

Texas Provider Orientation

Today's discussion

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

Our mission and values

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

Medicaid enrollment

MAXIMUS — State enrollment broker:

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

Enrollment:

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

Medicaid enrollment (cont.)

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

Medicaid enrollment (cont.)

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

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

Marketing activities

Sanctioned marketing activities:

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

In Texas, the following activities are prohibited:

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

Community involvement

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

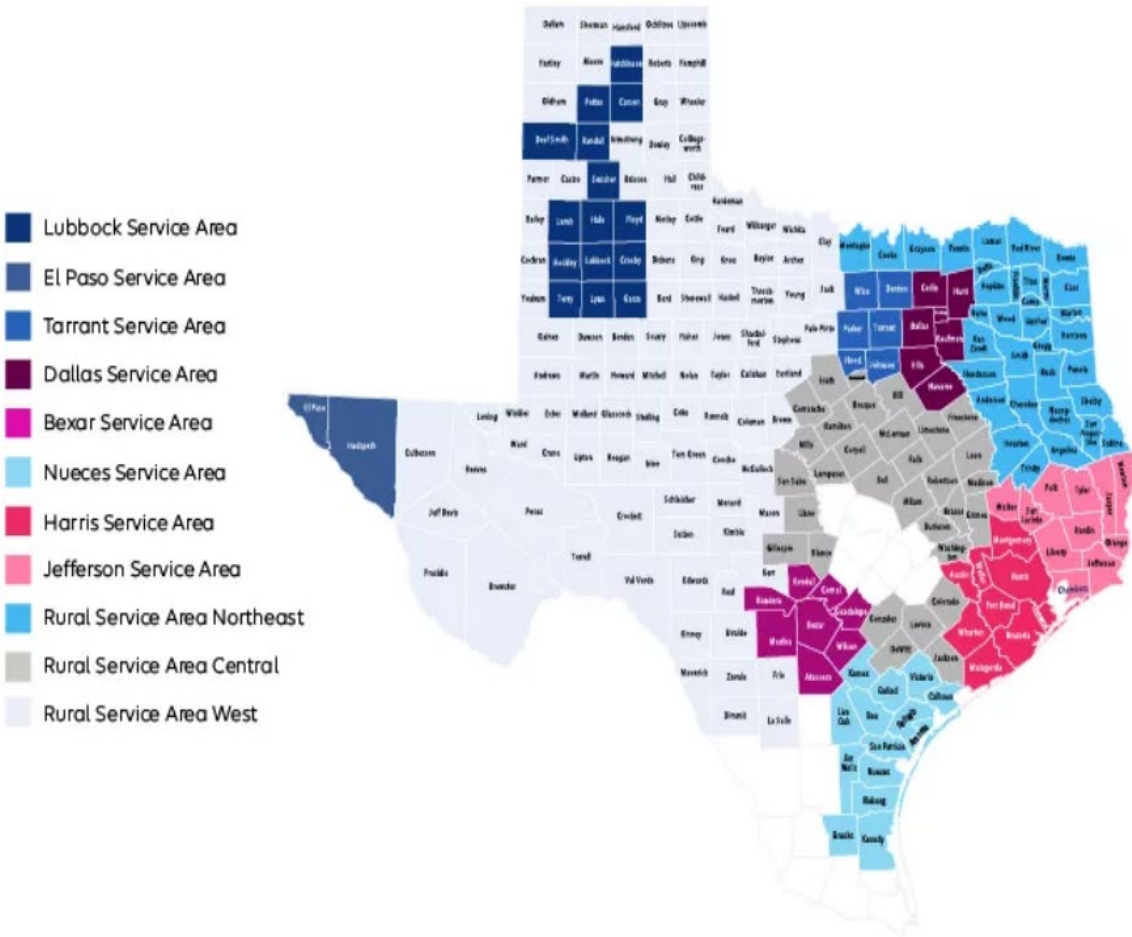
We organize and participate in activities throughout the state, like:

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

Eligibility and benefits

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

Medicaid and CHIP by service area



STAR:
 Bexar, Dallas, Harris, Jefferson, Lubbock, Tarrant, Rural Service Areas-Central, Northeast, and West

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

STAR+PLUS:
 Jefferson, Lubbock, Nueces, and Rural Service Area-West

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

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

Benefits of STAR+PLUS

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

Texas Health Steps

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

Early childhood intervention

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

ECI responsibilities

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

ECI responsibilities (cont.)

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

ECI responsibilities (cont.)

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

Children of migrant farmworkers

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

Your responsibilities

Providers should review both provider and member responsibilities detailed in the provider manual found at <https://www.wellpoint.com/tx/provider/state-federal/resources/policies-guidelines-manuals>

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

- [Center for Medicare & Medicaid Services](#)
- [Texas Health and Human Services](#)
- [Texas Administrative Code](#)
- [Federal OIG Exclusions](#)
- [Texas OIG Exclusions](#)




Collaboration and communication

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

Appointment availability and after-hours standards

- We are dedicated to timely access to care for our members. Our ability to provide quality access depends upon the accessibility of network providers. We evaluate HHSC, the Texas Department of Insurance, and the National Committee for Quality Assurance (NCQA) requirements and follow the most stringent of the three.
- Providers are required to adhere to access standards that apply to both Medicaid and CHIP unless specified. Standards are measured from the date of presentation or the date of request, whichever occurs first.
- To learn more and access the Appointment Availability and After-hours training, please visit: <https://www.wellpoint.com/tx/provider/state-federal/resources/training-academy/training-resources>.


Texas | Medicaid

Appointment availability and after-hours access requirements

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

Appointment availability requirements

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

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

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

Behavioral health

| | |
|---|--|
| Behavioral health, nonlife-threatening emergency care | Within 6 hours (NCQA) |
| Behavioral health, urgent care | Within 24 hours |
| Behavioral health, routine care — initial visit | The earlier of 10 business days (NCQA) or 14 calendar days |
| Behavioral health, routine care — follow-up visits | Within 3 weeks |


Members may request an after-hours appointment to the ER for needed services

- Returning after-hours calls outside of a 30-minute time frame

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

Learn more about Wellpoint programs
[provider.wellpoint.com/tx/](https://www.wellpoint.com/tx/)



Ongoing credentialing

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

Digital provider enrollment

The Availity platform hosts a provider enrollment tool that enhances and automates the provider's online enrollment process.

Providers must be registered in Availity to access DPE for submission and status checks on the application.

If you have any questions or require further assistance, please do not hesitate to reach out to our support team at TXCREDENTIALING@Elevancehealth.com.

All communication regarding provider enrollment and network management requests will come from providermanagement@elevancehealth.com.

DPE Capabilities



Apply to add new practitioners to an already existing group



Apply and request a contract to enroll a new group of practitioners

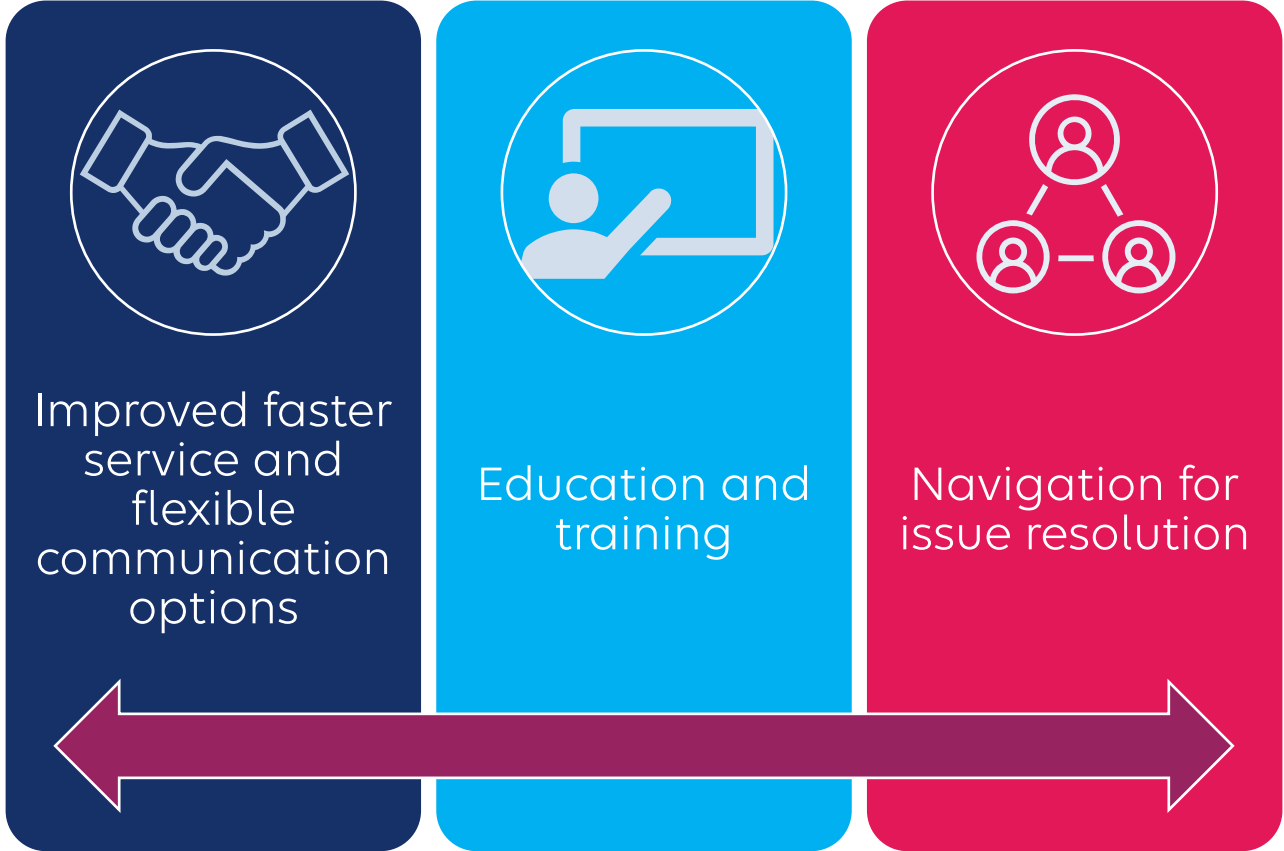


Monitor submitted applications statuses real-time with a digital dashboard



Facilities and ancillary may join through Availity

Provider Relations account management responsibilities



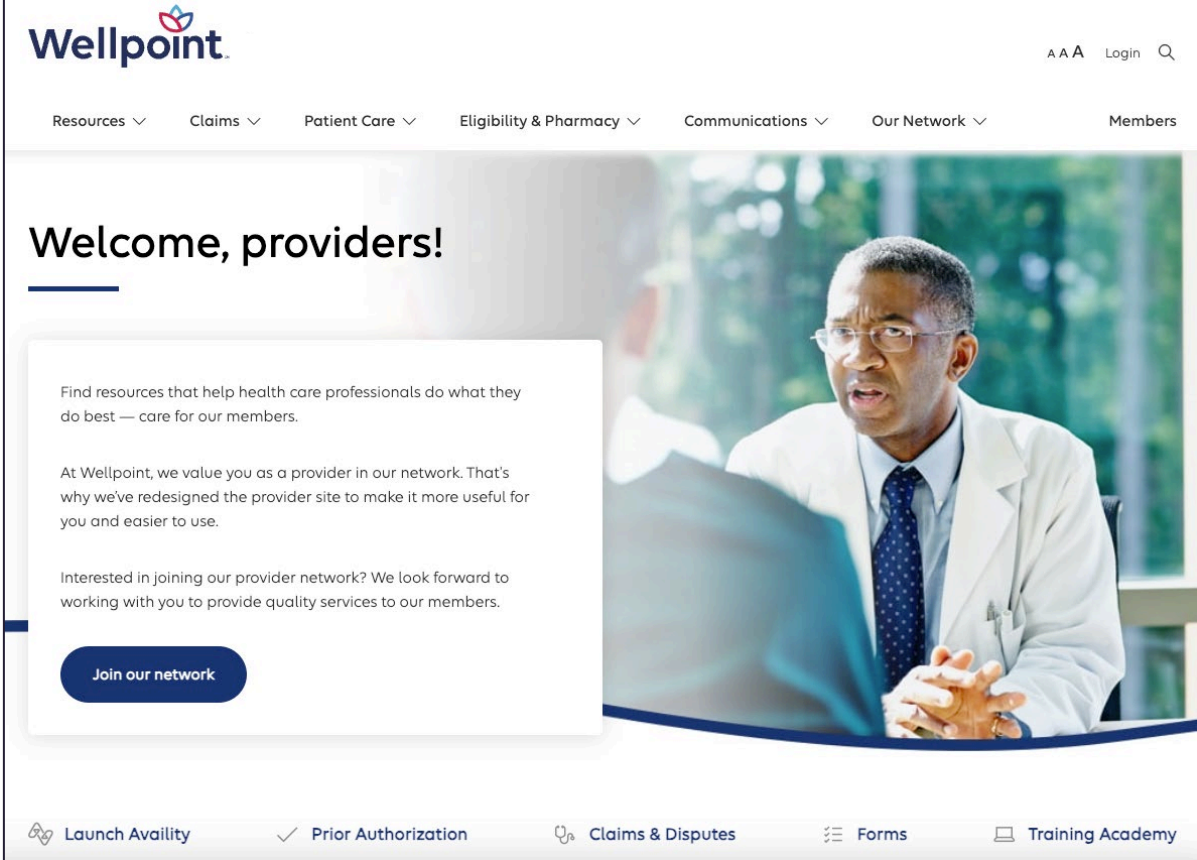
Contact us

Wellpoint has created a seamless way for you and your staff to reach a dedicated staff member by contacting us. Here are ways to do just that:

- Web – <https://www.wellpoint.com/tx/provider/state-federal/contact-us>
- Email – mpsweb@wellpoint.com or messaging service at <https://www.wellpoint.com/tx/provider/state-federal/contact-us/email>
- Phone: **833-731-2162**

Provider website

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



The screenshot shows the Wellpoint provider website homepage. At the top left is the Wellpoint logo. To the right are accessibility options (AAA) and a login link with a search icon. Below the logo is a navigation menu with links for Resources, Claims, Patient Care, Eligibility & Pharmacy, Communications, Our Network, and Members. The main content area features a large background image of a doctor in a white coat looking at a laptop. Overlaid on this is a white text box with the heading "Welcome, providers!" and three paragraphs of text. The first paragraph says "Find resources that help health care professionals do what they do best — care for our members." The second paragraph says "At Wellpoint, we value you as a provider in our network. That's why we've redesigned the provider site to make it more useful for you and easier to use." The third paragraph says "Interested in joining our provider network? We look forward to working with you to provide quality services to our members." Below the text is a dark blue button labeled "Join our network". At the bottom of the page is a footer with icons and text for "Launch Availability", "Prior Authorization", "Claims & Disputes", "Forms", and "Training Academy".

Wellpoint. AAA Login Q

Resources ▾ Claims ▾ Patient Care ▾ Eligibility & Pharmacy ▾ Communications ▾ Our Network ▾ Members

Welcome, providers!

Find resources that help health care professionals do what they do best — care for our members.

At Wellpoint, we value you as a provider in our network. That's why we've redesigned the provider site to make it more useful for you and easier to use.

Interested in joining our provider network? We look forward to working with you to provide quality services to our members.

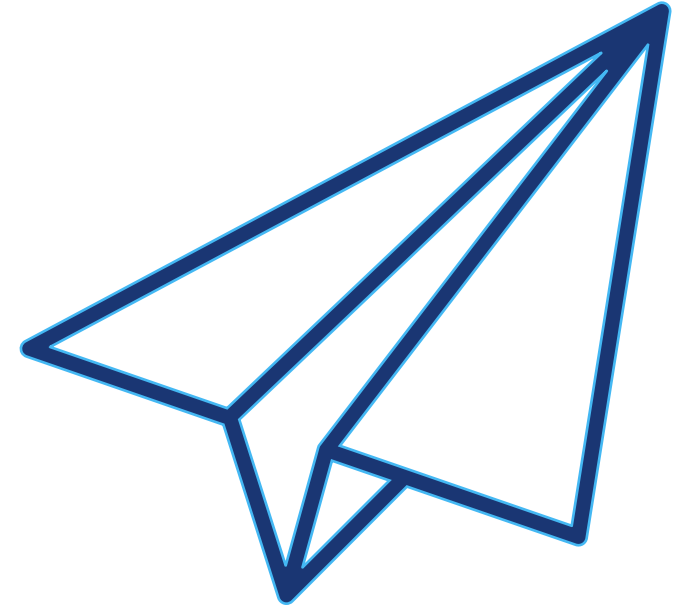
[Join our network](#)

Launch Availability ✓ Prior Authorization Claims & Disputes Forms Training Academy

Provider news and updates

Email is the quickest and most direct way to receive important information from Wellpoint.

- To start receiving email from us (including some sent in lieu of fax or mail), submit your information via our online form <https://providernews.wellpoint.com/tx/signup>



Availity Essentials resources

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

Online claims submission:

- Use our free online claim submission tool at <https://Availity.com>. You have the ability to submit claims, check claims status, dispute claim payment, use Clear Claim Connection, etc.

Eligibility verification/authorization:

- You can verify member eligibility and submit authorizations by simply searching by Wellpoint subscriber or state-issued identification number. Submit prior authorization requests online through Availity Essentials, by fax, or by calling Provider Services at **833-731-2162**.

Interactive Care Reviewer (ICR):

- Can be accessed by any staff member at anytime. ICR allows users to inquire about prior authorization requests submitted via phone, fax, ICR, or other online tools.



Availity Essentials resources (cont.)

Digital provider enrollment: Accessible through Availity for new provider enrollment. Demographic changes received outside the standard independent physician association (IPA) or physician-hospital organization (PHO) process will not be processed separately.

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

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

Provider data attestation

Attest demographic data every 90 days.



Maintain updated data to ensure members can reach you when they need you most.



Failure to complete the 90-day attestation may lead to non-compliance and removal from the directory.



Additional resources can be found under Provider News:
<https://providernews.wellpoint.com/tx/articles/reminder-provider-data-attestation-24382>

Member sample ID cards — Medicaid and CHIP

Wellpoint
PCP Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR

WELLPOINT TEXAS, INC.
wellpoint.com/bx/medicaid

Member Name: JOHN Q SAMPLE
Medicaid Number:
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:
Vision: 1-800-426-8789 Pharmacy Member Services: 1-833-235-2022
Wellpoint Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-833-731-2160
24-hour Nurse HelpLine: 1-833-731-2160
Transportation: 1-833-721-8184

Wellpoint
PCP Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR+PLUS

WELLPOINT INSURANCE COMPANY
wellpoint.com/bx/medicaid

Member Name: JOHN Q SAMPLE
Medicaid Number:
Wellpoint Service Coordination: 1-833-731-2160
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:
Vision: 1-800-426-8789 Pharmacy Member Services: 1-833-235-2022
Wellpoint Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-833-731-2160
24-hour Nurse HelpLine: 1-833-731-2160
Transportation: 1-844-867-2837

Wellpoint
PCP Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: CHIP

WELLPOINT TEXAS, INC.
wellpoint.com/bx/medicaid

Member Name: JOHN Q SAMPLE
CHIP Number:
Primary Care Provider (PCP):
PCP Telephone #:
Copays: Office Visits: \$5 Emergency Room Visits: \$5
Pharmacy: \$0 FOR GENERIC / \$5 FOR BRAND NAME
Vision: 1-800-426-8789 Pharmacy Member Services: 1-833-235-2022

Wellpoint Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-833-731-2160
24-hour Nurse HelpLine: 1-833-731-2160

TDI

Wellpoint
Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR+PLUS

WELLPOINT INSURANCE COMPANY
wellpoint.com/bx/medicaid

Member Name: JOHN Q SAMPLE
Medicaid Number:
Wellpoint Service Coordination: 1-833-731-2160
Pharmacy Member Services: 1-833-235-2022

Wellpoint
PCP Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR Kids

WELLPOINT INSURANCE COMPANY
wellpoint.com/bx/medicaid

Member Name: JOHN Q SAMPLE
Medicaid Number:
Wellpoint Service Coordination: 1-866-696-0710
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:
Vision: 1-800-426-8789 Pharmacy Member Services: 1-833-370-7463
Wellpoint STAR Kids Only Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-844-756-4600
24-hour Nurse HelpLine: 1-844-756-4600
Transportation: 1-844-864-2443

Wellpoint
Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: CHIP

WELLPOINT TEXAS, INC.
wellpoint.com/bx/medicaid

Member Name: JOHN Q SAMPLE
CHIP Paricate Number:
Pharmacy Member Services: 1-833-235-2022

Wellpoint Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-833-731-2160
24-hour Nurse HelpLine: 1-833-731-2160

TDI

Wellpoint
Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR Kids

WELLPOINT INSURANCE COMPANY
wellpoint.com/bx/medicaid

Member Name: JOHN Q SAMPLE
Medicaid Number:
Wellpoint Service Coordination: 1-866-696-0710
Pharmacy Member Services: 1-833-370-7463

Wellpoint
Effective Date:
Date of Birth:
Subscriber #: 123456789
Type of Coverage: STAR Kids

WELLPOINT INSURANCE COMPANY
wellpoint.com/bx/medicaid

Member Name: JOHN Q SAMPLE
Medicaid Number:
Wellpoint Service Coordination: 1-866-696-0710
Pharmacy Member Services: 1-833-370-7463



Eligibility

Retro-enrollment:

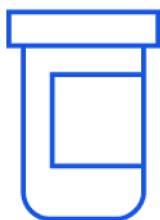
- Medicaid coverage may be assigned retroactively for a client. For claims for an individual who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the notification of eligibility is received from HHSC and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

Retro-disenrollment:

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

Total Member View

Patient 360 has been renamed to Total Member View (TMV). TMV is a dashboard accessible via Payer Spaces in the Availity Essentials platform, offering a comprehensive view of a patient's health and treatment history to aid in care coordination. It allows you to explore specific details:



Pharmacy

- prescription history, prescriber, pharmacy, and quantity



Demographic information and Claims details

- member eligibility, other health insurance, assigned PCP, and assigned case managers
- status, assigned diagnoses, and services rendered



Authorization details and Care management related activities

- status, assigned diagnoses and assigned services
- assessment, care plans and care goals



Care summaries

- emergency department visit history, lab results, immunization history, and due
- or overdue preventive care screenings

To access Total Member View, log in to <https://Availity.com>, select **Wellpoint** under *Payer Spaces*, and it will appear under the *Applications* tab on the bottom portion of the screen.

Is prior authorization required?

Determine if specific outpatient procedures and/or services require prior authorization through the **Precertification Lookup Tool (PLUTO)**, which allows you to search by market, member's product, and CPT® code.

- All inpatient stays require prior authorization.
- All out-of-network service requests require prior authorization.
- All non-emergency ambulance transportation requires prior authorization.
- Some services/procedures have Medicaid allowable limits or age restrictions and should be verified through the Texas Medicaid Provider Procedures Manual (TMPPM).

The Wellpoint provider website, provider manual, Precertification Lookup Tool, and Quick Reference Guide specify services that require prior authorization and include contact information.

Prior authorization required documentation

- A completed prior authorization request is required to prevent delays in processing, which includes all required essential information, documentation, current clinical information, and a signed authorization form by the requesting provider.
- **Please note:** Obtaining prior authorization does not guarantee payment.

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



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



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



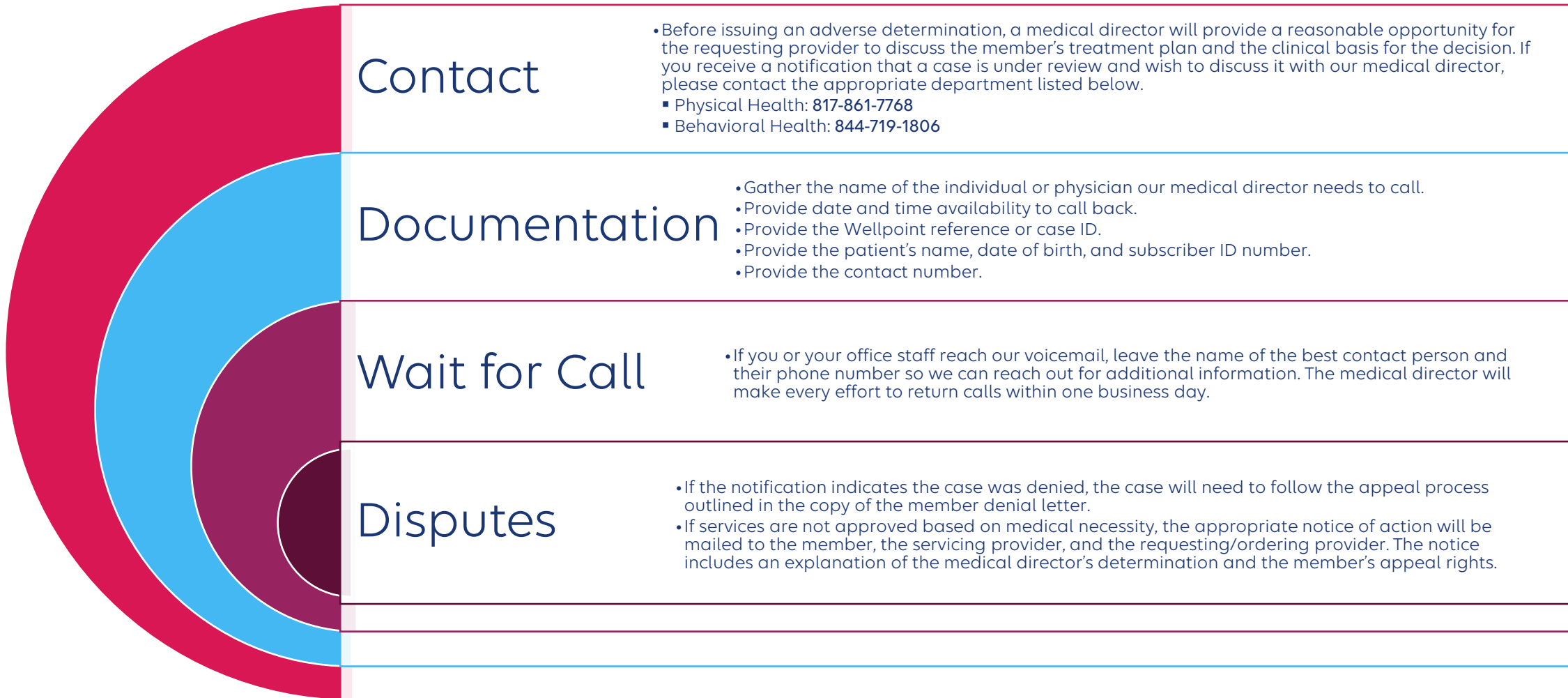
Service request start and end dates, and Quantity of service units requested based on the CPT, HCPCS, or CDT requested



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

Steps to process peer to peer review

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



Prior authorization and important contact information

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

| | |
|---|---|
| Inpatient/outpatient surgeries: | 800-964-3627 (fax), 833-731-2162 (phone) |
| Inpatient discharge planning (fax only): | <ul style="list-style-type: none">Physical health: 888-708-2599Behavioral health: 844-430-6805 |
| Behavioral health services (digital and fax options): | <ul style="list-style-type: none">Digital submission (preferred method) at https://Availity.comBehavioral health (inpatient): 844-430-6805Behavioral health (outpatient): 844-442-8010 |
| Specialized care services (fax only): | <ul style="list-style-type: none">Back and spine procedures: 800-964-3627Durable medical equipment (DME): 866-249-1271Home health nursing (PDN, SNV, HHA): 866-249-1271Medical injectable/infusible drugs: 844-512-8995 (for additional information, refer to the pharmacy prior authorizations document on our provider website)Pain management injections and wound care: 866-249-1271Therapy (physical, occupational, and speech): 844-756-4608 |
| Carelon Medical Benefits Management, Inc.: | 833-342-1260 (phone); careloninsights.com (online) <ul style="list-style-type: none">CardiologyGenetic testingRadiology (high-tech)Sleep studiesRadiation oncology |

Prior authorization and important contact information (cont.)

| | |
|--|--|
| | |
| Superior Vision of Texas (medical/surgical): | 855-313-3106 (fax); ecs@superiorvision.com (email) |
| Nursing facility: | 844-206-3445 (fax) |
| Ambulance Transportation (non-emergency): | Physical health (nonurgent): 866-249-1271 (fax) Behavioral health (nonurgent): 844-442-8010 (fax) Urgent: 833-731-2162 (phone) For additional information, refer to the Ambulance Transportation Services (Nonemergent) section of the Medicaid/CHIP provider manual. |
| Long-Term Services and Supports (LTSS)/ Personal Attendant Services (PAS) for STAR Kids members: | 844-756-4604 (fax) STAR Kids Urgent Services: 866-696-0710 (phone) |
| LTSS/PAS requests for STAR+PLUS members are to be submitted by service area: | Service Area Fax: <ul style="list-style-type: none">• Jefferson: 888-220-6828• Lubbock: 888-822-5761• Nueces: 888-822-5790• West RSA: 888-822-5761 STAR+PLUS Urgent Services: 877-405-9872 (phone) |
| STAR/CHIP Urgent services: | [833-731-2162] (phone) |
| Nurse HelpLine: | CHIP, STAR, STAR+PLUS: 833-731-2160 (TTY 711) STAR Kids: 844-756-4600 (TTY 711) |

Referrals

Specialty referrals:

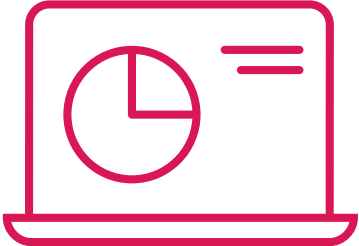
- Providers are not required to call Wellpoint and authorize a referral to a specialist; referrals may be coordinated directly between the PCP and an in-network chosen specialist.

Approval of a specialist as a PCP:

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

Claim submission options

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



| Paper submissions | Electronic submission payers | EDI Hotline |
|--|--|---|
| Wellpoint P.O. Box 61010 Virginia Beach, VA 23466-1010 | <ul style="list-style-type: none">• Availity Essentials: 800-282-4548• Website: https://Availity.com• Payer ID: WLPNT | <ul style="list-style-type: none">• Phone: 800-590-5745 |

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

Electronic remittance advice (835)

The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these easy steps:

- Log in to <https://Availity.com>.
- Select My Providers > Enrollment Center > ERA Enrollment.

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

Electronic funds transfer (EFT):

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

Provider Enrollment Management System (PEMS)

Ensure your demographic information is current with both TMHP and Wellpoint.

To revalidate, do the following:

- **Check Revalidation Date:** Log in to PEMS to view your revalidation date and confirm enrollment details.
- **Timely Revalidation:** Submit your application via PEMS before your enrollment period ends, generally every five years.
- **Consequences:** Failure to revalidate will prevent participation as a Medicaid MCO provider, resulting in unprocessed or denied claims and authorization requests.

Rejected versus denied claims

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

Rejected:

- Does not enter the adjudication system due to missing or incorrect information
- Resubmission subject to 95-day timely filing deadline

Denied:

- Does go through the adjudication process, but is denied for payment
- Appeal deadline of 120 days from the Explanation of Payment (EOP) date applies.
 - For claims inquiries, please call Provider Services at **833-731-2162**.

Submitting a corrected claim

- If you need to submit a corrected claim due to errors or changes on the original submission, it can be submitted through Availity Essentials, EDI, or by mail.
- Corrected claims must be clearly identified; handwritten alterations to billing information are not accepted. Claims with such alterations will be returned with an explanation. For timely original submissions, corrected claims must be resubmitted within 120 calendar days of the EOP.

Claim Information

| | |
|---|---|
| * Patient Control Number / Claim Number: ? | <input type="text"/> |
| Medical Record Number: | <input type="text"/> |
| * Place of Service: ? | 11 - Office <input type="button" value="v"/> |
| * Billing Frequency: ? | 7 - Replacement of Prior Claim <input type="button" value="v"/> |
| * Payer Control Number (ICN / DCN): ? | <input type="text"/> |
| | <input type="checkbox"/> this is an HMO claim |
| * Provider Signature on File: | Select One <input type="button" value="v"/> |
| Prior Authorization Number: ? | <input type="text"/> |
| Care Plan Oversight Number (for Medicare Patients): ? | <input type="text"/> |
| Chiropractic Patient Condition Code: | Select One <input type="button" value="v"/> |

This claim also includes...

Medicaid members must not be billed for covered services

- Our agreement with the state **mandates** members should not be burdened with any non-approved, out-of-pocket expenses for services covered under the Medicaid program.
- Fundamental principle does not change when a member has other insurance.
- Members should receive the best benefits available from both coverage plans.
- When claims are denied or reduced for services that are within the amount, duration, and scope of benefits of the Medicaid program.

For services not submitted for payment, including claims not received:

- When claims are denied for timely filing (95 days).
- When there is a failure to submit corrected claims within 120 days.
- When there is a failure to appeal claims within the 120-day appeal period.
- When there is a failure to appeal a medical denial.
- When submission of unsigned or otherwise incomplete claims, such as:
 - Omission of Hysterectomy Acknowledgement Form.
 - Sterilization Consent Form.

Billing Medicaid members for noncovered services



Before billing members for services not covered, providers must:

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

Sample Client Acknowledgment Statement

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

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

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

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

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

The above sample is found in your provider manual.

Coordination of benefits payment methodology

- Wellpoint is the payer of last resort.
- Coordination of Benefits claims is paid up to the Wellpoint allowable, regardless of the primary carrier's allowable:

- **Example 1:**

| | |
|---------------------------------------|----------------|
| Wellpoint allowable: | \$4,000 |
| <i>Minus</i> primary carrier payment: | \$2,000 |
| <i>Minus</i> Wellpoint payment: | <u>\$2,000</u> |
| Final balance: | \$ 0 |

When the primary carrier denies your claim

- If the primary carrier does not cover a service because the member or provider did not follow guidelines for the primary payer, then Wellpoint becomes the next payment source.
- At this point, the Wellpoint standard requirements, such as authorization rules and timely filing rules, are applied.
- Primary EOPs must still be submitted within 95 days from the date of the primary EOP, with some exceptions.



Wellpoint is the payer of last resort

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

Wellpoint provider complaints

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

Filing a formal HHSC complaint

TEXAS
Health and Human
Services

How to Submit a Complaint as a Medicaid Provider

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

STEP 1: Contact the health or dental plan

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

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

- › Call **800-925-9126**
- › or write to:
TMHP, Complaints Resolution Department
PO Box 204270, Austin, TX, 78720-4270

If you still need help:

STEP 2: Contact HHSC

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

What you'll need when you contact HHSC:

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

What you can expect from HHSC:

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

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

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

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TXPEC-4014-20

October 2020

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

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

Member complaints and appeals

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

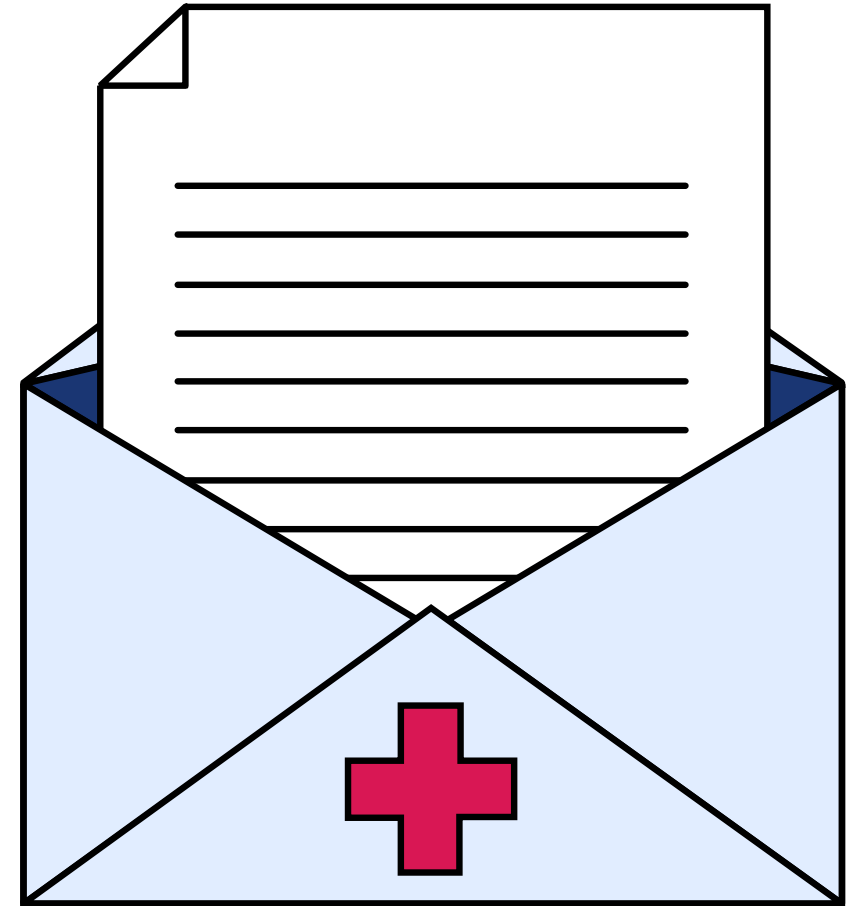
Member Advocates
Wellpoint
2505 N. Highway 360, Suite 300
Grand Prairie, TX 75050

Member medical appeals

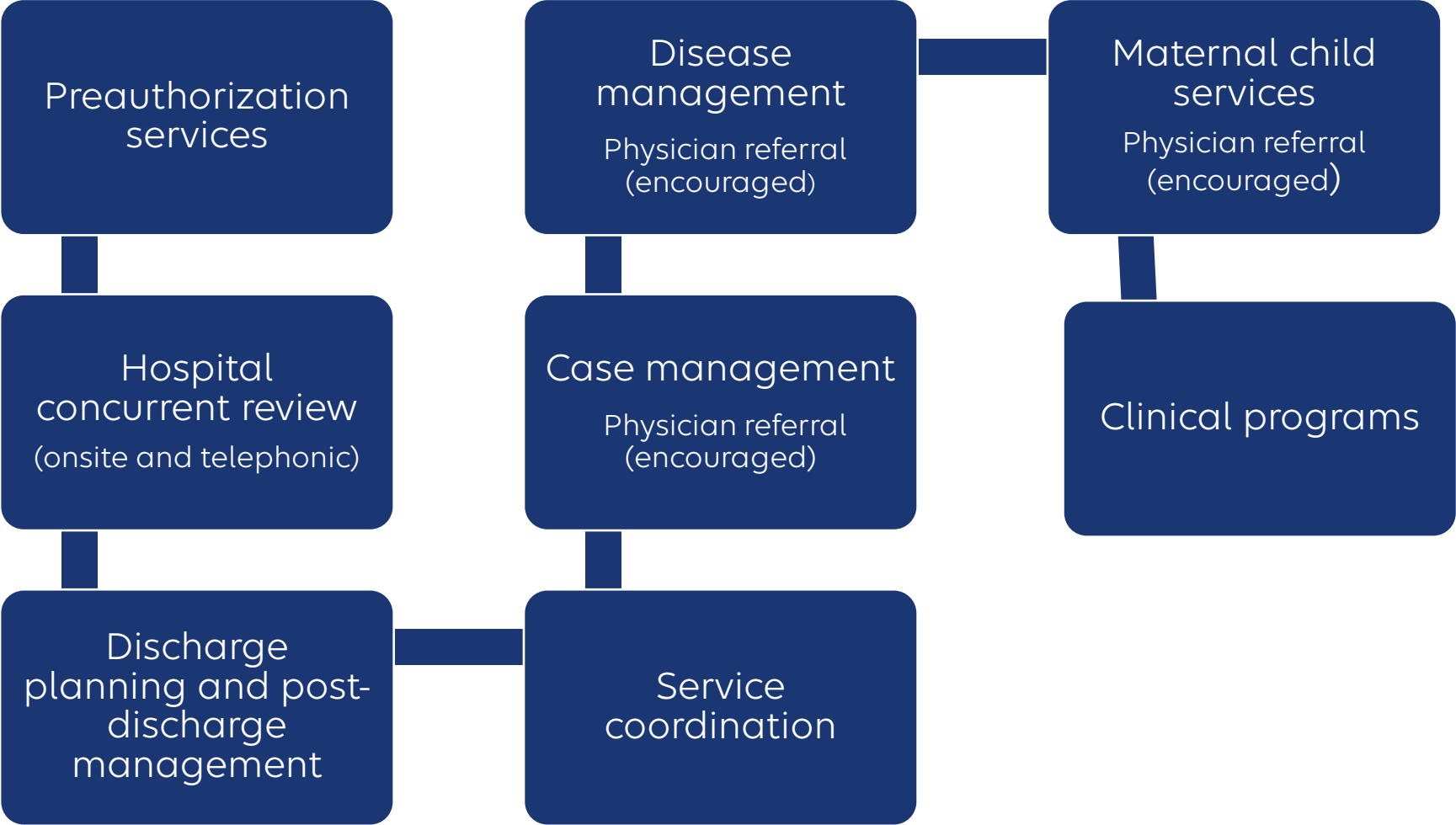
- Member medical appeals can be initiated by the member or the provider on behalf of the member, with the member's signed consent, and must be requested within 60 calendar days of the adverse benefit determination. CHIP member appeals do not require signed consent.
- Member medical appeals can be submitted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

Payment dispute process

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



Medical management services



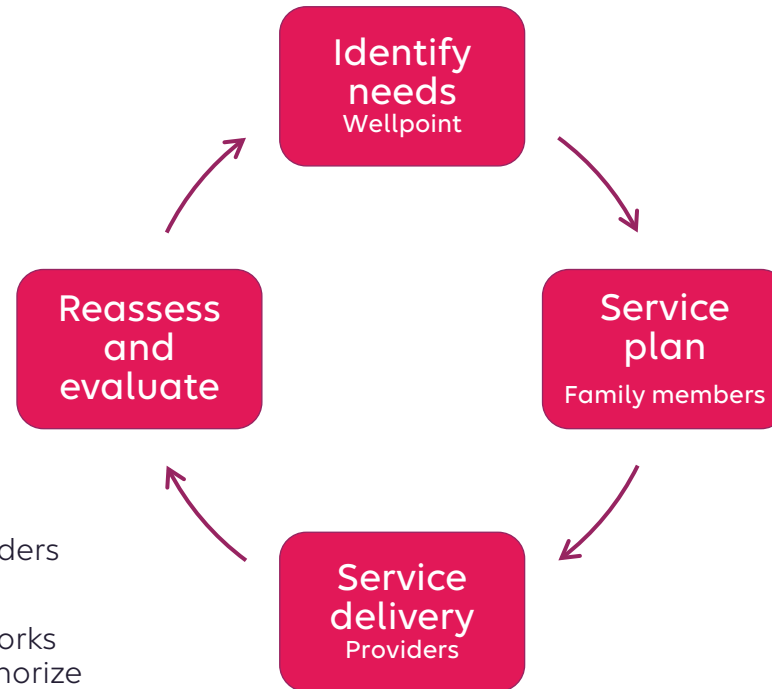
Service coordination model

Reassess and evaluate

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

Service delivery

- The member selects providers from the network.
- The service coordinator works with the care team to authorize and deliver services.
- The service coordinator ensures that all appropriate services are authorized and delivered in accordance with the service plan.



Identify needs

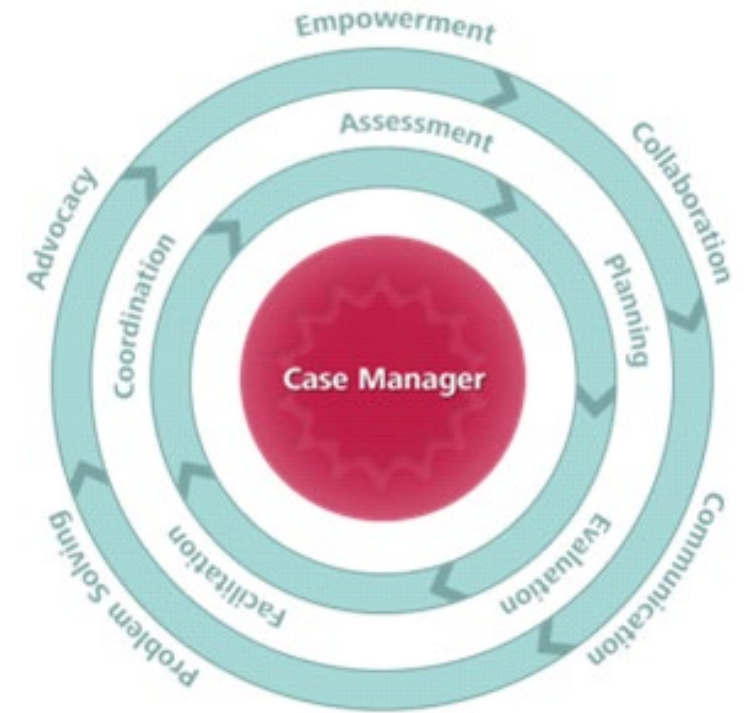
- Members contacted in the first 30 days and screened for complex needs and high-risk conditions.
- Identify complex and high-risk members for a home visit in the next two weeks.

Service plan

- The service coordinator makes a home visit and conducts a comprehensive assessment of all medical, behavioral, social, and long-term care needs.
- The service coordinator works with a team of experts to develop a service plan that meets members' needs.
- The service coordinator contacts the member's PCP for concurrence.
- The member and the member's family review and sign the service plan.

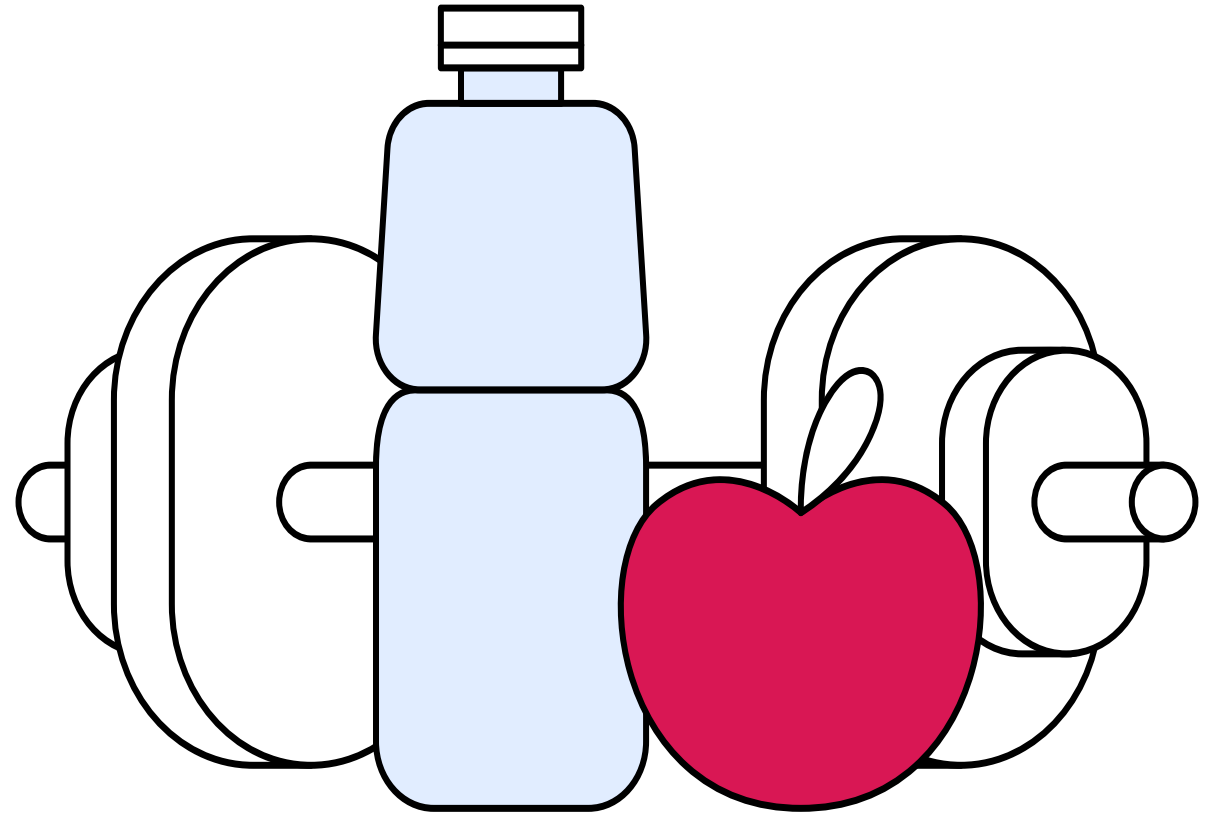
Case management program

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



Disease management

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



Continuity of care services

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

HHSC Primary Health Care Program

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

Maternal child services



- Individualized, one-on-one case management support for identified high-risk pregnancies.

- Educational materials and information on community resources

- Care coordination for moms who may need a little extra support

- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born

- Digital offering available by smartphone app that provides timely, proactive and culturally appropriate education



Healthy Texas Women program (HTW)

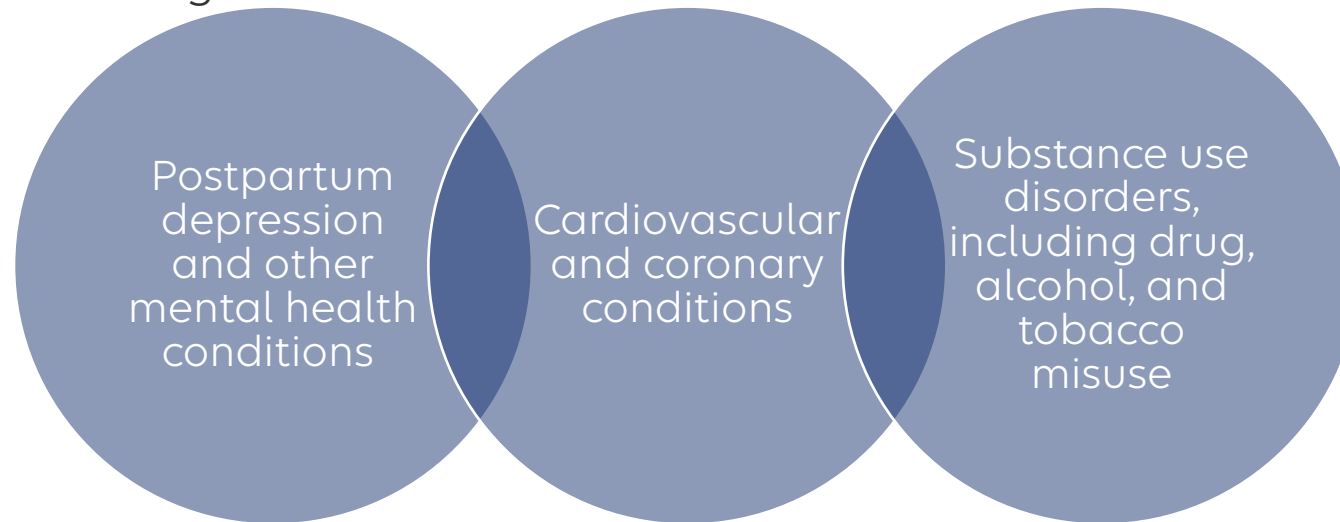
- Health and Human Services launched the Healthy Texas Women program.
- The program is designed to support women's health and family planning services at no cost to eligible, low-income Texas women.
- Wellpoint will ensure our members have the right to choose any Medicaid family planning provider regardless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

HTW (cont.)

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

Healthy Texas Women Plus

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



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

HHSC Family Planning Program

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

Healthy Rewards program

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



HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Mental health/substance use disorders

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

Authorizations:

- Digital submission (preferred method): <https://www.Availity.com>
- Fax (inpatient): 844-430-6805
- Fax (outpatient): 844-442-8010
- Phone: 833-731-2162

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

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



Pharmacy program

- The Texas Vendor Drug Program formulary and *Preferred Drug List* are available on our website: <https://provider.wellpoint.com/texas-provider/member-eligibility-and-pharmacy/pharmacy-information>
- Prior authorization is required for:
 - Nonformulary drug requests.
 - Brand-name medications when generics are available.
 - High-cost injectable and specialty drugs.
 - Any other drugs identified in the formulary as needing prior authorization.
- Online pharmacy prior authorization: covermymeds.com
- Pharmacy prior authorization fax: **844-474-3341**
- Pharmacy Prior Authorization Form accessible at <https://provider.wellpoint.com/texas-provider/member-eligibility-and-pharmacy/pharmacy-information/prior-authorization-forms>
- Phone: **833-731-2162** (Wellpoint pharmacy)
- Medical injectable/infusible drugs prior authorization fax: **844-512-8995**

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

Outpatient information can be found here:
[\[xvendordrug.com/resources/manuals\]](https://xvendordrug.com/resources/manuals)

Pharmacy online drug reference information

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



Laboratory services

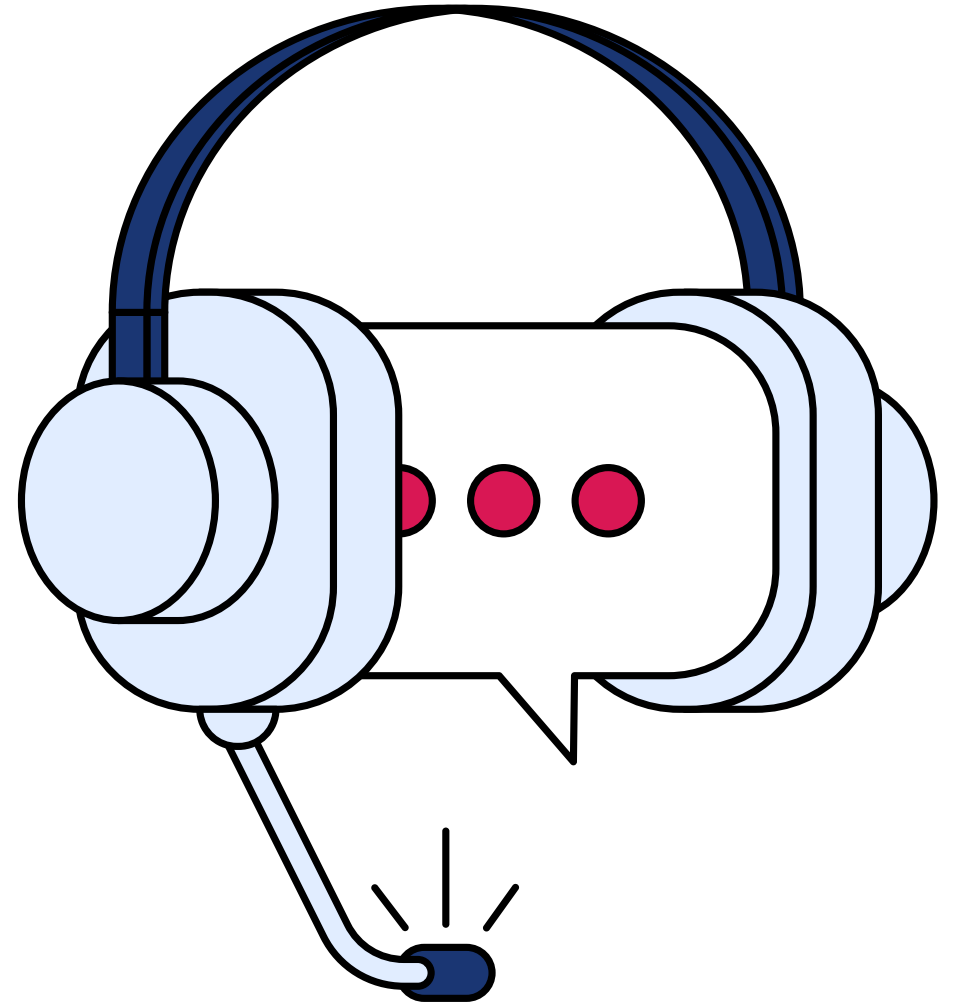
All clinical and anatomic laboratory services not performed in a physician's office must be sent to Clinical Pathology Laboratories, Inc., Quest Diagnostics, LabCorp, or a participating independent reference laboratory to ensure services are directed to the most appropriate setting. This Wellpoint policy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

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

Translation services

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

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



LiveHealth Online (LHO)

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

Telehealth and telemedicine services

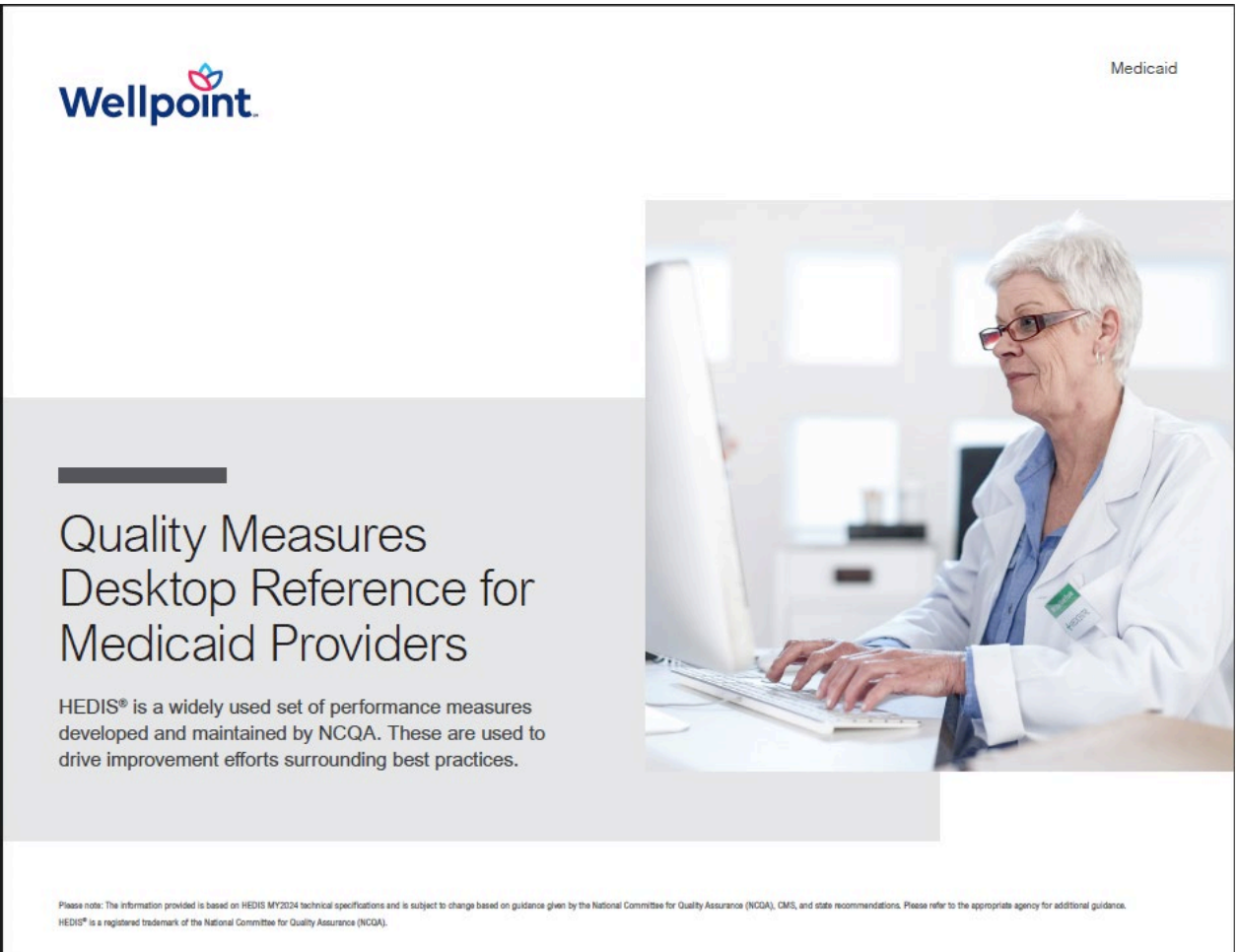
- Telemedicine and telehealth services are covered by Medicaid benefits. The use of telemedicine and telehealth services is intended to promote and support Patient-Centered Medical Homes™ and care coordination. We encourage our network providers to offer telemedicine and telehealth capabilities to our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

Telehealth and telemedicine notifications to PCPs

- The use of telemedicine and telehealth services is intended to promote and support patient-centered medical homes and care coordination.
 - As outlined in *Senate Bill 670* from the 86th Legislature, Medicaid telemedicine and telehealth providers are required to notify the Medicaid member's PCP or provider of the telemedicine or telehealth service, provided the member or their parent/legal guardian consents to the notice. This includes a summary of the telemedicine or telehealth service rendered, exam findings, a list of prescribed or administered medications, and patient instructions.
 - Telehealth and telemedicine providers must attest that they are providing notice of all telemedicine/telehealth encounters and outcomes to the member's PCP, providing the parent/legal guardian consents.
 - To receive a copy of the attestation form, contact your representative.
 - Telemedicine and telehealth providers must keep a record of notifications to primary care physicians and providers in the member's medical records.
- Note:** ECI providers do not follow these requirements. Behavioral health providers are not required to report telemedicine or telehealth services to PCPs unless the service is provided in the school setting.

Quality management

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



The image shows the cover of a document titled "Quality Measures Desktop Reference for Medicaid Providers". The cover features the Wellpoint logo in the top left and the word "Medicaid" in the top right. A photograph of an elderly female doctor in a white lab coat sitting at a computer workstation is on the right side. The title is centered in a large font, and a short paragraph about HEDIS is below it. At the bottom, there is a small "Please note" section.

Wellpoint Medicaid

Quality Measures Desktop Reference for Medicaid Providers

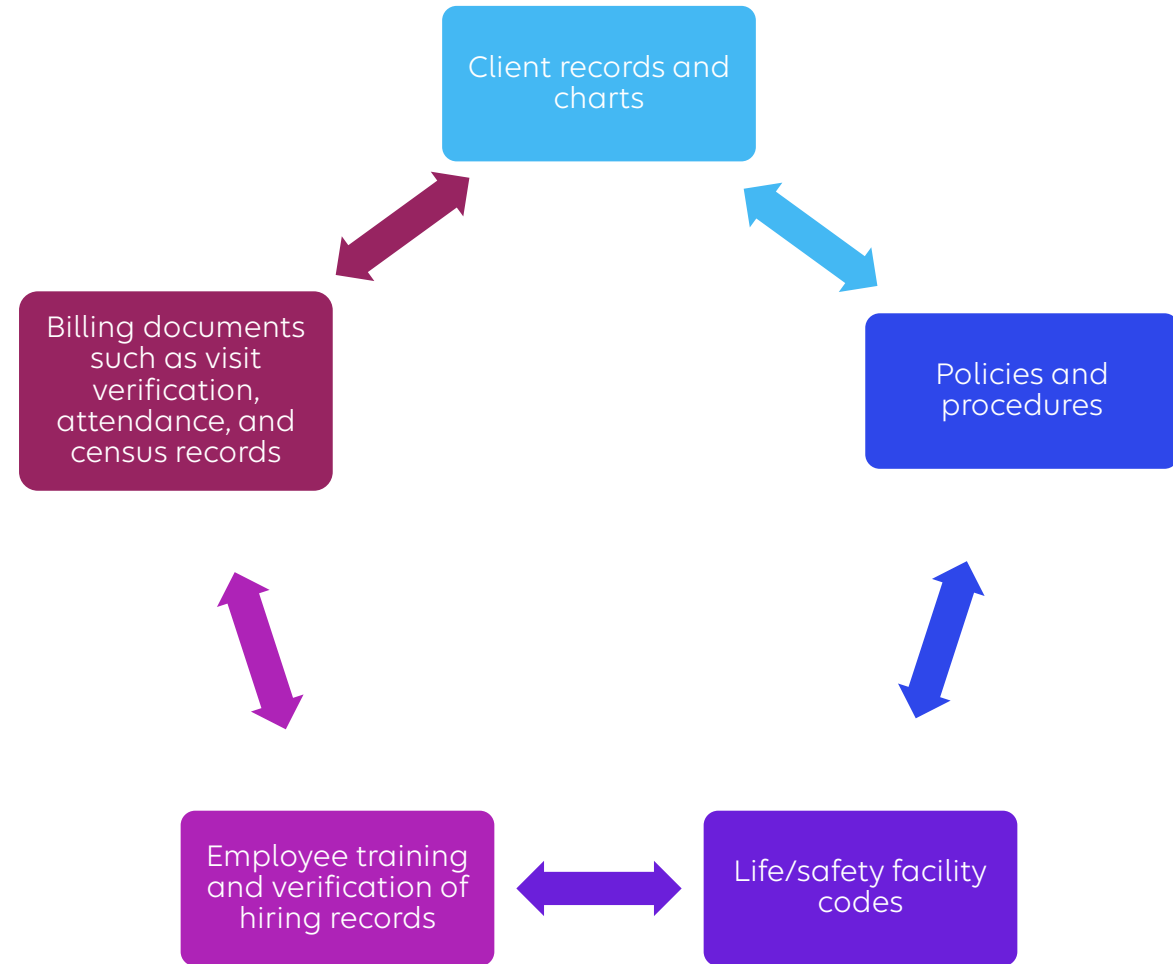
HEDIS® is a widely used set of performance measures developed and maintained by NCQA. These are used to drive improvement efforts surrounding best practices.

Please note: The information provided is based on HEDIS MY2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), CMS, and state recommendations. Please refer to the appropriate agency for additional guidance. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Quality compliance program

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

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



Quality compliance program process

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

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

Join our advisory committees

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

Nonemergency medical transportation (NEMT)

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

| Type of Service | Contact by membership type |
|---|--|
| Access2Care (nonemergent transportation other than ambulance) | Members and providers call the number below for their membership type: <ul style="list-style-type: none">• STAR: 833-721-8184 (TTY 711)• STAR+PLUS: 844-867-2837 (TTY 711)• STAR Kids: 844-864-2443 (TTY 711) |

Nonemergency Medical Transportation (NEMT) services (conti.)

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

Provider Satisfaction Survey

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



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

Why focus on patient experience?

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

How to improve patient experience:

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

External medical review (EMR) provider training

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

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

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

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

Fraud, waste, and abuse

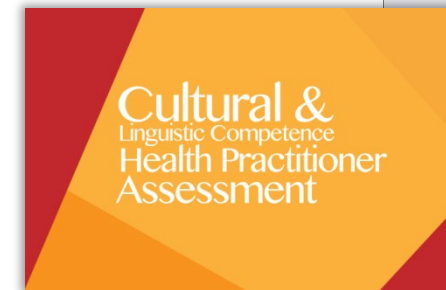
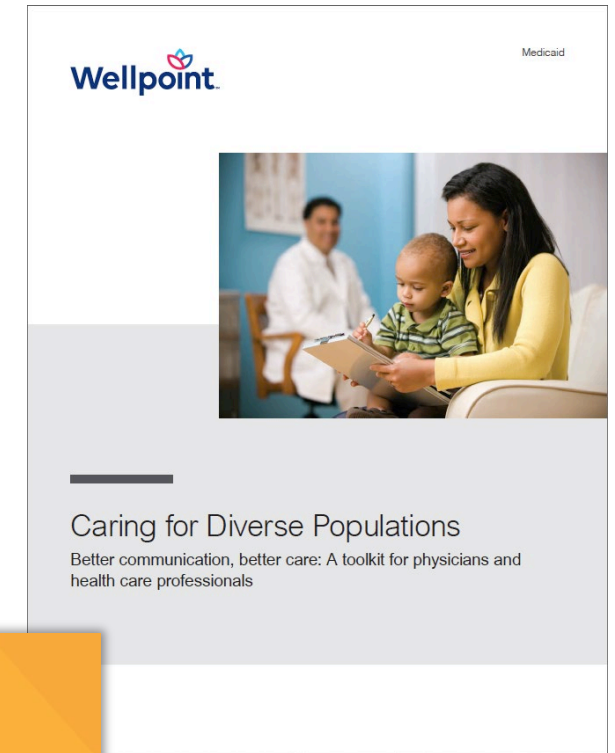
Help us prevent it and tell us if you suspect it

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

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

Cultural competency

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



Provider communications/training resources

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

- For more information, visit:
<https://provider.wellpoint.com/texas-provider/resources/training-academy>.



Additional resources and information

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

Next steps

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



Thank you
for working with us!



Coverage provided by Wellpoint Insurance Company or Wellpoint Texas, Inc.

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