, Family Planning Carve-Out Services.

References



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1. Texas Medicaid Provider Procedures Manual: Volume 2, Gynecological, Obstetrics, and Family Planning Title XIX Services Handbook, Sections 2.2.2.1, 2.2.2.2, and 2.2.5.4.  
Available at:  
[http://www.tmhp.com/pages/medicaid/Medicaid\\_Publications\\_Provider\\_Manual.aspx](http://www.tmhp.com/pages/medicaid/Medicaid_Publications_Provider_Manual.aspx)
2. Long-Acting Reversible Contraception Products, Medicaid/CHIP Vendor Drug Program.  
Available at: <http://www.txvendordrug.com/formulary/larc.shtml>

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### 16.1.2.9 Home Health Care Services

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#### 16.1.2.9.1 Home Health Therapy Provider Rates

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Notice: October 4, 2013

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 FFS rates to therapy providers should pay close attention to the acute care FFS rates versus the Comprehensive Care Program therapy services rates. Home health agency providers performing 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 1 and is treated as CCP.

#### References

1. TMHP. Home Health Fee Schedule and Online Fee Lookup. February 19, 2010. Available at: <http://public.tmhp.com/FeeSchedules>.

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#### 16.1.2.9.2 Homebound Policy

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Release Date August 14, 2013

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





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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 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 Members do not have to be homebound to qualify for services.

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

1. 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
2. Receive services that meet the client's existing medical needs and can be 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://public.tmhp.com/FeeSchedules>.

**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                November 1, 2018

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



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Effective October 1, 2015, the 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 PA, 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 hospital 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 SOI 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 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; and 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 five diagnoses on any inpatient PA 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 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 are 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



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(there is no exempting diagnosis on the PA form or a claim). MCOs must ensure that the April 2016 stay does not factor into the SOI 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 heart failure, and not Schizophrenia, the Member is still exempt from the SOI limitation because Schizophrenia is listed as a top five diagnosis.

#### *Example Scenarios*

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

1. In May 2016, a Member is admitted to an Acute Care Hospital for injuries resulting from a car accident. The Hospital includes the Member's 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 PA request or a submitted claim form.



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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.

- The Member described in scenario #1 is readmitted to a different Hospital the following month, June 2016, for complications related to diabetes. This 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 SOI limitation.

Analysis: The MCO appropriately applied the SOI limitation for this Member. An exempting diagnosis must be noted as a top five diagnosis on either the pre-authorization (PA) 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 TMPPM. 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.

- A Member who has a diagnosis of Schizophrenia (F20) is admitted to Austin State Hospital (state hospital), an institution for mental disease, under the "in-lieu-of" contractual provision in the managed care contracts. During the PA 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 stayed for 28 days before being discharged and the PA form and claims did not include any exempting diagnoses. The MCO denies any stay past 2 days at the 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 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 PA form exempted the Member from the SOI limitation.

- 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 SOI 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 PA 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



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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 PA 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 SOI limitation. This diagnosis resulted in the stay for days 31-37 being eligible for Medicaid reimbursement.

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**16.1.2.11 Laboratory Services**

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**16.1.2.11.1 Zika Virus Testing**

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Release Date            May 5, 2017  
 Effective Date        November 1, 2018

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

MCOs must educate their Providers about the appropriate procedure codes to use when ordering a test for Zika.

MCOs should require their Providers to use clinical judgment and follow recommendations from the Texas Department of State Health Services (DSHS) regarding testing. These guidelines can be found at [TexasZika.org](http://TexasZika.org). MCOs should share the DSHS recommendations with their Providers.

Additional information, including appropriate procedure codes to use when ordering a test for Zika, is available in the TMPPM, Radiology and Laboratory Services Handbook Section 2.2.13.1.

References

TMPPM. Radiology and Laboratory Services Handbook. 2.2.13.1.

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**16.1.2.124 Reserved -16.1.2.20**

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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)





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### **16.1.2.21.1 Background**

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MCOs have discretion under their Contracts with HHSC to design policies and procedures to implement the Medicaid benefit. For example, MCOs may have different PA requirements than those in FFS Medicaid. In implementing the Medicaid benefit and furnishing Medicaid services to their Members, MCOs must offer a sufficient benefit and ensure that services are furnished in an amount, duration, and scope that is equal to that furnished in FFS Medicaid. At a minimum, this means that MCO medical policies must, for each Covered Service, reflect the amount, duration, and scope of that Covered Service in FFS Medicaid. The following guidance is provided to all Medicaid MCOs to assist in creating and maintaining medical policies that comply with Contract standards and applicable federal regulations.

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### **16.1.2.21.2 Definitions**

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#### **Medicaid benefit**

The specific service categories covered under Texas Medicaid, as outlined by the Medicaid state plan, are further defined in the TMPPM. For the purposes of Medicaid managed care, the Medicaid services include all services "carved-in" to the managed care delivery system under the MCOs' Contract with HHSC, and excludes any "carved-out" services as described in that contract. The Medicaid benefit under managed care must include the broad service categories covered under FFS Medicaid and all procedure codes covered under FFS Medicaid.

#### **Early and Periodic Screening, Diagnosis, and Treatment**

Known in Texas as Texas Health Steps (THSteps), Early and Periodic Screening, Diagnosis and Treatment (EPSDT) refers to the Medicaid program's obligation to provide comprehensive medical and dental preventive and treatment services to children and young adults under age 21. The program offers comprehensive and periodic evaluation of a child's health, development, and nutritional status, as well as vision, dental, and hearing care. As a component of this EPSDT mandate, Medicaid must also cover all Medically Necessary Medicaid services, even those otherwise unavailable or limited in the Medicaid state plan, that are required to correct or ameliorate the Medicaid Member's physical, behavioral, or developmental condition.

#### **Amount**

The numerical quantity of a service available to a Medicaid Member. This includes the number of discrete procedures, the number of visits, and the number of units of a service a Medicaid Member may receive, either during a defined period of time or over the course of a lifetime. It also includes the number of physical items a Medicaid Member may receive under a benefit, such as durable medical equipment. The MCO must offer at least the same quantity of service or item to a Member as would be offered to that beneficiary under FFS Medicaid.



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**Duration**

The length of time that a service is available to a Medicaid beneficiary. This includes the time that a benefit may be provided per episode, e.g., two weeks of hospitalization per episode of a disease or procedure. This also includes the length of time a beneficiary may receive an item, such as a medical supply. For those benefits that have a lifetime limit, e.g., transition assistance services in the Medically Dependent Children Program, the duration is a beneficiary's lifetime. The MCO must offer the Member the service or item for at least the same duration as would be offered to that same beneficiary under FFS Medicaid.

**Scope**

Scope encompasses the nature of a Medicaid benefit, what is included or excluded. The scope of a Medicaid benefit, which must be addressed in the MCO's medical policy, includes the following categories:

1. Which Members are eligible for the benefit?
  - a. This includes both program eligibility and medical necessity.
    - i. An example of the program eligibility category is a Member enrolled in the STAR+PLUS HCBS program, who by virtue of Membership in the program has access to a set of benefits not available to beneficiaries not in the STAR+PLUS program. Members who do not have Program eligibility for a benefit (i.e., are not in a particular eligibility group) may not receive that benefit. If FFS Medicaid covers a benefit for beneficiaries with certain Program eligibility, the MCO must cover that benefit for Members with that same Program eligibility.
    - ii. An example of medical necessity is the requirement, under 1 Tex. Admin. Code §354.1231, that, in order to qualify for hearing aid services, a Member must have "an air conduction puretone average (500 Hz, 1000 Hz, 2000 Hz) in the better ear of 35 dB hearing loss (HL) or greater." Members who do not meet medical necessity criteria for a benefit are not eligible to receive that benefit. If FFS Medicaid covers a benefit for beneficiaries who meet certain medical necessity criteria, the MCO must cover that benefit for Members who meet those medical necessity criteria.
2. Which Providers may provide the benefit?
  - a. The MCO must allow the same provider types that may deliver a service in FFS Medicaid to deliver that same service in managed care, provided that the Provider has met all applicable contracting and credentialing standards. For example, if a physician assistant may perform a medical checkup in FFS Medicaid, the MCO must allow a physician assistant to deliver this same service.
3. Where the benefit may be provided?





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- a. The MCO must cover services in the same places of service that are allowable under FFS Medicaid. For example, if FFS Medicaid covers therapy in an outpatient setting, the MCO must also cover therapy in an outpatient setting.
- 4. What specific procedures are covered under the benefit category?
  - a. The MCO must cover all components of a benefit category that are covered under FFS Medicaid. For example, if FFS Medicaid covers the code T1019, the MCO must cover this code as well.

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#### **16.1.2.21.3 Key Requirements**

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1. HHSC is the single state Medicaid agency in Texas responsible for defining and obtaining approval from the Centers for Medicare and Medicaid Services (CMS) for all benefits offered under the Medicaid state plan.
2. Pursuant to 42 C.F.R. §440.230(b), Medicaid state plan services must be sufficient in amount, duration, and scope to reasonably achieve their purposes. HHSC, through its role as single state Medicaid agency, is responsible for ensuring that Medicaid services are sufficient.
  - a. Under 42 C.F.R. §438.210(a)(3)(i), HHSC must, through contract, require MCOs to ensure that services are sufficient. This means, although HHSC has the final authority in determining the Medicaid benefit through the Medicaid state plan, MCOs are responsible for ensuring that all Medicaid services delivered through a managed care delivery system remain sufficient in amount, duration, and scope.
  - b. MCOs cannot arbitrarily deny or reduce the amount, duration, or scope of services to an otherwise eligible Member solely because of diagnosis, type of illness, or condition. 42 C.F.R. §438.210(a)(3)(ii). This means, for example, an MCO cannot: (1) make private duty nursing unavailable to those Members who are fed with a G-tube; (2) cap the number of personal care services hours at 40 per week for all Members who use a wheelchair; or (3) offer behavioral health services only to adult Members who have a diagnosis of schizophrenia.
3. Pursuant to 1 Tex. Admin. Code §353.409(b), and in accordance with 42 C.F.R. §438.210(a)(2), Medicaid managed care services must be provided at least in an amount, duration, and scope available to FFS Medicaid beneficiaries, unless otherwise explicitly authorized by HHSC through a waiver.
  - a. This means that, other things being equal, a beneficiary would receive at least the same medically necessary care with any contracted Medicaid MCO as he or she would in FFS Medicaid.



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- b. The amount, duration, and scope of benefits in Medicaid managed care may exceed the scope of FFS Medicaid on a case-by-case basis, as allowed by 1 Tex. Admin. Code §353.409(f).
- 4. Medicaid MCOs must adhere to HHSC medical policy as documented in the TMPPM insofar as it defines the amount, duration, and scope of each Medicaid benefit.
- 5. As required by Social Security Act §1905(r)(5), Texas Medicaid must cover such Medicaid services required to correct or ameliorate the physical, behavioral, or developmental condition of a beneficiary under age 21, as identified in an EPSDT screening, regardless of whether such services are otherwise covered under the state plan. In practice, this means:
  - a. Medicaid eligible children and young adults under age 21 qualify for a broader array of Medicaid services than do adults over age 21.
  - b. Regardless of the amount, duration, and scope of a Medicaid service set forth in the Medicaid state plan or described in a managed care contract, MCOs must provide Medically Necessary Covered Services in the amount, duration, and scope that are required to correct or ameliorate a child or young adult Member's physical, behavioral, or developmental condition. This applies to all Medicaid Members under age 21, regardless of Program in which the Member is enrolled.

**16.1.3 Access to Care - Reserved**

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

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**16.1.3.2 Access to Network Providers**

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**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)



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### 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

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 a NF. STAR Members admitted to NF are disenrolled prospectively. a NF are required to provide the HHSC with a notification of a STAR Member's admission to a NF. However, to ensure HHSC receives expeditious notification of a STAR Member's NF admission, MCOs should also notify HHSC of the Member's admission. MCOs should send the NF's admission notification to the following mailbox: [ManagedCareEligibilityEnrollment@hhsc.state.tx.us](mailto:ManagedCareEligibilityEnrollment@hhsc.state.tx.us)

After receiving and entering the information in the system, HHSC will terminate the Member's enrollment prospectively at the end of the month in which HHSC receives such notification.

During the Member's stay in the NF before the Member is disenrolled from STAR, MCOs are responsible for all covered services they normally provide, including pharmacy, for the month(s) they received capitation payments.

### 16.1.3.2.7 Reserved [All Other Covered Services]

## 16.1.4 Provider Network

### 16.1.4.1 Preferred Provider Arrangements and Network Access

MCOs are contractually obligated to transition provider payment methodologies from volume based payment approaches to quality-based alternative payment models (APMs). APMs are designed to improve health outcomes for Members, improve Members' experience of care and lower healthcare cost trends. One arrangement MCOs may consider to further these goals is a preferred provider arrangement. While this is an allowable arrangement, MCOs must continue to offer Members choice of provider to the extent possible and appropriate (42 CFR §438.3(l)).

If an MCO enters into a preferred provider arrangement, the MCO must notify Members of the arrangement in writing at least 30 Days in advance of execution of the arrangement, consistent



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with Chapter 4 of the UMCM. The MCO must also develop and implement a process whereby Members have the opportunity to opt out of using the preferred provider and use another Provider. The MCO must provide clear written instructions on how a Member may opt out of using the preferred provider. The MCO must manage its opt out process, including the receipt and review of all Member requests, and may not delegate any process steps to its Providers.

For preferred provider arrangements already in effect prior to the issuance of HHSC guidance, MCOs must provide notification to impacted Members and provide clear written instructions on how the Member may opt out of using the preferred provider. Furthermore, the MCO may not change a Member's Provider without notifying the Member of the change and providing clear written instructions on how the Member may opt out of using the Provider.

Only those preferred provider arrangements for which some portion of the overall healthcare payment is based on quality-based performance will be considered eligible for fulfillment of the value-based contracting requirements.

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#### **16.1.4.2 Primary Care Providers**

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

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Notice: December 3, 2013  
 Effective: November 1, 2018

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 MCOs are required to use advanced practice registered nurses (APRNs) and physician assistants (PAs) as primary care providers (PCPs) to increase the availability of PCPs 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, should 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 PCP 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>



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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 CMS, and state law, APRNs and PAs are prohibited from prescribing for any DME, including home health supplies and outpatient schedule II controlled substances for Medicaid and CHIP Members.<sup>5</sup> See Section 157.0511 of the Texas Occupations Code for 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 Texas Government; see also Section 62.1551 of the Texas Health and Safety Code.

<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> 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 8.1.4.2, Attachment B-1, STAR Health 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

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 42 C.F.R. 440.70, guidance from the CMS, and state law, (APRNs) and (PAs) are prohibited from prescribing any DME, including home health supplies and outpatient schedule II controlled substances for Medicaid and CHIP Members. See Section 157.0511 of the Texas 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 DME, including home health supplies and outpatient schedule II controlled substances when prescribed by APRNs and PAs.



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References

<sup>1</sup> 42 C.F.R. §440.70

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

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**16.1.4.3 - 16.1.4.14 Reserved**

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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)

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**16.1.4.15 Ambulance Providers**

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**16.1.4.15.1 Ambulance Provider Network Agreement**

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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.



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16.1.4.16 Mental Health Rehabilitative Services (Reserved)

**16.1.5 Member Services**

**16.1.5.1 Cultural Competency Plan**

Notice: June 27, 2014

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 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 MCO’s capitation rates.<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:

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



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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 7.054a)(1); STAR+PLUS Expansion Contract, Attachment A, Section 7.05(a)(1); STAR Health 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 48.1.5.8; Dental Services Contract, Attachment B-1, Section 8.1.6.8; CHIP RSA Contract, Attachment B-1, Section 8.1.5.8

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

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

**16.1.8 Utilization Management**

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**16.1.8.1 CHIP Notice for Approved Services**

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Notice: April 24, 2013  
 Effective: November 1, 2018

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

TDI rules, found at 28 Tex. Admin. Code Chapter 19, Subchapter R, on utilization reviews for health care providers under a health benefit plan including dental and pharmacy services, affect





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CHIP but not Medicaid. These rules require CHIP plans to provide notification to their Membership on services that are approved, not just those that are denied.

References

- 28 Tex. Admin. Code § 19.1709. Notice of Determinations Made in Utilization Review. Available at [https://texreg.sos.state.tx.us/public/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=1711](https://texreg.sos.state.tx.us/public/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=1711):
- UMCC. 8.1.8. Utilization Management.

**16.1.9 Early Childhood Intervention**

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

Notice: August 25, 2015  
Effective: November 1, 2018

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 to age three, with disabilities or developmental delays. ECI provides 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 or LAR. Each child’s team develops an 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



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is a contract between the ECI contractor and child’s parent or LAR. Section 8.1.9.5 indicates the IFSP serves as authorization for services provided by the ECI contractor.

*Form*

DARS 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. The change to the IFSP form was 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 he or she has a medical need. 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 or 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>			



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	Program Provided (PP)	Parent Choice (PC)	Program Arranged (PA)	Not Part C (NP)
<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 does <b>not meet at least one</b> of the following:
	<ol style="list-style-type: none"> <li>ECI trained per 40 TAC, 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>			
<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	ECI contractor <b>does not</b> submit claims for the services provided.		



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	Program Provided (PP)	Parent Choice (PC)	Program Arranged (PA)	Not Part C (NP)
	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:

1. 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.
2. The IFSP authorizes payment to the ECI contractor not to exceed 60 minutes of OT once a month for 12 months.
3. Neither the physical therapy (PT) nor speech therapy (ST) will be provided by the ECI contractor. The designation of PA (or NP) indicates the ECI contractor will work with the



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MCO to assist the family in locating a 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 he or she has medical need. 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

- UMCC. 8.1.9.4 Individual Family Service Plan.

**16.1.9.2 Out-of-Network Reimbursement for Early Childhood Intervention Services**

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

The purpose of this section is to clarify Out-of-Network (OON) reimbursement requirements for the delivery of Early Childhood Intervention (ECI) services, including physical therapy (PT),



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occupational therapy (OT), and speech therapy (ST) for certain Medicaid Members. MCOs must ensure these Members have access to ECI services, regardless of whether the MCO contracting process with the ECI providers is completed. In this case, MCOs must make arrangements to pay ECI providers an OON rate until the contract(s) are in place.

Under the terms of Texas' managed care contracts, MCOs are required to reimburse OON providers when Medically Necessary Covered Services are not available through Network Providers. For example, section 8.1.9.3 of the UMCC states: "The MCO must allow an Out-of-Network provider to provide ECI covered services if a Network Provider is not available to provide the services in the amount, duration, scope, and service setting as required by the Individual Family Service Plan (IFSP)"

ECI provides family-based services in the child's natural environment, e.g., home, daycare, or playground, by a multidisciplinary team. Children must have a need for ECI services as determined by an ECI contractor. The professionals on the child's interdisciplinary team and the services provided will vary according to the child's functional needs and the family's priorities, but may include PT, OT, and ST. ECI services, including therapies, are distinct from traditional therapies provided to Managed Care Members with short-term needs. For example, if a child enrolled in STAR breaks her wrist, the MCO may authorize PT services for a relatively short duration of time to help the child get back to her normal function. In ECI, the Individual Family Service Plan (IFSP) serves as the plan of care, and PT, OT, and ST must be performed and delivered as identified in the IFSP. Services may be ongoing and evolve over time to improve function and address the child's disability or developmental delay.

Each of the State's ECI contractors has a service area, which is different from the managed care service area. Each ECI-enrolled child has an IFSP, which describes the services the child needs, as well as whether the services are provided by ECI staff ("program provided services") or other providers ("program arranged services"). Only ECI contractors and their staff are authorized to provide "program provided services."

MCOs must reimburse ECI contractors and providers who are enrolled with Texas Medicaid and who are providing ECI "program provided services" in accordance with a child's IFSP, whether the ECI contractor or provider is contracted with the MCO, or not. If there is no contract, the MCOs must reimburse ECI contractors and providers at an OON reimbursement rate or under a single-case agreement. The IFSP serves as the PA for ECI services. The purpose of paying an OON rate to non-contracted ECI contractors or providers is to ensure children are receiving timely access to medically necessary ECI services.



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**16.1.9.3 Federal Entitlement to Medicaid and Early Childhood Intervention (ECI) Services**

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

The purpose of this section is to clarify certain Medicaid Members’ rights with regard to accessing similar services from more than one type of provider. In particular, this section focuses on situations where an ECI contractor is one of these providers.

As explained more fully below, families with children who are eligible to receive ECI services are entitled to simultaneously receive the ECI services as well as other Medicaid-covered therapy services. The MCO must ensure that the Providers are not requiring families to decline ECI services before other Medicaid-covered therapy services are provided. MCOs must ensure their Providers are not creating barriers for Members in accessing Medically Necessary Medicaid services, including ECI services.

Access to Medically Necessary services is a federal entitlement under both Title XIX of the Social Security Act (Medicaid) and Part C of the Individuals with Disabilities Education Act (IDEA). Eligible children are entitled to receive Medicaid Medically necessary services from IDEA Part C Early Childhood Intervention (ECI) contractors and other Medicaid service providers. Therefore, independent practitioners, home health agencies, rehabilitation clinics, and ECI contractors may provide complementary Medicaid-funded services to the same child.

ECI is a statewide program for families with children, birth to age 3, with disabilities and developmental delays. To be eligible for ECI the child must have a medically diagnosed condition that has a high probability of resulting in developmental delay, an auditory or visual impairment, or a developmental delay. Children with severe to profound developmental delays, major medical diagnoses related to their therapeutic needs, or a high acuity of medical needs may qualify for ECI and be appropriately served by ECI contractors.

Section 1905(r)(5) of the Social Security Act requires that a Medicaid recipient under the age of 21 has access to the health care services listed in Section 1905(a) of the Act for which she or he has medical need. If the family of a child with Medicaid wants services listed in Section 1905(a) of the Social Security Act including, but not limited to, occupational therapy, physical therapy, or speech therapy, other than, or in addition to, what the ECI contractor provides, and these services are medical necessary, the child is entitled to receive those additional services.



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Similarly, the US Department of Education has stated that access to Part C early intervention services (i.e., ECI services) cannot be denied or reduced because a family wishes to receive services that are provided outside of the Part C service system (US Dept. of Ed. letter dated Sept. 4, 2007). Access to services from providers other than ECI contractors cannot create a barrier to the child’s access to ECI services. Therefore, a child may receive medically necessary Medicaid services in addition to ECI services.

Both Medicaid and IDEA Part C regulations ensure the right of the parent or legally authorized representative to choose their child's service providers and to decline services they do not want. Federal regulations for Medicaid and IDEA Part C convey the importance of informed decision-making and the parent’s right to accurate information.

Based on federal statutory language, rules, and subsequent guidance, families do not have to choose between ECI and other Medicaid service providers. If there is medical necessity for Medicaid services, the child is entitled to receive her or his services from multiple providers.

- 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 16.1.13 MCO Responsibilities in the Event of a Disaster**

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

MCOs must maintain a disaster recovery plan, business continuity plan (also referred to in the contract as the continuity of operations business plan), and a continuity of Member care emergency response (COMCER) plan that can be implemented at HHSC’s direction or as declared by a health plan in the event of a disaster. Disasters may include, but are not limited to, Federal Emergency Management Agency (FEMA) - or Governor-declared disaster, or other emergencies that are internal, man-made, or natural. Plans must use an “all hazards” approach,





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focusing on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters.

An “all hazards” approach addresses effects of emergencies and disasters with varying causes and the emergency functions that must be carried out to meet the needs of Members and Providers. MCOs can address functions common in their plans that will apply across many types of emergencies that lead to displacement of Members or Providers, or major disruptions in health care for Members in a service area. Examples of such emergencies include, but are not limited to, hurricanes, floods, wildfires, tornadoes, mass shootings, and bombings.

#### 16.1.13.1 Disaster Recovery Plan and Business Continuity Plan

The disaster recovery plan outlines details for the restoration of the MIS in the event of an emergency or disaster. The business continuity plan provides for a quick and smooth restoration of MIS operations after a disruptive event, including business impact analysis, business continuity plan development, testing, awareness, training, and maintenance. The disaster recovery plan and business continuity plan may be combined into one document.

#### 16.1.13.2 Continuity of Member Care Emergency Response Plan

The COMCER plan must be based on a risk assessment for each service area in which the MCO operates (Dental Contractors must complete a statewide risk assessment because their Service Area is the entire state). The COMCER plan must address, at a minimum, the following:

1. The method used to ensure that Members are able to see Out-of-Network provides if Members are unable to access Covered Services from Network Providers;
2. The method used to ensure that prior authorizations are extended and transferred without burden to providers not previously serving the Member, when Members or Providers are displaced;
3. The method used to ensure that claims will be accepted from providers within an extended deadline;
4. The method used to allow providers who complete a simplified provider enrollment application to temporarily enroll in Medicaid, to submit claims, and for the MCO to process claims;
5. The method used to allow pharmacies who complete an HHSC Vendor Drug Program Temporary Pharmacy Agreement form to submit claims, and for the MCO to process claims;
6. The method used to track and monitor Members who reside in Nursing Facilities that have been evacuated, and to provide support to evacuating and accepting facilities proactively and as needed;
7. The method by which the MCO will pay the evacuating Nursing Facility the full, contracted rate for services rendered by the accepting facility, even if the accepting facility is out-of-network or a non-Medicaid provider;



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8. The method by which the MCO/Pharmacy Benefit Manager claims system will waive edits or allow override of edits by at least Zip code for specific date ranges;
9. The method used to ensure that CHIP co-pays including pharmacy, are not collected for a specific duration;
10. The method by which the MCO will communicate with its contracted LTSS providers, including home and community support services agencies, assisted living facilities, adult foster care settings, nursing facilities, and MDCP and STAR+PLUS Waiver providers; and
11. The method by which the MCO will track and monitor the status of the delivery of LTSS for Members impacted by the disaster.

The COMCER plan must include the actions the MCO will take and the objective the action(s) are trying to achieve. Objectives should include requirements listed in this section and any additional objectives required by the state or decided upon by the MCO.

In the course of any disaster, HHSC may work with state and federal partners to invoke any flexibilities listed above, or other flexibilities as needed. Flexibilities will be invoked for a specific geographic area and a specific timeframe, as identified by HHSC and in accordance with state and federal declarations, if applicable. MCOs must operationalize any flexibilities invoked by HHSC and in accordance with HHSC guidance.

MCOs must coordinate with local emergency management when creating COMCER plans immediately prior to, if the event is expected, and during an event to the extent possible. MCOs must identify plans to escalate needs through local emergency management, and mechanisms for assistance at the local level. Mechanisms for assistance at the local level may include resources for Members or Providers who reach MCO staff, such as:

1. Search and rescue contacts;
2. Emergency shelter contacts;
3. Information on applications to local, state, and federal resources for housing and food assistance;
4. Information on mental health resources including and beyond the MCOs provider network; and
5. Any other resources deemed relevant to MCO contact with Members and Providers by the MCO and local emergency management.

COMCER plans should have a primary and secondary response plan in the event that the disaster does not allow for certain actions to be carried out. For example, MCOs should have a plan and backup plan if call center operations need to be temporarily moved if MCO staff are unable to report to work for a significant amount of time, and for other scenarios the MCO foresees as potentially disrupting day to day operations that impact Members and Providers.

#### 16.1.13.3 Exercising of plans and updates



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MCOs must conduct disaster recovery, business continuity, and COMCER plan exercises at least annually, and should include in the exercises LTSS and other providers serving medically fragile populations, such as Nursing Facilities. Exercises should be designed to engage MCO staff and other relevant stakeholders to work together to manage the response to a hypothetical incident. MCOs must make adjustment to plans upon identifying needs through exercises, upon experiencing a disaster, or learning new information about outside resources.

16.1.13.4 MCO communication with HHSC

MCOs must be able to communicate with HHSC on a daily basis or other interval, as set by HHSC, for a set period of time during a disaster and upon recovery from the disaster. MCOs must work with HHSC to gather and report on key information, such as Member location for Nursing Facility residents, provider network capabilities post-disaster, and other needs as identified by HHSC. At a minimum, MCOs should be able to communicate with HHSC:

- What the disaster is
- The date(s) of the event
- If any of their Members were affected, and if so how many were affected

If Members needed to be moved, and if so where they were moved

**16.1.14 Reserved [Disease Management (DM)]**

**16.1.15 Behavioral Health (BH) Network and Services**

**16.1.15.1 Behavioral and Physical Health Integration**

**Impacted Programs:**

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

MCOs are required to work toward the integration of physical and behavioral health services and administration. This guidance is not intended to limit MCOs’ ability to subcontract with a third party or subsidiary for the delivery of behavioral health services. Terms of the MCO Contract apply to any MCO Subcontracts.

For purposes of this section, the term “behavioral health” means administration of services delivered to Members for mental health and substance use disorders. The term “physical health”



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refers to Covered Services other than behavioral health services. For purposes of this section, the term “care coordination” includes case management, service coordination, and service management.

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#### **16.1.15.1.1 Best practices**

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MCOs and their third-party contractors or subsidiaries must have policies and procedures that follow best practices for physical and behavioral health integration. Best practices are those identified by the Substance Abuse and Mental Health Services Administration (SAMHSA), Texas and other state Medicaid and CHIP programs, academicians, and other stakeholders such as foundations. Best practices may include, but are not limited to:

1. streamlining provider credentialing procedures;
2. regular joint rounds with all necessary staff;
3. maintaining and sharing with behavioral health and primary care providers performance and quality metrics for members that have seen that provider within the past 12 months. Performance and quality metrics should be shared at least annually, effective September 1, 2019. Examples of metrics MCOs may identify to share include, but are not limited to:
  - a. ADD (Follow up care for children prescribed ADHD medication)
  - b. AMM (Antidepressant medication management)
  - c. APC (Use of multiple concurrent antipsychotics in children and adolescents)
  - d. APM (Metabolic monitoring for children and adolescents on antipsychotics)
  - e. APP (Use of first-line psychosocial care for children and adolescents on antipsychotics)
  - f. FUA (Follow up after emergency department visit for alcohol and other drug dependence)
  - g. FUH (Follow up after hospitalization for mental illness)
  - h. FUM (Follow up after emergency department for mental illness)
  - i. IET (Initiation and engagement of alcohol and other drug dependence treatment)
  - j. MPT (Mental health utilization)
  - k. SAA (Adherence to antipsychotic medications for individuals with schizophrenia)
  - l. SMD (Diabetes monitoring for people with diabetes and schizophrenia)
  - m. Potentially preventable event measures;
4. maintaining care coordination, service authorization, and utilization management data in a manner that allows for all information about a Member to be accessible to care coordination and utilization review staff working on the Member’s case; and
5. operating a single provider portal for physical and behavioral health providers to submit claims and claims appeals, prior authorization requests, and clinical data or other documentation needed for prior authorization and claims processing.



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**16.1.15.1.2 Sharing and integration of care coordination, service authorization, and utilization management data**

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Per contract, MCOs are required to share and integrate care coordination, service authorization, and utilization management data internally and, if applicable, between the MCO and the third party or subsidiary contracted with the MCO to manage behavioral health services. The goal of this requirement is to ensure that the full spectrum of a Member’s health is taken into account when coordinating care, authorizing services, and reviewing utilization data. MCOs and if applicable, its third party contractor or subsidiary, must have written policies and procedures and implement procedures to share and integrate care coordination, service authorization, and utilization management data (including pharmacy and non-pharmacy information) to the fullest extent allowed by federal law no later than March 1, 2019. All care coordination, service authorization, and utilization management data must be available to both physical and behavioral health care coordination staff and utilization review staff in a manner that allows both physical and behavioral health care coordination staff and utilization review staff to access a Member’s entire care coordination, service authorization, and utilization history. The information must include complete pharmacy data for all Members and other data relevant to a Member’s case. MCOs must establish policies and procedures that ensure that if care coordination and utilization review staff do not have immediate access to a Member’s full spectrum of data, the care coordination or utilization review staff Member requesting information from their counterpart receives that information within one business Day, or, if an emergency occurs, within eight hours.

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**16.1.15.1.3 Joint rounds or another effective means for sharing clinical information**

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Per contract, MCOs must implement joint rounds for physical health and behavioral health services network providers, or implement another effective means for sharing clinical information. Joint rounds are clinical meetings inclusive of MCO staff who coordinate care and care plans for Members with complex needs. At a minimum, MCOs and their third party or subsidiary if applicable, must implement written policies and procedures outlining medical and functional criteria for Members with behavioral health and physical health needs to be escalated for discussion in joint rounds.

All provider contracts, including those for physical and behavioral health providers, should include language requiring clinical information sharing among a Member’s providers, to the extent allowed by federal law, and a process by which providers alert the MCO or third party contractors or subsidiaries to Members they have identified that have co-occurring mental and physical health needs. MCOs and third party contractors/subsidiaries should have a process in place to easily identify and track these Members, such as an indicator. MCOs and third party contractors/subsidiaries should, at a minimum, conduct joint rounds twice monthly to discuss Members with complex cases and determine a plan that addresses the Members physical and



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behavioral health needs. MCOs with a large number of Members with complex needs may need to meet more frequently. Joint rounds should include, at a minimum, care coordination staff, utilization review staff, and pharmacy staff representing both physical and behavioral health, including staff from the MCOs third party contractors or /subsidiaries as applicable.

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**16.1.15.1.4 Co-location of and warm call transfers between physical health and behavioral health care coordination staff**

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Per contract, and to the extent feasible, MCOs should co-locate physical health and behavioral health care coordination staff and must conduct warm call transfers between physical health and behavioral health care coordination staff. MCOs and, if applicable, their third party contractors or subsidiaries must have one or more of the following capabilities for physical health and behavioral health care coordination staff to work together:

Real time tele-consultation such as HIPAA compliant instant messaging, video chat, or telephone calls, or physical co-location of physical health and behavioral health care coordination staff in the same general vicinity of the same office space. The intent of this requirement is for physical and behavioral health care coordination staff to exchange information on an immediate basis. MCOs and their third parties/subsidiaries must have the capability to transfer provider and Member calls between physical and behavioral health care coordination staff without hanging up the phone or putting the provider/Member on hold. MCOs must have written policies and procedures to implement these requirements.

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**16.1.15.1.5 Seamless provider portal**

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Per contract, MCOs are required to make available a seamless provider portal for both physical health and behavioral health services network providers, to the fullest extent allowed by federal law. MCOs are required to provide a provider portal that supports functionality to reduce administrative burden on Network Providers at no cost to the Providers. MCO contracts require that the provider portal functionality must include: client eligibility verification, submission of electronic claims, prior authorization requests, claims appeals and reconsiderations, and exchange of clinical data and other documentation necessary for prior authorization and claims processing. At a minimum, MCOs that have separate provider portals for physical and behavioral health providers must have a link on the top left hand side of their physical health provider portal to their behavioral health provider portal, whether operated by a third party or subsidiary or another arrangement. MCOs must also require that their behavioral health provider portal have a link on the top left hand side to the physical health provider portal. If the MCO or its third party or subsidiary operates a smart phone application-based provider portal, it must also include a link to the other provider portal prominently within the app.



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HHSC encourages MCOs and, if applicable, their third party or subsidiary to operate a single sign on page or single provider portal for both physical and behavioral health care providers, with a specific location for behavioral health provider communications to ensure that integrated physical and behavioral health providers are able to bill and receive payment for services rendered in the least administratively burdensome way.

All MCOs must develop policies and procedures for communicating billing practices to providers who are integrating physical and behavioral health care (ex: how and where to bill a primary care visit and psychotherapy for crisis visit in the same day at an integrated provider site - to MCO portal, BHO portal (if applicable), or separated in a specific way). These policies and procedures should allow for both physical and behavioral health care providers to be reimbursed for the services they deliver. MCO billing practices should allow for an integrated provider billing under one National Provider Identifier (NPI)/Texas Provider Identifier (TPI) to bill for both physical and behavioral health care services, per the credentials of their providers. Billing practices should also include specific information on how to bill integrated services such as HBAI and SBIRT.

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### **16.1.15.2 Mental Health Parity**

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To comply with provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all its related regulations, MCO's policies as written and in operation must not apply any non-quantitative treatment limitations to mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency services, or pharmacy) that violate MHPAEA.

A non-quantitative treatment limitation (NQTL) is a limit on the scope or duration of benefits that are not expressed numerically.

Any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits are required to be comparable to, and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the same classification. MCOs must use benefit classifications as defined by HHSC to complete parity analyses.

### **16.1.16 Reserved [Financial Requirements for Covered Service]**

### **16.1.17 Accounting and Financial Reporting Requirements**

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#### **16.1.17.1 HMO Deliverables related to MIS Requirements**

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Notice: May 15, 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

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

\*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





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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 PA requirements for services provided without a PA. Standard timely filing and Claims requirements apply. Claims received from out-of-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 Providers 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**

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

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Notice: July 18, 2013  
Effective: November 1, 2018

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

1 Tex. Admin. Code §353.911 prohibits MCOs from requiring Member to use mail-order pharmacies. Also, 1 Tex. Admin. Code §353.905(e)(3) specifies that a MCO cannot require a



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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. Texas Government Code §533.005(a)(23)(l)
2. 1 Tex. Admin. Code §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]**

**16.1.24 Reserved [Immunizations]**

**16.1.25 Dental Coverage**

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**16.1.25.1 Dental Fluoride Varnish**

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Notice: October 13, 2015  
 Effective: November 1, 2018

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

CHIP MCOs must provide coverage for fluoride varnish in accordance with American Academy of Pediatrics (AAP) guidelines. CHIP Members should receive preventive care in accordance with the AAP periodicity schedule as described in Uniform Managed Care Contract 8.1.3.1 and the CHIP State Plan. This periodicity schedule contains an oral health component.



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Medicaid MCOs must provide coverage for fluoride varnish administered by physicians for children ages 6 months through 35 months of age through Oral Evaluation and Fluoride Varnish in the Medical Home (OEFV) as described in section 5.3.12.1 of the Texas Medicaid Provider Procedures Manual (TMPPM). OEFV is aimed at improving oral health outcomes for clients who are 6 through 35 months of age by initiating a limited set of preventive dental services (not a dental checkup) in the medical home. Although OEFV is not a required component of a THSteps medical checkup, MCOs should encourage providers to participate in this preventive intervention.

Medicaid and CHIP dental maintenance organizations (DMOs) must provide coverage for topical fluoride as recommended by the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. Medicaid Members ages 6 months through 20 years may receive topical fluoride as described in section 4.2.14 of the TMPPM Children’s Services Handbook. CHIP Members ages 6 months through 18 years may receive fluoride according to the AAPD Periodicity schedule.

References

1. TMPPM. Oral Evaluation and Fluoride Varnish in the Medical Home. Section 5.3.12.1
2. TMPPM. Preventive Services. Section 4.2.14
3. TMPPM. First Dental Home. Section 4.2.7
4. American Academy of Pediatrics. Periodicity Schedule. <https://www.aap.org/>
5. American Academy of Pediatric Dentistry. Periodicity Schedule. <http://www.aapd.org/>

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**16.1.25.2 Prior Authorization for Level 4 Deep Sedation and General Anesthesia Provided in Conjunction with Therapeutic Dental Services**

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Notice: July 1, 2017  
 Effective: November 1, 2018

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

Beginning July 1, 2017, all level 4 sedation services by a dentist, procedure code D9222 and D9223, and any anesthesia services provided by an anesthesiologist (M.D./D.O) or certified registered nurse anesthetist (CRNA), procedure code 00170, with U3 modifier, to be provided in conjunction with therapeutic dental services for Medicaid dental Members from ages zero (0) through six (6) years, must be prior authorized. MCOs may choose whether to require a modifier on claims for CPT 00170 or 41899.



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PA for both therapeutic dental services and level 4 sedation or general anesthesia is mandatory for the reimbursement of either service. The DMO must ensure that the PA has been obtained by the dentist performing the therapeutic dental services prior to payment of the claim.

The MCO must review and prior authorize the general anesthesia service following the PA review performed by the DMO. The DMO will review and make determinations on appropriate dental procedure codes or diagnosis codes. The MCO will review and make determinations on appropriate medical procedure codes or diagnosis codes.

A DMO may not rely on the 22-point threshold on the “Criteria for Dental Therapy Under General Anesthesia” form as the sole criteria for approval of a prior authorization or payment of claims for level 4 sedation for children zero (0) through six (6) years of age. The DMO must ensure that the Provider submits Member-specific documents and information. The DMO must consider the Member-specific documents and information in determining whether PA is appropriate. The Member-specific documents include but are not limited to:

1. The completed Criteria for Dental Therapy Under General Anesthesia form
2. Location where procedures will be performed (in office, or inpatient/outpatient hospital facility)
3. Narrative unique to the Member detailing reasons for the proposed level of anesthesia (indicate procedure code D9222, D9223 or 00170) including:
  - a. History of prior treatment;
  - b. Failed attempts at other levels of sedation;
  - c. Behavior in the dental chair;
  - d. Proposed restorative treatment (tooth ID and surfaces);
  - e. Urgent need to provide comprehensive dental treatment based on extent of diagnosed dental caries; and
  - f. Any other relevant medical condition(s)
4. Diagnostic quality radiographs or photographs
  - a. When appropriate radiographs or photographs cannot be taken prior to general anesthesia, the narrative must support the reasons for an inability to perform diagnostic services. For these special cases that receive authorization, diagnostic quality radiographs or photographs will be required for payment and must be reviewed by the DMO.

### *Emergency Treatment*

In cases of an emergency medical condition, accident or trauma, PA is not necessary. A narrative and appropriate pre- and post-treatment radiographs or photographs must be submitted with the claim. These will be reviewed by the MCO for appropriateness prior to payment.

### *Coverage Determinations and Appeals Processes*



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Requirements for PA, coverage determinations, and appeals processes for services provided through Medicaid managed care are included in Texas Government Code Chapter 533 and the Medicaid managed care contracts. Prior authorizations by DMOs and MCOs must be approved within the timeframe prescribed in the managed care contracts. These requirements are listed in section 8.1.9 of the Dental Services Contract, section 8.1.8 of the Uniform Managed Care Contract, section 8.1.9 of the STAR Kids Contract, and section 8.1.8 of the STAR Health Contract.

DMOs and MCOs use utilization management criteria found in the managed care contracts to evaluate the need for medically necessary covered services. Appeals for denials of medical necessity follow standard Provider Appeals provisions of the DMO and MCO contracts. In the case of a denial of PA of medical necessity by the MCO when the dental services have been prior authorized by the DMO, the MCO and DMO are responsible for coordinating to resolve the issue and appropriately notify the respective Providers.

All MCOs and DMOs will accept the TDI Standard Prior Authorization form. Each MCO and DMO may have its own forms and methods for submission for prior authorizations.

#### *OPERATIONAL GUIDANCE FOR DMOS/MCOS*

Once the DMO has approved a dental Provider's request for PA for therapeutic dental services provided in conjunction with deep sedation or general anesthesia services for Members' ages zero (0) through six (6) years, the DMO must provide proof of approved PA to the dental Provider. The DMO may deliver this proof of approved PA to the dental Provider using its established Provider notification process.

The MCO must require PA for general anesthesia (00170) in advance of dental related anesthesia services being performed by its Network Providers. This PA must include proof of approved PA for dental services from the DMO. The MCO may also require PA for the facility fee (41899). The MCO may request supporting clinical documentation as part of the PA for general anesthesia.

The DMO is responsible for processing claims from Network Providers for CDT code D9222, D9223 and appropriate CDT codes for payment. The MCO is responsible for processing claims for in-office or outpatient general anesthesia (00170) and/or facility fees (41899) from Network Providers for general anesthesia.

The DMO must ensure that the PA number from the treating dentist is included on the claims, The DMO must ensure that all dental Providers comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including the standards for documentation and record maintenance for dental procedures. The DMO must ensure that dental Providers have a current level 4 anesthesia sedation permit issued by the TSBDE to be reimbursed for level 4 deep sedation/general anesthesia services.



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The proof of approved prior authorization from the DMO must contain at least the following elements:

1. DMO information
  - a. DMO name
  - b. DMO address
  - c. DMO phone number
  - d. DMO fax number
2. Provider information
  - a. Provider name
  - b. Provider address
  - c. Provider phone
  - d. Provider NPI
  - e. Rendering provider name
  - f. Rendering provider NPI (if different from requesting provider)
  - g. Treatment location (office or outpatient facility)
3. Member information
  - a. Member name
  - b. Member Medicaid ID number
  - c. Member date of birth
4. Prior Authorization details
  - a. Prior authorization/pre-authorization number
  - b. Date authorization request received by DMO
  - c. Type of authorization request (standard or expedited)
  - d. Date of determination by DMO
  - e. Determination (approved or denied)
  - f. Authorization effective date (if approved)
  - g. Authorization end date (if approved)
  - h. Procedures authorized (CDT, description, tooth # or area)
5. Comments/Remarks on the PA request: Enter reason for denial or additional documentation received, such as x-rays, photographs, type of sedation required.

*Procedure for Level 4 Sedation or General Anesthesia Services Rendered in a Dental Office*

For level 4 sedation or general anesthesia, DMOs and MCOs (as appropriate) must implement policies and procedures to ensure that Network Providers follow the steps below to obtain PA for level 4 sedation or general anesthesia to be provided in conjunction with therapeutic dental services for Medicaid dental Members ages zero (0) through six (6) years when the place of service is a dental office:



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1. The treating dentist determines the level of care needed and submits a PA request and supporting documentation to the Member's DMO.
2. The Member's DMO reviews the request for medical necessity and approves or denies the PA request.
3. If approved, the DMO notifies the treating dentist that the services were approved for the place of service requested. The DMO will provide the treating dentist proof of the approved PA using its established provider notification process.
4. The treating dentist provides a copy of the DMO's approval to the medical anesthesiologist or provider. The dental Provider must use an anesthesia provider who is contracted with the Member's MCO.
5. If the Provider administering level 4 sedation or general anesthesia is a dentist, separate PA from the DMO for level 4 sedation or general anesthesia is not required. The dental anesthesiology provider must obtain the PA number from the treating dentist and submit that number on a claim to the DMO after services are rendered. DMOs should ensure that separate claims from the treating dentist and dental anesthesia provider are able to be paid appropriately.
6. The medical anesthesiology Provider submits a PA request and supporting documentation to the Member's MCO. This supporting documentation must include the proof of approved PA from the DMO.
7. The Member's MCO reviews the request for medical necessity and approves or denies the medical anesthesiology provider's PA request.
8. If approved, the MCO notifies the medical anesthesiology Provider that the anesthesia services are approved for an in-office setting.
9. The medical anesthesiology Provider coordinates with the dental Provider to schedule services for the Member.
10. Upon completion of general anesthesia and therapeutic dental services, the treating dentist submits a claim for appropriate CDT codes for payment to the DMO, including the PA number. If a dental anesthesiologist is utilized, the dental anesthesiologist submits a claim for D9222/D9223 to the DMO, including the PA number from the DMO.
11. The DMO reviews and adjudicates the claim according to the guidelines in its Provider manual.
12. Upon completion of anesthesia services, the medical anesthesiology Provider submits a claim for payment of anesthesia procedures (00170).
13. Upon receipt of the claim(s), the MCO reviews and adjudicates the claim according to the guidelines in its Provider manual.

*Procedure for Level 4 Sedation or General Anesthesia Services Rendered in an Ambulatory Surgical Center (ASC), Hospital Ambulatory Surgical Center (HASC), or Hospital*

For level 4 sedation or general anesthesia, DMOs and MCOs (as appropriate) must implement policies and procedures to ensure that Network Providers follow the steps below to obtain prior authorizations for level 4 sedation or general anesthesia to be provided in conjunction with



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therapeutic dental services for Medicaid dental Members ages zero (0) through six (6) years when the place of service is an ambulatory surgical center, hospital ambulatory surgical center, or hospital:

1. The treating dentist determines the level of care needed and submits a PA request and supporting documentation to the Member's DMO.
2. The Member's DMO reviews the request for medical necessity and approves or denies the PA request.
3. If approved, the DMO notifies the treating dentist that the services were approved for the place of service requested. The DMO will provide the treating dentist proof of the approved PA using its established Provider notification process.
4. The treating dentist provides a copy of the DMO's approval to the medical anesthesiologist or Provider. The dental Provider must use an anesthesia Provider who is contracted with the Member's MCO.
5. If the Provider administering level 4 sedation or general anesthesia is a dentist, separate PA from the DMO for level 4 sedation or general anesthesia is not required. The dental anesthesiology Provider must obtain the PA number from the treating dentist and submit that number on a claim to the DMO after services are rendered. DMOs should ensure that payments from the treating dentist and dental anesthesia Provider are able to be paid appropriately.
6. The medical facility submits a PA request and supporting documentation to the Member's MCO. This supporting documentation must include the proof of approved PA from the DMO. The supporting documentation must include the proof of PA from the DMO. MCOs may also require prior authorization of the facility fee (41899).
7. The Member's MCO reviews the request for medical necessity and approves or denies the medical facility's PA request.
8. If approved, the MCO notifies the medical facility that the anesthesia services are approved for the facility setting.
9. The medical facility coordinates with the dental Provider to schedule services for the Member.
10. Upon completion of both general anesthesia and therapeutic dental services, the treating dentist submits a claim for appropriate CDT codes for payment to the DMO, including the prior authorization number from the DMO.
11. The DMO reviews and adjudicates the claim according to the guidelines in its Provider manual.
12. Upon completion of general anesthesia services, the medical facility submits a claim to the MCO for anesthesia services (00170) and the facility fee (41899) if applicable.
13. Upon receipt of the claim(s), the MCO reviews and adjudicates the claim(s) according to the guidelines in its Provider manual.

References





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1. TMPPM. 4.2.25. Dental Therapy Under General Anesthesia; 4.2.24. Dental Anesthesia. Available at:  
[http://www.tmhp.com/pages/medicaid/Medicaid\\_Publications\\_Provider\\_Manual.aspx](http://www.tmhp.com/pages/medicaid/Medicaid_Publications_Provider_Manual.aspx)
2. Medicaid Managed Care Contracts. Available at:  
<http://www.hhsc.state.tx.us/medicaid/managed-care/forms.shtml>
3. Texas State Board of Dental Examiners. Anesthesia Privileges. Available at:  
<https://www.tsbde.texas.gov/AnesthesiaPrivileges.html>

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**16.1.25.3 Topical Dental Fluoride Varnish for CHIP Members**

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Notice: November 1, 2018  
Effective: November 1, 2018

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

The CHIP State Plan assures coverage of covered services including topical fluoride. D1206 (topical application of fluoride varnish) is a benefit for CHIP Dental Members, in addition to D1208 (topical application of fluoride - excluding varnish). Application of fluoride is allowed once every six (6) months. Topical application of fluoride varnish (D1206) is a benefit for CHIP Members ages 6 months to 19 years of age.

**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]**



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## **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 Member Rights and Responsibilities**

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### **16.2.5.1 Dissemination of Practice Guidelines**

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In accordance with 42 C.F.R. §438.915, the MCO must make available to any Member, potential Member, or contracting provider upon request, the MCO's practice guidelines for the specific, requested mental health or substance use disorder benefit. Practice guideline information include at minimum:

1. Clinical guidelines such as established treatment guidelines and/or plan-specific treatment guidelines if applicable;
2. Processes and procedures required to access the benefit; and,
3. Utilization management guidelines.

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### **16.2.5.2 Dissemination of Medical Necessity Criteria When Issuing An Adverse Determinations**

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In accordance with 42 C.F.R. §438.404(b)(1) and (2), when payment for service is denied, the MCO must make available to the Member upon request the reason for any denial by MCO of reimbursement or payment for benefits. At minimum, the MCO must explain the reasons for denial, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of:



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1. All medical documents, records, and other information relevant to the enrollee’s adverse benefit determination,
2. Medical necessity criteria relevant to the enrollee’s adverse benefit determination; and,
3. Any processes, strategies, or evidentiary standards used in setting coverage limits.

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

### 16.2.7 Additional Medicaid Behavioral Health Provisions

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#### 16.2.7.1 Substance Use Disorder Benefit

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Notice: June 6, 2014

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 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.

#### *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 FFS billing codes, FFS prior authorization requirements, and service limitations are as follows:

1. Clinical assessment. (Billing code: H0001; modifier HF. Does not require prior authorization.)
  - o Allowed once per episode of care.
2. Ambulatory detoxification. (Billing codes: H0016, H0050, and S9945; modifier HF. Requires prior authorization)
  - o Up to 21 Days.
3. Outpatient individual and group chemical dependency counseling. (H0004, H0005; both with modifier HF. Does not require PA)
  - o Up to 26 hours of individual counseling and 135 hours of group counseling.



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4. 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. Reimbursement for procedure codes H0020/U1 and H2010/HG/U1 is limited to a maximum quantity of 30 per 30 days. MAT does not require PA)
  - o Providers must follow federal regulations in 42 C.F.R. §8, and 1 Tex. Admin. Code §448.902
5. Residential detoxification. (H0031, T1007, H0047, H2017, S9445; modifier HF. Requires PA)
  - o Up to 21 Days.
6. Residential treatment. (H2035; H0047; modifier HF. Requires PA.)
  - o Up to 35 Days.

HHSC considers residential SUD treatment and residential detoxification to be outpatient services and should use Form 1500 to bill for such services.

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 it has adequate numbers of CDTFs, including opiate treatment providers, in its network and that its 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.

Children younger than 21 can exceed service limitations with medical necessity and PA.

*Substance abuse treatment 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*



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HHSC is 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.

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

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Notice: June 6, 2014

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.

Some Members who have full dual eligibility status are referred to as "fully dual eligible individuals," and are eligible to receive any covered Medicaid benefits that are not paid by Medicare. 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 by 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 for a provider to be eligible to enroll in Texas Medicaid, that provider typically must be a Medicare participating provider. Certain types of providers, however, are not required to meet the



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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*

Members eligible for STAR+PLUS who have Medicare and Medicaid are Medicaid Qualified Medicare Beneficiaries (MQMBs), Specified Low-Income Medicare Beneficiary (SLMB) Plus recipients or Qualified Medicare Beneficiary (QMB) Plus recipients. For these Members, Medicaid will pay for their SUD treatment in a CDTF, even if the Member normally would have their Acute Care paid through Medicare. Claims for SUD services rendered to a STAR+PLUS dual eligible Member should be submitted to TMHP: [www.tmhp.com](http://www.tmhp.com), not the STAR+PLUS health plan.

### *Full Dual eligible individuals who are not enrolled in STAR+PLUS*

If the client is dual eligible and has full Medicaid 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 Dual Eligibles with full Medicaid coverage qualify for reimbursement of CDTF services.

Medicaid will not reimburse CDTF-rendered services to dual eligible individuals who do not qualify for full Medicaid coverage, such as individuals with: SLMB, Medicare Qualified Individuals (QI), or Qualified Disabled and Working Individuals (QDWI).

### *Prior Authorization for Dual Eligible Individuals*

For Dual Eligible individuals with full Medicaid coverage, no PA is required for Medicaid CDTF SUD services for Members enrolled in a STAR+PLUS health plan. Dual eligible clients who have full Medicaid coverage and are not enrolled in a STAR+PLUS health plan must have a PA 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 individuals who are dual eligible.



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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 individuals, 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 Member is enrolled in the Dual Demonstration, claims for Medicaid-covered CDTF services need to be submitted to the Member's health plan if the Member receives full Medicaid coverage. Providers will need to check with the Member's health plan regarding any potential PA requirements for SUD treatment.

Things to remember when Billing SUD Services to TMHP:

1. 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. 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.
2. 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]**

**16.2.9 Reserved [Coordination with Public Health Entities]**



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**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]**

**Prescribed Pediatric Extended Care Centers**

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**16.2.15.1 Private Duty Nursing and Prescribed Pediatric Extended Care Center Services**

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Notice: September 9, 2016  
Effective: November 1, 2016

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

Private duty nursing (PDN) services and nursing services provided through a Prescribed Pediatric Extended Care Center (PPECC), are considered to be an equivalent level of nursing care; a Member who qualifies for PDN will qualify for PPECC.

A Member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing care. Members must be informed of their service options for ongoing skilled nursing care (PDN or PPECC), when PPECC services are available in the Service Delivery area. A Member may receive both PDN and PPECC on the same day, but not at the same time. (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the Member's medical condition or the authorized hours are not commensurate with the Member's medical needs. Per 1 Tex. Admin. Code §363.209 (c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.





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Because the total number of approved skilled nursing hours do not decrease, HHSC views a shift from PDN to PPECC as a provider change, and not an adverse action. The fee-for-service Nursing Addendum to Plan of Care for Prescribed Pediatric Extended Care Centers and Private Duty Nursing includes updated Member acknowledgements, including an acknowledgement that PDN hours may decrease if the Member shift their hours to the PPECC, or vice versa.

Achieving a one-to-one replacement of existing PDN hours with PPECC (or vice versa) to prevent service duplication will require an examination of authorizations for both PDN and PPECC services, including a review of the 24-hour flow sheet for nursing care. For example, when a Member with PDN decides to shift hours to a PPECC, then the PDN authorized hours will be decreased by the amount of hours shifted to a PPECC, unless there is a change in the Member's medical condition requiring additional hours, or the authorized hours are not commensurate with the Member's medical needs. The MCO will notify the PDN Provider of the revised authorized hours. The PDN provider may submit a revision request with documentation to justify medical necessity for any additional hours requested. The PPECC and PDN Providers are expected to coordinate on their respective plan of care for the Member. The Service Manager is expected to play a role in ensuring the coordination between PPECC and PDN service providers and authorized services.

**16.2.15.2 Prescribed Pediatric Extended Care Centers Criteria for Admission and Benefits**

Notice: September 9, 2016  
Effective: November 1, 2016

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

PPECC benefits include the following services:

1. The development, implementation, and monitoring of a comprehensive plan of care that:
  - a. is provided to a medically dependent or technologically dependent Member;
  - b. is developed in conjunction with the Member's caregiver(s), ordering physician, and interdisciplinary team;
  - c. specifies the services needed to address the medical, nursing, psychosocial, therapeutic, dietary, functional, and developmental needs of the Member and the training needs of the Member's caregiver(s);
  - d. specifies if transportation to and from the PPECC is needed; and
  - e. is revised for each authorization of services or more frequently as the ordering physician deems necessary.
2. Direct skilled nursing care and caregiver training and education intended to:



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- a. optimize the Member’s health status and outcomes; and
- b. promote and support family-centered, community-based care as a component of an array of service options by:
  - i. preventing prolonged or frequent hospitalizations or institutionalization;
  - ii. providing cost-effective, quality care in the most appropriate environment;
  - iii. providing training and education of caregivers;
  - iv. providing nutritional counseling and dietary services as specified in a Member’s plan of care’
  - v. providing assistance with activities of daily living while the Member is in the PPECC;
  - vi. providing psychosocial and functional development services, and
  - vii. providing transportation services to and from a PPECC.

Transportation must be provided by a PPECC when a Member has a stated need or has a prescription for transportation to the PPECC. A nurse employed by the PPECC must accompany the Member on the transport vehicle. A non-emergency ambulance may not be used for transport to and from a PPECC. A Member or the Member's responsible adult may decline PPECC transportation, and choose to transport by other means, including by his or her responsible adult. Transportation is billed separately by the PPECC.

A Member’s legally authorized representative is not required to accompany a Member when the Member receives PPECC services, including transportation services to and from the center and therapy services that are billed separately.

PPECC services do not include services that are mainly respite care or child care, or that do not directly relate to the Member’s medical needs or disability, nor for services that are the primary responsibility of a local school district. PPECC services also do not include provision of baby food or formula, services to Members that are related to the PPECC owner by blood, marriage or adoption, services covered separately by Texas Medicaid, such as therapies or DME, or individualized comprehensive case management beyond that required for service coordination.

PPECC services may be a benefit of the Texas Health Steps Comprehensive Care Program (THSteps-CCP) for STAR Kids Members who meet the following medical necessity criteria for admission:

1. eligible for THSteps-CCP;
2. age 20 years or younger;
3. has an acute or Chronic Condition that requires ongoing skilled nursing care and supervision, skillful observations, judgments and therapeutic interventions for all or part of the day to correct or ameliorate health status;
4. considered to be a medically dependent or technologically dependent Member
5. stable for outpatient medical services, and does not present significant risk to other individuals or personnel at the PPECC;



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6. requires ongoing and frequent skilled interventions to maintain or ameliorate health
7. status, and delayed skilled intervention is expected to result in:
  - a. deterioration of a chronic condition;
  - b. loss of function;
  - c. imminent risk to health status due to medical fragility; or
  - d. risk of death:
8. has a prescription for PPECC services signed and dated by an ordering physician who has personally examined the Member within 30 Days prior to admission and reviewed all appropriate medical records; has consent for the Member's admission to the PPECC signed and dated by the Member or the Member's responsible adult. Admission must be voluntary and based on the preference for PPECC services in place of PDN by the Member or Member's responsible adult in both managed care and non-managed care service delivery systems.
9. resides with the responsible adult and does not reside in a 24-hour inpatient facility, including a general acute hospital, skilled nursing facility, intermediate care facility or special care facility.

PPECC services require PA, and are intended as an alternative to PDN. However, an admission authorized under this section is not intended to supplant the right of a Member to access PDN, personal care services(PCS), home health skilled nursing (HHSN), home health aide services (HHA), physical, occupational speech and respiratory therapies and early childhood intervention services rendered in the Member's residence when medically necessary.

PPECC services may be billed on the same day as PDN, PCS, HHSN, and HHA, but PPECC services must not be billed for the same span of time a Member receives these other services.

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### **16.2.15.3 Reassessment and Reauthorization**

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Notice: September 9, 2016  
 Effective: November 1, 2016

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

At a minimum, the need for and the amount and duration of PPECC services must be reassessed 90 Days following initial authorization and every 180 Days thereafter, or when requested due to a change in the Member's health or living condition. A physician's order must be renewed with any reassessment.



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**16.2.15.4 Providers of Prescribed Pediatric Extended Care**

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Notice: September 9, 2016  
 Effective: November 1, 2016

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

A PPECC Provider must be currently licensed by the Department of Aging and Disability Services, with one of the following:

1. a temporary license,
2. Initial license, or
3. renewal license,

Providers must further comply with 40 Tex. Admin. Code Chapter 15 (relating to Licensing Standards for Prescribed Pediatric Extended Care Centers), and be contracted with a Member's MCO to provide services to that Member.

The Uniform Managed Care Contract and STAR Health Contract provisions for Continuity of Care apply to PPECC Providers and the provision of PPECC.

Per PPECC licensure requirements, PPECC services are

1. non-residential,
2. must be included in a PPECC plan of care,
3. are limited to no more than 12 hours in a 24-hour period, and
4. may not be provided overnight (9:00 PM to 5:00 AM).

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**16.2.15.5 PPECC Plan of Care**

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Notice: September 9, 2016  
 Effective: November 1, 2016

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



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A PPECC Plan of Care (POC) must include components as detailed in the PPECC-related provisions of the TMPPM.

Transportation services needed by a Member to access PPECC services.  
A non-emergency ambulance may not be utilized for transport to and from a PPECC.

Services are outlined in 1 Tex. Admin. Code §363.211 (Benefits and Limitations)

An in-person evaluation must be performed annually by the ordering physician. A physician order is required for each initial and recertification authorization, and revisions. A physician that is employed by or contracted with a PPECC cannot provide the physician's order, unless the physician is the Member's treating physician and has examined the Member outside of the PPECC setting.

The following services may be rendered at a PPECC, but are not considered part of the PPECC services and must be billed separately by a Provider contracted with the STAR Kids MCO:

1. Speech, physical, and occupational therapies, including therapies rendered by a home health agency;
2. Certified respiratory care services; and
3. Early intervention services provided through the Early Childhood Intervention (ECI) program, which are subject to ECI policies.

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#### **16.2.15.6 Authorization requirements**

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Notice: September 9, 2016  
Effective: November 1, 2017

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

MCOs are subject to 1 Tex.Admin. Code §363.211, regarding prior authorization for initial, recertification and revision requests for PPECC services.

MCOs may use the FFS forms for PPECC or their own forms. The FFS forms available online for PPECC include:

1. Comprehensive Care Program (CCP) Prior Authorization Request form
2. Prescribed Pediatric Extended Care Center Plan of Care



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Providers may use their own POC form, but it must contain the required elements per the PPECC provisions in the Texas Medicaid Provider Procedures Manual.

3. Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form. This form contains required Member and physician acknowledgements and consent.

When an MCO decides to use their own forms for PPECC authorizations, the forms must be equivalent to the fee-for-service forms, and are subject to approval by HHSC.

**16.2.16      Reserved [Supplemental Payments for Qualified Providers]**

**16.2.17      Reserved [Electronic Visit Verification]**



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## 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/>

## 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]**

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



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

**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)





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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)
16.7.5.21	Drug Benefits	(Reserved)

## 16.8 Additional Scope of Work for Dental Maintenance Organizations

### 16.8.1 Scope of Work

#### 16.8.1.1 Substitute Dentist

Notice: October 15, 2018  
Effective: March 1, 2017

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

DMOs may allow a dentist to act as a billing agent, and submit claims pursuant to 42 C.F.R. §447.10.

A billing agent is a business agent as described in 42 C.F.R. §447.10(f). A substitute dentist is a doctor of dentistry (DDS, DMD, or DDM) who provides services in place of another dentist of the same license type under a billing arrangement. These arrangements must comply with Medicaid policy, billing, reporting, and documentation requirements contained in the TMPPM.

To qualify for reimbursement, DMOs must ensure that the billing agent dentist and substitute dentist comply with the following requirements:

1. The substitute dentist must be licensed to practice in the state of Texas.
2. Consistent with the requirements of 1 Tex. Admin. Code §371.1605 and §371.1705 (relating to Provider Responsibility and Mandatory Exclusion, respectively), the substitute



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dentist must be enrolled in Medicaid and must not be on the Medicaid or Social Security Act Title XX provider exclusion list.

3. The substitute dentist's National Provider Identifier (NPI) must be entered on the dental claim form.
4. The billing agent dentist must submit the claims on behalf of the substitute dentist and may recover no more than the actual administrative cost of submitting the claim on behalf of the substitute dentist. The cost is not reimbursable by Medicaid.
5. The billing agent dentist may only bill for services furnished by a substitute dentist on a temporary basis, for no longer than a 90 day consecutive period. Except as provided in paragraph (6) of this subsection, the billing agent dentist may not submit a claim for services furnished by a substitute dentist to address long-term absences or vacancies in a dental practice.
6. A billing agent dentist may submit claims for the services of a substitute dentist for longer than 90 continuous days if the billing agent dentist has been called or ordered to active duty as a Member of a reserve component of the Armed Forces. Medicaid accepts claims from the billing agent dentist for services provided by the substitute dentist for the duration of the billing agent dentist's active duty as a Member of a reserve component of the Armed Forces.

Based on guidance from CMS, HHSC recommends that dental maintenance organizations require a modifier for services provided by a substitute dentist.

References

1. 1 Tex. Admin. Code § 354.1221
2. 42 C.F.R. § 447.10(f)

**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]



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**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]