Central Texas
Medicaid Rural Service Area (MRSA)

2025 Provider Manual

RIGHTCARE

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

RightCare.swhp.org
1-855-TX-RIGHT (1.855.897.4448)

TEXAS STAR
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

RCSWHP 21233 1024

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CHAPTER 1. INTRODUCTION

Welcome to RightCare from Scott and White Health Plan

HHSC contracts with Managed Care Organizations (MCOs) to provide STAR services to Medicaid recipients throughout the state of Texas. HHSC's goal is to achieve five main objectives: improved access to care, improved quality of care, improved client and provider satisfaction, improved cost effectiveness and improved health status. Since March 1, 2012, RightCare from Scott and White Health Plan has provided STAR medical services in the Central Texas Medicaid Rural Service Area (MRSA).

The Central Texas MRSA is made up of the following counties:

Bell	DeWitt	Hill	McLennan
Blanco	Erath	Jackson	Milam
Brazos	Falls	Lampasas	Mills
Bosque	Freestone	Lavaca	Robertson
Burleson	Gillespie	Leon	San Saba
Colorado	Gonzales	Limestone	Somervell
Comanche	Grimes	Llano	Washington
Coryell	Hamilton	Madison	

STAR in the MRSA covers all Medicaid covered benefits, as well as some additional services. We are pleased you decided to participate in a partnership that provides the highest quality health care services to our managed Medicaid enrollees.

Who is RightCare?

RightCare from Scott and White Health Plan is a Managed Care Organization (MCO) committed to providing the highest access to health care. Backed by the Scott and White Health Plan (SWHP) and its parent organization, Baylor Scott and White Healthcare, RightCare is distinct among health care plans in central Texas. Drawing upon the rich history of service and highest quality care provided throughout the Baylor Scott and White Healthcare network, RightCare offers a full continuum of health care -- tailored to the needs of the Medicaid population.

RightCare believes that commitment to relationships is critical to providing successful care under a managed care plan. RightCare is building on Scott and White's reputation of making quality health care a top priority. Our goal is to always be reliable, responsive and relevant – achieving the goal of improving members' lives.

Program Objectives

The STAR program is a Medicaid managed care program providing clients with acute care medical assistance in specific geographical areas designated by the state.

The objectives of the program are to:

- Increase quality and continuity of care for clients
- Decrease inappropriate use of the health care delivery system, such as Emergency Rooms for non-emergencies
- Improve access to care for clients enrolled in the program
- Promote provider and client satisfaction
- Achieve cost effectiveness and efficiency for the State

Our Mission, Vision, and Values

Baylor Scott and White Health was born from the 2013 merger of two exemplary systems. Scott and White Healthcare was established in Temple in 1897. Baylor Health Care System was founded in Dallas in 1903. Both grew into systems respected nationally for patient care, medical research and education. We see great opportunity in the changes that have come, and will yet come, to our industry. With a commitment to and a track record of innovation, collaboration, and integrity in our methods and measures, and compassion for the patient – who is the central focus of all we do – Baylor Scott and White Health stands to be one of the nation's exemplary health care organizations

Baylor Scott and White's Mission

Founded as a Christian ministry of healing, Baylor Scott and White Health promotes the well-being of all individuals, families and communities.

Baylor Scott and White's Ambition

To be the trusted leader, educator and innovator in value-based care delivery, customer experience and affordability.

Baylor Scott and White's Values

- We serve faithfully
- We act honestly
- We never settle
- We are in it together

Phone List

RightCare from Scott and White Health Plan Resources

RightCare Provider Relations (including claims questions)	1-855-TX-RIGHT (1-855-897-4448)
RightCare Member Services	1-855-TX-RIGHT (1-855-897-4448)
RightCare Medical Management Prior Authorizations and Notifications	1-855-691-SWHP (1-855-691-7947) FAX 1-512-383-8703 or 1-800-292-1349
RightCare Medical Disease and Service Coordination	1-855-897-4448
RightCare Behavioral Health Disease and Case Management	1-855-395-9652 FAX 1-844-436-8779
RightCare Behavioral Health Management -Prior Authorizations and Notifications	1-855-395-9652 FAX 1-844-436-8779
RightCare Crisis Hotline	1-844-436-8781
RightCare Health Plan TTY #	7-1-1
Pharmacy Prior Authorizations (Navitus Health Solutions)	1-877-908-6023 (preferred) FAX 1-920-735-5312
Pharmacy Claims Questions (Navitus Health Solutions)	1-877-908-6023
Eligibility Verification (IVR Line)	1-800-925-9126 -- or -- 1-855-TX-RIGHT (1-855-897-4448)
Superior Vision (for all vision-related services, including prior authorizations)	1-866-819-4298
Delta Dental (dental for pregnant women 21 and older)	866-496-2383
RightCare Compliance HelpLine	1-888-484-6977

Other Texas Medicaid Resources

Texas Medicaid Managed Care Helpline (MMCH)	1-866-566-8989
STAR Program Helpline	1-800-335-8957
The Enrollment Broker	1-800-964-2777
TDD# (for hearing impaired)	1-866-222-4306
THSteps Medical Service Coordination Line	1-877-THSteps (1-877-847-8377)
Non Emergency Medical Transportation	877-447-3101
Early Childhood Interventions (ECI) Care Line	1-800-628-5115
DentaQuest (dental benefit information)	1-800-516-0165
MCNA Dental (dental benefit information)	1-800-494-6262
Women Infant and Children (WIC)	1-800-942-3678
Office of the Inspector General (OIG) Hotline	1-800-436-6184
Department of Family and Protective Services	1-800-252-5400

Primary Care Providers (Medical Home)

PCPs and other professional providers are responsible for establishing a 'medical home' for their SWHP members. PCPs are responsible for providing timely preventive services, giving diagnosis and treatment, and educating members on how to appropriately use available health services. PCPs must comply with all state and federal laws and abide by the terms of their contracts. Primary care is limited to the member's benefit coverage. PCPs can offer behavioral health services when:

- Clinically appropriate and within the scope of their practice
- The member's current condition is not so severe, confounding or complex as to warrant a referral to a behavioral health provider
- The member is willing to be treated by the PCP
- The services rendered are within the scope of the benefit plan
- Additional information is available in the *Provider Rights and Responsibilities* section of this manual.

Specialty Care Providers

Specialty care providers are responsible for supplementing PCP services. PCPs identify and refer members to SWHP's contracted network specialist physicians or other professional providers for conditions that are beyond the PCP's scope of practice and medically necessary. SWHP must not pay any claims submitted by a provider based on an order or referral that excludes the National Provider Identifier (NPI) for the ordering or referring provider. In addition, SWHP must not pay any claim submitted by a provider excluded or suspended from the Medicare, Medicaid, CHIP, or CHIP Perinate programs for fraud, abuse, or waste. Specialists diagnose and treat conditions specific to their area of expertise. Specialist care is limited to the member's benefit coverage.

Specialists must give regular reports to the member's assigned PCP after the initial consultation and follow-up evaluations, and must include the diagnosis, recommendations and treatment plan. Members with Special Health Care Needs (MSHCN) such as disabling conditions and chronic illnesses, pregnant women, or children with special health care needs may request that their specialist also be their PCP. The request for a specialist to be a PCP must be sent to Medical Management for review and approval to ensure that the specialist is willing and able to meet the requirements. Medical management will approve the specialist as a PCP

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

Role of Pharmacy

Pharmacy is a benefit of the Texas Medicaid Program. RightCare's pharmacy benefits will be administered by Scott and White Pharmacy Services, in conjunction with Navitus Health Solutions.

Additional information for pharmacy providers is available in the pharmacy section of this manual.

Role of Main Dental Home

Dental plan Members may choose their Main Dental Homes. Dental plans will assign each Member to a Main Dental Home if he/she does not timely choose one. Whether chosen or assigned, each Member who is 6 months or older must have a designated Main Dental Home.

Role of Main Dental Home

A Main Dental Home serves as the Member's main dentist for all aspects of oral health care. The Main Dental Home has an ongoing relationship with that Member, to provide comprehensive, continuously accessible, coordinated, and family-centered care. The Main Dental Home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists can serve as Main Dental Homes.

Network Limitations

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

- General Practitioner
- Family Practitioner
- Internal Practitioner
- Nurse Practitioner
- Pediatrician
- FQHCs
- Rural Health Clinics (RHCs) and similar community clinics
- Obstetrics/Gynecology (OB/GYN)
- Certified Nurse Midwife
- Physicians serving members residing in nursing facilities
- Specialist (when appropriate, see Provider Responsibilities section for more information)
- Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) when APRNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP

STAR providers must maintain active Texas Provider Identifiers with the Texas Medicaid and Healthcare Partnership in one of the specialties listed above to serve as a PCP.

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

Texas Health Steps

Texas Health Steps is a comprehensive preventive care program that combines diagnostic screenings, communication and outreach, and medically necessary follow up care including dental, vision and hearing examinations for Medicaid-eligible children, adolescents and young adults under the age of 21. RightCare is committed to the wellness of each Member and encourages Providers to follow the steps outlined in this section when providing preventive health services to RightCare Members.

Additionally, RightCare will educate members about the importance of regularly scheduled Texas Health Steps medical checkups and developing a relationship with their Primary Care Provider within the first 90 days of enrollment. A RightCare member may self-refer to any Texas Health Steps provider to receive all checkups.

Becoming a Texas Health Steps Provider

Providers performing medical, dental and Service Coordination services can become Texas Health Steps Providers. You must be an enrolled Texas Health Steps Provider in order to be reimbursed for Texas Health Steps services. Enrollment must be completed through Texas Medicaid and Healthcare Partnership (TMHP) at www.tmhp.com. Providers who are not already certified to perform Texas Health Steps medical checkups and who are acting as Primary Care Provider for members under the age of 21 are encouraged to become Texas Health Steps providers.

More about Texas Health Steps

For information regarding Texas Health Steps requirements, providers can refer to the resources listed below:

Resource	Link
Texas Medicaid Provider Procedures Manual	http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx
Texas Health Steps Website	http://www.txhealthsteps.com/
Checkup Periodicity Schedule	https://www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers

Information includes:

- Periodicity schedule
- State and federally mandated elements of the Texas Health Steps exam
- State provider enrollment requirements and TPI requirements
- Referrals
- Vaccines for Children Program description
- Dental varnish provider participation requirements
- Advisory Committee in Immunization Practice (ACIP) immunization schedule
- Immtrac (immunization registry)
- Submission of all laboratory specimens (collected as a required component of a Texas Health Steps checkup to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code for analysis)

Texas Health Steps Medical Checkups and Screenings

The Texas Health Steps medical checkups are a requirement for children under the age of 21. The recommended services at each checkup are based on the optimal time for assessing growth and development at different stages of the member's life. RightCare encourages Primary Care Providers (PCP) to perform the Texas Health Steps checkups. However, RightCare will allow any Provider to perform the Texas Health Steps medical checkup and screening, as long as the individual is also recognized as a Texas Health Steps Provider by HHSC. It is the responsibility of the PCP to ensure that these checkups are provided in their entirety and at the required intervals. Immunizations must be provided as part of the examination. Members may not be referred to local health departments to obtain immunizations.

If the PCP is not the Provider performing the Texas Health Steps checkup, the performing Provider must provide the PCP with a report regarding the screening. In addition, if the performing Provider diagnoses a medical condition that requires additional treatment, the patient must be referred back to their PCP or a referral for further treatment must be obtained from the PCP. RightCare will not issue retroactive prior authorizations for follow-up treatment. RightCare covers sports physicals as a value-added service. If a sports physical is requested and the child is due for a Texas Health Steps checkup, the checkup including all the required Texas Health Steps components should be completed, as well. Providers may be reimbursed for sports physicals performed at the same time as a Texas Health Steps checkup or during a separate medical visit.

Documentation of Completed Texas Health Steps Components and Elements

Each of the six components and their individual elements according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual must be completed and documented in the medical record. Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

THSteps checkups are made up of six primary components. Many of the primary components include individual elements. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. **Comprehensive health and developmental history**, which includes nutrition screening, developmental and mental health screening and TB screening.
    - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
2. **Comprehensive unclothed physical examination** which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening.
    - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years), and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.
3. **Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV.
    - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule-United States," unless medically contraindicated or because of parental reasons of conscience including religious beliefs.

- The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
- Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
- Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit https://www.dshs.texas.gov/immunize/tvfc/.

4. **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia
    - Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
    - Anemia screening at 12 months.
    - Dyslipidemia Screening at 9-12 years of age and again 18-20 years of age.
    - HIV screening at 16-18 years.
    - Risk-based screenings include:
        i. Dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.
5. **Health education** (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.
6. **Dental referral** every 6 months until the parent or caregiver reports a dental home is established.
    - Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

Use of the THSteps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Their use is optional, and recommended. Each checkup form includes all checkup components, screenings that are required at the checkup and suggested age appropriate anticipatory guidance topics. They are available online in the resources section at www.txhealthsteps.com.

Texas Health Steps Billing Information

The following table lists the number of visits allowed at each age range and must be submitted with a valid diagnosis code.

Age Range	Number of Visits
Birth through 11 months does not include 12 month checkup)	6
1 through 4 years	7
5 through 11 years	7
12 through 17 years	6
18 through 20 years	3

- New client codes: 99381, 99382, 99383, 99384, 99385
- Established client codes: 99391, 99392, 99393, 99394, 99395
- Follow Up visit: 99211
- Must include 2-digit modifier to indicate practitioner (AM, SA, TD, or U7)
- RHC provider must use national place of service code, 72
- FQHC provider muse use additional 2-digit modifier, EP
- Providers must bill for Texas Health Steps services using their state issued Texas Health Steps ID number (TPI/NPI) and include the Texas Health Steps indicator. Please note: every provider location enrolled in Texas Medicaid must have its own unique Texas Health Steps TPI number.

Timing of Texas Health Steps Checkups

Texas Health Steps checkups for Medicaid members are considered timely based on whether member is New or Existing. Medicaid members that are new to RightCare must receive Texas Health Steps checkups at enrollment unless documentation of previous Texas Health Steps check is provided:

- New member must receive within first 90 days of enrollment
- Existing member based on most recent periodicity schedule

It is recommended that for checkups that are due based on the child's birthday, the checkup should be performed within the month following that birthday or within 364 days after the member's birthday (for children/members aged 36 months-20 years). Performing a make-up exam for a late Texas Health Steps medical checkup, previously missed under the periodicity schedule, is not considered an exception to periodicity or an accelerated service. It is considered a late checkup.

Performing Newborn Screenings

Inpatient newborn examinations that are billed with procedure code 99460, 99461, or 99463 may qualify and are counted as a THSteps medical checkup when all required components are completed according to the THSteps Periodicity Schedule and documented in the medical record.

Requirements at a minimum:

- Family and neonatal history
- Physical exam (including length, weight and head circumference)
- Vision and hearing screening
- Health education/anticipatory guidance
- State-required newborn hereditary/metabolic test
- Hepatitis B immunizations

RightCare will ensure that all newborn children of RightCare members have an initial newborn checkup before discharge from the hospital and again within two weeks from the time of birth.

Newborn Testing

Any Provider attending the birth of a baby must require testing for PKU, galactosemia, hypothyroidism, sickle hemoglobin and congenital adrenal hyperplasia on all newborns as required by Texas law. All infants must be tested a second time at one to two weeks of age. These tests must be submitted to the DSHS Laboratory Services Section. For complete information, instructions and newborn screening forms contact:

DSHS – Laboratory Services Section
1100 West 49th Street
Austin, Texas 78756-3199

888-963-7111, ext. **7318**
www.dshs.state.tx.us/lab/default.shtm

Performing Adolescent Screenings

Adolescent preventive screenings are covered under the Texas Health Steps medical program. An "adolescent preventive visit" is not considered an exception to periodicity. The adolescent screening visits are performed in addition to regular Texas Health Steps periodic checkups.

The protocol for performing these screens includes:

- Screening for specific conditions common to adolescents
- Comprehensive/anticipatory health guidance for adolescents and their parents
- Immunizations to prevent selected infectious diseases

Performing Pregnant Adolescent Screenings

Pregnant members under age 21 should continue to receive their required Texas Health Steps checkup in addition to their necessary OB care. If the member's OB is a primary care provider and a Texas Health Steps provider, the OB can complete the Texas Health Steps medical checkup.

Exceptions to Periodicity Allowed

On occasion, a child may require a Texas Health Steps checkup/Dental checkup that is outside of the recommended schedule.

Such reasons for an exception to periodicity include:

- Required for dental services provided under general anesthesia
- Environmental high risk (for example, sibling of child with elevated lead blood level)
- Required to meet state or federal exam requirements for Head Start, day care, foster care or pre-adoption or to provide a checkup prior to the next periodically due checkup if the client will not be available. This includes clients whose parents are migrant or seasonal workers.
- Medically necessary service, based on risk factors and health needs (includes clients who are birth through 6 months of age).
- Clients' choice to request a second opinion or change service providers (not applicable to referrals).
- Subsequent therapeutic services necessary to complete a case for clients who are 5 months of age and younger when initiated as emergency services, for trauma, or early childhood caries.

Exceptions to periodicity must be billed on the CMS 1500 and should comply with the standard billing requirements as discussed in the Section 9, Claims and Encounters Administration. For claims filed electronically, check "yes" when prompted. For claims filed on paper, place comments in Block 35. If a Provider other than the PCP performs the exception to periodicity exam, the PCP must be provided with medical record information. In addition, all necessary follow up care and treatment must be referred to the PCP.

For ICF/ID clients who are 21 years of age and older, the periodicity schedule for preventive dental procedures (exams, prophylaxis, fluoride, and radiographs) does not apply.

Texas Health Steps Environmental Lead Investigation (ELI)
Lead Screening and Testing

In accordance with current federal regulations, Texas Health Steps requires blood lead screening at ages notated on the Texas Health Steps Periodicity Schedule and must be performed during the medical checkup.

Environmental lead risk assessments, as part of anticipatory guidance, should be completed at all check-ups through age 6 when testing is not mandated, and may be performed using the Lead Risk Questionnaire, Form Pb-110, which is provided in both English and Spanish at http://www.dshs.state.tx.us/THsteps/forms.shtm.
Providers may also opt to use an equivalent form of their choice.

All blood lead levels in clients who are 14 years of age or younger must be reported to DSHS. Reports should include all information as required on the Child Blood Lead Reporting, Form F09-11709 or the Point-of-Care Blood Lead Testing report Form Pb-111, which can be found at http://www.dshs.state.tx.us/lead/Providers.shtm or by calling **1800-588-1248**.

Information related to blood lead screening and reporting for clients who are 15 years of age or older is available on the DSHS Blood Lead Surveillance Group's website at http://www.dshs.state.tx.us/lead/Providers.shtm.

Initial blood lead testing using point-of-care testing (procedure code 83655 with modifier QW) may be reimbursed to Texas Health Steps medical Providers when performed in the Provider's office. Providers must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver.

State and local health departments that employ or contract certified lead risk assessors must be enrolled with Texas Medicaid as a THSteps provider to perform environmental lead investigation (ELI) services. State and local health departments that are currently enrolled in Texas Medicaid must complete the THSteps Provider Enrollment Application.

Texas Health Steps Laboratory Testing

Laboratory specimen collection testing materials and necessary forms and supplies are made available free of charge to all Texas Health Steps Providers. For forms and supplies, Providers should contact the

Laboratory Services Section at the phone number or website below:
DSHS – Laboratory Services Section
1100 West 49th Street
Austin, Texas 78756-3199

888-963-7111, ext. **7318**
www.dshs.state.tx.us/lab/default.shtm

Providers may not bill for supplies and services provided by the DSHS laboratory.

Tests for hemoglobin/hematocrit, chlamydia, gonorrhea and lead must be sent to the DSHS lab, with the exception of point-of-care testing in the Provider's office for the initial lead specimen. All other tests may be sent to the lab of the Provider's choice.

Immunizations

Children, adolescents and young adults must be immunized during medical checkups and, according to the Advisory Committee on Immunization Practices (ACIP) schedule, by age and immunizing agent. RightCare requires the immunizations be done unless medically contraindicated or against parental beliefs.

Providers are required to submit immunization information to the Texas Immunization Registry (ImmTrac) when an immunization is given. Written consent must be obtained by Provider from parent or guardian before any information is included in the registry. The consent is valid until Member becomes 18 years of age (those 18 and older may now consent for their records to be maintained in ImmTrac as well). Provider must verify consent before information is included in ImmTrac. If Provider is unable to verify consent, the Provider will be notified by ImmTrac and given instructions for obtaining the consent and resubmitting the immunization to the registry. For more information, please see the ImmTrac website at www.immtrac.tdh.state.tx.us/.

Vaccines for Children

The Department of State Health Services (DSHS) uses the Center for Disease Control and Prevention (CDC) federal contracts to purchase vaccines at federal contract prices for provision to Providers enrolled in Medicaid. Vaccines not available on a federal contract will be purchased using a state contract price or using state purchasing procedures for vaccines not on a state contract. The vaccines purchased will be based on the most current recommended childhood immunization schedule of the ACIP.

DSHS will purchase, store, and distribute vaccines purchased using the Texas Vaccines for Children program (TVFC). DSHS will monitor vaccine reports and track vaccine distribution to Medicaid Providers to assure an adequate inventory of vaccines for Medicaid Providers. Vaccines are ordered through regional and local health departments. A TVFC Provider may not charge for the vaccine itself, but is permitted to charge an administration fee.

If you are not enrolled in the TVFC program, contact the DSHS TVFC division at **1-800-252-9152**. To enroll, a Provider must:

- Fill out the Provider Enrollment and Provider Profile forms.
- Agree to screen for eligibility.
- Agree to maintain screening records.

More information is also available at www.dshs.state.tx.us/immunize/tvfc/tvfc_about.shtm. Providers will not be reimbursed for a vaccine that is available through TVFC.

Vaccine Administration and Preventive E/M Visits

Use with THSteps preventive visit checkup procedure codes to indicate a significant, separately identifiable E/ M service that was rendered by the same provider on the same day as the immunization administration.
Significant, separately identifiable evaluation-Use modifier 25.

Texas Health Steps Dental Checkups

Patients are required to enroll in a Medicaid dental plan. Members must select a dental plan and main dentist. Patients should be encouraged to visit a Texas Health Steps Dental Provider from within their dental plan's network for routine dental checkups. Routine dental checkups do not require a referral.

Dental checkups are required once every six (6) months from the last date of dental service for Medicaid clients age 6 months through 20 years of age. If a periodic dental checkup has been conducted within the last six months, the client still may be able to receive another periodic dental checkup in the same six-month period by any provider.

It is the provider's responsibility to verify that the client is eligible for the date that dental services are to be provided. Eligibility may be verified through www.YourTexasBenefitsCard.com, TexMedConnect, or the TMHP Contact Center.

If dental checkups results in treatment requiring a facility or anesthesia charge, the dentist must contact RightCare's Medical Management department to request authorization for facility services and dental procedures at **1-855-691-SWHP** (**1-855-691-7947**).

Oral Evaluation and Fluoride Varnish (OEFV)

Oral Evaluation and Fluoride Varnish (OEFV) in the medical home offers limited oral health services provided by Texas Health Steps enrolled physicians, physician assistants and advance practice registered nurses. The service is provided in conjunction with the Texas Health Steps medical checkup and includes immediate oral evaluation, fluoride varnish application, dental anticipatory guidance and referral to a dental home.

If you are a physician, advanced practice nurse or physician assistant, you can be reimbursed for a limited oral health evaluation and application of fluoride varnish for children 6 months through 35 months of age. This is in addition to the reimbursement for the Texas Health Steps checkup and claims should be sent to RightCare for reimbursement consideration. Providers must attend the FDH training or OEFV training offered by the Department of State Health Services Oral Health program to be certified to bill for these services. For more information on both programs, go to www.dshs.state.tx.us/dental.

An OEFV visit is billed utilizing CPT code 99429 with U5 modifier. The service must be billed with one of the following medical checkup codes: 99381, 99382, 99391, or 99392. The Provider must document all components of the OEFV on the appropriate documentation form and maintain record of the referral to a dental home. Federally Qualified Health Centers and Rural Health Centers do not receive additional reimbursement for these services.

Vision Exams and Services

Vision screening is a part of a complete Texas Health Steps exam according to the Periodicity Schedule. Either a subjective or an objective screen should be completed by the provider performing the exam. An age appropriate screening chart should be used. Further vision care should be referred to a specialist if needed.

Documentation of test results from a school vision screening may replace the objective screening if conducted within 12 months before the checkup.

RightCare has partnered with Superior Vision for member vision exams and vision services. RightCare members under age 21 are eligible for an eye examination with refraction for the purpose of obtaining eyewear during each State fiscal year (September 1-August 31). The eye exam limitation can be extended for a STAR member over age 21 if the Primary Care Provider believes the eye examination is medically necessary. Please refer to the current Texas Medicaid Provider Procedures Manual (TMPPM) for further details. For additional questions, including information on how to refer a member for vision services, please call Superior Vision at **866-819-4298**. Utilization of Superior Vision's website, https://www.superiorvision.com/ is also available for access to a list of Superior Vision participating providers in your area.

Hearing Exams and Services

Hearing screening is a mandatory part of each Texas Health Steps medical checkup, as per the Periodicity Schedule. Diagnostic screening services are available when medically necessary. Members who are 35 months of age or younger should must be referred to ECI, as well as a hearing loss specialist, within two days of an abnormal hearing screening. Documentation of test results from a school hearing screening may replace the required objective screening if conducted within 12 months before the checkup.

Comprehensive Care Program

The Comprehensive Care Program (CCP) is a federally mandated expansion of the Medicaid program for Medicaid recipients under age 21 (Texas Health Steps members). CCP covers any health care services that are medically necessary and appropriate, and federally allowable Medicaid services. Services are available under Texas Health Steps-CCP for members ineligible for Texas Medicaid home health services and for those specific services not provided under home health.

- Psychiatric hospitals
- Private duty nurses
- Occupational therapy
- Speech therapy
- Durable medical equipment
- Medical supplies
- Licensed professional counselors
- Licensed social workers with at least a Master's Degree
- Advanced clinical practitioners
- Dieticians

Members are no longer eligible for Texas Health Steps-CCP services beginning on their 21st birthday.

Children of Migrant Farmworkers

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

Please contact RightCare's Service Coordination at 1-855-897-4448 for information and assistance coordinating expedited services for these members.

Refusal of Services

If the member or member's parent or guardian refuses to set an appointment for their initial or periodic Texas Health Steps checkup, providers must document the refusal in the format provided by HHSC and be included as part of the patient's medical record. Please call RightCare's Service Coordination at 1-855-897-4448 if you have a member or member's parent or guardian refuse a Texas Health Steps checkup.

Referrals for Conditions Identified During a Texas Health Steps Medical Checkup

If a problem is identified that requires evaluation and management significantly beyond what is usually completed during Texas Health Steps medical checkups, the Primary Care Provider can arrange for additional services as needed. If the Primary Care Provider is not performing the exam for the member, they should be notified in order to make the referrals to specialists for the member. The routine process for making a referral to a specialist is further detailed in the Referrals section of this manual.

Medicaid Covered Services for STAR

RightCare provides Medicaid services as outlined below. Please refer to the current Texas Medicaid Provider Procedures Manual (TMPPM) for a complete listing of limitations and exclusions that apply to each service category. RightCare's benefit package includes all Fee-for-Service (FFS) services provided through Texas Medicaid. These services are subject to modification based on federal and state mandates. Medicaid members do not have deductibles or copayments for Medicaid covered services, and providers are prohibited from balance billing for Medicaid Covered Services

Covered Services (Core Medicaid services covered by RightCare)

The following details the member benefit package available to RightCare members. Please refer to the current *Texas Medicaid Provider Procedures Manual* (TMPPM), found at www.tmhp.com, for the listing of limitations and exclusions of Texas Medicaid.

- Ambulance services — emergency transportation
- Audiology services, including hearing aids for adults and children
- Behavioral health services including:
    - Inpatient mental health services for children (birth through age 20)
    - Acute inpatient mental health services for adults
    - Outpatient mental health services for adults and children
    - Psychiatry services
    - Counseling services for adults (21 years of age and over)
    - Outpatient substance use disorder treatment services, including:
        - Assessment
        - Detoxification services
        - Counseling treatment
        - Medication assisted therapy
    - Residential substance use disorder treatment services including:
        - Detoxification services
        - Substance use disorder treatment (including room and board)
- Birthing services provided by a physician and certified nurse midwife in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic and treatment services

- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency services
- Family planning services
- Home health care services
- Hospital services including inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and external breast prosthesis-related, follow-up procedures, including:
    - Inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; physician and professional services provided in an office, inpatient, or outpatient setting for:
        - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed
        - Surgery and reconstruction on the other breast to produce symmetrical appearance
        - Treatment of physical complications from the mastectomy and treatment of lymphedemas
        - Prophylactic mastectomy to prevent the development of breast cancer
    - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed; surgery and reconstruction on the other breast to produce symmetrical appearance
- Medical checkups and Comprehensive Care Program (CCP) services for children (birth through age 20) through the Texas Health Steps program
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
- Podiatry
- Prenatal care
- Prenatal care provided by a physician, certified nurse midwife, nurse practitioner, clinical nurse specialist or physician assistant in a licensed birthing center
- Prescription drugs, medications and biologicals
- Primary care services
- Preventive services, including an annual adult well check for patients 21 years of age and older
- Radiology, imaging and X-rays

- Specialty physician services
- Telemedicine
- Telemonitoring
- Therapies — physical, occupational and speech
- Transplantation of organs and tissues
- Vision — Includes optometry and glasses; contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A Member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services, and must be coordinated to prevent duplication. A Member may receive both in the same day, but not simultaneously (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.

Adoption Assistance and Permanency Care Assistance

The adoption Assistance (AA) programs provides help for certain children who are adopted from foster care. The Permanency Care Assistance (PCA) program gives financial support to family members who provided a permanent home to children who were in foster care but could not be reunited with their parents. AAPCA may provide Medicaid coverage for the child, monthly cash assistance from DFPS and a one-time reimbursement from DFPS for some legal expenses that come with adopting or becoming the managing conservator of the child. Authorizations for basic care are honored for 90 days, until the authorization expires or until the health plan issues a new one. Authorizations for LTC services and supports are honored for six months or until a new assessment is completed. During the transition period, members can keep seeing current providers, even if they are out of the health plan’s network.

Medicaid Program Exclusions

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

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

CHAPTER 4. COORDINATION WITH NON-MEDICAID MANAGED CARE COVERED SERVICES

There are several services that are available to RightCare Members based on their eligibility and are accessed outside of the RightCare Provider network. In addition, the services are not a part of the managed care program. These services are described in the *Texas Medicaid Provider Procedures Manual* (TMPPM).

- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) Service Coordination/service coordination
- Early Childhood Intervention Specialized Skills Training
- Department of State Health Services (DSHS) Targeted Service Coordination (non-capitated service coordinated by LMHAs until August 31, 2014)
- DSHS Mental health rehabilitation (non-capitated until August 31, 2014)
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Department of Aging and Disability Services (DADS) hospice services
- Admissions to inpatient mental health facilities as a condition of probation
- For STAR, Texas Health Steps Personal Care Services for members birth through age 20
- DADS contracted providers of long-term services and supports (LTSS) for individuals who have intellectual or developmental disabilities
- DADS contracted providers of Service Coordination or service coordination services for individuals who have intellectual or developmental disabilities
- For members who are prospectively enrolled in STAR or STAR+PLUS from Medicaid FFS during an inpatient stay, hospital facility charges associated with the inpatient stay are non-capitated services except for a stay in a Chemical Dependency Treatment Facility

Texas School Health and Related Services (SHARS)

SHARS is for children under age 21 with disabilities who need audiology services, medical services, occupational therapy, physical therapy, psychological services, speech therapy, school health services, assessment and counseling.

Rightcare's Service Coordination Program

Our Service Coordination Program is included in health plan coverage as an added benefit for our members. The program is at no cost to our members and completely voluntary. Your patient may opt in or out at any time.

Service Coordination Program provides:

- Coordination to bridge gaps in care for needed treatment, services and/or equipment
- Empowerment towards self-management of chronic diseases/conditions
- Specialized management options based on diagnoses, medications, and health status including pregnancy and behavioral health
- Guidance and advice on the healthcare system and patient benefits
- Assistance with coordination of referrals and authorizations
- Referrals to community resources to alleviate social determinant of health barriers

Referring a patient to Service Coordination:

All health plan members with current coverage are eligible to participate in the Service Coordination Program. Anyone can refer a member to Service Coordination, including providers. Members may even self-refer to Service coordination by calling the number on the back of their insurance card and asking to speak with a member of our team.

Referrals can be completed online at https://rightcare.swhp.org/en-us/prov/forms-tools or

by sending a secure email to: CaseManagement@BSWHealth.org. Please include the members name, date of birth and information on why you are sending the referral.

What to expect after referring to Service Coordination:

A member of the Service Coordination team will call your patient within four business days, offer Service Coordination and attempt to complete a comprehensive health assessment. Any needs or opportunities for assistance identified during the assessment will be utilized to develop an individualized plan of care with your patient. Our staff will continue to work with you and your patient until the goals are met, the member's coverage terminates, the member remains unreachable, or they decline to continue.

Service Coordination for Children and Pregnant Women (CPW)

Service Coordination for Children and Pregnant Women (CPW)

Service Coordination for Children and Pregnant Women (CPW) is a program that provides services to high-risk Medicaid children (under age 21) and high-risk Medicaid pregnant women. CPW providers are social workers or Registered Nurses (RNs) working as individuals or employed by schools, health departments, counseling agencies, health clinics, and other agencies. Providers must be approved by Department of State Health Services (DSHS) and enroll with Texas Medicaid and Healthcare Partnership (TMHP) as CPW Medicaid Providers. CPW helps high-risk members get help in the following areas:

- Supplies and equipment;
- Family problems;
- Financial concerns;
- Accesses to medical services;
- Education and school problems; and
- Finding help near the member.

The main difference in services provided by CPW versus and internal RightCare Service Coordination services, is CPW:

- Home visits are conducted
- Visits are face to face
- Case manager may attend school meetings with parent to advocate for client
- The whole family is assessed, not just the client
- Services are provided only if client currently has needs related to their health condition or health risk
- CPW Providers cannot provide health education

In most cases, the Member needs can be met by the RightCare Service Coordination/Service Coordination department. If the Member requires services RightCare is unable to provide and can be met via a CPW provider, the Health Plan will coordinate with the CPW provider and will issue a referral reference number to indicate the CPW services are

not a duplication of RightCare provided services.

CPW providers should submit a referral for services request to RightCare prior to providing Member services to confirm services are not a duplication of RightCare services and assist in claims processing. Referral for services request can be requested verbally by contacting the Member Services Department or via secure email directly to the RightCare Service Coordination/Service Coordination department.

Required Referral Information (must provide via secure email or telephonically)

- Member Name and Insurance Member Number
- Member phone number
- CPW Provider to Render Services (include NPI and/or Supplier Number claims will be billed to)
- CPW Provider contact information for coordination of services and referral
- Services to be provided (example: CPW)
- Planned start date for services
- Planned end date for services
- How many days/visits expected to be needed
- Reason Services are needed

Send Secure Email Requests to

- For Pregnant Women and Birth to 1 Year of Age: hpmaternitycasemanagement@bswhealth.org
- For Children 1 to 20 Years: casemanagement@BSWHealth.org
- For Behavioral Heath Related Cases: HPBHCaseManagement@BSWHealth.org

*If unknown, all requests can be sent to casemanagement@BSWHealth.org and the request will be directed to the appropriate department.

*Referral completion process dependent on reachable status and coordination engagement of the CPW provider and the Member with the RightCare Service Coordinator/Case Manager.
For more information about CPW visit the program's website at http://www.dshs.state.tx.us/caseman/default.shtm
RightCare coordinates services with CPW when member's needs are identified. Disclosure of medical records or information between providers, MCO's and CPW case managers does not require a medical release form from the member.

Billing for CPW Services – Individual

- CPW providers will continue billing for G9012 (Other specified Service Coordination service not elsewhere classified) and related modifiers U2, U5, and TS
- HHSC expects the codes used for Service Coordination for children and pregnant women services to remain the same. Refer to the TMPPM Behavioral Health and Service Coordination Services Handbook, Section 3.3
- Service Coordination for children and pregnant women is distinct from Early Childhood Intervention Targeted Service Coordination. Service Coordination for children and pregnant women is not in the Medicaid Children's Handbook. The benefit is defined in the Behavioral Health and Service Coordination Services Handbook.
- Service Coordination for children and pregnant women services are not billed by time increments but by the service encounter.
- T1017 is not a procedure code associated with Service Coordination for Children and Pregnant Women services. **Billing for CPW Services – FQHC**
- The FQHC prospective payment system (PPS) wrap payment methodology applies to CPW services delivered.
- FQHCs will bill using G9012 (Other specified Service Coordination service not elsewhere classified) and TS in addition to T1015 and appropriate modifiers.
- Refer to TMPPM Clinics and Other Outpatient Facility Services Handbook, Section 4.1.2 for the most up to date codes.

G9012

- Service Coordination for Children and Pregnant Women services are limited to one contact per day per person. Additional provider contacts on the same day are denied as part of another service rendered on the same day.
- Procedure code G9012 is to be used for all Service Coordination for Children and Pregnant Women services. Modifiers are used to identify which service component is provided.

Procedure Code	Procedure Description	Additional Information
G9012	Comprehensive visit (in-person)	Modifier U2 and U5
G9012	Comprehensive visit (synchronous audiovisual)	Modifier U2, U5 and 95
G9012	Follow-up visit (in-person)	Modifier U5 and TS
G9012	Follow-up visit (synchronous audiovisual)	Modifier U5, TS and 95
G9012	Follow-up visit telephone (audio only)	Modifier TS and 93

Modifier	Description
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
TS	Follow-up service
U2	Comprehensive visit
U5	Face to face visit

Women, Infants and Children (WIC)

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a health and nutritional program with a successful record of improving the diets of infants, children, and pregnant, postpartum and breastfeeding women who are at risk for nutrition-related illness, focusing on educating mothers on proper nutrition for babies and young children.

WIC services include providing nutritional supplementation for pregnant women and children under age 5, as well as nutritional education and counseling services. RightCare has one-stop access to a number of services which can meet several maternal and child health needs. Providers which include physicians, nurse practitioners, physician assistants, social workers, and nutritionists, among others, assist members with registering for and obtaining WIC services, which can be accessed within the same facility. For more information and to find a local WIC office near you, call **1-800-942-3678**.

It is essential for RightCare providers to educate members on the importance of the WIC program in order to ensure that members are aware of the positive impact that effective nutritional supplementation can have on health outcomes for women, infants, and children.

Including:

- The type and nature of WIC services available.

- The importance of WIC in maintaining maternal and child health.
- Eligibility requirements for obtaining WIC services.
- The referral process and tracking system.
- WIC providers are located at the local WIC community office. The local WIC office provides multiple services at one convenient located in the member's neighborhood.
- WIC providers are geographically more accessible to members.
- Information is given to members about the WIC program.
- Members are made aware of the WIC program and the service it provides through the:
    - Member Handbook
    - RightCare Website

To effectively meet the needs of women, infants, and children, RightCare will:

- Ensure that members and providers are given WIC specific medical information to WIC programs including: height, weight, hematocrit, hemoglobin, and other risk conditions.
- Ensuring that all eligible RightCare members not already participating in the WIC program are referred.
- Coordinate effective member and provider education through the RightCare's Member Advocate Outreach Department.
- Screen members for WIC participation through the Community Outreach Department activities.
- Advise RightCare providers to refer every newly pregnant member to WIC at the first prenatal contact and to check on WIC status during prenatal visits and at the time of delivery.

DARS Service Coordination for the Visually Impaired

The Department of Assistive and Rehabilitative Services (DARS) Service Coordination services are available for Medicaid-eligible Texans under 15 years of age who are blind or visually impaired to get high quality jobs, live independently, or help a child receive the training needed to be successful in school and beyond through the Division of Blind Services (DBS). This is limited to one contact per client, per month.

Tuberculosis (TB) Services Provided by DSHS-Approved Providers

RightCare network providers must coordinate with the local TB control program to ensure that all members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). The Network providers must report to the DSHS or the local TB control program any member who is noncompliant, drug resistant, or who is or may be posing a public health threat.

DADS Hospice Services

The Department of Aging and Disability Services (DADS) manages the Hospice Program through provider enrollment contracts with hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Texas Medicaid and Healthcare Partnership (TMHP) pays for services related to the treatment of the member's terminal illness and for certain physician services (not the treatments). Hospice care is a program of palliative care which allows for care to be provided at the individual's place of residence and consists of medical, social and support services to a terminally ill patient when curative treatment is no longer possible.

CHAPTER 5. BEHAVIORAL HEALTH

In addition to medical care, behavioral health care is available for RightCare members. Covered services include the treatment of mental, emotional, or chemical dependency disorders. RightCare is responsible for the provision of medically necessary behavioral health services and maintains a robust network of behavioral health and substance use disorder Providers including psychiatrists, nurse practitioners, psychologists, social workers, licensed professional counselors, hospitals and Local Mental Health Authority (LMHA) centers.

Behavioral Health Services Explained

RightCare defines "behavioral health" as both acute and chronic psychiatric and substance use disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association.

Behavioral Health Covered Services

- Inpatient mental health services (including services provided in Freestanding Psychiatric Facilities)
- Outpatient mental health services
- Psychology services
- Psychiatry services
- Medication management
- Lab services
- Supported employment and housing services
- Respite services
- Counseling services for adults (age 21 and older)
- Outpatient substance use disorder treatment services, including:
- Assessment
- Detoxification services
- Counseling treatment
- Medication-assisted therapy
- Residential substance use disorder treatment services, including detoxification services
- Substance use disorder treatment, including room and board
- Mental Health Rehabilitative Services
- Targeted Service Coordination

RightCare does not cover behavioral health services that are experimental or investigative. Covered services are not intended primarily for the convenience of the member or the provider

For more details on behavioral health benefits, please see the Texas Medicaid Provider Procedures Manual (TMPPM) or contact RightCare at **1-855-395-9652**.

Behavioral Health Authorizations

RightCare will preauthorize, review and pay claims for medically necessary procedures whether or not the primary diagnosis falls between DSM-5 and ICD-10 and the treating Provider is a behavioral health or addiction specialist. Please note inpatient hospital services require prior authorization through RightCare. This includes services provided in freestanding psychiatric facilities for children and adults enrolled in the Medicaid program. Please see section 9 for more information on obtaining an authorization.

When assessing Members for BH Services, providers must use the DSM multi-axial classification in effect at the time of service.

Primary Care Provider Requirements

Primary care providers may provide behavioral health-related and/or substance abuse treatment to members within the scope of their practice.

Primary Care Providers (PCPs) are responsible for coordinating the Members' physical and behavioral health care, including making referrals to behavioral health practitioners when necessary. However, the Member does not need a referral to access mental health or substance abuse treatment with a participating RightCare Provider. The PCP serves as the "medical home" for the patient.

In addition, PCPs must adhere to screening and evaluation procedures for the detection and treatment of or referral for any known or suspected behavioral health problems or disorders. Practitioners should follow generally accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies.

Primary Care Providers are required to:

- Send the behavioral health Provider initial and quarterly (or more frequently if clinically indicated or court ordered) summary reports of the Member's physical and behavioral health status.
    - The report must minimally include: Behavioral health medications prescribed.
    - Behavioral health medication effects reported during PCP visits and information about physical health conditions and treatments that may affect behavioral health conditions and treatments.
- Administer a screening tool at intake, and at least annually thereafter, to identify Members who need behavioral health referrals. Behavioral health assessment tools, if available, may be utilized by the PCP.
- Send a copy of the physical health consultation record and the behavioral health screening tool results to the behavioral health Provider that referred the Member. Make referrals to behavioral health Providers when the required Texas Health Steps screen reveals the need for a mental health, substance abuse and/ or developmental disability assessment.

Member Access to Behavioral Health Services

The goal of RightCare is to support the provision and maintenance of a quality-oriented patient care environment, and to provide easy access to quality mental health and substance abuse treatment services.

Routine Access

Providers who furnish routine outpatient behavioral health services must schedule appointments within the earlier of 10 business days or 14 calendar days of a request. Providers who furnish inpatient psychiatric services must schedule outpatient follow-up and/or continuing treatment prior to a patient's discharge.

Urgent Access

An urgent behavioral health situation is defined as a condition that requires attention and assessment within 24 hours. In an urgent situation, the member is not an immediate danger to him/herself or others and is able to cooperate with treatment. Care for non-life-threatening emergencies should be within 6 hours.

Emergent Access

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

A behavioral health emergency occurs when the member is:

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

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

Attention Deficit Hyperactivity Disorder (ADHD)

Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity). Please refer to the current *Texas Medicaid Provider Procedures Manual*, (TMPPM), found at www.tmhp.com, for the listing of limitations and exclusions for Screening and Treatment of Attention Deficit Hyperactivity Disorder.

314.xx	Attention Deficit Disorder
314.0	Attention Deficit Disorder, predominantly inattentive type (if only sufficient symptoms for inattention have been met)
314.01	Attention Deficit Disorder, predominantly hyperactive-impulsive type (if only sufficient symptoms of hyperactivity-impulsivity have been met) or Attention Deficit Disorder, Combined type (if sufficient symptoms of both inattention and hyperactivity-impulsivity have been met)
314.8	Attention Deficit Disorder, residual type
314.9	Attention Deficit Disorder Not Otherwise Specified (for individuals with prominent symptoms of inattention or hyperactivity-impulsivity who do not meet the full criteria)

Follow-up Care for Children Prescribed ADHD Medication

Members who are newly prescribed ADHD medications should have at least one follow-up visit within 30-days of the prescription. Members who remained on the medication should have at least two additional follow-up visits after the initial 30-day visit.

Reimbursement for ADHD

Claims billed by a physical health provider will be considered for reimbursement by RightCare if billed with an ADHD diagnosis code. Reimbursement will be based on the prevailing Texas Medicaid fee schedule and the contracted reimbursement agreement with RightCare.

Referrals

All members may self-refer to a RightCare in-network behavioral treatment specialist. RightCare promotes early intervention and health screening for identification of behavioral health problems and patient education. Providers who need to refer members for further behavioral health care should contact RightCare at **1-855-395- 9652**.

Coordination of Care

RightCare is committed to coordinating medical and behavioral health care for members who will be appropriately screened, evaluated, treated and/or referred for physical health, behavioral health or substance abuse, dual or multiple diagnoses, mental retardation, or developmental disabilities. RightCare will designate behavioral health personnel to facilitate coordination of care and Service Coordination efforts.

Primary Care Provider (PCP) and participating specialists are expected to communicate frequently regarding the health care provided to each member. Copies of prior authorization/referral forms and other relevant communications between the specialist and the Primary Care Provider should be maintained in both providers' files for the member. Coordination of care is vital to assuring members receive appropriate and timely care.
Compliance with this coordination is reviewed closely during site visits for credentialing and re-credentialing, as well as during audit, quality improvement and utilization management reviews.

RightCare ensures that the care of newly enrolled members is not disrupted or interrupted. RightCare will take special care to provide continuity in the care of newly enrolled members whose physical health or behavioral health condition has been provided by specialty care providers or whose health could be placed in jeopardy if care is disrupted or interrupted.

Medical Records Documentation

All RightCare behavioral health providers are required to include documentation in the member's medical record of a formal diagnosis, using the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), current edition.

The referral source(s) should be documented clearly to allow necessary follow up service coordination efforts with the member's written permission. It is also necessary for the treating behavioral health provider to document all efforts to coordinate care with the member's primary care physician, with member's written consent.

Consent for Disclosure

In order to adhere to the continuity of care between the Primary Care Provider, Specialist, and/or Behavioral Health provider, sharing of medical history regarding a patient's health is necessary. An authorization to release confidential information, such as medical records regarding treatment, should be signed by the patient prior to receiving care from a behavioral health provider. This can be done using the "Authorization to Release Confidential Information" form found in the Forms section of this manual. If the Member refuses to release the information, they should indicate their refusal on the release form. In addition, the Provider will document the reasons for declination in the medical record.

Court Ordered Commitments

A "Court-Ordered Commitment" means a confinement of a member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C. RightCare is required to provide inpatient psychiatric services to members under the age of 21, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, related to Court-Ordered Commitments to psychiatric facilities. RightCare will not deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court-Ordered Commitment for members under age 21.

To ensure services are not inadvertently denied, Providers must contact RightCare's customer service line at the numbers listed in this section and provide telephonic or written clinical information as well as a copy of the court order.

Any professional services provided that are part of a court order must be billed with an E9 modifier as described in the Texas Medicaid Provider Procedures Manual. Court ordered services that require authorization or notification per RightCare's prior authorization list must also have an authorization.

Facilities providing court ordered services should bill using the appropriate code (8 or 08 per the Texas Medicaid Provider Procedures Manual) in the Source of Admission field of the UB-92 claim form.

RightCare will make best efforts to authorize services from the court order once provided. To ensure accurate claims payment, the Provider should call **1-855-395-9652**.

Coordination with the Local Mental Health Authority (LMHA) & State Psychiatric Facilities

RightCare will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning, treatment objectives and projected length of stay for members committed by a court of law to the state psychiatric facility. RightCare will comply with additional behavioral health services requirements relating to coordination with the LMHA and care for special populations. Covered services will be provided to members with Severe and Persistent Mental Illness (SPMI)/Severe Emotional Disturbance (SED) when medically necessary, whether or not they are receiving targeted Service Coordination or rehabilitation services through the LMHA.

RightCare works with participating behavioral health care practitioners, Primary Care Providers, medical/ surgical specialists, organizational providers and other community and state resources to develop relevant primary and secondary prevention programs for behavioral health.

These programs may include:

- Educational programs to promote prevention of substance abuse
- Parenting skills training
- Developmental screening for children
- ADHD screening
- Postpartum depression screening
- Depression screening in adults

Assessment Instruments for Behavioral Health

Please refer to the *Texas Medicaid Provider Procedures Manual* (TMPPM) for additional assessment instruments for behavioral health.

Focus Studies and Utilization Reporting Requirements

RightCare's Quality Assessment and Performance Improvement (QAPI) Program ensures a systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of behavioral health services provided to our members. Special focus is on the improvement of physical health outcomes resulting from behavioral health integration into the member's overall care. RightCare routinely monitors claims, encounters, referrals and other data for patterns of potential over and under-utilization.

RightCare works with HHSC's External Quality Review Organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to members and to identify opportunities for improvement. To facilitate this process, RightCare will supply claims data to the EQRO and will supply medical records for focused clinical reviews conducted by the EQRO.

Missed Appointments

Provider will make contact with the member within 24 hours of a missed appointment for the purposes of rescheduling. Providers are asked to contact RightCare Behavioral Health Service Coordination at **1-855-395-9652** to report any missed outpatient appointment that cannot immediately be rescheduled with the member.

Providers will work with Service Coordination to follow-up with RightCare members and attempt to reschedule missed appointments.

Member Discharged from Inpatient Psychiatric Facilities

RightCare requires that all members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within 7 days from the date of discharge.

Behavioral Health Value-Added Services

Some Members are eligible for value added services. Value added services are behavioral health care services, benefits or positive incentives that HHSC determines will promote healthy lifestyles and improve health outcomes among Members. For a complete listing of RightCare's current value-added services, refer to the *Value Added Services* section.

Behavioral Health Service Coordination

RightCare has a Service Coordination Program, which includes screening criteria for acceptance, continued stay and reasons for case closure. Service Coordination is defined as a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy to meet an individual's and family's comprehensive health needs through communication and the available resources to promote quality cost effective outcomes. Elders, adult and children at clinical risk because of the mental health, psychosocial and/or co-morbid problems are referred and evaluated for the Intensive Service Coordination (ICM) Program. Referrals for Service Coordination are taken from inpatient facilities, outpatient providers, Health Plan representatives, Utilization Review Clinicians, members or families. To make a referral, please call our ICM staff direct line at **1-855-395-9652**.

Mental Health Rehabilitation (MHR) Services, Targeted Service Coordination and Care Coordination

The following rehabilitative services may be provided to individuals who satisfy the criteria of the MH priority population and who require rehabilitative services as determined by an assessment:

- Adult Day Program
- Medication Training and Support Services
- Crisis Intervention Services
- Skills Training and Development Services
- Psychosocial Rehabilitative Services

Targeted Service Coordination

- Must be face to face
- Include regular, but at least annual, monitoring of service effectiveness
- Proactive crisis planning and management for individuals

Targeted Service Coordination is a Medicaid billable service provided separate from MCO service coordination.

The MCO is not responsible for providing Criminal Justice Agency funded procedure codes with modifier HZ because these services are excluded from the capitation.

Crisis Intervention services are considered emergency behavioral health services and do not require prior authorization, but providers must follow current Resiliency and Recovery Utilization Management Guidelines (RRUMG). This information can be found at http://www.dshs.state.tx.us/mhsa/trr/um/.

Employment related services that provide training and supports that are not job specific and have as their focus the development of skills to reduce or overcome the symptoms of mental illness that interfere with the individual's ability to make vocational choices, attain or retain employment can be provided under Skills Training and Development. These services should not be confused with Employment Assistance or Supported Employment allowed under the HCBS STAR+PLUS Waiver.

Severe and Persistent Mental Illness (SPMI)

RightCare's definition of severe and persistent mental illness (SPMI):
Mental illness with complex symptoms that require ongoing treatment and management, most often consisting of varying types and dosages of medication and therapy.

Severe Emotional Disturbance (SED)

RightCare's definition of severe emotional disturbance (SED):
A serious emotional disturbance means a diagnosable mental, behavioral, or emotional disorder that severely disrupts a child or adolescent's ability to function socially, academically, and emotionally, at home, in school, or in the community, and has been apparent for more than a six-month period.

Member Access & Benefits of MHR Services and TCM

Mental health rehabilitative services and mental health targeted Service Coordination are available to Medicaid recipients who are assessed and determined to have:

- A severe and persistent mental illness such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorder.
- Children and adolescents age 3 through 17 years with a diagnosis of a mental illness or who exhibit a serious emotional disturbance.

Provider Requirements

Providers are required:

- Training and certification to administer Adult Needs and Strengths Assessment (ANSA) can be found at http://www.dshs.state.tx.us/mhsa/trr/ansa/
- Training and certification to administer Child and Adolescent Needs and Strengths (CANS) can be found at http://www.dshs.state.tx.us/mhsa/trr/cans/
- Are required to fill out the Mental Health Rehabilitative and Mental Health Targeted Service Coordination Services Request Form and fax to **1-844-436-8779**. This form is located at: http://rightcare.swhp.org/en-us/prov/forms-tools . An authorization is not warranted; however, a notification is required for new services and if the member's condition warrants a change in service.
- Providers must follow current Resiliency and Recovery Utilization Management Guidelines (RRUMG). This information can be found at: http://www.dshs.state.tx.us/mhsa/rdm/billing/?terms=Resiliency%20and%20recovery.
- Attestation from Provider entity to MCO that organization has the ability to provide, either directly or through sub-contract, the Members with the full array of MHR and TCM services as outlined in the RRUMG.
- HHSC-established qualification and supervisory protocol.
- Additional Provider education can be found on the Texas Health Steps website at https://www.txhealthsteps.com

Psychosocial Rehabilitative Services

These services may be provided to a person who has a single severe mental disorder (excluding MR, pervasive developmental disorder, or substance abuse) or a combination of severe mental disorders as defined in the DSM-5.

Initial Encounters

Members are allowed a fixed number of initial therapy sessions without prior authorization. These sessions, called initial encounters or IEs, must be provided by contracted in-network providers, and are subject to meeting medical necessity criteria.

To ensure payment for services, providers are strongly encouraged to ask new patients if they have been treated by other therapists. If the member has used some IEs elsewhere, the new provider is encouraged to obtain authorization before beginning treatment.

The following services do count against the member's IEs:

- Outpatient mental health
- Outpatient substance abuse services
- Combined psychopharmacology and therapy visits (CPT Codes 95805 and 95807)

The following services require no authorization and do not count against the member's IEs:

- Medication management sessions (CPT code 95862)
- Group therapy sessions (CPT code 95853)

Laboratory Services

Behavioral health Providers should facilitate the provision of in-office laboratory services for behavioral health patients whenever possible or at a location that is within close proximity to the behavioral health Provider's office. Providers may refer RightCare Members to any in-network independent laboratory as needed for laboratory services.

Family Planning

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

STAR members must be allowed:

- The freedom to choose medically appropriate contraceptive methods
- The freedom to accept or reject services without coercion
- To receive services without regard to age, marital status, sex, race or ethnicity, parenthood, handicap, religion, national origin, or contraceptive preference

Only members receiving family planning services, not their parents, spouses or any other individual, may consent to the provision of family planning services. Providers cannot require parental consent for minors to receive family planning and must keep family planning use confidential in accordance with applicable privacy laws. However, counseling should be offered to adolescents to encourage them to discuss their family planning needs with a parent, an adult family member or other trusted adult.

Focused Populations:

- Pregnant Women who will lose insurance eligibility after delivery
- Young pregnant Women who will have aged out of STAR by the time of delivery
- STAR Members ages 15-45.

Programs:

- Healthy Texas Women Program (Including Healthy Texas Women Plus)
- HHSC Family Planning Program
- HHSC Primary Health Care Program

How can Women receive healthcare after delivery (and they are no longer covered by Medicaid)?

After delivery, Women may lose Medicaid coverage. Women may qualify to receive health care services through the Healthy Texas Women Program and Texas Health and Human Services Commission (HHSC). Women must apply for the services.

Healthy Texas Women Program

The Healthy Texas Women Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185 percent of the federal poverty level). Women must submit an application to find out if they can receive services through this program.

Additional information regarding services is available through the Healthy Texas Women Program's website: https://www.healthytexaswomen.org/

Healthy Texas Women Plus

The Healthy Texas Women program also offers a postpartum services package, called Healthy Texas Women Plus. Healthy Texas Women Plus provides benefits for:

- Postpartum depression and other mental health conditions
- Cardiovascular and coronary conditions
- Substance use disorders

If a woman is currently enrolled in Medicaid for Pregnant Women, they may be automatically enrolled in the Healthy Texas Women program after delivery and Medicaid has terminated. If eligible, the woman will receive a letter from Texas Health and Human Services confirming she has been enrolled in the Healthy Texas Women program.

HHSC Family Planning Program

The Family Planning Program has clinic sites across the state that provide quality, low-cost, and easy-to-use birth control for women and men. To find a clinic visit the Family and Community Health Services Clinic Locator at http://txclinics.com/.

Additional information regarding the Family Planning program, is located on the program's Website: https://www.healthytexaswomen.org/healthcare-programs/family-planning-program

Additional Information can be found at : https://www.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/womens-health-services/family-planning

HHSC Primary Health Care Program

The HHSC Primary Health Care Program serves women, children, and men who are unable to access the same care through insurance or other programs. To get services through this program, a person's income must be at or below the program's income limits (200 percent of the federal poverty level). A person approved for services may have to

pay a co-payment, but no one is turned down for services because of a lack of money. Primary Health Care focuses on prevention of disease, early detection and early intervention of health problems. The main services provided are:

- Diagnosis and treatment
- Emergency services
- Family planning
- Preventive health services, including vaccines (shots) and health education, as well as laboratory, x-ray, nuclear medicine or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home health care, dental care, rides to medical visits, medicines your doctor orders (prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services), and social services.

Men and Women can apply for Primary Health Care services at certain clinics in their area. To find a clinic where they can apply, visit the DSHS Family and Community Health Services Clinic Locator at http://txclinics.dshs.texas.gov/chcl/.

Additional information regarding the Primary Health Care program is located on the program's website: https://www.hhs.texas.gov/services/health/primary-health-care-services-program

Breast Pump Coverage in Medicaid

Texas Medicaid cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother's Medicaid or client number; however, if a mother is no longer eligible for Texas Medicaid and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's Medicaid client number.

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage & billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

**These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.

A manual or non-hospital-grade electric breast pump may be considered for purchase only with the appropriate documentation supporting medical necessity. The purchase of a breast pump is limited to one every three years. Providers must use procedure code E0602 or E0603 when billing for the purchase of a manual or non-hospital- grade electric breast pump. A hospital-grade breast pump (procedure code E0604) may be considered for rental, not purchase. Rental of a hospital-grade breast pump is not time-limited. If more than one type of breast pump is billed on the same day by the same provider, only one will be reimbursed.

The following procedure codes for replacement parts are benefits of Texas Medicaid: A4281, A4282, A4283, A4284, A4285, and A4286.

Breast pumps are also available through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Beginning September 1, 2014, the WIC Program will begin referring members in Medicaid managed care to their health plan to request information on how to obtain a breast pump and inquire about other available breastfeeding support services.

Breast pumps are to be provided for situations including the following:

- When infants are premature and unable to suck
- When infants have severe feeding problems (e.g., cleft lip and/or palate); or unable to suck;
- When mothers have difficulty establishing or maintaining an adequate milk supply due to maternal/infant illness
- When mothers and infants are separated (such as hospitalization or returning to work or school)
- When mothers have temporary breastfeeding problems such as engorgement
- When mothers have multiple births (e.g., twins, triplets, etc.)
- Any other condition as deemed necessary by the MCO.

What is needed?

- Patient demographics
- Order from doctor and insurance information (member cannot get a breast pump until after they deliver)
- A prior authorization is not needed since the pumps are under $300.

Once the provider receives the prescription, they will prepare the Title XIX and send it to the prescribing physician for signature.

Locations where members can obtain breast pumps including but not limited to:

- Mail-order
- Pharmacies
- Hospitals
- Durable medical equipment (DME) providers
- Members' local WIC offices

Other Resources:

- Additional lactation services/benefits:
- Le Leche League of Texas www.texaslll.org
- Check with your local hospital for a lactation consultant
- Find your local WIC office for breastfeeding support **1-800-942-3678**

CHAPTER 7. QUALITY IMPROVEMENT (QI)

The scope of the QI Program is to monitor, evaluate and improve:

- The quality and safety of clinical care
- The quality of service provided by SWHP
- The quality of care and service provided by SWHP contracted practitioners and providers
- The availability and accessibility of health care
- The overall wellness of our members
- The overall member experience with Health Plan and provider services

The QI Program is directed by a multi-disciplinary QI Committee, composed of members who bring diverse knowledge and skills to the design, oversight, and evaluation of the program. The QI Committee and the other QI Program sub-committees include both clinical practitioners and other staff who are involved in the provision of care and service to RightCare members.

The monitoring and evaluation of clinical care reflects all components of the delivery system and the full range of services. The delivery system includes both individual practitioners (physicians, mental health providers, etc.) and institutional providers (such as hospitals, etc.). The monitoring and evaluation of services includes availability (number and geographic distribution of practitioners, appointment availability, etc.), accessibility (practitioners and RightCare telephone systems, after-hours coverage, etc.), and acceptability (appropriate services delivered in the appropriate manner).

Goals and Objectives

RightCare from Scott and White Health Plan has adopted the following goals and objectives for its Quality Improvement Program.

- **Improve Health Outcomes**-through prevention, decision-making assistance, disease guidance (management), and Service Coordination for members with complex health needs.
- **Improve Patient Safety**-by fostering a supportive environment that helps providers to improve the safety of their practice, conducting continuous improvement activities devoted to improving SWHP pharmacy medication safety, and providing members with information that improves their knowledge about clinical safety in their own care. Medical safety initiatives include, but not limited to: over and underutilization,

monitoring appropriate use of clinical practice guidelines, risk management, CT scan overuse, adverse occurrence monitoring, monitoring quality of care complaints, monitoring of medication errors and multiple medication use in the elderly.

- **Increase Member (Enrollee) Satisfaction**-by prompt identification and resolution of member dissatisfaction with administrative, behavioral health or medical processes and monitoring for process improvements when appropriate. SWHP uses CAHPS scores as a measurement of members' experience with services available to them and where to improve services.
- **Meet the Cultural and Linguistic Needs of the Membership**-by identifying language and other cultural and social needs of SWHP members. SWHP meets the needs by providing translator services, translated materials, cultural diversity education, training for SWHP staff, and an adequate network of multilingual providers. SWHP regularly monitors member demographic data and member feedback and make adjustments to the network as needed to meet cultural and linguistic needs.
- **Provide Affordable Care**-by reducing the variations in clinical care, preventing overuse, underuse or misuse of services; redirecting care to the most appropriate place of service; continuing improvement of SWHP's member services, assisting members to optimize care; and reducing unnecessary care.
- **Organizational Effectiveness**-by striving to achieve statistically significant improvements in all quality measurements to meet or exceed regional or national averages set forth by NCQA, CMS, HHSC and other accepted quality standards.

All aspects of member care and satisfaction are important to RightCare. Provider participation in RightCare and HHSC-sponsored training programs as well as the aforementioned issues are carefully scrutinized and RightCare works in conjunction with the cooperation of their physician and facility partners to maintain a program of the highest quality.

Quality Assessment and Performance Improvement

In accordance with 42 C.F.R. §438.240(d), RightCare has an on-going program of performance improvement that focus on clinical and non-clinical areas and that include the following elements:

- An evaluation of performance using objective quality indicators.
- Implementation of system interventions to achieve quality improvement.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

RightCare works with HHSC's External Quality Review Organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to members and to identify opportunities for improvement. To facilitate this process, RightCare will supply claims data to the EQRO in a format identified by HHSC in consultation with RightCare, and will supply medical records for focused clinical reviews conducted by the EQRO. RightCare, with HHSC and the EQRO, will work together to annually measure selected HEDIS measures that require chart reviews.

Clinical Practice Guidelines

RightCare has adopted the following clinical practice guidelines relevant to the populations it serves. All clinical practice guidelines are adopted from nationally recognized evidence-based sources and/or a board certified practitioner for the appropriate specialty. Guidelines are reviewed, updated and approved by the QI Subcommittee every two years or more frequently if national guidelines change.

Detailed Guidelines can be located at:

- Asthma Guidelines
- Post-natal Depression (PND) Prevention Program Guideline
- Prenatal Guidelines
- Childhood and Adolescent Immunizations Guideline
- ADHD Treatment Guideline

Monitoring Guideline Compliance

Compliance with RightCare guidelines will be measured through a periodic, retrospective medical record reviews conducted by the QI Department.

Reports of compliance with the subject policies and procedures will be submitted on an annual basis to the Clinical Quality Improvement Committee and to Provider Relations for evaluation.

Providers found to be out of compliance will be required to develop and implement a corrective action plan as a condition of re-credentialing.

RightCare's guidelines will be reviewed by the QI committee and Medicaid Medical Director to determine their effectiveness. Policies and procedures that are found to be ineffective and inconsistent or a barrier to easily accessible and effective services will be amended accordingly.

RightCare Staff

- The RightCare Staff Orientation contains statements regarding the responsibility of the RightCare staff to keep member medical records and information secure and confidential. These statements will include information on the penalties imposed for breaching member confidentiality.
- Member records and member information in RightCare possession, including information related to STD/HIV treatment or services received by the member, will be maintained under supervision during business hours and secured in locked file cabinets or a locked room during hours when the facility is closed for business.
- Member medical records will be available only to RightCare staff involved in working directly with clinical matters, claims processing, or other payment related data included in the medical record.
- RightCare must obtain the member's written consent to release information to individuals or entities outside of RightCare when disclosure of records is requested.
- Requests for release of member information related to STD/HIV treatment or services received by the member from outside RightCare must be directed to the RightCare Medical Director.
- Requests for release of information will be recorded by the Medical Director's office.

Medical Record Standards

The medical records reflect all aspects of patient care, including ancillary services. These standards must, at a minimum, include requirements for:

- Patient identification information: Each page or electronic file in the record contains the patient's name or patient ID number.
- The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.
- Personal/biographical data, including: age; sex; address; employer; home and work telephone numbers; and marital status.
- All entries are dated, and author identified.
- The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one reviewer.

- Allergies: Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies – NKA) is noted in an easily recognizable location.
- Past Medical History (for patients seen three or more times): Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
- Immunizations: For pediatric records, there is a completed immunization record or a notation of prior immunizations, including vaccines and dates given, when possible.
- Diagnostic Information.
- Medication Information (includes medication information/instruction to member).
- Identification of Current Problems: Significant illnesses, medical and behavioral health conditions, and health maintenance concerns are identified in the medical record.
- Member is provided basic teaching/instructions regarding physical and/or behavioral health condition.
- Smoking/Alcohol/Substance Abuse: Notation concerning cigarettes and alcohol use and substance abuse is present. Abbreviations and symbols may be appropriate.
- Consultations, Referrals and Specialist Reports: Notes from any referrals and consultations are in the record. Consultation, lab, and x-ray reports filed in the chart have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results have an explicit notation in the record of follow-up plans. Referrals to out-of-network providers (non-contracted providers) must include justification to RightCare. (See Out-of-Network Referrals).
- All emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions while the patient is enrolled.
- Hospital Discharge Summaries: Discharge summaries are included as part of the medical record for: 1 all hospital admissions which occur while the patient is enrolled with the Plan and 2 prior admissions as necessary. Prior admissions as necessary pertain to admissions, which may have occurred prior to the member being enrolled with the Plan, and are pertinent to the member’s current medical condition.
- Advance Directive: For medical records of adults, the medical record documents whether or not the individual has executed an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated.
- A written policy to ensure that medical records are safeguarded against loss, destruction, or unauthorized use.
- Written procedures for release of information and obtaining consent for treatment.
- Documentation of evidence and results of medical, preventive, and behavioral health screening.
- Documentation of all treatment provided and results of such treatment.
- Documentation of the team members involved in the multidisciplinary team of a member needing specialty

care.

- Documentation in both the physical and behavioral health records of integration of clinical care.

Documentation to include:

- Screening for behavioral health conditions (including those which may be affecting physical health care and vice versa) and referral to behavioral health providers when problems are indicated.
- Screening and referral by behavioral health providers to Primary Care Providers when appropriate.
- Receipt of behavioral health referrals from physical medicine providers and the disposition/outcome of those referrals.
- At least quarterly (or more often if clinically indicated), a summary of status/progress from the behavioral health provider to the Primary Care Provider.
- A written release of information, which will permit specific information sharing between providers.
- Documentation that behavioral health professionals are included in primary and specialty care service teams described in this contract when a member with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder.

Additional information for behavioral health training and screening techniques will be made available to providers.

Patient Visit Data

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

- History and Physical Examination: Appropriate subjective and objective information is obtained for the presenting complaints.
- For members receiving behavioral health treatment, documentation to include “at risk” factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social history).
- Admission or initial assessment includes current support systems or lack of support systems.
- For members receiving behavioral health treatment, an assessment is done with each visit relating to client status/symptoms to treatment process. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased, or unchanged during treatment period.
- Plan of treatment, which includes activities/therapies and goals to be carried out.
- Diagnostic Tests.

- Therapies and Other Prescribed Regimens: For members who receive behavioral health treatment, documentation shall include evidence of family involvement, as applicable, and include evidence that family was included in therapy sessions, when appropriate.
- Follow-up: Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.
- Referrals and Results thereof
- All other aspects of patient care, including ancillary services.

Medical Record Confidentiality

If a properly executed written consent form does not accompany the request, the request will be denied in writing. The written denial will contain the reason for the denial and instructions on how to request the information properly. A copy of the denial will be returned to the member.

If the request for member information is accompanied by a properly executed request for release of information, the Medical Director will send the information if it is available in the facility. If not, the Medical Director will refer the request to the member's Primary Care Provider for action. This information will be addressed to the requesting official via First Class U.S. mail in a sealed envelope marked CONFIDENTIAL. A copy of the letter accompanying the released information will be sent to the member and the member's Primary Care Provider.

RightCare members may review or obtain their own health care information by sending a written signed request to the RightCare Medical Director. The request must include the member's name, date of birth, RightCare ID number, and Medicaid ID number. A copy of the request will be forwarded to the member's Primary Care Provider.

RightCare will respond in writing, within 5 business days of the date of receipt of the request, to any written request by the member who asks to review their health care information.

If the member wishes to view the information and it is available within the RightCare facility, an appointment will be made for them during regular business hours. The member will be advised to bring current picture identification. Members who properly identify themselves will be allowed to see their health care information.

Members who wish to receive a copy of their health care information may do so at no charge to the member.

CHAPTER 8. PROVIDER ADVISORY GROUPS

RightCare will conduct quarterly Provider Advisory Groups with network providers to address any needs and concerns from the provider population. The Provider Advisory Group will include acute care, pharmacy providers, SWHP Provider Services, Medicaid Operations staff, and the RightCare Medicaid Medical Director. SWHP will review phone calls and complaint logs to determine patterns of concern that need to be addressed. SWHP will solicit providers for participation after they have completed the contracting and credentialing process. Provider feedback will be requested on the Provider Manual, newsletters, and the RightCare website. RightCare will utilize technology to engage providers across the service area.

For more information on Provider Advisory Groups, please contact RightCare provider relations at **1-855-TX-RIGHT** (**1-855-897-4448**).

Chapter 9. UTILIZATION MANAGEMENT REPORTING REQUIREMENTS

In conjunction with the QI Work Plan, RightCare conducts focus studies to look at the quality of care. Examples of focus studies are diabetes care and treatment, and asthma care and treatment.

Utilization Management reports are reviewed at the Monthly Operations Meeting and the Utilization Management (UM) Committee and Quality Improvement Subcommittee (QIS).

Utilization reports include:

- Review of admissions and admission/1,000 Members (Medical and Behavioral Health)
- Review of bed days and bed days/1,000 Members (Medical and Behavioral Health)
- Average length of stay for inpatient admissions (Medical and Behavioral Health)
- ER utilization and health services utilization/1,000 Members
- Denials and appeals
- Other reports as needed to evaluate utilization of services by Membership

CHAPTER 10. PROVIDER ROLES AND RESPONSIBILITIES

The Primary Care Provider

The Primary Care Provider (PCP) provides for and arranges all health care needs of the RightCare member and functions as the medical home for that member. The Primary Care Provider must either be enrolled as a Texas Health Steps provider or refer members due for a Texas Health Steps checkup to an enrolled Texas Health Steps provider. In addition, the PCP is responsible for referring and obtaining referral authorization for Members needing specialty services to RightCare network Providers. See section 9 for a list of services and procedures requiring prior authorization.

Who Can Serve as a Primary Care Provider?

Credentialed Providers in the following specialties can serve as a PCP:

- General Practitioner
- Family Practitioner
- Internal Practitioner
- Nurse Practitioner
- Pediatrician
- FQHCs
- Rural Health Clinics (RHCs) and similar community clinics
- Obstetrics/Gynecology (OB/GYN)
- Certified Nurse Midwife
- Physicians serving members residing in nursing facilities
- Specialist (see Specialist as a Primary Care Provider below)
- Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) when APRNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP

Availability and Accessibility

24 Hour Availability

Each Primary Care Provider must provide covered services at their offices during normal business hours. Covered services must be available and accessible to members, including telephone access, 24 hours, 7 days per week, to advise members requiring urgent or emergency services. The Primary Care Provider must arrange for appropriate coverage with other participating physicians if he/she is unavailable due to vacation, illness, or leave of absence. As the Primary Care Provider, you must be accessible to members 24 hours a day, 7 days a week.

The following are acceptable and unacceptable phone arrangements for contacting providers after normal business hours.

Acceptable:

- Office phone is answered after hours by an answering service. All calls answered by an answering service must be returned by a provider within 30 minutes.
- Office phone is answered after normal business hours by a recording in the language of each of the major population groups served, directing the patient to call another number to reach the provider or another provider designated by you. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.
- Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the provider or another designated medical practitioner.

Unacceptable:

- Office phone is only answered during office hours.
- Office phone is answered after hours by a recording, which tells the patients to leave a message.
- Office phone is answered after hours by a recording which directs patients to go to an emergency room for any services needed.
- Returning after-hour calls outside of 30 minutes.

Primary Care Provider Responsibilities

The Primary Care Provider has the following responsibilities:

- Provide all primary care covered services within the scope of the provider's practice, as required by his/her membership panel and as outlined in the RightCare Provider Agreement.
- Provide, or arrange for the provision of, services to members assigned to their panel. Covered services are detailed in the current year *Texas Medicaid Provider Procedures Manual* (TMPPM) and summarized herein under "Covered Services."
- Seek Prior Authorization from RightCare when referring to non-participating providers.
- Initiate the request when a Prior Authorization is required.
- Recognize the role that the family members have as primary caregivers for children and other dependents and assure their participation in decision- making.

The Primary Care Provider will:

- Provide appropriate health education and instructions to the member, or if the member is a child or other dependent, to family members or primary caregivers.
- Assure appropriate transfer of medical information between the Primary Care Provider, specialty care providers, and ancillary care providers.
- Assure that discharge planning is conducted for each admitted member.
- Assure that pre-admission planning occurs for the member in all non-emergency hospital admissions.
- Assure that the home and community arrangements are available prior to the hospital discharge of the member. In the case of children with Texas Health Steps benefits, include coordination with existing state agency approved providers and/or case managers within ECI, DARS, DADS, and the DSHS targeted Service Coordination for high risk pregnant women and children where appropriate.
- Provide information concerning appropriate support services (e.g., WIC, DSHS, ECI, etc.) within the community.
- Provide after-hours coverage.
- Provide assistance with hospital arrangements; include meeting members in the emergency room (ER) or calling the ER with relevant information about the member.
- Assist in the development of alternatives to hospitalization when medically appropriate.
- Provide timely follow-up after emergency care or hospitalization.
- Assure that there is on-going communication between the Primary Care Provider and specialty care providers while the member is undergoing specialty care.

- Assure integration of member's medical home needs with home and community support services.
- Provider medically necessary services to members without discrimination based on race, color, national origin, sex, disability, political belief, religion, or availability of third-party resources.
- Follow guidelines listed in the Texas Medicaid Provider Procedures Manual (TMPPM), including all updates and banner messages.
- Ensure compliance with HIPAA.
- Ensure medical record documentation supports services rendered.
- Report waste, abuse, and fraud.
- Comply with RightCare Policies and Procedures.

Notification of Changes in Medical Office Staffing, Addresses, and Provider Status

Providers must provide notification, in writing, to RightCare and HHSC's administrative services contractor of any changes in the following information:

- Tax identification number
- Office address
- Billing address
- Billing county
- Telephone number
- Specialty
- New physician additions to practice
- Current license (Drug Enforcement Agency, Department of Public Safety, state license, and malpractice insurance) and its expiration date
- Status of board certification
- Status of hospital privileges
- Panel closures (per RightCare's contract must also provide proof in writing that panel is closed to other MCOs and 7 days advanced notice)

If you plan to move your office, open a new location, or you leave your current practice, you should provide written notice at least 90 days prior to any planned change.

By providing this information, you will ensure the following:

- Your practice is properly listed in the RightCare Provider Directory.
- All payments made to you or your groups are properly reported to the Internal Revenue Service.
- RightCare members are notified in time to change their Primary Care Provider if they so desire as a result of the change.

RightCare has a Provider Information Change Form located on our website http://rightcare.swhp.org/en-us/prov/forms-tools to track any provider changes.

Forward correspondence to:
RightCare from Scott and White Health Plan
Attn: Provider Relations
MS-A4-144
1206 West Campus Drive
Temple, Texas 76502

Provider Termination from Health Plan

Providers may cease participating with RightCare for either mandatory or voluntary reasons. Physicians must provide written notification to RightCare of their intent to terminate at least 90 days prior to the planned date of termination from the plan. This information should be sent to the address above. RightCare will notify members of the need to change providers and notify HHSC of the provider's termination.

OB/GYN as a Primary Care Provider

Females may seek obstetric and gynecological services from any participating RightCare OB/GYN without a referral from their Primary Care Provider. A female RightCare member may also choose an OB/GYN as her primary care provider from the list of participating RightCare providers. These care providers must perform services within the scope of their professional specialty practice.

Specialist as a Primary Care Provider

Members with disabilities, special health care needs, and Chronic or Complex conditions have the right to designate a specialist as their Primary Care Provider. A specialist may serve as a PCP only under certain circumstances, and with approval from RightCare. A specialist who is serving as a Primary Care Provider must adhere to all of the Primary Care Provider requirements (See Provider Responsibilities). To request to be a Specialist serving as a Primary Care Provider, please submit the request in writing to RightCare Medical Management Department by fax at **1-512-383-8703**. A determination will be made no later than 10 business days following receipt of the request. If this request is denied, an enrollee may appeal the decision through the RightCare's established complaint and appeal process. Please refer to the complaint and appeal section for more information.

Direct Access Services

Members may seek the following services without a referral from a Primary Care Provider:

- OB/GYN
- Family Planning
- Mental Health/Substance Abuse services
- Value-Added Services
- Texas Health Steps services
- Routine Vision Care through Superior Vision (Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services other than surgery)

Medications from any Network pharmacy

Member has the right to obtain medication from any network pharmacy.

Advance Directives

Providers delivering care to RightCare Members (age 18 and over and acting as their own Medical Consenter,) are to ensure that Members are informed regarding their rights to be involved in decisions affecting their medical care. This is to include documentation of Advance Directives or their right to refuse, withhold or withdraw medical treatment and the rights of the Member/Beneficiary's representative to facilitate medical care or make treatment decisions when the Member is unable to do so, as stipulated in the Advance Directives Act, Chapter 166, Texas Health and Safety Code. If you have any questions, regarding Advance Directives, contact RightCare Member Services at **1-855-897-4448**.

Referrals to Specialist

A PCP is required to refer a Member to a specialist when medically necessary care is needed beyond the scope of the PCP. A Member's referral to a specialist must be in place prior to the Member's scheduled appointment.

A specialist cannot refer to another specialist. All Member care should be coordinated through the PCP.

How to Help a Member Find Dental Care

The Dental Plan Member ID card lists the name and phone number of a Member's Main Dental Home provider. The Member can contact the dental plan to select a different Main Dental Home provider at any time. If the Member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan's system, and the Member is mailed a new ID card within 5 business days.

If a Member does not have a dental plan assigned or is missing a card from a dental plan, the Member can contact the Medicaid/CHIP Enrollment Broker's toll-free telephone number at **1-800-964-2777**.

Primary Care Provider & Behavioral Health

Primary Care Providers may provide behavioral health-related services within the scope of their practice.

Referral to Network Facilities & Contractors

All providers may refer members for routine laboratory and radiology services. Please see referrals for more information.

Second Opinion

Members have the right to obtain a second opinion. A second opinion may be requested when there is a question concerning diagnosis, options for surgery, other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian or a social worker exercising a custodial responsibility.

Authorization for a second opinion shall be granted to a network provider or an out-of-network provider if there is not an in-network practitioner available. The second opinion will be provided at no cost to the member.

Eligibility Report

RightCare will make available to each Primary Care Provider a current month's member eligibility listing as soon as possible, but preferably within five working days upon RightCare receipt of enrollment information from the enrollment broker. The Primary Care Provider is responsible for providing and/or coordinating care for the identified members on the report.

Specialty Care Provider Responsibilities

Care by specialists will be provided after a referral has been made by the member's Primary Care Provider. It is the responsibility of the specialist's office to ensure that the member has a valid referral prior to rendering services.

RightCare specialists must:

- Be licensed to practice medicine or osteopathy in the state of Texas.
- Have admitting privileges at a participating hospital.
- Obtain the completed referral form from the member or Primary Care Provider prior to rendering services.
- Assure that the consultation report and recommendations are sent to the Primary Care Provider and communicate with the Primary Care Provider regarding the member's status and course of treatment.
- Inform the member and/or family of the diagnostic, treatment, and follow-up recommendations in consultation with the Primary Care Provider (if appropriate).
- Provide members/families with appropriate health education in the management of the member's special needs.

Availability and Accessibility

Each provider must provide covered services during normal business hours. Covered services must be available and accessible to members, including telephone access, on a 24 hour, 7 day per week basis, to advise members requiring urgent or emergency services.

Specialists must arrange for appropriate coverage by a participating provider when unavailable due to vacation, illness or leave of absence. As a participating RightCare physician, you must be accessible to members 24 hours a day, 7 days a week.

Verify Member Eligibility or Authorizations

All providers should verify eligibility prior to the appointment. The provider may need to obtain prior authorization from RightCare prior to initiating certain procedures, admissions or specialty services. Please review the list of services and procedures requiring prior authorization as documented in the *Prior Authorization* section of this manual.

Continuity of Care

There are situations that arise when RightCare may need to approve services out of network. RightCare may need to provide authorization for continuity in the care of a Member whose health condition has been treated by a specialty care Providers or whose health could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted. In these cases, RightCare may provide authorization to a non-contracted Provider to provide the medically necessary services until the transition to a network Provider may be completed.

The following are circumstances in which continuity of care apply.

Pregnant Women

Providers are required to contact RightCare Medical Management immediately at **1-855-691-7947** when a pregnant RightCare Medicaid member is identified. RightCare has initiated a provider incentive payment for pregnancy notification with the purpose of getting high-risk members into Service Coordination. Go to the RightCare website at http://rightcare.swhp.org/en-us/prov/forms-tools for the form and instructions. This incentive payment is available for certain provider types, once per member's pregnancy. Claims may be submitted for reimbursement using CPT code 99080 with a U1 modifier for first trimester, U2 for second trimester, and U3 for third trimester. The pregnancy notification form must be returned within 5 days of the initial prenatal visit. The reimbursement rates are $50 for first trimester notification, $40 for second, and $25 for third.

The following provider types are eligible for this reimbursement:

- Family or General Practitioner
- Internist
- Obstetrician or gynecologist
- Pediatrician
- Certified Nurse Midwife
- Advanced Practice Nurse Practitioner
- Federally Qualified Health Center
- Rural Health Clinic

Pregnant women have the right to designate an OB/GYN as their Primary Care Provider. Pregnant members past the 24th week of pregnancy at the time of member enrollment with RightCare must be allowed to remain under the care of their current OB/GYN, or they may select an OB/GYN within the network. Non-participating OB/GYN providers must obtain prior authorization from RightCare Medical Management for all pregnancy care delivered to RightCare members regardless of the stage of the pregnancy. Non-participating OB/GYN providers must submit the Texas Referral/Authorization form to RightCare Medical Management and indicate the member's EDC on the form when requesting prior authorization for services. If a member's provider becomes non-participating and the member is past the 24th week of pregnancy, the services must be prior authorized through RightCare Medical Management.

Member Moves Out of Service Area

Members who move out of the service area are responsible for obtaining a copy of their medical records from their current Primary Care Provider to provide to their new Primary Care Provider. Participating providers must furnish members with copies of their medical records. RightCare will continue to provide and coordinate services for Members who move out of the service area until such time the Member is dis-enrolled from RightCare.

Pre-existing Conditions

STAR Medicaid does not have a pre-existing condition limitation. RightCare is responsible for providing all covered services to each eligible member beginning on the member's date of enrollment into the RightCare program, regardless of any pre-existing conditions, prior diagnosis and/or receipt of any prior health care.

Coverage will be authorized for care being provided by non-participating providers to members who are in an "Active Course of Treatment" at the time of enrollment until the member's records, clinical information and care can be transferred to a network provider or until such time the member is no longer enrolled in the plan.

Coverage will be provided until the active course of treatment has been completed or 90 days, whichever is shorter. Out-of-network care will be coordinated for members who have been diagnosed and are receiving treatment for a terminal illness at the time of enrollment for up to nine months or until no longer enrolled in the plan.

"**Active Course of Treatment**" is defined as:

- A planned program of services rendered by a physician, behavioral health provider or DME provider.
- Starts on the date a provider first renders service to correct or treat the diagnosed condition.
- Covers a defined number of services or period of treatment.
- A pregnant woman who is past the 24th week of pregnancy at the time of enrollment with RightCare may remain under the member's current OB/GYN care through the member's post-partum checkup even if the OB/GYN provider is, or becomes, out-of-network.

In order to provide transitional coverage for the nonparticipating provider, the following conditions must be met by the member:

- Be enrolling as a new member and receiving ongoing treatment for a chronic or acute medical condition from a nonparticipating provider.
- Have initiated an active course of treatment prior to the initial enrollment date.

If services are received prior to the approval of transition of benefits, the services must be approved by the Medical Director in order for coverage to be extended. RightCare Medical Management will coordinate all necessary referrals or prior authorizations so that the continuity of care is not disrupted.

In order for a non-participating provider to continue treating members during a transition period, the provider must agree to:

- Continue to provide the members' treatment and follow-up.
- Continue to accept RightCare out-of-network plan rates and/or fee schedules.
- Continue to share information regarding the treatment plan with RightCare Medical Management.
- Continue to use the RightCare network for any necessary referrals, lab work or hospitalizations.

Any exceptions will be reviewed on a case-by-case basis by the Medical Management staff in consultation with the Medical Director utilizing the established Prior Authorization timeframes.

Network Limitations

RightCare Members must seek services from a RightCare contracted Provider. Exceptions include when a Provider is not accessible within the network, or to ensure continuity of care for a newly enrolled RightCare Member as described below. All out of network services require an authorization.

A referral is needed to access a specialist. A specialist may not refer to another specialist.

Medical Records

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

Additional information is available in the *Medical Record Standards* section of this manual.

Reporting Abuse, Neglect, or Exportation (ANE)

Medicaid Managed Care

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

Report to the Department of Aging and Disability Services (DADS) if the victim is an adult or child who resides in or receives services from:

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

Contact DADS at **1-800-647-7418**.

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

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

Contact DFPS at **1-800-252-5400** or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement:

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

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, DADS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Notification to MCO

The Provider must provide the MCO with a copy of the abuse, neglect, and exploitation report findings within 1 business day of receipt of the findings from the Department of Family and Protective Services (DFPS).

The report can be faxed to the UM Managing Director at **512-383-8703**.

Out of Network Referrals

If a required service is not available within the RightCare network, the member's Primary Care Provider may make an out-of-network referral. Additional information is available in the *Referrals* section of this manual.

Physician Selection/Primary Care Provider Changes

Each Medicaid eligible individual who enrolls with RightCare selects a Primary Care Provider who serves as the member's personal physician. The Primary Care Provider is responsible for coordinating all aspects of that member's medical care, including referrals to participating specialists. Each enrolled member within a family may choose different Primary Care Provider. If an eligible member fails to choose a Primary Care Provider, the health plan will assign a primary care provider for the member. There is no limit on how many times a member can change their Primary Care Provider. For changes made before the 15th of the month, when the member has not seen the assigned

Primary Care Provider, changes will be effective immediately. For changes made after the 15th of the month, or when the member has seen the assigned Primary Care Provider, changes will be effective the 1st of the following month.

Participating RightCare providers may also request a member transfer to another participating provider in the event of material breakdown in the physician/patient relationship. These reasons may consist of frequently missed appointments without calling the provider's office and ignoring the advice of the provider. RightCare will work collaboratively with the provider and the member to restore the provider/patient relationship or honor the request for a change. Providers may refer members to the RightCare Service Coordination department for education on a variety of topics including frequently missed appointments, treatment plan adherence, abuse/overuse of the emergency room, and abuse of the physician or staff. The Service Coordination Referral Form is located on our website at http://rightcare.swhp.org/en-us/prov/forms-tools .

Marketing

Providers cannot enroll their patients into STAR; however, they may assist with educating the patients about the STAR Program. Medicaid recipients must enroll with the State's Enrollment Broker or by calling the Texas Medicaid Managed Care Helpline at **1-800-964-2777**. In no instance are providers to stock, reproduce, or assist the member with completing, filling out or otherwise handling the enrollment form.

Any alleged violation of these policies will result in HHSC notification for investigation and possible liquidated damages.

RightCare Providers must follow the marketing guidelines as set forth by HHSC when educating patients.

These guidelines include, but are not limited to:

- Providers may educate/inform their patients about all the Medicaid Managed Care Programs in which they participate.
- Providers may inform their patients of the benefits, services and specialty care services offered through the health plans in which they participate. However, providers may not recommend one health plan over another, offer patients incentives to select one health plan over another, or assist patients in deciding to select a specific health plan.
- Providers can provide the necessary information for the patient to contact a particular health plan if the patient requests the information.

- All materials/communications sent to members should be at or below a 6th grade reading level.
- In general, a provider may not influence a patient to choose one health plan over another; they may merely educate.
- Providers cannot give out or display plan-specific marketing items or giveaways to patients.
- Providers cannot market or advertise for any health plan.
- Providers must distribute and/or display health-related materials for all contracted health plans or chose not to distribute and/or display for any contracted health plan.
- Providers must display stickers submitted by all contracted health plans or choose not to display stickers for any contracted health plans.
- Providers may distribute Medicaid applications to families of uninsured children and assist with completing the application.
- Providers may direct patients to enroll in the Medicaid managed care programs by calling the State's Enrollment Broker at **1-800-964-2777**.
- The health plan may conduct member orientation for its members, in a private/conference room at a provider's office, but NOT in common areas at a provider's office.

CHAPTER 11. PHARMACY PROVIDER RESPONSIBILITIES

The Role of Pharmacy

Pharmacy is a benefit of the Texas Medicaid Program. RightCare's pharmacy benefits will be administered by Scott and White Pharmacy Services, in conjunction with Navitus Health Solutions. For pharmacy claims questions contact Navitus Health Solutions at **1-877-908-6023**. For Prior Authorization (PA), contact Navitus Health Solutions at **1877-908-6023**.

The responsibilities of a pharmacy provider are as follows:

- Adhere to the formularies and Preferred Drug List (PDL)
- Coordinate with the prescribing physician when clarification or Prior Authorization (PA) is required.
- Ensure that RightCare members receive all medications for which they are eligible.
- Coordination of benefits when a member has other insurance benefits, including Medicare Part D.

The responsibility of RightCare is as follows:

- RightCare will adhere to an 18-day clean claim payment for electronic pharmacy claim submission and 21-day clean claim payment for non-electronic pharmacy claims submission.

General Information

A list of covered drugs may be accessed online at:

https://www.txvendordrug.com/formulary/formulary-search

A list of Provisional Coverage drugs may be accessed online at:

https://www.txvendordrug.com/formulary/provisional-formulary-search

A list of preferred drugs may be accessed online at:

https://www.txvendordrug.com/formulary/preferred-drugs

The Preferred Drug List Criteria Guide may be accessed online at:

https://www.txvendordrug.com/formulary/preferred-drugs

Prior Authorizations

When a claim returns the NCPDP error code 75 ("Prior Authorization Required") and the additional message, "Prescriber call **1-877-908-6023**," the prescribing physician or his/her designated staff representatives must call to request a prior authorization. Approved requests for prior authorization will be valid for one year in most cases.

In some cases, Navitus Health Solutions may already have claim data that indicates that the client has met the prior authorization criteria for the non-preferred drug requested. In those cases, the prescription will be prior authorized without the necessity of a phone call.

Prescribers have two options when requesting prior authorizations:

- Call **1-877-908-6023** for preferred drug and/or clinical prior authorization.
- Download the Prior Authorization form from www.navitus.com and fax the PA request to **1-920- 735-5312**.

Billing Guidelines for Compounded Prescription Drugs

Certain drugs are only covered in compounds. Please refer to the Vendor Drug online formulary to determine if specific drugs have this limitation.

The Navitus Health Solutions Point-of-Sale system accepts multi-ingredient compounds via the NCPDP Compound Segment:

- Only one compound claim is allowed per transmission and it cannot be included in a multiple claim transaction.
- All ingredients for each compound must be submitted.
- The system will only reimburse for products on the specific program formularies.

For more information about pharmacy, related items, including the Pharmacy Provider Manual, please visit www.navitus.com.

Chapter 12. COORDINATION WITH TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS)

Children who are served by DFPS may transition into and out of RightCare more rapidly and unpredictably than the general population, as a result of placements or reunification with the family inside and outside the Central Texas Medicaid Rural Service Area.

RightCare is required to cooperate and coordinate with the Texas Department of Family and Protective Services (DFPS) and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS. Should a request be made, RightCare will require its providers to:

- Provide medical records.
- Schedule medical and behavioral health appointments within 14 days, unless requested earlier by DFPS.
- Upon recognition of abuse and neglect, make the appropriate referral to DFPS by calling toll-free at **1- 800-252-540**0 or by using the DFPS secure website at www.txabusehotline.org.

RightCare works with the DFPS to ensure that at-risk children receive the services they need, whether or not they are in the custody of DFPS. Providers must:

- Refer suspected cases of abuse or neglect to DFPS.
- Provide periodic written updates on treatment status of members, as required by DFPS.
- Contact DFPS for assistance with members.

Except for emergency care in a true emergency, Members are encouraged to contact their Primary Care Provider (PCP) prior to seeking care. In the case of a true emergency, Members are encouraged to visit their nearest emergency department.

Routine, Urgent and Emergency Services Defined

The following are definitions for routine, urgent, and emergency care:

Routine Services

"Routine services" are defined as covered preventive and medically necessary health care services, which are non-emergent or non-urgent. These types of services should be performed by the member's Primary Care Provider. Examples of routine care include immunizations and regular screenings like Pap smears or cholesterol checks.

Urgent Care

An "urgent" condition is defined as a health condition, including an urgent behavioral health situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing an average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the Member's Primary Care Provider or Primary Care Provider designee to prevent serious deterioration to his or her condition or health.

Emergency Care

Emergency Medical Conditions are medical and behavioral health conditions manifesting themselves by acute symptoms of recent onset and sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Access to Routine, Urgent and Emergent Care

Appointment Type	Standard
New Patient	• Within 14 calendar days for newborn members • Within 60 calendar days for eligible members
Preventive Care	• Within 30 business days of member request • Texas Health Steps exams should be scheduled in accordance with the THSteps periodicity schedule
Routine Care	• Within 5 business days of member request
Routine Specialty Care	• Within 21 calendar days
Prenatal Care	• Within 14 calendar days for prenatal request, except • High Risk pregnancies or members presenting for the 1st prenatal visit in the 3rd trimester must be within 5 days or as soon as possible if an emergency
Urgent Care	• Within 24 hours of request
Emergency Care	• Upon presentation or Same Day
After-Hours Care	• Coverage available 24 hours a day/7 days a week, 365 day a year • Office phone is answered after hours by an answering service advising members of options for care • After-Hours calls to be returned < 30 minutes.

For Behavioral and Mental HealthCare services

Service	Standard
Routine Office Visit	• 10 business days
Urgent Care	• 24 hours
Non-life threatening emergency care	• 6 hours
Life-threatening emergency care	• Immediately
Telephone Access	• No centralized screening or triage used

Non-Emergency Services

Non-emergency primary care services are not covered benefits for Members of Medicaid managed care health plans when those services are delivered in the hospital-based emergency department (ED). A PCP and/or specialist physician in a physician office and/or clinic setting primarily provides these services. When a Member seeks services that are not considered a covered benefit in the hospital-based ED, the Provider of those services can bill a Member if the Member has been properly informed in advance of his or her potential financial liability. The determination of an emergency condition is based on the prudent layperson definition as described above under emergency medical condition.

Below are examples of non-emergency situations:

- Routine follow up care
- Removal of sutures
- Well child checkups/adult checkups
- Immunizations, including tuberculosis
- Other non-emergency primary care services

Hospital Emergency Department Claims

Hospital emergency department claims are paid in accordance to the rate schedule included in the contract agreement between RightCare and the hospital. For out-of-network Providers, hospital emergency department claims are paid in accordance with state guidelines.

Emergency Room Visit after Hours

If a member presents for care at an Emergency Room after normal business hours and identifies himself or herself as a member, services will not be denied, but the Emergency Room staff should notify the member's Primary Care Provider.

Emergency Room Reimbursement Reduction for Non-Emergency Visits

RightCare may reduce the reimbursement for Emergency Room E/M services billed at the 99281, 99282, or 99283 level. This reduction will be applied to both the provider (professional) and facility reimbursement. RightCare will continue to pay for the EMTALA-mandated medical screening exam without imposing a reduction in payment. Per EMTALA, the initial medical screening examination is to be performed by a qualified medical person. If the screening exam determines that the patient has a non-emergent condition, the hospital does not have to provide treatment, and can refer the patient to a more appropriate outpatient clinical setting.

Emergency Admission

Admissions for observation or inpatient services for post-stabilization care are subject to prior authorization and notification requirements. RightCare Medical Management must be notified within 1 business day of the admission. To notify, please call **1-855-691-SWHP** (**7947**) or fax to **1-512-383-8703**.

Post-stabilization care provided to maintain, improve or resolve the member's stabilized condition is covered for the period of time it takes RightCare Medical Management to make a determination -- including times RightCare cannot be contacted, does not respond to a request for approval, or a Medical Director is not available for consultation when medical necessity is questioned by the Medical Management staff.

Admissions for observation or inpatient services for post-stabilization care at non-participating providers are subject to the same prior authorization and notification requirements. RightCare Medical Management must be notified of the admission and provide prior authorization for the admission. To notify RightCare Medical Management, please call **1-855-691-SWHP** (**7947**) or fax to **1-512-383-8703**.

Emergency Prescription Supply

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

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

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

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

"8" in "Prior Authorization Type Code" (Field 461-EU).
"8Ø1" in "Prior Authorization Number Submitted" (Field 462-EV).
"3" in "Days Supply" (Field 4Ø5-D5, in the Claim segment of the billing transaction).

Call Navitus at 1-877-908-6023 or RightCare at 1-877-908-6023 for more information about the 72-hour emergency prescription supply policy.

Urgent/Emergent Hospital-to-Hospital Transportation

Emergency ground transportation does not require prior authorization. All Air Transportation requires prior authorization. Emergency Air Transportation Providers must notify RightCare within 1 business day of providing Emergency Air Transportation (hospital to hospital) if prior authorization was not obtained. To notify RightCare Medical Management, please call **1-855-691-SWHP** (**7947**) or fax to **1-512-383-8703**.

Emergency Ambulance Services

When the member's condition is life-threatening, and trained attendants must use special equipment, life support systems, or close monitoring while in route to the nearest appropriate facility, ambulance transport is deemed an emergency service. Emergency ground transportation does not require prior authorization.

Emergency Air Services

All Air Transportation requires prior authorization. Emergency Air Transportation Providers must notify RightCare within 1 business day of providing Emergency Air Transportation (hospital to hospital) if prior authorization was not obtained.

Non-Emergency Transportation

Non Emergency 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 from a hospital when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation. If a RightCare Member's medical condition is such that the use of an ambulance is the only appropriate means of transport, the ambulance transport is a non-emergency service. All non-emergency transports (air and ground) for RightCare Members require prior authorization.

This includes:

- All facility to facility transports
- All out of state (air and ground) transports

According to Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health- care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency. 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.

A request for a 1 day transport may be submitted on the next business day following the transport in some circumstances. However, every attempt should be made to obtain a prior authorization before the transport takes place. Authorization requests for one-day transports submitted beyond the next business day will be denied.

For non-emergency transportation services rendered to a member, ambulance providers may coordinate the prior-authorization (PA) request between the Medicaid-enrolled physician, health-care provider, or other responsible party and RightCare. Ambulance providers may assist in collecting necessary information, but the prior-authorization request must be signed and submitted by the Medicaid-enrolled physician, health-care provider, or other responsible party to RightCare.

Prior authorization may be obtained by:

- Calling the Medical Management department at **1-855-691-SWHP** (**7947**).
- Faxing a request for prior authorization, using the form available on our website.
- Faxing clinical information establishing medical necessity to **1-512-383-8703**.

If applicable, Medical Management team will complete the Non-Emergency Medical Transportation (NEMT) form with assistance from the Provider. Medical Management will submit completed form to the State for review and approval. See Section 4.4.13 for more information on NEMT services.

Non Emergency Medical Transportation (NEMT)

What are NEMT services?

NEMT services provide transportation to covered health care services for Medicaid Members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips. RightCare partners with Access2Care to provide these services for our members.

What services are part of NEMT?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered healthcare service. The ITP can be the Member, the Member's family member, friend, or neighbor.
- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a Member needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the Member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children

15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered healthcare service is confidential in nature.

If you have a Member that you think would benefit from receiving NEMT services, please refer him or her to RightCare at 877-447-3101 for more information.

Providers for NEMT benefits can refer to Access2Care Provider Handbook

RightCare follows TMHP billing standards for STAR. If special billing requirements are necessary for NEMT Services, RightCare Health Plans through our NEMT partner, Access2Care, will inform the Provider.

Emergency Dental Services

Medicaid Emergency Dental Services:

RightCare is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts; and
- treatment of oral abscess of tooth or gum origin.

Non-Emergency Dental Services

Medicaid Non-emergency Dental Services:

RightCare is not responsible for paying for routine dental services provided to Medicaid Members. These services are paid through Dental Managed Care Organizations.

RightCare is responsible for paying for treatment and devices for craniofacial anomalies and of Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for Members aged 6 through 35 months.

An OEFV visit is billed utilizing CPT code 99429 with U5 modifier. The service must be billed with one of the following medical checkup codes: 99381, 99382, 99391, or 99392. The Provider must document all components of the OEFV on the appropriate documentation form and maintain record of the referral to a dental home.

Federally Qualified Health Centers and Rural Health Centers do not receive additional reimbursement for these services.

When providing OEFV benefits, please use the following guidelines and documentation criteria:

- OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.
- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.

- Texas Health Steps providers must assist Members with establishing a Main Dental Home and document Member's Main Dental Home choice in the Members' file.

Durable Medical Equipment & Other Products Normally Found in a Pharmacy

RightCare reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bedpans, and other supplies and equipment. For children (birth through age 20), RightCare also reimburses for items typically covered under the Texas Health Steps Program, such as prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must be enrolled as a RightCare provider, or have obtained prior authorizations necessary for out of network services and follow claims submission guidelines.

Call RightCare at **1-855-897-4448** for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

All providers must obtain prior authorization for DME and medical supplies where the total amount for an item or one-month supply is more than $300. RightCare reserves the option to purchase current durable medical equipment being rented from a provider.

The following procedures apply to DME prior authorizations:

- Participating Provider submits request for services on Prior Authorizations list.
- Primary Care Provider may request a Prior Authorization via fax using the Texas Referral/Authorization form and the Title XIX form.
- Durable Medical Equipment Requests must be submitted on the Title XIX form located on our website at http://rightcare.swhp.org/en-us/prov/forms-tools .
- The provider must submit written documentation of medical necessity to include an estimate of the length of time the equipment will be needed.
- Medical Management receives information, reviews member and provider eligibility, benefits and determines medical necessity.
- Once Medical Management has determined medical necessity, the physician is notified in writing of Medical Management's final decision regarding use of the equipment, and its rental or purchase.

- Rendering provider sends information to the Primary Care Provider post visit.

Mail-order DME providers please note that the date of service billed on a claim should reflect the date the member receives the delivered supplies.

For example:

- 30-day supply approved 1/15
- 30-day supply shipped to the member 1/20
- 30-day supply received by the member 1/22

The claim should indicate a 30-day supply from 1/22 through 2/22. If another claim for the same member and supply before the 30 days expire, the claim will be denied because the system reflects that the member has not exhausted their current supply. RightCare has implemented a +/- 3 day window for the flexibility in delivering supplies to the member. For instance, in the example provided above, a date of service of 1/19- 1/25 would be acceptable for payment consideration, as long as only one-month's supply is billed every 30 days.

ELECTRONIC VISIT VERIFICATION (EVV)

GENERAL INFORMATION ABOUT EVV

1. What is EVV?

EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV System documents the following:

- Type of service provided (Service Authorization Data);
- Name of the Member to whom the service is provided (Member Data);
- Date and times the visit began and ended;
- Service delivery location;
- Name of the Service Provider or CDS Employee who provided the service (Service Provider Data); and
- Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.

2. Is there a law that requires the use of EVV?

Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. § 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Section

531.024172, requires HHSC to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To comply with these statutes, HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. HHSC plans to require the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2023.

3. Which services must a Service Provider or CDS Employee electronically document and verify using EVV?

The EVV required services that must be electronically documented and verified through EVV are listed on the HHSC EVV website. Refer to the Programs, Services and Service Delivery Options Required to Use Electronic Visit Verification.

Check the EVV Service Bill Codes Table on the HHSC EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services.

https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification-evv

4. Who must use EVV?

The following must use EVV:

- Provider: An entity that contracts with an MCO to provide an EVV service.
- Service Provider: A person who provides an EVV required service and who is employed or contracted by a Provider or a CDS Employer.
- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
- Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employer as described in Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, § 41.103(25), Consumer Directed Services Option.
- CDS Employer: A Member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a service provider who delivers a service.

EVV SYSTEMS

5. Do Providers and FMSAs have a choice of EVV Systems?

Yes. A Provider or FMSA must select one of the following two EVV Systems:

- EVV vendor system. An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV

proprietary system.

https://www.tmhp.com/topics/evv/evv-vendors

- EVV proprietary system. An EVV proprietary system is an HHSC-approved EVV System that a Provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
    - Is purchased or developed by a Provider or an FMSA.
    - Is used to exchange EVV information with HHSC or an MCO; and
    - Complies with the requirements of Texas Government Code Section 531.024172 or its successors.

https://www.tmhp.com/topics/evv/evv-proprietary-systems

6. Does a CDS Employer have a choice of EVV Systems?

No. A CDS Employer must use the EVV System selected by the CDS Employer's FMSA.

7. What is the process for a Provider or FMSA to select an EVV System?

- To select an EVV vendor from the state vendor pool, a Provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV vendor's website.

https://www.tmhp.com/topics/evv/evv-vendors

- To use an EVV proprietary system, a Provider or FMSA, signature authority, and the agency's appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV PSO Onboarding process and HHSC EVV Proprietary System approval process.

https://www.tmhp.com/topics/evv/evv-proprietary-systems

8. What requirements must a Provider or FMSA meet before using the selected EVV System?

Before using a selected EVV System:

- The Provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor. https://www.tmhp.com/topics/evv/evv-vendors
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
    - An EVV Proprietary System Request Form
    - EVV PSO Detailed Questionnaire (DQ)
    - TMHP Interface Access Request
- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV proprietary system to comply with HHSC EVV requirements.

- If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
    - Complete all required EVV training as described in the answer to Question #18; and
    - Complete the EVV System onboarding activities:
        - Manually enter or electronically import identification data;
        - Enter or verify Member service authorizations;
        - Setup member schedules (if required); and
        - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

9. Does a Provider or FMSA pay to use the selected EVV System?

- If a Provider or FMSA selects an EVV vendor system, the Provider or FMSA uses the system free of charge.
- If a Provider or FMSA elects to use an EVV proprietary system, the Provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

10. Can a Provider or FMSA change EVV Systems?

Yes. A Provider or FMSA may:

- Transfer from an EVV vendor to another EVV vendor within the state vendor pool;
- Transfer from an EVV vendor to an EVV Proprietary System;
- Transfer from an EVV Proprietary System to an EVV vendor; or
- Transfer from one EVV Proprietary system to another EVV Proprietary system.

11. What is the process to change from one EVV System to another EVV System?

To change EVV Systems, a Provider or FMSA must request a transfer as follows:

- To request a transfer to an EVV vendor, a Provider or FMSA must submit an EVV Provider Onboarding Form to the new EVV vendor.
- To request a transfer to an EVV proprietary system, a Provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A Provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 Days before the desired effective date of the transfer.
- If a Provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the Provider or FMSA and the newly selected EVV vendor agree on an earlier date.
- If a Provider or FMSA is transferring to an EVV proprietary system, the Provider or FMSA, TMHP, and

HHSC will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.

- An FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
- A Provider or FMSA must complete all required EVV System training before using the new EVV System.
- A Provider or FMSA who transfers to a new EVV vendor or proprietary system:
    - Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement; and
    - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.
- After a Provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

12. Are the EVV Systems accessible for people with disabilities?

The EVV vendors provide accessible systems, but if a CDS Employer, service provider or CDS Employee needs an accommodation to use the EVV System, the vendor will determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.

If the Provider or FMSA is using a proprietary system, the Service Provider, CDS Employer or CDS Employee must contact the Provider or FMSA to determine accessibility features of the system and if an accommodation can be provided.

EVV SERVICE AUTHORIZATIONS

13. What responsibilities do Providers and FMSAs have regarding service authorizations issued by an MCO for an EVV required service?

A Provider and FMSA must do the following regarding service authorizations issued by an MCO for an EVV-required service:

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:
    - Name of the MCO;
    - Name of the Provider or FMSA;

- Provider or FMSA Tax Identification Number;
- National Provider Identifier (NPI) or Atypical Provider Identifier (API);
- Member Medicaid ID;
- Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s);
- Authorization start date; and
- Authorization end date.

- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System; and
- Manually enter service authorization changes and updates into the EVV System as necessary.

EVV CLOCK IN AND CLOCK OUT METHODS

14. What are the approved methods a Service Provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?

A Service Provider or CDS Employee must use one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to end service delivery when providing services to a member in the home or in the community. A Service Provider or CDS Employee may use one method to clock in and a different method to clock out.

(1) Mobile method

- A Service Provider must use one of the following mobile devices to clock in and clock out:
  - the Service Provider's personal smart phone or tablet; or
  - a smart phone or tablet issued by the Provider.
- A Service Provider must not use a Member's smart phone or tablet to clock in and clock out.
- A CDS Employee must use one of the following mobile devices to clock in and clock out:
  - the CDS Employee's personal smart phone or tablet;
  - A smart phone or tablet issued by the FMSA; or
  - the CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.
- To use a mobile method, a Service Provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the Service Provider or CDS

Employee has downloaded to the smart phone or tablet.

- The mobile method is the only method that a Service Provider or CDS Employee may use to clock in and clock out when providing services in the community.

(2) Home phone landline

- A Service Provider or CDS Employee may use the Member's home phone landline, if the Member agrees, to clock in and clock out of the EVV System.
- To use a home phone landline, a Service Provider or CDS Employee must call a toll-free number provided by the EVV vendor or the PSO to clock in and clock out.
- If a Member does not agree to a Service Provider's or CDS Employee's use of the home phone landline or if the Member's home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another approved clock in and clock out method.
- The Provider or FMSA must enter the Member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.

(3) Alternative device

- A Service Provider or CDS Employee may use an HHSC-approved alternative device to clock in and clock out when providing services in the Member's home.
- An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
    - An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
    - The alternative device codes are active for only seven days after the date of service and must be entered into the EVV system before the code expires.
        - The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit.
        - An alternative device must always remain in the Member's home even during an evacuation.

15. What actions must the Provider or FMSA take if a Service Provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?

- If a Service Provider does not clock in or clock out of the EVV System or an approved clock in or clock out method is not available, then the Provider must manually enter the visit in the EVV System.

- If a Service Provider makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the Provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to manually enter the clock-in and clock-out information and other service delivery information, if applicable.
- If a CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to correct the inaccurate service delivery information in the EVV System.
- After the Visit Maintenance time frame has expired, the EVV System locks the EVV visit transaction and the program provider, FMSA or CDS Employer may only complete Visit Maintenance if the MCO approves a Visit Maintenance Unlock Request.
- The EVV Policy Handbook requires the Provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

EVV VISIT MAINTENANCE

16. Is there a timeframe in which Providers, FMSAs, and CDS Employers must perform Visit Maintenance?

In general, a Provider, FMSA, or CDS Employer must complete any required Visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in HHSC EVV Policy Handbook.

Note: the standard Visit Maintenance timeframe as set in EVV Policy Handbook may be changed by HHSC to accommodate Providers impacted by circumstances outside of their control.

17. Are Providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance?

Yes. Program providers, FMSAs or CDS Employers must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing Visit Maintenance in the EVV System.

- Reason Code Number(s) describe the purpose for completing Visit Maintenance on an EVV visit transaction.
- Reason Code Description(s) describe the specific reason Visit Maintenance is necessary.
- Free text is additional information the program provider, FMSA or CDS Employer enters to further describe

the need for Visit Maintenance.

https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification-evv

EVV TRAINING

18. What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training:
  - EVV System training provided by the EVV vendor or EVV PSO;
  - EVV Portal training provided by TMHP; and
  - EVV Policy training provided by HHSC or the MCO.
- CDS Employers must complete training based on delegation of Visit Maintenance on Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities:
  - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked In the EVV System;
    - EVV System training provided by the EVV vendor or EVV PSO;
    - Clock in and clock out methods; and
    - EVV Policy training provided by HHSC, the MCO or FMSA.
  - Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
    - EVV System training provided by EVV vendor or EVV PSO; and
    - EVV Policy training provided by HHSC, the MCO or FMSA.
  - Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
    - Overview of EVV Systems training provided by EVV Vendor or EVV PSO; and
    - EVV policy training provided by HHSC, the MCO or FMSA.

- Providers and CDS Employers must train Service Providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.

https://rightcare.swhp.org/Electronic-Visit-Verification

COMPLIANCE REVIEWS

19. What are EVV Compliance Reviews?

- EVV Compliance Reviews are reviews conducted by the MCO to ensure Providers, FMSAs, and CDS

Employers are in compliance with EVV requirements and policies.

- The MCO will conduct the following reviews and initiate contract or enforcement actions if Providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:
  - EVV Usage Review - meet the minimum EVV Usage Score;
  - EVV Required Free Text Review – document EVV required free text; and
  - EVV Landline Phone Verification Review - ensure valid phone type is used.

EVV CLAIMS

20. Are Providers and FMSAs required to use an EVV System to receive payment for EVV required services?

Yes. All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim by the MCO. The MCO may deny or recoup an EVV claim that does not match an accepted visit transaction.

21. Where does a Provider or FMSA submit an EVV claim?

Providers and FMSAs must submit all EVV claims to the HHSC Claims Administrator in accordance with the MCO's submission requirements.

https://rightcare.swhp.org/en-us/prov/forms-tools

22. What happens if a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator?

If a Provider or FMSA submits an EVV claim to the MCO instead of the HHSC Claims Administrator, the MCO will reject or deny the claim and require the Provider or FMSA to submit the claim to the HHSC Claims Administrator.

23. What happens after the HHSC Claims Administrator receives an EVV claim from a Provider or FMSA?

The HHSC Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHSC Claims Administrator for further claims processing. After completing the EVV claims matching process, the HHSC Claims Administrator forwards the claim to the MCO for final processing.

24. How does the automated EVV claims matching process work?

The claims matching process includes:

- Receiving an EVV claim line item.
- Matching data elements from each EVV claim line item to data elements from one or more accepted EVV transactions in the EVV Aggregator.
- Forwarding an EVV claim match result code to the MCO once the claims matching process is complete.

The following data elements from the claim line item and EVV transaction must match:

- Medicaid ID;
- Date of service;
- National Provider Identifier (NPI) or Atypical Provider Identifier (API);
- Healthcare Common Procedure Coding System (HCPCS) code;
- HCPCS modifiers; and
- Billed units to units on the visit transaction, if applicable.

Note: No unit match is performed on CDS EVV claims and unit match is not performed on visit transactions against the billed units on the claim line item for specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the units matching process.

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match codes viewable in the EVV Portal are:

- EVV01 – EVV Successful Match
- EVV02 – Medicaid ID Mismatch
- EVV03 – Visit Date Mismatch
- EVV04 – Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 – Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 – Units Mismatch
- EVV07 – Match Not Required
- EVV08 – Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. The MCO will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHSC implements a bypass of the claims matching process for disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- The MCO will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- The MCO may still deny an EVV claim if other claim requirements fail the claims adjudication process.
- If allowed by HHSC, the MCO may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

25. How can a Provider and FMSA see the results of the EVV claims matching process?

Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and the MCO system. The MCO's Provider Portal also provides additional claims status information, such as whether the MCO has paid or denied the claim. In addition, the MCO provides an Explanation of Payment (EOP) to Providers and FMSAs to inform them of whether the MCO paid or denied the claim, and if denied, the reason for denial. https://tmhp.exceedlms.com/student/collection/521629-evv-training

26. Could an MCO deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?

Yes. An MCO may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a Member's loss of program eligibility or the Provider's or FMSA's failure to obtain prior authorization for a service.

CHAPTER 14. CREDENTIALING AND RE-CREDENTIALING

Scott and White Health Plan is responsible for contracting directly with physicians and providers for the RightCare network. In determining whether to initially contract, or continue an existing contract, with a particular physician or provider, SWHP has developed a set of criteria to assist in guiding its decision. Such criteria is for guidance only, and the fact that a particular physician or provider meets all or some of the criteria will not necessarily result in SWHP seeking an offer to contract from that physician or provider. Below are some of the criteria SWHP uses to consider a practitioner or organizational provider for affiliation.

Criteria

Category I. Eligibility for Participation

- Professional: credentials in accordance with regulatory requirements and SWHP policy and procedure.
    - Valid Texas State License.
    - Appropriately credentialed and actively admitting at a relevant facility affiliated with the SWHP or if you do not have privileges at a SWHP network hospital, our expectations are that you will have prior established relationships with physicians who are on the active medical staff who can admit the member. Referring to the "physician on city call" would not be acceptable.
- Malpractice limits of at least $1,000,000/$3,000,000 or the minimum requirements of the SWHP affiliated hospital where privileged. Higher levels of coverage may be required as determined necessary by SWHP.

Category II. Quality of Services/Care

- Facility management: If a reasonable member complaint is received, an office site visit will be conducted to review physical accessibility, physical appearance, adequacy of waiting/examining room space, availability of appointments, and adequacy of treatment record keeping. A score of at least 90% must be achieved from the site review.
- HEDIS/Utilization/Member Complaint measures: Quality of service and utilization levels will be evaluated to ensure that SWHP’s high standards of quality are being met, and that the level of utilization is appropriate.
- Quality Reviews: Providers will cooperate with data collection for quality initiatives.
- Physicians who do procedures that require consent forms have adopted and implemented the Joint Commission standards for wrong site/wrong procedure and the "Time Out" policy.

Category III. Member Needs in Accordance with Contractual Benefits

- Appointments accessible in accordance with medical accessibility standards, i.e. urgent care within 24-48 hours, emergency care same day, primary care within 5 days, and preventative care within 6 weeks.
- Geographic location.
- Distance from other practice sites with same type of provider.
- Hours of operation, after-hours coverage, and emergency call provisions.
- Areas of RightCare membership growth trends.
- Comprehensiveness, nature, and scope of service.
- Unique expertise not found among other providers/physicians.

Category IV. Personal Attributes

- Good communication skills, language enhancements.
- Experience – in field of practice, in geographic area, and with Scott and White.
- Stability, commitment to professionalism.
- Professional appearance, attire.
- Commitment to patient safety protocols and initiatives.

Category V. Organizational Fit

- Professional reputation.
- Practice and referral patterns.
- Commitment to patient care.
- Cost appropriate for service provided in conjunction with member need.
- Commitment to community.
- Efficient, solvent, and properly managed business practice patterns.
- Demonstrates attitude of cooperation and willingness to work within the Scott and White system.
- Will submit to billing audits.
- Accurate and appropriate billing practices.

Category VI. Other

- Any other factor, which might either enhance or dilute the ability to provide comprehensive, personalized, high quality health care in a cost effective manner will be taken into consideration.

Credentialing & Re-credentialing

Physician/Physician Group

Scott and White Health Plan (SWHP) implements a rigorous credentialing and re-credentialing process to evaluate and select the practitioners who assume responsibility for managing the healthcare of its members, consistent with state and federal requirements and guidelines specified by the National Committee for Quality Assurance (NCQA).

Each practitioner is credentialed separately. As required the Texas Department of Insurance (TDI), SWHP uses the Texas Standardized Credentialing Application for credentialing and re-credentialing of all practitioners. Re-credentialing is required at least every 3 years.

Professional Practitioners

The scope of Providers to be credentialed and re-credentialed includes but is not limited to licensed physicians, podiatrists, psychiatrists, psychologists, mental health professionals, optometrists, master social workers, audiologists and professional counselors (licensed professional counselors, licensed clinical social workers, licensed chemical dependency counselors, licensed marriage and family therapists). Medicaid physician assistants and nurse practitioners who will be practicing as Primary Care Providers will be credentialed.

Practitioners and providers that are not required to be credentialed or re-credentialed include:

- Health care professionals who are permitted to provide services only under the direct supervision of another practitioner
- Hospital-based health care professionals who provide services to members only incident to hospital services, unless those health care professionals are separately identified in Provider directories available to members
- Students, Residents, and Fellows

Availity/Aperture Credentialing

Aperture Credentialing, LLC is SWHP's Credentialing Verification Organization (CVO) and will perform primary source verification functions on behalf of SWHP through the Texas Association of Health Plans and the joint standard credentialing initiative with HHSC for credentialing and re-credentialing. After contracting is initiated, SWHP will notify Aperture to begin the credentialing process with the practitioner or institutional Provider. Aperture will then contact the Provider for a completed application with current attestations and willperform primary source verifications. SWHP utilizes the Availity web based solution to capture provider data. Aperture will then pull the information from Availity to perform primary source verifications.

Once the verifications have been completed, the Providers' completed application packet and primary source verification documentation are released back to SWHP to complete the credentialing process. SWHP will incorporate the information into our systems and submit it to the Credentialing Committee for final consideration and approval before acceptance into the network.

Providers that do not meet the minimum acceptable standards are denied participation in our Network. If we decline to include individual or groups of providers in our Network, we inform the affected providers by written notice. The written correspondence will document the reason(s) as to why the Provider did not meet our credentialing requirements.

Hospital Privileges

Providers must have hospital privileges at a SWHP contracted facility. If the provider does not have privileges, a letter must be signed by the practitioner stating that he/she will send SWHP members to a contracted facility, and is aware this may mean transferring the care to another provider who is contracted with SWHP. If the provider is a specialist, a letter of agreement must be provided from the physician/group who will admit the member to a SWHP facility when needed.

Full Residency Requirement

Physicians who graduated from medical school after 1970 must have completed a full internship and residency. An exception would be DO physicians who graduated from medical school prior to 1985. They must have completed a one year internship and be board certified by the American Osteopathic Association (AOA). DO physicians who graduated from medical school after 1985 must have completed a full internship and residency.

Board Certification

Scott and White Health Plan (SWHP) requires physicians to have current American Board of Medical Specialties (ABMS) board certification or American Osteopathic Association (AOA) certification (or be in the active process of obtaining such) in the specialty physicians are practicing in.

If a physician is NOT board certified or let them certification lapse, SWHP requires that each year the physician obtain at least 50 AMA Physician Recognition Award (PRA) or equivalent CME credits, of which 25 are Category I. Twenty five of those 50 credits (either Category I, II or combination) must be in the field in which the physician is practicing medicine. Failure to complete the 50 CME credits per year will result in failure to be an eligible practitioner within SWHP's network.

Medicaid Providers

To be reimbursed for services rendered to Medicaid managed care members, providers must be enrolled in Texas Medicaid. Providers are not considered participating with Medicaid for SWHP until they have enrolled in Texas Medicaid and have provided SWHP with their TPI number.

Institutional Providers

SWHP confirms before contracting and then every three years thereafter that the institutional providers meet NCQA, TDI, CMS, HHSC and SWHP standards. Institutional providers credentialed by SWHP include, but not limited to hospitals, skilled nursing facilities, home health agencies, rehabilitation facilities, dialysis centers, free-standing surgical centers, diagnostic imaging centers, cancer centers, inpatient behavioral health facilities, residential behavioral health facilities, ambulatory behavioral health facilities, rural health clinics, and federal qualified health centers.

Prior to contracting with an institutional provider, SWHP requires the following:

- A copy of state licensure, if one is required by the State of Texas
- Documentation of an appropriate Medicare certification as required by state or federal regulations. A copy of the Medicare certificate or provision of the Medicare number will be acceptable proof of participation certification. New facilities awaiting a Medicare number can be considered for participation if they have received accreditation.
- Provide a current copy of their malpractice liability coverage face sheet showing expiration and coverage amounts.
- Evidence of applicable state or federal requirements, e.g. Bureau of Radiation Control certification for diagnostic imaging centers, Texas Mental Health and Mental Retardation certification for community mental health centers and CLIA (Clinical Laboratory Improvement Amendments of 1998) certification for laboratories.
- The most recent accreditation certificate, if applicable to the institution. SWHP accepts certifications from recognized accrediting bodies that assure an independent measure of the quality of services.

If the institution is not accredited, SWHP requests a copy of the most recent state or Medicare site survey results. If a national accrediting body does not accredit the institution and if the institution has not had a recent State or Medicare site visit within the past 3 years, SWHP will delay credentialing of the institution pending Medicare site visit or SWHP will conduct an on-site evaluation. SWHP reviews state or Medicare site surveys for the deficiencies found by the accrediting body or Medicare.

SWHP utilizes the Availity web based solutions to collect the credentialing application developed in conjunction with the Texas Association of Health Plans. Aperture Credentialing then pulls the information from Availity and verifies the information prior to sending to SWHP for Credentialing Committee approval/ denial.

SWHP re-credentials institutional providers at least once every 3 years utilizing the same process as initial credentialing.

Expedited Credentialing

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

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

- Be a member of a provider group already contracted with SWHP
- If Medicaid, have a TPI#
- Agree to comply with the terms of the existing provider group contract
- Submit all documentation and other information required by us to begin the credentialing process

Mid-level Providers

Mid-level providers must have a supervising physician in a similar specialty, who is a participating provider in the SWHP network.

Credentialing Decisions

All credentialing decisions are made by the Credentialing Committee and all proceedings are confidential and privileged. Information obtained or documentation created by SWHP credentialing staff for credentialing and re-credentialing is treated in a confidential manner. Providers or groups are not denied participation with SWHP or have any such contract terminated on the basis of sex, race, creed, color, national origin, age, or disability. The selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions.

Providers are notified within 60 calendar days of their status in the network according to the determination made by the committee. If initial provider participation is denied, the provider is notified in writing of the reason for the denial. If an existing providers participation is altered based on quality of care or service the provider is notified in writing of the reason for the denial and is given an opportunity to appeal the decision of the Credentialing Committee through a review panel.

Rights of Applicants to the Scott and White Health Plan

- Right to Inquire About Credentialing Status
- Each applicant to the Scott and White Health Plan retains the right to at any time inquire about their credentialing status. The practitioner at any time may contact the Provider Relations Department to obtain the current status.
- Right to Review
- Practitioners will have the right to review the information submitted in support of their credentialing applications. However, SWHP respects the right of the Peer Review aspects that are integral in the credentialing process. Therefore, practitioners will not be allowed to review references or recommendations or any other information that is peer review protected. In the event that through the review process, a practitioner discovers an error in the credentialing file, the practitioner does have the right to request a correction of the information in question.
- Right to Notification
- Practitioners will be notified of any information obtained during the credentialing process that varies substantially from the information provided by the practitioner.
- Right to Correct Erroneous Information
- Practitioners will have the right to correct erroneous information. The practitioner will be afforded 15 working days to provide corrected information in a written format to the QI Coordinator and/or Credentialing Delegate.
- A provider has the right to inquire about the status of an application by the following methods:
    - Phone: **254-298-3064**
    - Email: SWHPPROVIDERRELATIONSDEPARTMENT@BSWHealth.org

On-Going Monitoring

SWHP monitors network providers to encourage the provision of safe, quality care to SWHP members between provider credentialing cycles. On a monthly basis, SWHP reviews the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE), the Office of Personnel Management (OPM), SAM, the state licensing board of each provider, as well as member and provider complaints, and adverse events.

Changes in Address or Practice Status

Providers are required to notify us of a change in address or practice status within 10 days of the effective date of the change. Practice status is defined as a change in office hours, panel status, etc. The inclusion of a new address on a re-credentialing application is NOT an acceptable form of notification. A notice of termination must adhere to the advance notice timelines stated in the provider's agreement. Please submit changes to via the SWHP.org website under the Manage Provider Account section.

Complaints

A complaint is defined as an expression of dissatisfaction, expressed by a complainant, orally or in writing to RightCare, about any matter related to RightCare other than an Action. As provided by 42 C.F.R. §438.400, possible subjects for complaints include, but are not limited to the quality of care of services provided, and aspects of the interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights. These complaints do not include claim reconsiderations. A Complainant is defined as a member or a treating provider or other individual designated to act on behalf of the Member who filed the complaint.

A complaint does not include an in-network provider's or member's verbal or written dissatisfaction or disagreement with an "Adverse Determination." A complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of an adverse determination.

Filing Complaints to RightCare

If a member or provider is dissatisfied with RightCare's policies, procedures, coverage or benefit decisions or with any aspect of the member's treatment by physicians, hospitals or other providers, he or she have the legal right to file a complaint to RightCare and/or the Health and Human Services Commission (HHSC). RightCare recommends that all complaints received from providers be submitted within 60 days of the specific event on which the complaint is based in writing to:

RightCare from Scott and White Health Plan
Attn: Appeals and Grievance Department
1206 West Campus Drive
Temple, TX 76502

Or by email to: hpappealsandgrievances@bswhealth.org or fax to **254-298-3086**. Note: Any complaints received at the wrong address will be returned to the sender.

RightCare will send written acknowledgement within 5 business days of the receipt of the complaint to the complainant. This acknowledgement letter will indicate a description of the complaint process and the 30 calendar day time frame for resolution of the complaint.

Once the complaint has been resolved, RightCare will send a response letter to the provider with the resolution of the complaint.

Coverage Determinations & Appeals

A physician or other professional provider may appeal a decision regarding payment for any service NOT related to non-medical necessity determinations. For these appeals, the physician or other professional provider should follow the Claims Appeal Process procedures set forth in the *Claims* chapter.

Provider Complaint Process to HHSC

A provider who believes that they did not receive full due process from RightCare may file a complaint with HHSC. Providers must exhaust the complaint process with RightCare before filing a complaint with HHSC. Complaints can be submitted orally or in writing and received by HHSC at the following address:

Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320
PO Box 85200
Austin, TX 78708

Or by e-mail to: HPM_Complaints@hhsc.state.tx.us

The network provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiries and to conduct investigations into provider and member complaints.

Provider Appeal Process to HHSC

Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

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

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

Mail appeal requests to:

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

A member or a member's designee can file a complaint with RightCare either in writing to:

RightCare from Scott and White Health Plan

Attn: Appeals and Grievance Department

1206 West Campus Drive

Temple, Texas 76502

Or by calling **1-855-TX-RIGHT** (**1-855-897-4448**)

Note: Any complaints or appeals received at the wrong address will be returned to the sender.

A member may call **1-855-897-4448 /TTY 711** to request a Member Advocate to assist with understanding and using the complaint and appeals process or for help filing a complaint.

RightCare will send a letter within 5 business days of receipt of a oral or written complaint to the member or member's designee, the Member Advocate. This acknowledgement letter will indicate a description of the complaint process and the 30-calendar day time frame for resolution of the complaint.

If a member is not satisfied with the outcome of the complaint, they may file a complaint to the Health and Human Services Commission (HHSC).

Once the RightCare's complaint process is completed, the member or a member's designee, can file a complaint with by writing to:

Texas Health and Human Services Commission

Health Plan Operations - H-320

ATTN: Resolution Services

P.O. Box 85200

Austin, TX 78708-5200

Or by calling toll-free **1-866-566-8989** and email to: HPM_Complaints@hhsc.state.tx.us.

Member Coverage Determination and Appeals

What can I do if the MCO denies or limits my Member's request for a Covered Service?

There may be times when RightCare's Medical Director denies or limits services or medicines. When this occurs, a member may appeal this decision. Call Member Services at **1-855-897-4448** to find out more.

How will a member find out if services are denied?

RightCare will send the member a letter telling you that the services were denied or limited.

In the event that the complaint is not resolved to the satisfaction of the member or member's designee, he/she may request an appeal. An appeal may also be filed for denial of payment for services in whole or part. RightCare will send the Member a letter explaining that services were limited or denied. A member or person authorized to act on behalf of the member, may appeal an action or adverse determination orally or in writing.

A member or a member's designee can file an appeal with RightCare in writing to:

RightCare from Scott and White Health Plan
Attn: Appeals and Grievance Department
1206 West Campus Drive
Temple, Texas 76502

Or by calling **1-855-TX-RIGH**T (**1-855-897-4448**)

Note: Any complaints or appeals received at the wrong address will be returned to the sender.

Every oral appeal received must be confirmed by a written, signed appeal by the Member or his or her representative, unless an emergent appeal is requested.

Can someone from RightCare help me file an Appeal?

A member may call **1-855-897-4448** to request a Member Advocate to assist with understanding and using the complaint and appeals process or for help filing an appeal.

In order to ensure continuity of current authorized services, the Member must file the appeal on or before the later of: 10 days following RightCare's mailing of the notice of the action, or the intended effective date of the proposed action.

The Member may be required to pay for the cost of services furnished while the appeal is pending if the final decision is adverse to the member.

All appeals must be received within 60 days from the date the notice of an action or adverse determination is made. The timeframe in which the appeal is resolved will be based on the medical immediacy of the condition, procedure, or treatment under review, but will not exceed 30 calendar days unless an extension is requested by the member or the member is notified of the reason an extension would be in the member's best interest.

Within 5 business days from receipt of the written or verbal appeal, RightCare will send an acknowledgement letter to the member.

The member will have 14 calendar days for a standard appeal to provide additional information. If the member requests an extension, the timeframe may be extended up to an additional 14 calendar days. If RightCare requests additional information that requires an extension of the established timeframes, the member must be provided with written notice of the delay and the reason the delay is in the member's best interest.

A Member can request a State Fair Hearing after RightCare's Appeal Process has been completed.

Member Emergency Appeal Process to RightCare

The member or member's designee may ask for an emergency appeal if he or she believes that taking the time for the standard appeal process could seriously jeopardize the life or health of the member. Requests for an emergency appeal can be made verbally or in writing; however, the member should submit the emergency appeal request verbally to RightCare Member Services at **1-855-897-4448** for the quickest resolution.

Who can help me file an Expedited Appeal?

A member may call **1-855-897-4448** to request a Member Advocate to assist with understanding and using the expedited appeal process.

Emergency appeals for ongoing emergencies or denial of continued hospitalizations must occur in accordance with the medical or dental immediacy of the case and not later than 1 business day after the member or member's designee request for the appeal is received. RightCare will follow up in writing within 3 business days on a decision for an emergency appeal.

What happens if the MCO denies the request for an emergency Appeal?

If the member or member's designee requests an expedited appeal for a denial that does not involve an emergency, an ongoing hospitalization or services that are already being provided, they will be notified that the appeal review cannot be expedited right away. The appeal will be reviewed, and the response will be made within 30 calendar days.

STATE FAIR HEARING INFORMATION

Can a Member ask for a State Fair Hearing?

If a Member, of the health plan, disagrees with the health plan's decision, a Member has the right to ask for a State Fair Hearing. The Member may name someone to represent him or her by contacting the health plan and giving the name of the person the Member wants to represent him or her. A provider may be the Member's representative if the provider is named as the Member's authorized representative. The Member or the Member's representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged.. If the Member does not ask for the State Fair Hearing within 120 days, the Member may lose his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member's representative should either send a letter to the health plan at:

RightCare from Scott and White Health Plan
Attn: State Fair Hearing Appeals and Grievance
MS-A4-144
1206 West Campus Drive
Temple, Texas 76502

Or call **1-855-TX-RIGHT** (**1-855-897-4448**)

If the Member asks for a State Fair Hearing within 10 days from the time the Member gets the hearing notice from the health plan, the Member has the right to keep getting any service the health plan denied, and at least until the final hearing decision is made. If the Member does not request a State Fair Hearing within 10 days from the time the Member gets the appeal resolution letter, the service the health plan denied will be stopped.

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

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

EXTERNAL MEDICAL REVIEW INFORMATION

Can a Member ask for an External Medical Review?

If a Member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the

Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of the MCO Internal Appeal Decisions letter and mail or fax it to RightCare by using the address or fax number at the top of the form.;
- Call RightCare at **1-855-897-4448**/ TTY 711
- Email RightCare at hpappealsandgrievances@bswhealth.org, or;

If the Member asks for an External Medical Review within 10 days from the time the health plan mails the appeal decision, the Member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

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

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the Member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, the State Fair Hearing decision is final. The State Fair Hearing decision can only uphold or increase Member benefits from the Independent Review Organization decision.

Can a Member ask for an emergency External Medical Review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling RightCare. To qualify for an emergency External Medical Review and emergency State Fair Hearing the Member must first complete RightCare's internal appeals process.

Enrollment and Eligibility Determination

HHSC identifies Medicaid recipients who are eligible for RightCare's participation. Eligible individuals must reside in one of the following counties in the Central Medicaid Rural Service Area: Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, or Washington counties.

Eligibility Category	**Criteria**
Temporary Assistance for Needy Families (TANF) (formerly AFDC)	Individuals age 18 and over who are eligible for the TANF Program.
TANF Children	Individuals under age 18 who are eligible for the TANF Program.
Pregnant Women - MAO	Medical Assistance Only (MAO) pregnant women whose families' income is below 185% of the Federal Poverty Limits.
Newborn (MAO)	Children under age 1 (one) year born to Medicaid-eligible mothers.
Expansion Children (MAO)	Children under age 18, ineligible for TANF because of the applied income of their stepparents or grandparents. Children under age 1 whose families' income is below 185% Federal Poverty Limit. Children age 1 – 5 whose families' income is at or below 133% of Federal Poverty Limit. Children under age 19, born before October 1, 1983, whose families income is below the TANF income limit
Federal Mandate Children (MAO)	Children under age 19, born on or after October 1, 1983, whose families' income is below 100% Federal Poverty Limit.

Enrollment Process

HHSC, in coordination with the Enrollment Broker, administers the enrollment process for STAR in the MRSA. The Enrollment Broker initiates the enrollment process by sending the recipient an enrollment packet. At that time, the member selects a health plan and a Primary Care Provider. All enrollments into RightCare may only occur through the Enrollment Broker. Enrollment counselors can be reached at **1-800-964-2777**.

Verifying Member Medicaid Eligibility

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's eligibility for the date of service prior to services being rendered. There are two ways to do this:

- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Call Provider Services at the patient's medical or dental plan.

Important: Members can request a new card by calling **1-800-252-8263**. Members also can go online to order new cards or print temporary cards at www.YourTexasBenefits.com and see their benefit and case information, view Texas Health Steps Alerts, and more.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients. A copy is required during the appeal process if the client's eligibility becomes an issue.

Your Texas Benefits gives providers access to Medicaid health information

Medicaid providers can log into the site to see a patient's Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). All of this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It's FREE and requires a one-time registration.

To access the portal, visit YourTexasBenefitsCard.com and follow the instructions in the 'Initial Registration Guide for Medicaid Providers'. For more information on how to get registered, download the 'Welcome Packet' on the home page.

YourTexasBenefitsCard.com allows providers to:

- View available health information such as:
  - Vaccinations
  - Prescription drugs
  - Past Medicaid visits
  - Health Events, including diagnosis and treatment, and
  - Lab Results
- Verify a Medicaid patient's eligibility and view patient program information.
- View Texas Health Steps Alerts.
- Use the Blue Button to request a Medicaid patient's available health information in a consolidated format.

Patients can also log in to www.YourTexasBenefits.com to see their benefit and case information; print or order a Medicaid ID card; set up Texas Health Steps Alerts; and more.

If you have questions, call **1-855-827-3747** or email ytb-card-support@hpe.com.

RightCare Identification Card

Every RightCare member should have a Your Texas Benefits Medicaid Card and a RightCare ID card. The provider should request the member's plan ID card and Your Texas Benefits Medicaid Card each time the member presents for services.

HHSC issues the Your Texas Benefits Medicaid Card. This card identifies the name of the member's health plan and date of eligibility. A member may have a temporary Medicaid identification form (Form 1027-A) which will include the plan indicator.

RightCare will issue a RightCare Member ID card to the member within 5 days after receiving notice of enrollment of the member into RightCare. The ID card will include the following: member's name; member's Medicaid ID number; Primary Care Provider's name, address, and telephone number; the toll-free number for member services; the toll-free number for behavioral health services; and directions for what to do in an emergency. Providers may also verify eligibility by visiting our portal at https://rightcare.firstcare.com or by calling RightCare at **1-855-8974448** or the State's Automated Inquiry System (AIS) at **1-800-925-9126**.


Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

RIGHTCARE

STAR/Medicaid

Member Name: **SW3Card1 A Sample**
Member ID#: **999910601**
Effective Date: 01/01/2015
PCP: PCPName
PCP Phone #: (555) 555-5555
Effective Date of PCP: 01/01/2016

Customer Service Phone #: **1-855-TX-RIGHT**
(1-855-897-4448)

RCSWHP 6145

TEXAS STAR
Your Health Plan + Your Choice

TEXAS
Health and Human Services


Important Information/Información Importante

24/7 Member Services/24/7 Departamento de Servicios para Miembros (gratis)	**1-855-897-4448**
24/7 Behavioral Health Crisis Line/24/7 Línea de Crisis de Salud Mental	**1-844-436-8781**
Vision Services/Servicios para la Vista	**1-800-879-6901**
Member Portal/Portal para miembros	https://rightcare.firstcare.com

Directions for what to do in an emergency. In case of emergency call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

Instrucciones en caso de emergencia. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de las 24 horas o tan pronto como sea posible.

NOTICE TO PROVIDER: The member whose name appears on the face of this card is covered by RightCare from Scott & White Health Plan for STAR/Medicaid services. For Medical Prior Authorization or UM questions, call 1-855-691-7947. The Medical UM FAX number is 1-800-292-1349.

For Behavioral Health Prior Authorization or UM questions, call 1-855-395-9652.
The Behavioral Health UM FAX number is 1-844-436-8779.

Submit Claims to: RightCare from Scott & White Health Plan
PO Box 0000, City, ST Zip Code Payer ID: 74205

Prescription Drug Information (Navitus): 1-877-908-6023
BIN: 610602 PCN: MCD GROUP: SWH
www.RightCare.SWHP.org

REV 10/19

Coordination of Benefits

If a RightCare member has insurance other than Medicaid, the other insurance becomes the primary carrier and claims should be submitted to that primary carrier first. When you receive the primary carrier's explanation of benefits (EOB), you can then file the claim, with the EOB attached, to RightCare. RightCare's authorization procedures must be followed to receive payment. Only those services listed in the benefit schedule are available for reimbursement. Exceptions to coordination of benefits include Texas Health Steps exams and family planning services. Texas Health Steps program is a federal mandate and is excluded from billing third party resources prior to billing Medicaid. Family planning services are excluded due to the sensitivity of the information. RightCare follows TMHP special billing standards for STAR, including for NEMT Services.

Providers must submit claims within 95 days of the rendering of service, or within 95 days of settlement with the primary carrier in a Coordination of Benefits case.

Medicaid recipients have the following additional benefits under STAR:

Spell of Illness Limitation Removed

Members of the STAR Medicaid program are not limited by the "spell of illness" limitation.

No Annual Inpatient Benefit Limit

The $200,000 annual limit on inpatient services is not applicable to STAR Medicaid members.

Unlimited Prescriptions

STAR Medicaid members are not subject to a limitation on the number of prescription medications prescribed by their health care provider.

Adult Annual Examination

RightCare adult members age 21 and over are eligible for an annual physical examination (once per calendar year.)

Second Opinion

RightCare members may seek a second opinion from a network provider (or out-of-network provider, if a network provider is not available), at no additional cost to the member.

Value-Added Services

RightCare offers benefits and services in addition to basic Medicaid covered services for our members called "value-added services (VAS)" because they are directly related to a member's health care. The services are designed to enhance the lifestyle and health care experience for our members.

Unless noted otherwise, members may obtain these value-added services by completing a voucher found here: http://rightcare.swhp.org/en-us/members/forms-tools.

Additional limitations may apply. See the RightCare Member Handbook, RightCare website, or call RightCare Member Services at **1-855-TX-RIGHT** (**1-855-897-4448**) for additional information.

RightCare provides the following value-added services:

Extra Dental Services for Pregnant Women (age 21 and older)	Up to $500 a year for dental checkups which includes: • Cleanings every 6 months • X-rays once a year • Simple extractions • Limited fillings • Fluoride treatments
Extra Vision Services	Eye checkup once a year for Members age 21 and older $150 allowance every 24 months for glasses, contacts, or lenses, not covered by Medicaid
Drug Store Services	Up to a 20% discount at Baylor Scott & White Health Pharmacies for members, including: • Personal care items, such as deodorants, toothbrushes, toothpastes, and shampoo • First aid items, such as bandages, ointments, and hand sanitizers • Baby care items, such as thermometers
Sports and School Physicals	1 sports physical each year for members 19 and younger
Help for Members with Asthma	$50 gift card every year for members age 5 to 64 who are prescribed a controller asthma medication and refill their medication regularly. $20 gift card for members who participate in an asthma disease management program for not well controlled or very poorly controlled asthma (Level 2 or 3).
Extra Help for Pregnant Women	Baby Shower and Baby Safety program: Baby shower includes diaper bag and other small gifts. $20 gift card for attending a Baby Shower and completing one prenatal visit during the 1st trimester or within 42 days of enrollment with RightCare. $20 gift card for attending a Baby Shower and completing a timely postpartum visit between 21 to 56 days after delivery. Up to $150 in gift cards for getting care while pregnant and after delivery: • $75 for completing a prenatal visit in the first trimester or within 42 day of enrollment • $75 for getting a postpartum visit between 21 and 56 days after delivery Up to $500 a year for extra dental services for pregnant members who are 21 or older, including X-rays (1 per year), simple extractions, limited fillings, fluoride treatments, and cleanings (every 6 months) Home visits for high-risk pregnant members in Service Coordination
Gift Programs	$50 gift card for new members under the age of 5 months who get a 4-month Texas Health Steps checkup on time $50 towards a toddler car seat per lifetime for members who get a 15-month, 18-month, or 24-month Texas Health Steps checkup on time $20 towards a booster car seat per lifetime for members getting a 3-year, 4-year, 5-year, 6-year, 7-year, 8-year, or 9-year Texas Health Steps checkup on time $50 gift card for members 15 months and younger who get all 6 Texas Health Steps checkups on time

	$25 gift card for members 20 years of age and younger who get a Texas Health Steps checkup on time
Additional Behavioral Health Benefits	$20 gift card for members age 5 and older who go to a 7-day follow up appointment after leaving the hospital Behavioral Health Online Mental Health Resources: members will have online access to behavioral health resources.
Additional Physical Health and Behavioral Health Benefits	Members will have access to wellness webinars through the Right*Care* Member Portal.

VAS Sport Physical Billing

For Non-FQHCs, the in-network PCP must bill ICD Z02.5 as the diagnosis code and 99201-99205 and 99211- 99215 with modifier SC. For FQHCs, the in-network PCP must bill codes 99201-99205 and 99211-99215 with modifier SC to receive payment. These can be billed with or without the T1015 code, but if billed with the T1015 the claim submission will need an additional procedure with appropriate SC modifier and diagnosis code.

CHAPTER 18. MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS and Responsibilities:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or healthcare provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to :
    a. Be told how to choose and change your health plan and your primary care provider.
    b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
    c. Change your primary care provider.
    d. Change your health plan without penalty.
    e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
    a. Have your provider explain your healthcare needs to you and talk to you about the different ways your health care problems can be treated.
    b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with your provider in deciding what health care is best for you.
    b. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
    b. Get a timely answer to your complaint.
    c. Use the plan’s appeal process and be told how to use it.
    d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get

information about how that process works.

e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    b. Get medical care in a timely manner.
    c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
    e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member Responsibilities:

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

a. Learn and follow your health plan's rules and Medicaid rules.
b. Choose your health plan and a primary care provider quickly.
c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
d. Keep your scheduled appointments.
e. Cancel appointments in advance when you cannot keep them.
f. Always contact your primary care provider first for your non-emergency medical needs.
g. Be sure you have approval from your primary care provider before going to a specialist.
h. Understand when you should and should not go to the emergency room.

3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
    a. Tell your primary care provider about your health.
    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
    a. Work as a team with your provider in deciding what health care is best for you.
    b. Understand how the things you do can affect your health.
    c. Do the best you can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to your provider about all of your medications.

Additional Member Responsibilities while using NEMT Services:

When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.

You must follow all rules and regulations affecting your NEMT services.

You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.

You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.

You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.

You must only use NEMT Services to travel to and from your medical appointments.

If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

CHAPTER 19. MEMBER'S RIGHT TO DESIGNATE AN OB/GYN:

RightCare **LIMITS** TO NETWORK

RightCare allows the Member to pick an OB/GYN but this doctor must be in the same network as the Member's Primary Care Provider

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the Member:

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

REPORTING WASTE, ABUSE, OR FRAUD BY A PROVIDER OR CLIENT

MEDICAID MANAGED CARE AND CHIP

Do you want to report Waste, Abuse, or Fraud?

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

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid or CHIP ID.
- Using someone else's Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

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

- Call the OIG Hotline at **1-800-436-6184**;
- Visit https://oig.hhs.texas.gov Click on red box labeled "Report Fraud" to complete the form online; or
- RightCare Compliance HelpLine Website, https://app.mycompliancereport.com/report?cid=swhp
- RightCare Compliance HelpLine (888) 484-6977
- You can report directly to your health plan:

RightCare from Scott and White Health Plan
Attn: Compliance Officer
1206 West Campus Drive
Temple, TX 76502
HPCompliance@BSWHealth.org

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

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
    - Name, address, and phone number of provider
    - Name and address of the facility (hospital, nursing home, home health agency, etc.)
    - Medicaid number of the provider and facility, if you have it
    - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
    - Names and phone numbers of other witnesses who can help in the investigation
    - Dates of events
    - Summary of what happened

- When reporting about someone who gets benefits, include:
    - The person's name
    - The person's date of birth, Social Security number, or case number if you have it
    - The city where the person lives
    - Specific details about the waste, abuse, or fraud

Claim Requirements

RightCare requires that all claim submissions be considered clean. 5010 compliancy is required, which mandates that the billing address be a physical address and not a P.O. Box. Effective 12/1/2013, claims that contain a P.O. Box address in the billing address field will be returned to providers. Additionally, paper claims require original claim forms, without stickers, stamps, or labels. RightCare does not accept handwritten claims.

Electronic Claim Filing

Providers can file claims electronically through Change Healthcare, RightCare's clearinghouse. The claims must be submitted using Change Healthcare's payer ID# **74205**. Please note that the use of RightCare's claim portal, provided free of charge from Change Healthcare, is for RightCare claims only.

RightCare CMS 1500s can be submitted in the standard NSF 2.0 format and the UB-04s (previously known as UB-92) can be submitted in the standard ANSI format. Change Healthcare can also accept electronic claims in the MCDS and HCDS formats. Please contact Change Healthcare customer service for more information at **1-800-735-8254**.

Paper Claims

Providers can mail paper claims to RightCare at the following address:
RightCare from Scott and White Health Plan
P.O. BOX 211342
Eagan, MN 55121-1342

Note: Any complaints or appeals received at the wrong address will be returned to the sender.

Any changes to the claims submission mailing address will be provided within 30 days of the effective date of the change. If it is not possible to give 30 days' notice prior to a change in claims processing entities, the filing deadline will be extended by 30 days.

Filing Limits

Except as specifically indicated in the Medicaid benefit descriptions, a provider may not bill or require payment, such as a co-pay, from members for Medicaid covered services. Providers may not bill, or take recourse against members for denied or reduced claims for services that are within the amount, duration, and scope of benefits of the STAR Program in the MRSA.

All claims must be submitted within 95 days from the date the covered service was rendered. If the claim is not filed with RightCare within 95 days from the date the covered service was rendered, the right to payment will be waived by the participating provider. Payment will not be waived if the participating provider establishes, to the reasonable satisfaction of RightCare, that there was justification for a delay in billing or that delay was caused by circumstances beyond the participating provider's control.

Participating providers shall be paid by RightCare, no later than 30 working days after receipt of a completed "clean" claim for covered services. A clean claim is one that is accurate, complete (i.e., includes all information necessary to determine RightCare liability), not a claim on appeal, and not contested (i.e., not reasonably believed to be fraudulent and not subject to a necessary release, consent or assignment). RightCare will explain to participating providers within 30 days of RightCare receipt of claims if claims received by RightCare, are not clean claims. RightCare must pay providers interest on a clean claim which is not adjudicated within 30 days from the date the claim is received by RightCare at a rate of 1.5% per month (18% annual) for each month the clean claim remains un-adjudicated. Should you have a question about claim issues, please contact RightCare at **1-855-897-4448**.

All Out-of-Network claims must be submitted within 95 days of the date of service.

Inpatient Admission Prior To Enrollment

For members hospitalized on the date of enrollment, RightCare is responsible for payment of physician and non-hospital charges from the date of eligibility with RightCare.

Inpatient Admissions after Enrollment

For members who voluntarily dis-enroll from Right Care and are hospitalized on the date of disenrollment, RightCare is responsible for payment of hospital facility charges but not Professional fees through the remainder of the stay. In such cases, RightCare is liable for all services during the period for which the member is enrolled in RightCare.

Discharge after Voluntary Disenrollment from RightCare and Re-Enrollment into a New MCO

RightCare remains responsible for payment of hospital charges until the member is discharged. The new MCO to whom the member transfers is responsible for payment of all physician and non-hospital charges beginning on the effective date of enrollment into the MCO.

Member Acknowledgement Statement/Private Pay Form

If a RightCare member decides to go to a provider that is not within the RightCare network or chooses to get services that have not been authorized or are not a covered benefit, the member must document his/her choice by signing the Member Acknowledgement Statement. Providers may also want the member to sign the Patient Member Private Pay Form where the member accepts responsibility for any services provided by that provider.

Examples of these forms are located on our website at http://rightcare.swhp.org/en-us/prov/forms-tools .

Medicaid Third Party Recovery

To the extent allowed by federal law, a health-care service provider must seek reimbursement from available third-party insurance that the provider knows about or should know about before billing Texas Medicaid.

Medicaid coverage is secondary when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Coverage provided under Medicaid will pay benefits for covered services that remain unpaid after all other insurance coverage has been paid.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's third-party resources (TPR) or other insurance. A TPR is a source of payment for medical services other than Medicaid, including no-fault automobile insurance such as personal injury protection and automobile medical insurance.

Providers must make a good faith effort to determine, at the time services are delivered, or at any time thereafter, whether the services being provided to the member are a result of injuries caused by a person who is or may be liable for payment of the services.

Providers must submit information relating to the existence or possible existence of third- party liability obtained from the member or legal representative of the member at the time a claim is submitted to the health plan for payment, or at any time thereafter, or when an informational claim is submitted under the provisions of Subchapter A, Division 1 §354.1003 of the Texas Administrative Code, relating to Time Limits for Submitted Claims.

Claim Forms

The claim forms providers use to submit claims to RightCare must change to accommodate the National Provider Identifier (NPI) requirements

CMS-1500 Professional Claim Forms

Providers must use the revised CMS-1500 (version 02/12) claim form to file or re-file claims, regardless of which version of the CMS-1500 claim form was used for prior submissions.

The table below provides HHSC Managed Care Organization paper claim filing requirements.

Field	Definition	Description	Requirement
11 c	Insurance Plan or Program Name	Enter the benefit code, if applicable, for the billing or performing provider.	Benefit code, if applicable
17	Referring Provider or Other Source	Name of the professional who referred or ordered the service(s) or supply(s) on the claim.	NPI
17a	Other ID#	The Other ID number of the referring provider, ordering provider, or other source should be reported in 17a.	NPI or Atypical
17b	NPI	Enter the NPI of the referring provider, ordering provider, or other source.	NPI
24j	Rendering Provider ID# (Performing)	The individual rendering the service should be reported in 24j. Enter the TPI in the shaded area of the field. Enter the NPI in the un-shaded area of the field.	TPI in shaded field and NPI in un - shaded area
32	Service Facility Location Information	Enter the name, address, city, state, and ZIP code of the location where the services were rendered.	Enter facility information when applicable
32a	NPI	Enter the NPI of the service facility location.	NPI
32b	Other ID#	Enter the non-NPI ID number of the service facility. This refers to the payer-assigned unique identifier of the facility.	TPI
33	Billing Provider Info and Ph. No.	Enter the provider's or supplier's billing name, address, ZIP code, and telephone number.	The billing provider's information
33a	NPI	Enter the NPI of the billing provider.	NPI
33b	Other ID#	Enter the non-NPI ID number of the service facility. This refers to the payer-assigned unique identifier of the facility.	TPI required

UB-04 Institutional Claim Form

Providers must use the revised UB-04 CMS-1450 claim form to submit or resubmit claims, including appeals, regardless of the version used for prior submissions.

The table below provides HHSC Managed Care Organizations paper claim filing requirements.

Field	Definition	Description	Requirement
56	NPI	Enter the NPI of the billing provider.	NPI
57a	Other ID#	Enter the non-NPI ID number of the billing provider.	TPI (optional)
73	Benefit Code	Enter the benefit code, if applicable, for the billing provider.	Benefit code, if applicable (optional)
76	Attending Provider	Attending provider name and identifiers (including NPI): Required when claim/encounter contains any services other than nonscheduled transportation services. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/encounter.	NPI required TPI in field to the right of Qualifier box, if applicable
77	Operating Provider	Operating provider name and identifiers (including NPI): Required when a surgical procedure code is	NPI required
		listed on the claim. The name and ID number of the individual with the primary responsibility for performing the surgical procedure(s).	TPI in field to the right of Qualifier box, if applicable
78-79	Other (a or b) Provider	Other provider name and identifiers (including NPI): The name and ID number of the individual corresponding to the action of the claim: Referring Provider – The provider who sends the patient to another provider for services. Required on an outpatient claim when the referring provider is different than the attending physician. Other Operating Physician – An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved. Rendering Provider – The health care professional who performs, delivers, or completes a particular medical service or non-surgical procedure.	NPI required TPI in field to the right of Qualifier box, if applicable

Claim Appeal

A claim appeal is a request for reconsideration of payment for a previously adjudicated claim. Providers who are filing an appeal of a claim decision will need to submit a copy of the Explanation of Benefits (EOB) page showing the claim in question, a claim form, and other supporting documentation including the reason for the appeal. Providers should submit one copy of the EOB for each claim to be appealed and circle which claim is being appealed. The reason for the appeal or reconsideration request may be written on the EOB or described in a separate document. All information should be printed on a single side of the copy. If the original claim was denied for incorrect information, a new CMS 1500 or UB-04 with the corrected information should be submitted as a corrected claim and follow the process indicated below. Appeals must be written and submitted within 120 days from the date of disposition, which is the date on the Remittance Advice. All appeal requests will receive an acknowledgement letter within 10 days of receipt of the appeal. RightCare will adjudicate all appeals within 30 days of receipt of the appeal.

Submit all correspondence to:

Dates of Service prior to 11/01/2019

RightCare from Scott and White Health Plan
Attn: Claims Appeals
MS-A4-144
1206 West Campus Drive
Temple, Texas 76502

Dates of Service 11/01/2019 and after

RightCare from Scott and White Health Plan
P.O. BOX 211342
Eagan, MN 55121-1342

Or https://rightcare.firstcare.com/Web/

Note: Any complaints or appeals received at the wrong address will be returned to the sender.

Corrected Claim

If the original claim was denied for incorrect information, providers can submit a corrected claim. Electronic corrected claims should reflect a resubmission code of **7**, and must reference the original claim number. Failure to do so may result in a denial for duplicate claim/service. Paper corrected claims should have corrected printed in either the header or the footer of the claim (outside of the red margins of the claim) and must also reference the original claim number. Submission timeframes for corrected claims are within 120 days of the date of discharge if an inpatient or date of service if an outpatient. Paper corrected claims should be sent to the original claim submission address:

Dates of Service prior to 11/01/2019

RightCare from Scott and White Health Plan
Attn: Claims Appeals
MS-A4-144
1206 West Campus Drive
Temple, Texas 76502

Dates of Service 11/01/2019 and after

RightCare from Scott and White Health Plan
P.O. BOX 211342
Eagan, MN 55121-1342

Capitated Services

For providers that are contracted under a capitation arrangement, please call **1-855-TX-RIGHT** (**1-855-897-4448**) for information or questions regarding what services are included in the monthly capitation. All providers must submit encounter claims for data reporting even if under capitation.

Directed Payment Programs(DPP)

RightCare will reimburse according to HHSC directive. For additional information, please refer to the TAC references below.

CHIRP : TAC §353.1306 & §353.1307 including UHRIP TAC §353.1305
TIPPS: TAC §353.1309 & §353.1311
RAPPS: TAC §353.1315 & §353.1317
BHS DPP: TAC §353.1320 & §353.1322

Emergency Services

Payment for emergency services is made based on the "Prudent Layperson" standard. Utilization of the emergency department for routine follow-up services such as suture removal, dressing change or well-person checkups is not appropriate. Claims for routine services provided in the emergency room will be denied.

National Drug Code (NDC) Requirements

Effective 10/1/2013, all RightCare providers that submit professional or outpatient claims with physician-administered prescription drug procedure codes are required to use the associated National Drug Code (NDC). The NDC is an 11-digit number on the package or container from which the medication is administered.

Drug claims submitted with procedure codes in the "A" code series do not require an NDC. The NDC is only required on outpatient hospital claims and physician claims. N4 can be entered before the NDC on claims.

The 11-digit National Drug Code (NDC) must be submitted on the claim with the appropriate procedure code. The NDC submitted to Texas Medicaid must be the NDC on the package or container from which the medication was administered.

Claims submitted without a valid NDC number will be denied.

For more information regarding HCPCS Procedure codes that require NDCs and billing information and requirements, refer to the *Texas Medicaid Provider Procedures Manual* (TMPPM).

Hospital Transfers

Discharge from one hospital and readmission or admission to another hospital within 24 hours for continued treatment shall not be considered a discharge but rather a hospital transfer.

CHAPTER 22. REFERRALS

The RightCare member's Primary Care Provider is responsible for and will coordinate referrals of the member to other providers, in- and out-of-network. Referrals must come from the member's Primary Care Provider, as a function of the medical home. Specialists may not refer to other specialists.

The Primary Care Provider and specialists are expected to communicate frequently regarding the health care provided to each member.

Please refer to the Prior Authorization List for a description of services that require authorization and notification.

In-Network Referrals

Authorization from RightCare for in-network referrals are not required for most specialty referrals. Exceptions include some services and specialists listed on the Prior Authorization List including, but not limited to, dermatology, plastic surgery, podiatry, and any primary care provider other than the Primary Care Provider of record (or a provider listed with RightCare as a covering provider for the Primary Care Provider).

The steps for an in-network referral are listed below:

- Primary Care Provider determines medical necessity for referral for specialty services.
- Primary Care Provider sends Referral Form to specialist with all pertinent information, including test results, etc., if available.
- Specialist provides follow-up information to the Primary Care Provider post visit.

The in-network referral is valid for 180 days for a maximum of 6 visits unless otherwise authorized by the Primary Care Provider.

Out-of-Network Referrals

If a required service is not available within the RightCare network, the member's Primary Care Provider may make an out-of-network referral. The Primary Care Provider must complete a Texas Referral/Authorization Form, documenting the need to utilize an out-of-network provider, and obtain prior authorization from RightCare Medical Management.

The steps for an out-of-network referral are as follows:

- The member's Primary Care Provider must complete the Texas Referral/Authorization Form, and specify the services required of the out-of-network provider including the rationale for requesting out-of-network services.
- The Primary Care Provider must fax the referral form, including all pertinent clinical information to **1-512383-8703**, or call RightCare Medical Management at **1-855-691-SWHP** (**7947**) to submit a request for prior authorization.
- An authorization number will be assigned by RightCare Medical Management if approved. If the determination results in a denial, the provider will receive written notification that includes instructions on how to submit an appeal.

The authorization number must be written on the Texas Referral/Authorization Form before it is faxed to the specialist.

The out-of-network referral is valid for 180 days, for a maximum of six visits. A new referral request must be completed if the referral is over 180 days old or more than six visits are required.

Referrals to Ancillary Services

All providers may refer members for routine laboratory and radiology services to a RightCare participating provider using the Texas Referral/Authorization Form. However, some procedures require prior authorization. Please see the *Prior Authorization* section for a comprehensive listing of these procedures. RightCare providers are **required** to send routine lab and radiology requests to one of the RightCare lab/radiology providers listed in the RightCare Provider Directory (full directory available at http://rightcare.swhp.org/en- us/ members/find-a-provider). If a required radiological service is not available within the RightCare network, the member's Primary Care Provider must complete a request for prior authorization using the Texas Referral/ Authorization Form and follow the standard out-of-network referral procedures outlined above.

Our commitment to promoting the "medical home" includes the expectation that the Primary Care Provider will direct patient care, such as referring members to specialists, as needed.

RightCare does not require in-network Primary Care Providers to submit referrals to in-network specialists to the health plan for approval unless the service requires prior authorization for limited benefits or selected procedures.

A list of services requiring a prior authorization can be found on the RightCare website at http://rightcare.swhp.org/en-us/prov/authorizations.

Notification: When a service requires notification, the requesting/performing provider must contact RightCare Medical Management within one business day of the requested services being provided. Failure to timely notify RightCare Medical Management may result in denial of days.

Prior Authorization: When a service requires prior authorization, the requesting/performing provider must contact RightCare Medical Management at least 3 business days before the requested services are provided. Failure to timely request prior authorization may result in denial of days.

Retro-authorization: If a service requiring prior authorization is provided without obtaining prior authorization, the provider will submit the claim for payment. If claim is denied, Provider may file an appeal for Payment Reconsideration. RightCare Medical Management does not process requests for retro- authorization.

Submission Process

- Participating Provider submits request for services on the Prior Authorization list.
- Primary Care Providers may request a Prior Authorization via:
    - Fax using Texas Referral /Authorization Form to **1-512-383-8703**
    - Calling RightCare Medical Management at **1-855-691-SWHP** (**7947**)
    - Provider Portal for Medical only

      https://rightcare.firstcare.com
- RightCare Medical Management receives information and reviews eligibility, benefits and medical necessity and returns authorization determination to the requesting provider. RightCare Medical Management processes prior authorization requests within 3 business days after receipt of a completed request.

- RightCare Medical Management processes inpatient hospitalization requests and requests for continued stay in the hospital (concurrent review) within one business day after receipt of a completed request.
- Rendering provider sends findings and recommendations to the Primary Care Provider after the visit.
- "PA Not Required" does not mean that a service is approved.

Authorization for Newborn Deliveries

Prior authorization is not required for normal routine deliveries when mom and baby discharge within the routine timeframes (48 hours for vaginal delivery or 96 hours for caesarian section). If the mom or baby does not discharge within the routine timeframes, the provider must notify the health plan and submit clinical records for review. All other admissions including antepartum or NICU admit, the provider must notify the health plan and submit clinical records for review.

Hospitals must notify RightCare Medical Management of the delivery within 1 business day of the delivery. Delivery notification may be submitted via:

- Fax using Texas Referral /Authorization Form to **512-383-8703**
- Calling RightCare Medical Management at **1-855-691-SWHP** (**7947**)

Requests for Therapy

Initial therapy requests for members under age 21 should be submitted using the TP-1 Form located on our website at http://rightcare.swhp.org/en-us/prov/forms-tools , and must include the results of the most recent evaluation. Requests for therapy beyond the initial authorization period should be submitted using the TP-2 Form located on our website at http://rightcare.swhp.org/en-us/prov/forms-tools .

Requests for Durable Medical Equipment

Durable Medical Equipment requests should be submitted on the Texas Referral/Authorization Form and the Title XIX Form located on our website at http://rightcare.swhp.org/en-us/prov/forms-tools . RightCare Medical Management will accept unsigned Texas Referral/Authorization Forms and Title XIX Forms only if a signed prescription is submitted along with the completed forms.

Request for Behavioral Health

Submission Process

- Participating Provider submits request for services on the Prior Authorization list.
- Primary Care Providers may request a Prior Authorization via:
    - Fax using Texas Referral /Authorization Form to **1-855-395-9652**
    - Calling RightCare Medical Management at **1-844-436-8779**
- RightCare Medical Management receives information and reviews eligibility, benefits and medical necessity and returns authorization determination to the requesting provider. RightCare Medical Management processes prior authorization requests within 3 business days after receipt of a completed request.
- RightCare Medical Management processes inpatient hospitalization requests and requests for continued stay in the hospital (concurrent review) within one business day after receipt of a completed request.
- Rendering provider sends findings and recommendations to the Primary Care Provider after the visit.
- "PA Not Required" does not mean that a service is approved.

See the *Behavior Health Prior Authorization List* for services requiring an authorization.

Primary Care Providers will:

- Coordinate patient care by directing/referring patients to in-network specialists using a mutually agreeable format and including all appropriate clinical information.
- Continue to submit prior authorization requests to RightCare if directing patients to non-participating providers. Out-of-network referrals require prior authorization in order to be covered. Failure to obtain prior authorization will result in payment denials.

Specialists will:

- Continue to provide care to RightCare members, as directed/referred by the Primary Care Provider.
- Not need to verify referral authorization for RightCare members except for specialty care, as outlined in the Prior Authorization List.
- Adhere to current prior authorization and claim guidelines, including services that may be performed in office.
- Provide information to the Primary Care Provider following the consultation to ensure continuity and coordination of care.

Review Process

The information provided and the recommendation of the patient's physician or provider will be used to make precertification determinations. Services will be approved as proposed or referred to a Medical Management Medical Director in the event there are questions about the clinical aspects for the recommended services, including appropriateness of level of care or medical necessity.

All denials of services are made by the RightCare Medical Director(s), after review of medical facts. Any person making decisions for services makes them based only on the appropriateness of care and services. No rewards are based on review of services or service denials. RightCare does not offer money or rewards, to providers or other people making decisions on services.

Medical Management makes decisions based on the appropriateness of care and service. Requests for coverage are reviewed to determine if the service requested is a covered benefit and is delivered in accordance with established guidelines. If a request for coverage is denied, the member (or a physician acting on behalf of the member) may appeal this decision through the complaint and appeal process.

Medical Management has adopted screening criteria and established review procedures which are periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians and other health care providers. Utilization review decisions are made in accordance with currently accepted medical or health care practices, taking into account the special circumstances of each case. InterQual®, the screening criteria, are nationally recognized objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norms when justified on a case-by-case basis. In addition, the Medical Management staff utilizes the *Texas Medicaid Provider Procedures Manual* (TMPPM) and the Texas Medicaid Bulletins as supplemental guidelines in determining the safety, effectiveness and medical necessity of selected medical technologies. Screening criteria is used to determine only whether to approve the requested service. Flexibility may be utilized when applying screening criteria in determining utilization review decisions for members with special health care needs. This may involve members who have a disability, acute condition or a life-threatening illness.

Cases that cannot be approved by a nurse reviewer are referred to a Medical Director to determine medical necessity. In any instance where a service authorization request is questioned, the health care provider who ordered the services may be asked to discuss the plan of treatment for the member with the Medical Director, prior to the issuance of a determination.

Prior authorization is not required for emergency services and RightCare does not determine what constitutes an emergency medical condition solely on the basis of diagnosis or symptom lists. The attending emergency physician or the provider actually treating the member is responsible for determining when the member is stable. However, admissions for observation or inpatient services for post-stabilization care are subject to prior authorization and notification requirements. Medical Management must be notified within one business day of the admission to a participating facility. Non-participating facilities must contact RightCare Medical Management for prior authorization prior to admitting a RightCare member.

RightCare Medical Management has a nurse and physician available 24 hours a day, 7-days a week. In the event the admission must occur after normal business hours, providers may contact RightCare Medical Management at **1-855-691-SWHP** (**1-855- 691-7947**).

Post-stabilization care provided to maintain, improve or resolve the member's stabilized condition is covered for the period of time it takes RightCare to make a determination, including times RightCare cannot be contacted, does not respond to a request for approval, or a Medical Director is not available for consultation when medical necessity is questioned by the Medical Management staff.

Transplants

Members who require organ/tissue transplants that include bone marrow, peripheral stem cell, heart, lung, liver, kidney and combined heart/lung may receive Service Coordination services to facilitate continuity and coordination of care among the providers who care for the member. Transplants must be performed in an institution that is a Texas Medicaid provider. Prior authorization for transplant services is required and exceptions to any provisions defined in the Texas Medicaid Provider Procedures Manual (TMPPM) must be approved by the Medical Director.

Physician Obligations for Hospital Admissions

The following steps should be followed when admitting a patient to the hospital:

Emergency Care:

- The patient is admitted.
- The patient receives care.
- The provider verifies eligibility.
- The admitting provider must notify RightCare's Medical Management by faxing a Texas Referral/Authorization form to **1-512-383-8703** within 1 business day.
- The prior authorization form is reviewed by a Medical Management nurse and an admission is entered into the system as appropriate.
- The Medical Management nurse performs a concurrent review based on the information supplied by the provider.
- If the patient meets criteria, the nurse will approve the stay for a specified period. For continued stay, providers must provide additional clinical information to RightCare Medical Management within 1 business day of expected discharge date.
- If the patient does not meet criteria, the admitting provider will be notified that the admission is in question and will be referred to the Medical Director for review and disposition.

Elective Admissions:

- A member presents for care and requires hospitalization (e.g., surgical procedure).
- The admitting physician completes the Texas Referral/ Authorization form and faxes it to RightCare's Medical Management at **1-512-383-8703** for approval. For elective admissions, the prior authorization form must be received 2 business days prior to the scheduled admission.
- The prior authorization form is reviewed by a Medical Management nurse and either approved or forwarded to the Medical Director for review. If the prior authorization is denied, a reason will be provided to the requesting provider.
- The Medical Management staff enters the prior authorization into the system and sends the authorization number to the provider to include on the claim when submitted for reimbursement. If the determination results in a denial, the provider will receive written notification which includes instructions on how to submit an appeal.

- The provider retains a copy of the authorization and provides a copy to the Primary Care Provider (if admitting provider is not the Primary Care Provider). The admitting provider must communicate his/her plan of treatment with the member's Primary Care Provider (Coordination of Care).

Facility Obligations for Admission

The following outlines the facility obligations when inpatient services are needed:

Emergency Admissions:

- A member presents for care and requires hospitalization.
- The facility staff verifies eligibility and notifies the member's Primary Care Provider.
- The patient is admitted.
- The facility staff cooperates with RightCare's Medical Management staff as they perform concurrent reviews.
- The facility staff will work with RightCare's Medical Management staff in preparation for discharge planning and/or referral to outpatient/ancillary services including home health and DME.
- The facility staff will notify the Primary Care Provider of all services performed while at the facility (Coordination of Care).

Elective Admissions:

- A member presents for care and requires hospitalization (e.g., surgical procedure).
- The admitting physician completes the Texas Referral/Authorization form and faxes it to RightCare's Medical Management at **1-512-383-8703** for approval. For elective admissions, the prior authorization form must be received within 2 days of the scheduled admission.
- The approved referral form must be presented at time of admission along with the RightCare's identification card and Your Texas Benefits Medicaid ID card.
- The facility must verify eligibility and admit the patient.
- The facility staff must work with RightCare's Medical Management staff in preparation for discharge planning and/or referral to outpatient/ancillary services including home health and DME.
- The facility staff must notify the Primary Care Provider of all services performed while at the facility.

Admission to Out-Of-Network Facilities

If a RightCare member is admitted to a non-participating facility, such an admission must first be approved by the member's Primary Care Provider and authorized by RightCare -- except in the case of an emergency. If a RightCare member has been admitted to a non-participating facility on an emergency basis, the member must be transferred to a RightCare participating facility as soon as it is medically safe to do so. The member's Primary Care Provider and/or RightCare Medical Management staff will assist with coordinating the transfer to an in-network facility by helping locate the nearest in-network facility and coordinating with the member's Primary Care Provider as necessary. Hospital-to-hospital transfers require physician-to-physician contact.

Concurrent Review

Concurrent Reviews are performed to ensure that the care provided in the acute level setting is medically necessary, assure that goals for length of stay (LOS) are appropriate, identify potential quality of care issues, implement discharge planning, and capture data for claims payment. Concurrent reviews will be performed on all hospitalized patients and initiated within 1 business day of admission. On-site review will be performed if necessary and will be done in accordance with all hospital policies. Reviewers will identify themselves appropriately and follow hospital guidelines for review of patient records, etc.

The following represent the procedures surrounding the review process:

- The Medical Management nurse will identify his/herself by name, title and the name of the plan.
- The Medical Management nurse will review the member's initial admission clinical and will provide a recommended length of stay depending on the medical status and/or severity of illness.
- Medical necessity and LOS will be reviewed against criteria and appropriate LOS guidelines.
- If medical necessity has been established, the targeted discharge date will be noted and the provider must submit additional clinical information within one business day of the last day approved.
- If upon review by the Medical Management nurse, the medical necessity for extending the LOS has not been established, the case is referred to the Medical Director or his/her designee. He/she may approve the extension based on the information provided. The Medical Director or his/her designee may also choose to discuss the case with the attending physician or a consulting physician. Ultimately, the decision for extending the LOS should occur the same day. In case of a denied authorization, the provider has a right to a standard or expedited appeal.

Newborn Enrollment

Newborns that are born to current RightCare members are automatically covered by RightCare for the first 90 days of life. However, it is the responsibility of the member to add the newborn to the STAR program to continue benefits. RightCare will allow providers to submit claims for the newborn. In order to expedite the payment of claims and systematically track the newborn, providers may submit claims for payment for newborns by using the mother's RightCare ID number and adding an "A" at the end. For multiple births you must use the mother's RightCare ID number along with a successive letter at the end (Such as "A" for the first infant, "B" for the next, etc.). Once the newborn is enrolled with the STAR program in the MRSA, the temporary ID number will be updated with the HHSC assigned Medicaid ID. Once this takes place providers may bill using the newborn's newly issued RightCare Medicaid ID number.

Automatic Re-Enrollment

Members who are dis-enrolled because they are temporarily ineligible for Medicaid will be automatically re- enrolled into their previously selected plan. Temporary loss of eligibility is defined as a loss of eligibility for a period of 6 months or less. RightCare will inform the members of their rights and responsibilities and the automatic re-enrollment process. This information is given to the member in the member handbook. Members can change health plans by calling the Texas STAR program Helpline at **1-800-964-2777**. Members can change plans as often as they want.

Member Disenrollment

A member may request disenrollment from managed care by providing medical documentation from their Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment.

RightCare has a limited right to request a member be disenrolled from the plan without the member's consent. Providers can request RightCare assistance in member disenrollment by following the process above. HHSC must approve any MCO request for disenrollment of a Member for cause.

HHSC may permit disenrollment of a Member under the following circumstances:

- Member misuses or loans their RightCare membership card to another person to obtain services.
- Member is disruptive, unruly, threatening or uncooperative to the extent the member's membership seriously impairs RightCare's or provider's ability to provide services to member or obtain new members, and member's behavior is not cause by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care restrictions (e.g./ repeatedly using emergency room in combination with refusing to allow RightCare to treat the underlying medical condition).
- RightCare will take reasonable measures to correct a member's behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.
- Additionally, a provider cannot take retaliatory action against a member who is dis-enrolled from RightCare.

Emergency and Nonemergency Transportation (for MCOs serving MMC Members)

Members with Special Health Care Needs are those members who have, or are at risk for, a chronic or complex physical, mental, emotional, behavioral or developmental disorder and who also require health and related services of a type or amount beyond that required by the general population. These conditions are expected to last at least 12 months or longer and require ongoing treatment and or monitoring. RightCare provides the following services for Members with Special Health Care Needs.

Ambulance Transportation

Medicaid reimburses for emergency and non-emergency transportation for those clients that meet the severely disabled criteria. Severely disabled means that "the clients' physical condition limits mobility and requires the client to be bed-confined at all times or unable to sit unassisted at all times, or requires continuous life support systems (including oxygen or IV infusion) or monitoring of unusual physical or chemical restraint." All non- emergency transports require prior authorization. Emergency transports do not require prior authorization. For more information regarding ambulance services and/or limitations, please refer to the *Texas Medicaid Provider Procedures Manual* (TMPPM).

Interpreter/Translation Services

RightCare provides language interpretation services to translate multiple languages. This is done through the CQ Fluency which may be accessed by calling RightCare Customer Service. Our Member Services staff will then contact the CQ Fluency as a third-party conversation. For persons who are deaf or hard of hearing, please call TTY line at **7-1-1** and ask them to call the RightCare Member Services Line at **1-855-897-4448**. RightCare also maintains a current list of interpreters who remain available to provide interpreter services for providers. RightCare will arrange, with 72-hour notice, to have someone that speaks the patient’s language meet the patient at the provider’s office when they come for their appointment. For members in need of a sign language interpreter, RightCare will provide an approved interpreter from the American Sign Language Association.

Trained interpreters must be used when technical, medical, or treatment information is to be discussed. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality or confidentiality is critical unless specifically requested by the member.

As soon as the patient knows they will need a language interpreter to meet them at the doctor's office, the patient should contact RightCare Member Services at **1-855-897-4448**. Language/Interpreter Services should be arranged at least 72 hours in advance of the scheduled appointment.

When billing sign language interpreting services, use procedure code 1-T1013. Modifier U1 should be used for the first hour of service, and modifier UA should be used for each additional 15 minutes of service. Procedure code 1T1013 billed with modifier U1 is limited to once per day, per provider, and procedure code 1-T1013 billed with modifier UA is limited to a quantity of 28 per day.

MCO/Provider Coordination

RightCare will comply with the HHSC standards regarding care for persons with disabilities or chronic and complex conditions.

RightCare will provide information, education and training programs to members, families, Primary Care Providers, specialty physicians, and community agencies about the care and treatment available within RightCare for members with disabilities or chronic or complex conditions. Specialists may function as a primary care provider for treatment of members with chronic/complex conditions when approved by RightCare.

Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of ethnicity, sex, age, religion, color, mental or physical disability, national origin, marital status, sexual orientation, or health status (including, but not limited to, chronic communicable diseases such as AIDS or HIV-positive status). All participating physicians and health care professionals may also have an obligation under the Federal Americans with Disabilities Act to provide physical access to their offices and reasonable accommodations for patients and employees with disabilities.

For each person with disabilities or chronic or complex conditions, the Primary Care Provider is required to develop a plan of care that meets the special preventive, primary acute care and specialty care needs of the member.

The plan must be based on:

- Health needs
- Specialist recommendations
- Periodic reassessment of the member's functional status and service delivery needs.

The Primary Care Provider must maintain an initial plan of care in the medical records of persons with disabilities or chronic or complex conditions and that plan must be updated as often as the member's needs change, but at least annually.

RightCare will ensure that members with Special Health Care Needs have direct access to primary care providers and specialists skilled in treating persons with disabilities or chronic or complex conditions. Service Coordination services are available to assist members with special health care needs, their families, and health care providers to facilitate access to care, continuity and coordination of services.

Reading/Grade Level Consideration

Adhering to the policies and procedures set by HHSC, any literature that is published for informational use by RightCare members' needs to be written at or below a 6th grade reading level. This will help to enhance the communication between the Medicaid population, providers, and RightCare.

Cultural Sensitivity

It is critical that RightCare providers develop a culturally competent system of care – one that acknowledges and incorporates at all levels the importance of culture and the adaptation of services to meet culturally-unique needs. RightCare members vary in language and culture (e.g., customs, religion, backgrounds, etc.). Our goal is to effectively serve members of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. We must operate at a level in which cultural knowledge is high and policies and practices are in place that produces positive results and satisfaction from the viewpoint of the culturally diverse client.