Wellpoint

Provider **Quick Reference Guide**

Medicaid and Children's Health Insurance Program (CHIP)

Important contact information | Prior authorization requirements

833-731-2162

provider.wellpoint.com/tx

TXWP-CD-062300-24

Easy access to prior authorization requirements and other important information

For more information about requirements, benefits and services, including the most recent, full version of the *Medicaid/CHIP Provider Manual,* visit our provider website at **provider.wellpoint.com/tx**. If you have questions about this *Quick Reference Guide (QRG)* or recommendations to improve it, call your provider relationship management representative. We want to hear from you and improve our service, so you can focus on serving your patients!

Prior authorization general information

Prior authorization requests may be submitted for review and approval as indicated below. Documentation and forms required for prior authorization requests are available on our provider website:

- Digital submission (preferred method): Availity.com
- Inpatient/outpatient surgeries and other general requests:
  - **800-964-3627** (fax); **833-731-2162** (phone)
- Inpatient discharge planning (fax only):
  - Physical health: **888-708-2599**
  - Behavioral health: **844-430-6805**
- Specialized care services (fax only):
  - Back and spine procedures: **800-964-3627**
  - Durable medical equipment (DME): **866-249-1271**
  - Home Health nursing (PDN, SNV, HHA): **866-249-1271**
  - Medical injectable/infusible drugs: **844-512-8995** (for additional information, refer to the ***Pharmacy*** section of this QRG)
  - Pain management injections and wound care: **866-249-1271**
  - Therapy (physical, occupational, speech): **844-756-4608**
- Behavioral health services:
  - Digital submission (preferred method) at Availity.com
  - Behavioral health — Inpatient: **844-430-6805** (fax)
  - Behavioral health — Outpatient: **844-442-8010** (fax)
- Carelon Medical Benefits Management, Inc. (formerly AIM Specialty Health): **833-342-1260** (phone); careloninsights.com (online):
  - Cardiology
  - Genetic testing
  - Radiation oncology
  - Radiology (high-tech)
  - Sleep studies
- Superior Vision of Texas (Medical/Surgical):
  - **855-313-3106** (fax)
  - ecs@superiorvision.com (email)
- Nursing facility: **844-206-3445** (fax)
- Ambulance transportation (nonemergent):
  - 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 ***Transportation*** section of this QRG
- STAR Kids:
  - Long-term services and supports (LTSS)/personal attendant services (PAS): **844-756-4604** (fax)
- STAR+PLUS requests for LTSS/PAS are to be submitted by service area (fax only):
  - Jefferson: **888-220-6828**
  - Lubbock/West RSA: **888-822-5761**
  - Nueces: **888-822-5790**
- Urgent services: **833-731-2162** (phone)

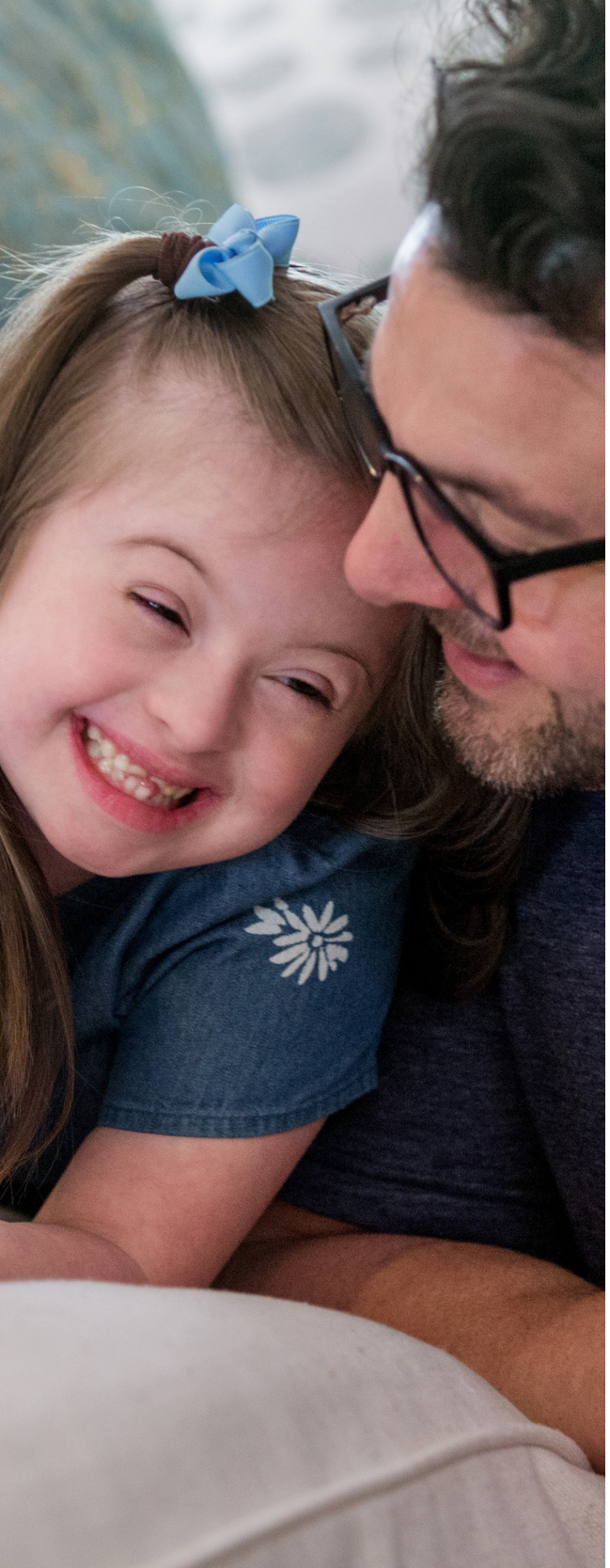
If you have questions, call Provider Services at **833-731-2162**. Staff are available Monday through Friday from 8 a.m. to 5 p.m. local time excluding state-observed holidays. You may leave a confidential voicemail after-hours, and your call will be returned within the next business day.

For code-specific requirements for outpatient procedures and/or services, visit the Precertification Lookup Tool on the Wellpoint provider website or Availity.com.

All elective services provided by or arranged at a nonparticipating provider or facility require prior authorization, except for emergency medical conditions, emergency behavioral health conditions, and minimum required maternity stays where prior authorization is not required. Some services/procedures have Medicaid allowable limits or age restrictions and should be verified through the Texas Medicaid & Healthcare Partnership (TMHP) *Texas Medicaid Provider Procedures Manual* (TMPPM). Documentation and forms required for prior authorization requests are available on the provider website.

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

The information in this *QRG* applies to Medicaid and CHIP-covered benefits. For STAR+PLUS and STAR Kids dual-eligible members, please refer to the member's Medicare plan carrier for information on Medicare covered services.



Behavioral health/substance use

- Members may self-refer to a network provider. No prior authorization or referral is required from the primary care provider.
- Providers may request prior authorization or refer members for services by:
  - Visiting Availity Essentials at Availity.com.
  - Faxing information to our dedicated behavioral health fax lines at **844-430-6805** for inpatient services or **844-442-8010** for outpatient services. Prior authorization forms are located on the provider website via provider.wellpoint.com/tx.
- All services require prior authorization except routine outpatient services. Inpatient mental health and substance use disorder services can be obtained at acute care or freestanding psychiatric or substance use disorder facilities.
- Substance use disorder benefits:
  - Outpatient: Members may self-refer or be referred to receive an assessment. Benefits include ambulatory detoxification, chemical dependency counseling, and medication-assisted treatment. No primary care provider referral is needed.
  - Inpatient: Benefits include residential detoxification and residential treatment. Prior authorization is required.
  - STAR, STAR Kids, and STAR+PLUS member benefits include mental health rehabilitative services and mental health targeted case management.

Chemotherapy

- For information on prior authorization requirements for chemotherapy drugs, please refer to the Precertification Lookup Tool on our provider website or Availity.com.
- Prior authorization is required for coverage of inpatient services.
- Limitations and exclusions apply for experimental and investigational treatments.

Chiropractic services

- Chiropractic manipulation therapy provided by a chiropractor is covered for STAR, STAR Kids, and STAR+PLUS members. Treatment is limited to an acute condition or an acute exacerbation of a chronic condition for a maximum of 12 visits in a consecutive 12-month period and a maximum of one visit per day.
- CHIP members are limited to spinal subluxation at 12 visits in a 12-month period.

Dental services

- Members 20 years old and younger receive dental services through one of the dental maintenance organizations listed in the ***Our service partners*** section of this *QRG*.
- Home- and Community-Based Services (HCBS) STAR+PLUS Waiver members should contact their service coordinator either directly or through Member Services at **833-731-2160 (TTY 711)** for dental services information.
- See the *Nursing Facility Provider Manual* for dental benefit information for STAR+PLUS members who reside in a nursing facility. The *Nursing Facility Provider Manual* can be found on the provider website at provider.wellpoint.com/tx.
- STAR+PLUS nondual members other than HCBS Waiver have coverage for certain routine dental services as a value-added benefit.

*For temporomandibular joint (TMJ) services, see the **Plastic/cosmetic/reconstructive surgery** section of this QRG.*

Dermatology services

- Services considered cosmetic in nature, or related to previous cosmetic procedures, are not covered.

Diagnostic testing

- Prior authorization through Carelon Medical Benefits Management (formerly AIM Specialty Health) is required for MRA, PET scan, MRI, CT/CTA scan, echocardiography (SE), resting transthoracic echocardiography (TTE), transesophageal echocardiography (TEE), arterial ultrasound, cardiac catheterization, percutaneous coronary intervention (PCI), and nuclear cardiology including myocardial perfusion and infarction imaging and FFR (fractional flow reserve) derived from CTA data.

Dialysis

- Refer to the Precertification Lookup Tool for prior authorization requirements.

Disposable medical supplies

- Refer to the Precertification Lookup Tool for prior authorization requirements.
- Coverage for CHIP members includes diabetic supplies and equipment; there is a $20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices and diabetes supplies and equipment are not counted against this cap).

*See the **Durable medical equipment (DME)** section of this QRG for more information.*

Durable medical equipment (DME)

- Refer to the *Prior Authorization Requirements* document found on our provider website under Resources > Prior Authorization Requirements for additional information.
- Prior authorization is required for coverage of certain DME, prosthetics, and orthotics. For code-specific prior authorization requirements for DME, prosthetics and orthotics, refer to the Precertification Lookup Tool on our provider website or Availity.com.
- Prosthetics and orthotics are not covered for Texas Medicaid members age 21 and older.

Durable medical equipment (DME) (cont.)

- Prior authorization for home health DME and supplies under the Exceptional Circumstances provision as described in the *Texas Medicaid Provider Procedures Manual* (TMPPM) may be requested by submitting the required forms and documentation included in the *Prior Authorization Requirements* document found on our provider website.
- The requested Healthcare Common Procedure Coding System (HCPCS) and/or other codes for billing covered services must be on the Wellpoint contracted fee schedule and/or be a Texas Medicaid & Healthcare Partnership (TMHP) payable service code, unless authorized as an Exceptional Circumstance.
- Detailed manufacturer's retail pricing information is needed for DME requests exceeding $3,000.

CHIP members are limited to $20,000 per 12-month period for DME, prosthetics, devices, and disposable medical supplies (implantable devices and diabetes supplies and equipment are not counted against this cap). See the ***Disposable medical supplies*** section of this QRG for guidelines on disposable medical supplies.

Refer to the Nursing Facility Provider Manual for requirements relating to STAR+PLUS members who are nursing facility residents.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visits

*See the **Texas Health Steps** section of this QRG.*

Electronic visit verification

- Electronic visit verification (EVV) is a computer-based system that electronically verifies the occurrence of authorized personal attendant service visits by electronically documenting the precise time a service delivery visit begins and ends. The EVV program was implemented to replace paper-based timesheets.
- EVV is a state requirement for certain Medicaid home-and community-based services. For more information on requirements, visit our ***Electronic Visit Verification*** **webpage**.

Emergency services

- Members may self-refer.
- No notification is required for emergency care given in the emergency room. If emergency care results in admission, notification to Wellpoint is required within 24 hours or the next business day.

*For observation prior authorization requirements, see the **Observation** section of this QRG.*

Ear, nose and throat (ENT) services (otolaryngology)

- Refer to the *Prior Authorization Requirements* document found on our provider website under Resources > Prior Authorization Requirements for additional information.

*See the **Diagnostic testing** section of this QRG* for more information.

Family planning/sexually transmitted disease (STD) care

- Members may self-refer to a network or Medicaid family planning provider.
- No prior authorization is required for family planning services available for STAR, STAR Kids and STAR+PLUS nondual members.
- Family planning services are not covered for CHIP members.
- Infertility services and treatment are not covered.

Gastroenterology services

- Refer to the *Prior Authorization Requirements* document found on our provider website under Resources > Prior Authorization Requirements for additional information.

*See the **Diagnostic testing** section of this QRG* for more information.

Genetic testing

- Prior authorization through Carelon Medical Benefits Management is required is required for all genetic testing.

Gynecology

- Members may self-refer to a participating provider.
- Refer to the *Prior Authorization Requirements* document found on our provider website under Resources > Prior Authorization Requirements for additional information.

Hearing aids

- Hearing aid instruments are covered for adults and children.
- Coverage includes hearing aids provided by licensed fitters enrolled in the Texas Medicaid program.
- Wellpoint covers hearing aid(s) for adults at the rate of one every five years. Children can receive one for each ear every five years.

Hearing screening

- No notification or prior authorization is required for the coverage of diagnostic and screening tests, hearing aid evaluations, or counseling.
- Hearing screenings are not payable on the same day as a Texas Health Steps checkup.
- Hearing screenings are covered for adults and children.

Home health care

- Prior authorization is required for all services.

Hospice care

- Hospice care is covered for CHIP members:
  - Prior authorization is required for coverage of inpatient services.
  - Notification is required for outpatient hospice services.
- STAR, STAR Kids, and STAR+PLUS members receive hospice care through the Texas Health and Human Services Commission (HHSC). STAR Kids and STAR+PLUS members will remain enrolled in managed care. For these members, Wellpoint covers services unrelated to the member's terminal illness and furnishes case management coordination. STAR members will be disenrolled from managed care and transferred to Medicaid Fee for Service (FFS).

Hospital admissions

- Inpatient elective and nonemergent admissions require prior authorization.
- Emergency admissions require notification within one business day.
- To be covered, a Wellpoint-preferred lab vendor must perform preadmission testing.
- Same-day admission is required for surgery.

*See exceptions to prior authorization and notification in the **Obstetrical care** section of this QRG.*

Laboratory services (outpatient)

- All laboratory services furnished by non-network providers require prior authorization by Wellpoint, except for hospital laboratory services in the event of an emergency medical condition.
- Laboratory services related to Texas Health Steps services may be sent to the state laboratory or Wellpoint-contracted vendors.
- For offices with limited or no office laboratory facilities, lab tests may be referred to a Wellpoint-preferred lab vendor.
- Visit provider.wellpoint.com/tx for a complete listing of participating vendors.

Long-term services and supports (LTSS) (STAR Kids and STAR+PLUS only)

- All LTSS require authorization before services are rendered.
- For STAR+PLUS members, see the *Medicaid/CHIP Provider Manual* for a list of LTSS benefit categories available, including day activity health services, personal assistance services, dental services, adaptive aids, assisted living/residential care, emergency response services, and respite care for members living in the community.
- For STAR Kids members, see the *Medicaid/CHIP Provider Manual* for a list of LTSS benefit categories available and who covers these benefits. For certain members, the waiver program provides some of the LTSS benefits.
- See the *Nursing Facility Provider Manual* for STAR+PLUS benefits information for members who reside in a nursing facility.
- Service coordination phone: **866-696-0710**.

Neurology

- Refer to the *Prior Authorization Requirements* document found on our provider website under Resources > Prior Authorization Requirements for additional information.

*See the **Diagnostic testing** section of this QRG for more information.*

Observation

- No prior authorization or notification is required for observation for in-network providers.
- If observation results in admission, notification to Wellpoint is required within one business day.

Obstetrical care

- Refer to the *Prior Authorization Requirements* document found on our provider website under Resources > Prior Authorization Requirements for additional information.
- Notification to Wellpoint is required at the first prenatal visit.
- No prior authorization is required for inpatient admission, as required under federal or state law, for in-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated delivery by cesarean section. We require notification and medical necessity review of maternity inpatient stays for any portion over these time frames.
- No prior authorization is required for coverage of labor, delivery, and circumcision for newborns birth through 12 weeks of age.
- Notification of delivery is required within 24 hours with newborn information.
- OB case management programs are available.

Ophthalmology

- Refer to the *Prior Authorization Requirements* document found on our provider website under Resources > Prior Authorization Requirements for additional information.
- Prior authorization through Superior Vision of Texas is required for medical/surgical services.
- Services considered cosmetic in nature are not covered.
- Certain laser eye treatment procedures are approved only for certain diagnosis codes.

*See the **Diagnostic testing** section of this QRG for more information.*

Oral maxillofacial

*See the **Plastic/cosmetic/reconstructive surgery** section of this QRG for more information.*

Otolaryngology (ENT services)

*See the **Ear, nose and throat (ENT) services (otolaryngology)** section of this QRG for more information.*

Out-of-area/out-of-plan care

- Prior authorization is required except for coverage of emergency care, including self-referral.
- No coverage for out-of-country care.

Outpatient/ambulatory surgery

Refer to the *Prior Authorization Requirements* document found on our provider website under Resources > Prior Authorization Requirements for additional information.

Pain management

Refer to the *Prior Authorization Requirements* document found on our provider website under Resources > Prior Authorization Requirements for additional information.

Pharmacy

- Pharmacy providers can call our Pharmacy Help Desk at **833-252-0329**.
- Pharmacy providers needing to check benefits eligibility can call Provider Services at **833-731-2162**.
- Prior authorization requests can only be made by prescribers or their authorized agents. Prescribers can submit requests by fax at **844-474-3341**, by phone at **833-731-2162**, or online at covermymeds.com for prior authorization of nonpreferred drugs and other drugs requiring prior authorization. Fax forms for pharmacy prior authorization are located on the provider website at provider.wellpoint.com/tx.
- Members can call Pharmacy Member Services at **833-235-2022** or **833-370-7463** for STAR Kids members. The Texas Medicaid formulary applies to STAR, STAR Kids, STAR+PLUS, and CHIP members. The *Texas Medicaid Preferred Drug List (PDL)* applies to STAR, STAR Kids, and STAR+PLUS members only.
- Wellpoint is required to follow the Texas Medicaid formulary and PDL.

Pharmacy (cont.)

- The Texas Medicaid formulary and PDL are available on the Vendor Drug Program website at txvendordrug.com.
- Certain injectable drugs and their counterparts in the same therapeutic class require prior authorization from our Pharmacy department by fax at **844-512-8995** or by phone at **833-731-2162** when administered in any outpatient setting. Please refer to the Precertification Lookup Tool on our provider website or Availity.com.

Physical, occupational, and speech therapy

- Treatment requires prior authorization.
- Initial prior authorization requests must be received no later than five-business days from the date therapy treatments are initiated. Requests received after the five-business day period will be denied for dates of service that occurred before the date the prior authorization request was received.
- Home speech therapy is not a covered benefit for members aged 21 and older.
- Any request for therapy greater than two days from the request date does not meet the criteria for an expedited review.
- No prior authorization is required for coverage of Early Childhood Intervention services for STAR, STAR Kids, or CHIP members under three years of age.

Refer to the Nursing Facility Provider Manual for requirements relating to STAR+PLUS members who are nursing facility residents.

Plastic/cosmetic/reconstructive surgery (including oral maxillofacial services)

- Refer to the *Prior Authorization Requirements* document found on our provider website under Resources > Prior Authorization Requirements for additional information.
- Services considered cosmetic in nature and services related to previous cosmetic procedures are not covered.

*See the **Diagnostic testing** section of this QRG for more information.*

Podiatry

- Refer to the *Prior Authorization Requirements* document found on our provider website under Resources > Prior Authorization Requirements for additional information.
- For CHIP members, routine foot care such as hygiene care is excluded.

Primary care

- Primary care provider services include addressing the member's health needs, coordinating the member's healthcare, promoting disease prevention and health maintenance (including coverage of seasonal inoculations), treating illnesses or injuries, maintaining the member's health records, and furnishing 24/7 access and availability for members.
- For STAR and STAR+PLUS members aged 21 and older, annual physical exams are covered. For members 20 years old and younger, see the ***Texas Health Steps*** and ***Well-child preventive care*** sections of this *QRG*.
- A sports/school physical every 12 months by a Wellpoint primary care provider for STAR, STAR Kids and CHIP members is covered as a value-added benefit.

Radiation oncology / Radiation therapy

Prior authorization through Carelon Medical Benefits Management is required for the outpatient procedures listed below:

- Brachytherapy
- Intensity modulated radiation therapy (IMRT)
- Proton beam radiation therapy
- Stereotactic radiosurgery/stereotactic body radiotherapy
- 3-D conformal therapy (EBRT) for bone metasteses and breast cancer
- Hypofractionation for bone metastases and breast cancer when requesting EBRT and IMRT
- Special procedures and consultations associated with a treatment plan (CPT® codes 77370 and 77470)
- Image guided radiation therapy

Radiology

*See the **Diagnostic testing** section of this QRG for more information.*

Sleep studies

Prior authorization through Carelon Medical Benefits Management is required for elective outpatient services, including home sleep tests, in-lab sleep tests, titration studies, initial and ongoing treatment orders (APAP, CPAP or BPAP), and sleep treatment equipment, and related supplies.

Sterilization

- No prior authorization or notification is required for sterilization procedures, including tubal ligation and vasectomy for Medicaid members aged 21 and older.
- A *Sterilization Consent Form* is required for claims submission.
- Reversal of sterilization is not a covered benefit.
- Sterilization is not a covered benefit for CHIP members.

Texas Health Steps

- Members may self-refer; Texas Health Steps services apply to STAR, STAR Kids and STAR+PLUS members aged 20 years old and younger.
- Use the Texas Health Steps Periodicity Schedule and document visits.
- Texas Health Steps services may be provided by any Texas Health Steps provider, whether or not the provider is the member's primary care provider or in the Wellpoint network.
- Vaccine serum is available under the Texas Vaccines for Children (TVFC) program.
- Wellpoint does not reimburse providers for serum available through TVFC.
- CHIP members do not receive Texas Health Steps services. CHIP members receive preventive services under the ***Well-child preventive care*** section of this *QRG*.

Tobacco cessation program

- Texas Medixcaid includes benefits for smoking and tobacco cessation counseling services for members aged 10 and older. Up to eight services may be received in a 12-month period. Additional services can be received if medically necessary and documented by the provider. Prescription nicotine replacement and other smoking or tobacco cessation medications are also covered by Texas Medicaid if the medications are included in the Texas Vendor Drug Program formulary.
- For CHIP members, up to $100 for a 12-month period is covered for a plan-approved program defined by the health plan.
- Smoking/tobacco cessation help for adults is available in our value-added benefit programs.

Transportation

- Nonemergency Medical Transportation (NEMT) services for STAR, STAR Kids, and STAR+PLUS members are provided by Wellpoint through our vendor Access2Care. Members can schedule rides by calling the numbers shown in the ***Our service partners*** section of this QRG. Use of this benefit generally requires a two business day notice except for urgent care, hospital discharge, and trips to the pharmacy to pick up medication or approved medical supplies. Ambulance transportation is excluded from this benefit.
- STAR+PLUS nursing facility residents' access to NEMT benefits is limited to trips for dialysis and discharge to home. The nursing facility is responsible for most medical transportation.
- Wellpoint also offers value-added benefits for some transportation not covered by Medicaid. CHIP members receive rides to doctor visits for chronic illnesses.
- All nonemergent ambulance transportation must be authorized by Wellpoint. Required forms are available on the provider website at provider.wellpoint.com/tx.
- Prior authorization by Wellpoint is required for coverage of fixed-wing transportation.

Urgent care center visits

No notification or prior authorization is required for participating facilities.

Vision care (routine) and supplies

- Members may self-refer for routine vision care and supplies.
- The contracted vendor is Superior Vision of Texas; call **866-819-4298** for providers and **800-428-8789** for members.
- For STAR, STAR Kids and STAR+PLUS members 20 years old and younger, one complete eye exam is covered every 12 months. Frames and regular lens types, including polycarbonate lenses or contact lenses when medically necessary, are covered once every 24 months.
- For STAR and STAR+PLUS nondual members aged 21 and older, one complete eye exam is covered every 24 months and eyeglasses or contact lenses if medically necessary.
- The benefit period begins with the month the glasses are first dispensed. If there is a change in visual acuity of ±.50 diopter in an eye, the member is eligible for new nonprosthetic eyeglasses, regardless of when the first pair was dispensed.
- STAR+PLUS nondual members have a $150 extra allowance for eyeglasses or contact lenses plus polycarbonate or plastic lenses as a value-added benefit.
- For CHIP members: one eye examination to determine the need and prescription for corrective lenses per 12-month period is covered, and one pair of nonprosthetic eyewear per 12-month period is covered.

Well-child preventive care

- Members may self-refer; for STAR, STAR Kids and STAR+PLUS members, see the ***Texas Health Steps*** section of this *QRG*.
- CHIP members receive preventive services. CHIP well-child care visits should be provided following the American Academy of Pediatrics periodicity schedule.
- Vaccine serum is available through the TVFC program for qualified members.

Well-woman exam

Members may self-refer; one exam is covered per calendar year.

Our service partners

Access2Care (nonemergent transportation other than ambulance)	STAR: **833-721-8184** STAR+PLUS: **844-867-2837** STAR Kids: **844-864-2443**
Carelon Medical Benefits Management, Inc. (cardiology, genetic testing, radiation oncology, high-tech radiology and sleep studies prior authorization)	careloninsights.com **833-342-1260**
Availity Essentials (claim filing, claim status inquiries, member eligibility and benefits information, prior authorization, demographic changes, and other functions)	Availity.com **800-AVAILITY (282-4548)**
DentaQuest (Dental managed care organization [MCO] for members 20 years old and younger)	CHIP: **800-508-6775** STAR: **800-516-0165**
MCNA Dental (Dental MCO for members 20 years old and younger)	**800-494-6262**
Superior Vision of Texas (vision services)	**866-819-4298** for providers **800-428-8789** for members
Superior Vision of Texas (medical/surgical services prior authorization)	**855-313-3106** (fax) ecs@superiorvision.com (email)
Texas Health Steps program	**877-847-8377**
UnitedHealthcare Dental (Dental MCO for members 20 years old and younger)	**877-901-7321**

Claims submission

Timely filing is within 95 calendar days from the date of service.

Refer to the *Nursing Facility Provider Manual* for timely filing requirements for STAR+PLUS members who are nursing facility residents.

Submit claims digitally through Availity Essentials. Log in to **Availity.com** and select the **Claims & Payments** tab. Choose the professional or facility claim option to efficiently complete your claim submission.

Information on paper claims filing can be found in the *Medicaid/CHIP Provider Manual.*

Electronic data interchange (EDI)

Availity is our exclusive partner for managing all EDI transactions. EDI, including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers to do business electronically. Refer to the provider manual for more information about EDI. Contact Availity with any questions at **800-AVAILITY (282-4548).**

Claim status

To learn the status of your claim, log in to **Availity.com** and from the *Claims & Payments* tab, select **Claim Status**.

Claim payment disputes

A claim payment dispute must be filed within 120 calendar days of the date of the *Explanation of Payment (EOP).*

Providers can file a claim payment dispute digitally through Availity.com. From the *Claims & Payments* tab, select **Claim Status**. Find your claim and use the Dispute button to file a dispute. Upload documents and records to support your dispute from your Appeals dashboard. Use the Appeals dashboard to track your dispute and receive related correspondence.

Providers may also fax a payment dispute request to **844-756-4607** or mail it to:

Payment Dispute Unit
Wellpoint
P.O. Box 61599
Virginia Beach, VA 23466-1599

Member medical appeals

A member medical appeal for a pre-service denial can be initiated by a member or a provider on behalf of the member and must be submitted within 60 calendar days from the date of the decision notification letter. File a medical appeal digitally through Availity.com. From the *Patient Registration* tab, select **Authorizations & Referrals** to access the *Authorization/Referral Dashboard*. Identify your authorization and use the **Appeal** function to submit the appeal.

Member medical appeals may also be requested by calling Member Services at **833-731-2160 (TTY 711)**/ STAR Kids at **844-756-4600 (TTY 711)** or submitted in writing to:

Appeals
Wellpoint
PO Box 62429
Virginia Beach, VA 23466-2429

A provider submitting an appeal on behalf of a member must have written authorization from the member to act as the member's designated representative except for CHIP members.

Provider medical appeals

Providers may submit an appeal request for post-service medical denials. The appeal must be requested within 120 calendar days of the earlier of the denial letter or *EOP* date and should be sent to:

Appeals Team
Wellpoint
P.O. Box 61599
Virginia Beach, VA 23466-1599

Provider demographic changes

The Provider Data Management (PDM) tool in Availity Essentials at Availity.com should be used to submit demographic change requests for all professional and facility providers. The HHSC administrative services contractor (Texas Medicaid & Healthcare Partnership) must also be notified of all demographic changes.

Provider Services program

Our Provider Services team offers prior authorization, case and disease management, automated member eligibility, claims status, health education materials, outreach services, and more. **Call 833-731-2162, Monday to Friday, from 7 a.m. to 6 p.m. CT**.

For Texas provider credentialing questions, please email TXCredentialing@wellpoint.com.

If you are contracted with MultiPlan directly, please call **866-971-7427**.

The provider websites are available 24/7/365

To verify member eligibility and benefits, request prior authorization and check status, file claims, check claims status, make provider demographic and enrollment changes, and submit claim disputes, access Availity.com. For other functions, such as looking up medical policies, clinical guidelines and reimbursement policies, finding forms, and other general information, visit **provider.wellpoint.com/tx**.

Can't access the Internet?

Call Provider Services at **833-731-2162**, and the recording will guide you through our menu of options — Just say your NPI when prompted by the recorded voice so that we can quickly help you get the right information.

Health services

Case management services – 833-731-2162

We offer case management services to members who are likely to have extensive healthcare needs. Our Nurse Case Managers work with you to develop individualized care plans, including identifying community resources, providing health education, monitoring compliance, assisting with transportation and more.

Condition care (CNDC) services – 888-830-4300

CNDC resources are designed to assist physicians and other healthcare professionals in managing members with chronic conditions. Services are available for members with the following medical conditions: asthma, bipolar disorder, COPD, CHF, CAD, diabetes, HIV/AIDS, hypertension, major depressive disorder in adult and child/adolescent, substance use disorder, and schizophrenia.

Interpreter services

We can provide interpreter services in many different languages and dialects for members who do not speak English. We will set up and pay for an American Sign Language interpreter to assist members who are deaf or hard of hearing. These services are available at no cost to providers or members. In-person interpreter services should be requested at least 24 hours before the appointment. Services can be arranged by calling Provider Services.

Nurse HelpLine – 833-731-2160 (TTY 711) STAR Kids Nurse HelpLine – 844-756-4600 – TTY 711

Members can call our 24-hour Nurse HelpLine for health advice 7 days a week, 365 days a year.

Member Services – 833-731-2160 (TTY 711) STAR Kids Member Services – 844-756-4600 – TTY 711

Learn more about Wellpoint programs
provider.wellpoint.com/tx