

Chapter 74. Policies for Travis County Medical Assistance Program¹

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74.001 General Provisions

- (a) Mission Statement. The Travis County Medical Assistance Program seeks to work in partnerships to ensure access to health care for the medically indigent in accordance with statutory requirements and Travis County policies and procedures as established by the Commissioners Court.
- (b) Travis County Medical Assistance Program (TCMAP) Description. TCMAP offers a medical benefits package to the Travis County rural indigent population in need of health care. Program benefits may include physician services, hospital care, specialty outpatient services, x-rays and laboratory tests, emergency care, home health services, durable medical equipment, prescription drug services, dental services and transportation services for the medically indigent in accordance with state-wide requirements and Travis County policies and procedures as established by the Travis County Commissioners Court.
- (c) Statement of General Policies:
- (1) The purpose of these policies is to provide guidelines in determining eligibility for services and for the operation of the County Medical Assistance Program Advisory Board for the Travis County Department of Health and Human Services (Department) Medical Assistance Program.
 - (2) These policies apply to the Advisory Board and all Travis County residents applying for the TCMAP (excluding City of Austin residents). Travis County reserves the right to change any provision of these policies unilaterally at any meeting of the Commissioners Court.
 - (3) No employee, supervisor, official, or representative of the County has any authority to change any portion of these policies without the express and specific authorization to do so granted by the Commissioners Court.

¹ Chapter 74 was replaced by Travis County Commissioners Court on 8/19/1997, Item 6a. This policy was changed at least four times after 2000 but the text amending the chapter could not be located. Please contact Commissioners Court Minutes for copies of the agenda backup.

- (4) All procedures not stated in the Travis County Policies, Procedures, and Regulations Manual must be approved by the Executive Manager of the Travis County Health, Human Services, and Veterans' Services Department and/or their designee. These procedures will be maintained in written form by the Department, and available upon request.
- (5) It is the intent of the Travis County Commissioners Court that this policy be implemented in a manner in which all services provided are done so in compliance with the Civil Rights Act of 1964, as amended, the Rehabilitation Act of 1973, Public Law 93-1122, Section 504, and with the provisions of the Americans With Disabilities Act of 1990, Public Law 101-336 (S.933).
- (6) All records regarding activities and services provided under these policies shall be maintained in a manner which will secure the confidentiality of records and other information relating to participants in accordance with the applicable Federal laws, rules and regulations, the applicable State laws and regulations and applicable professional ethical standards.

74.002 Advisory Board

- (a) Purpose and Intent. It is the purpose and intent of the Travis County Commissioners Court to create, in joint cooperation with the City of Austin, an advisory panel to advise Travis County and the City of Austin in the provision of coordinated, accessible and efficient health care services through the medical assistance programs of both entities as administered by the combined Austin/Travis County Health and Human Services Department. This panel shall be designated as the Austin/Travis County MAP Advisory Board ("Board").
- (b) Members. The Board shall consist of thirteen members as follows:
 - (1) Program User Members. Five members shall be users of the City or County's medical assistance programs when appointed, but shall not be required to sustain their eligibility. These members shall be known as "Program User Members." Three Program User Members shall be appointed by the City Council and two shall be appointed by the Travis County Commissioners Court.
 - (2) Provider Members. Three members shall be providers of health services who are not employed by the Austin and/or Travis County Health and Human Services Department(s), or otherwise associated with the City or County's medical assistance programs. These shall be known as the "Provider Members" and shall include one of each of the following: a physician, a dentist and a registered pharmacist. Two Provider Members shall be appointed by the City Council and one

Provider Member shall be appointed by the Travis County Commissioners Court.

- (3) At-Large Members. Five members shall be citizens not associated with the City or County's medical assistance programs, as either a program user or a provider. These members shall be known as "At-Large Members," and shall include one representative at large from the community; one representative with a legal, business or financial background, and one representative with a background in health insurance. Three At-Large Members shall be appointed by the City Council and two shall be appointed by Travis County Commissioners Court.
- (4) Ex-Officio Members. The Director of the Austin/Travis County Medical Assistance Program shall be an ex-officio member of the Board. The ex-officio member shall have no voting rights on the Board.
- (c) Terms. Board members shall be appointed to two-year staggered terms. The length of terms of original Board members shall be determined by casting lots. Thereafter, the terms of members shall be for two years.
- (d) Functions. The Board shall not exercise administrative control over any employee or any administrative matter of the Austin or Travis County Health and Human Services Department, but shall serve in an advisory capacity only to assure the development and maintenance of high quality and effective health care services and to advise the Director of the Austin/Travis County Medical Assistance Program on enhancing and optimizing the health services provided under the City's and County's medical assistance programs. The Board shall further serve to assure the responsiveness of the medical assistance programs to the needs of the Austin/Travis County community.
- (e) Officers. The Board shall elect a Chairperson and such additional officers as are necessary.
- (f) Rules of Procedures. A voting majority of the Board shall constitute a quorum. The Board shall establish rules of procedure for the conduct of business and shall meet at least monthly. The Board may appoint technical committees determined to be necessary and such committees may include individuals who are not members of the Board.

74.003 Eligibility Policies

- (a) Overview. The TCMAP eligibility guidelines include but are not limited to three areas: Travis County residency (outside the limits of the City of Austin), family unit's income, and family unit's assets.
- (b) Residency Requirements.
 - (1) Resident. A resident is an individual who lives in Travis County (outside the limits of the City of Austin) at the time of application. Persons who self-declare that they moved to Travis County with the

sole intent of receiving TCMAP services are not eligible for coverage. A person is not required to live in Travis County (outside the limits of the City of Austin) for a specific period of time prior to declaring residency.

- (2) Citizenship. United States citizenship is not required.
- (3) Students. Students living out of the program boundaries whose family resides in the TCMAP area are ineligible for TCMAP benefits.
- (4) Others. Residents of state or federal schools, inmates of a correctional facility, patients in mental health institutions, and residents of a rest home, sanitarium, extended care facility or nursing home are ineligible for TCMAP. If residents of a rest home, sanitarium, extended care facility or nursing home do not have any payor available for these benefits, and if they meet other applicable eligibility guidelines, medical and dental benefits will be available.

(c) Income

- (1) Travis County MAP - At or Below 100% if Federal Poverty Index Guidelines (FPIG).
 - (A) TCMAP is available to Travis County residents who reside outside the limits of the City of Austin with family incomes at or below 100% of the FPIG.
 - (A) Individuals that receive Medicare and are under the present Social Security Administration's definition of elderly (currently age 67) and do not meet the grandfather clause criteria qualify at or below 100% FPIG.
- (2) Travis County MAP - Between 100% and 200% FPIG. Individuals who have been determined disabled through the Social Security Administration and receive Social Security payments (SSDI or RSDI) or are elderly (as defined by the Social Security Administration) may qualify for TCMAP if the total combined household income is at or below 200% FPIG. Family members of individuals who are elderly and/or disabled must qualify at or below 100% FPIG. Individuals that receive Medicare and are under the current Social Security Administration definition of elderly and do meet the grandfather clause criteria qualify at or below 200% FPIG.
- (3) Grandfather Clause. Previous TCMAP enrollees who qualified at or below 200% FPIG on their last TCMAP applications because they were elderly (62 years or older) will continue to be eligible at 200%; however, the family members that are not elderly or disabled will qualify at 100% FPIG, and not 200% FPIG as they did prior to October 1, 1995. The individuals that meet the grandfather clause criteria may be eligible for TCMAP if their household income falls at or below 200% FPIG and they meet all other eligibility criteria.

(d) Assets. To qualify for TCMAP, an applicant and his/her family must have assets less than the allowable limit, excluding occupied homestead. The equity value of any assets will be counted that is not specifically exempted.

(1) Allowable Asset Limit:

| Family Size | Assets Limit |
|-------------|--------------|
| 01 | \$5,000.00 |
| 02 | \$ 6,000.00 |
| 03 | \$ 7,000.00 |
| 04 | \$ 8,000.00 |
| 05 | \$ 9,000.00 |
| 06+ | \$10,000.00 |

(2) Exemptions. The following assets are exempted: Burial Plots, Vehicles, Homestead, and Inaccessible Resources (e.g., irrevocable trust funds, life insurance, and personal possessions).

(e) Appeals. The Department will determine and maintain an appeals process by which applicants may submit requests for review of eligibility determinations.

74.004 Benefits

(a) Services. The services listed below are benefits of the TCMAP; however, pre-authorization may be required prior to the provision of services: (Note: All services must be provided within the TCMAP designated network.)

| | |
|---|--------------------|
| Physician Services | \$ 5.00 Co-payment |
| Primary and preventive care | |
| Hospital Care | \$30.00 Co-payment |
| Hospital Room | |
| Operating Room/Recovery Room | |
| X-ray, Laboratory, Diagnostic, and Therapeutic Services | |
| Medications | |
| Intensive Care/Coronary Care | |
| Physician Hospital Visits and Care | |
| Outpatient Services | \$ 5.00 Co-payment |
| Surgery Services | |
| Occupational Therapy* | |
| Physical Therapy* | |
| Speech Therapy* | |
| Specialty Physician Services | |

*Co-payment for therapy is a one-time charge and covers all visits in the treatment plan.

| | |
|----------------------------------|--------------------|
| Diagnostic X-Rays and Laboratory | \$ 0.00 Co-payment |
| Home Health Services | \$ 0.00 Co-payment |

Emergency Care \$10.00 Co-payment

Prescription Drug Services \$ 4.00 Co-payment

Prescriptions and disposable supplies (e.g., insulin syringes, chemstrips, etc.) obtained through the City of Austin FQHC pharmacies or other participating pharmacies.

Any client not able to pay the prescription drug services co-payment will be assisted in accessing the Travis County Emergency Assistance Program.

Refer to the separate policy for Travis County Dental Assistance

Transportation Services (local only) \$ 0.00 Co-payment

Emergency ambulance transportation.

Call 911 only in URGENT emergency situations.

(b) Exclusions. The following is a list of exclusions from the TCMAP health plan coverage:

(1) Services

(A) Services or supplies not specifically provided by the TCMAP.

(B) All services that have been denied by the TCMAP

(C) Services not provided within the TCMAP designated network.

(D) Services, supplies and equipment provided or primarily utilized outside Travis County.

(E) Services and supplies for persons whose primary residence is outside the Travis County limits.

(F) Services and supplies for persons whose primary residence is inside the City of Austin City limits.

(G) Services, supplies or equipment provided prior to the effective date of coverage by TCMAP or after the effective date of denial of eligibility.

(H) Services and supplies to any individual who is a resident or inmate in a public institution.

(I) In-patient hospital services for a patient in an institution for tuberculosis, mental disease, or in a public institution for the mentally retarded.

(J) Services provided for any work related illness, injury or complication thereof arising out of the course of employment for which Worker's Compensation Benefits or any other similar regulation of the United States are provided or should be provided according to the laws of the state, territory or subdivision thereof governing the employer under which such illness or injury occurred.

- (K) Services or supplies provided in connection with cosmetic surgery except as required for the prompt repair of accidental injury.
 - (L) All services provided by non-TCMAP providers and not pre-authorized.
 - (M) Services or supplies for which benefits are available under a manufacturer's Patient Benefit Program, or any other contract, policy or insurance which would have been available in the absence of the TCMAP.
 - (N) Services payable by any health, accident, or other insurance coverage; or by any private or other governmental benefit system, or any legally liable third party.
 - (O) Services and items considered experimental or investigational, i.e., services and items which have not been approved for marketing by the Food and Drug Administration.
 - (P) Services or supplies provided to a client after a finding has been made under utilization review procedures that the services or supplies were not medically necessary.
 - (Q) Services or supplies furnished in connection with any procedures which involve harvesting, storage and/or manipulation of eggs and sperm. These procedures include, but are not limited to, the following:
 - (i) In-vitro fertilization
 - (ii) Gamete intra-fallopian transfer
 - (iii) Embryo transfer
 - (iv) Embryo freezing
 - (R) Any services to include, but not be limited to, drugs, surgery, medical or psychiatric care or treatment for transsexualism, gender dysphoria, sexual re-assignment or sex change.
 - (S) Services related to weight reduction, or dietetic control treatment for client(s) requiring weight loss necessitated by a specifically identifiable medical condition (Exception: nutritional counseling at a FQHC).
 - (T) Services, medications, equipment or supplies provided without pre-authorization, if pre-authorization is required (e.g., Specialty Care, special procedures, certain medications, durable medical equipment, etc.)
 - (U) Services and supplies that are provided under any governmental plan or law under which the individual is or could be covered (e.g., Victims of Crime, Veteran's Benefits, Medicare, Medicaid, CHAMPUS, etc.).
- (2) Charges/Fees

- (A) Charges for in-patient hospital tests that are not specifically ordered by a physician/doctor who is responsible for the diagnosis or treatment of the patient's condition.
- (B) Co-insurance fees and deductibles. TCMAP is not a secondary payor for any other insurance or governmental health care program.
- (C) Charges/fees for physician services are excluded except when contractually approved by TCMAP.
- (D) Charges for services not medically necessary, which are not incident to and necessary for the treatment of an injury or illness.
- (E) Charges for hospital services and supplies provided as an in-patient to the extent that it is established upon review of the claim submitted that:
 - (i) the Covered Person's condition does not require constant direction and supervision of a physician, constant availability of licensed nursing personnel and immediate availability of diagnostic therapeutic facilities and equipment found only in the hospital setting; or
 - (ii) the primary reason for confinement was for rest cure or custodial type care consisting of daily routine personal maintenance, administration of medication on schedule, preparation of diet and assistance in ambulating; or
 - (iii) the Covered Person's condition did not require a hospital level of acute care and could have been provided safely at a lesser level of care.
- (F) Charges for hospital care and services rendered after the patient has been discharged from the hospital by the attending physician, or for hospital care and services when a registered bed patient is absent from the hospital.
- (G) Charges resulting from or in connection with the commission of any illegal act, occupation or event (including the commission of a crime or conditions of probation) if the Covered Person is incarcerated or if there is a similar benefit available.
- (H) Charges resulting from or in connection with any acts of war, declared or undeclared, or any type of military conflict; charges incurred due to diseases contracted or injuries sustained in any country while such country is at war or while en route to or from any such country at war; charges resulting from illness/injuries incurred while engaged in military services.
- (I) Charges for in-patient rehabilitation.
- (J) Charges for custodial or sanitarium care, or for rest cure.
- (K) Charges for respite or custodial care.

- (L) Charges for services not rendered.
- (M) Charges for room and board, nursing care, supplies, equipment or drugs while a patient is in a rest home, sanitarium, extended care facility or convalescent nursing home unless pre-authorized by TCMAP.
- (N) Charges for care and treatment of mental and/or nervous disorders, psychiatric treatment or individual, family or group counseling services unless as a co-morbidity or secondary diagnosis during an inpatient stay.
- (O) Charges for treatment of substance abuse and/or detoxification.
- (P) Charges for ambulance or non-emergency transport services unless the condition of the client contra-indicates transportation by any other means (e.g., when other transportation could be utilized without endangering the patient's health, whether or not such means of transportation is actually available, program payment may not be made).
- (Q) Charges for ambulance or non-emergency transport services to or from a physician's office or clinic unless the ambulance or transport stops at a physician's office or clinic because the patient requires emergency treatment and then continues to the hospital.
- (R) Charges for ambulance or non-emergency transport services for the purpose of obtaining treatment or services not available at an acute care facility while the client is an in-patient or out-patient.
- (S) Charges for travel (except as described in the Benefits section) and/or accommodations, whether or not recommended by a physician.
- (T) Charges for private room except when appropriate documentation of medical necessity is provided.
- (U) Charges for chiropractic services/treatment.
- (V) Charges for rolfing.
- (W) Charges for meridian therapy (acupuncture), acupressure, or biofeedback.
- (X) Charges for services rendered by a massage therapist.
- (Y) Charges for drug therapy for infertility which involves:
 - (i) Non-FDA approved indications; or
 - (ii) Non-standard dosages, length of treatment or cycles of therapy.
- (Z) Charges for drugs or treatment of nicotine addiction unless pre-authorized.
- (AA) Charges for hypnosis.

- (AB) Charges for eye refractions, eye glasses, eye exercises, contact lenses, or other corrective devices, including materials and supplies, or for the fitting or examinations for prescribing, fitting or changing of these items.
 - (AC) Charges for whole blood or packed red cells that are available at no cost to the client.
 - (AD) Charges for autologous blood donations.
 - (AE) Charges for blood clotting factors.
 - (AF) Charges for antigens.
 - (AG) Charges for luxury/entertainment items (e.g., T.V., video, beauty aids, etc.)
 - (AH) Charges/fees for completing or filing required forms/pre-authorizations.
 - (AI) Charges which accumulate during any period of time in which the client removes rental equipment from the delivery site and fails to immediately notify the TCMAP of the new location.
- (3) Procedures (Not all inclusive)
- (A) Autopsies.
 - (B) Acupuncture or acupressure.
 - (C) Biofeedback therapy.
 - (D) Cellular Therapy.
 - (E) Chemolase injections (Chemodiactin, Chymopapain).
 - (F) Chemonucleolysis inter vertebral disc.
 - (G) Cosmetic or reconstructive surgery/treatment for repair of disfigurement except in the following circumstances:
 - (i) The Disfigurement is the result of accidental injury, AND
 - (ii) There is no alternate payor AND initial treatment is received within 12 months of the accident in which the injury was sustained.
 - (H) Dermabrasion.
 - (I) Dialysis (in-patient or out-patient).
 - (J) Ergonovine provocation test.
 - (K) Fabric strapping of abdominal aneurysms.
 - (L) Hair analysis.
 - (M) Histamine therapy(A) intravenous.
 - (N) Hyperactivity testing.
 - (O) Hyperthermia.
 - (P) Immunotherapy for malignant disease.
 - (Q) Immunizations required for travel outside the United States.
 - (R) Implantations (e.g., silicone, saline, penile, etc.)

- (S) In-born errors of metabolism.
- (T) Intestinal bypass surgery and gastric stapling for the treatment of morbid obesity.
- (U) Intra-gastric balloon for obesity.
- (V) Intravenous embolization(A) cerebral, maxillary, and renal.
- (W) Joint sclerotherapy.
- (X) Investigational or experimental procedures/tests (e.g., magnetic resonance angiography, etc.).
- (Y) Keratoprosthesis/Refractive keratoplasty.
- (Z) Laetrile therapy.
- (AA) Mammoplasty for gynecomastia.
- (AB) Multiple sleep latency testing (diagnostic test for narcolepsy).
- (AC) Obsolete tests including but not limited to:
 - Amylase, blood isoenzymes, electrophoretic
 - Bendien's test for cancer and tuberculosis
 - Bolen's test for cancer
 - Calcium saturation clotting time
 - Calcium feces, 24-hour quantitative
 - Capillary fragility test (Rumpel-Leede)
 - Cat scratch fever
 - Cephalin flocculation
 - Chromium, blood
 - Chymotrypsin, duodenal contents
 - Circulation time, one test
 - Colloidal gold
 - Congo red, blood
 - Gastric analysis, tubeless
 - Gastric analysis, pepsin
 - Guanase, blood
 - Hormones, adrenocorticotropin quantitative bioassay
 - Hormones, adrenocorticotropin quantitative, animal tests.
 - Reh fuss test for gastric acidity
 - Skin test, actinomycosis
 - Skin test, brucellosis
 - Skin test, psittacosis
 - Skin test, trichinosis
 - Skin test, lymphopathia venereum
 - Starch, feces, screening

- Thymol turbidity, blood
- Zinc sulphate turbidity, blood
- (AD) Organ transplants, medications and/or treatments associated with the transplant.
- (AE) Orthodontic treatment, crown and bridge procedures
- (AF) Pain management programs and/or treatment
- (AG) Penile prosthesis.
- (AH) Procedures for infertility including the Quest test
- (AI) Prosthetic eye or facial quarter
- (AJ) PUVA or other ultraviolet therapy for home use except in the treatment of intractable, disabling psoriasis when hospital outpatient treatment is contraindicated, and only after the psoriasis has not responded to more conventional treatment (requires pre-authorization).
- (AK) Radial and hexagonal keratotomy or refractive surgeries.
- (AL) Reverse sterilization.
- (AM) Routine circumcision for clients one year of age or older.
- (AN) Tattooing and/or tattoo removal.
- (AO) Thermogram
- (AP) TORCH screen.
- (4) Equipment/Supplements/Supplies/Misc.
 - (A) Adaptive equipment for daily living such as eating utensils, reachers, etc.
 - (B) Admission kit.
 - (E) Air cleaners/purifiers.
 - (D) Air conditioners.
 - (E) Any equipment, supplements, or supplies not ordered by a physician or provider and/or considered appropriate and necessary to treat a documented medical condition/disease process.
 - (F) Bed cradles.
 - (G) BIPAP S covered subject to the following conditions:
 - (i) the client is diagnosed with moderate or severe Obstructive Sleep Apnea,
 - (ii) surgery is a likely alternative, AND
 - (iii) the physician documents that the patient finds the magnitude of pressure delivered through a CPAP intolerable, or the physician establishes other rationale for minimizing the delivered pressure (requires pre-authorization).

- (H) BIPAP ST not covered except for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease and with physician documentation of actual or anticipated treatment failure with CPAP and/or BIPAP S (requires pre-authorization).
- (I) Bladder stimulator (pacemaker).
- (J) Car seats.
- (K) Cervical pillows.
- (L) CPAP not covered except under the following conditions:
 - (i) the client is diagnosed with moderate or severe obstructive Sleep Apnea AND
 - (ii) surgery is a likely alternative (requires pre-authorization).
- (M) CPM equipment (outpatient).
- (N) Customized inserts and accessories for wheelchairs (e.g., quad forms, etc.).
- (O) Digital, finger, or automatic blood pressure monitoring equipment, including oscillometric cuff.
- (P) Durable medical equipment such as bedside commodes and bathing equipment for temporary or short term use.
- (Q) Electric hospital bed (outpatient).
- (R) Electric Wheelchair (outpatient).
- (S) Enuresis monitor.
- (T) Equipment or services not primarily and customarily used to serve a medical purpose (e.g., an air conditioner might be used to lower room temperature to reduce fluid loss in a cardiac patient or whirl pool bath might be used in the treatment of osteoarthritis; however, because the primary and customary use of these items is a non-medical one, they cannot be considered as medical equipment).
- (U) Evaluations for learning disabilities.
- (V) Feeding supplements (e.g., Ensure, Osmolyte) and supplies for long-term use.
- (W) Hearing aides.
- (X) Home exercise equipment including treadmills.
- (Y) Home and vehicle modifications, including ramps, tub rails/bars.
- (Z) Humidifiers, except when used with respiratory equipment (e.g., oxygen concentrators, CPAP/BIPAP, nebulizers), or for clients with a tracheostomy (requires pre-authorization).
- (AA) IV and injectable drugs and related supplies and diluents for other than clients covered solely by the TCMAP.

- (AB) Maintenance items for medical equipment (e.g., batteries, filters, etc.).
- (AC) Nicotine patches unless pre-authorized.
- (AD) Orthopedic shoes and modifications (e.g., extra depth shoes, inserts, etc.) except with current or history of foot ulcers, Charcot foot, peripheral neuropathy, to correct foot deformities, or for the prevention of complications in clients with a diagnosis of Diabetes Mellitus on insulin (requires pre-authorization).
- (AE) Overbed tables.
- (AF) Personal comfort/convenience items (i.e., items which do not contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member).
- (AG) Prosthetic breasts and mastectomy bras.
- (AH) Prosthetic limbs that are covered by other payers or the Texas Rehabilitation Commission.
- (AI) Replacement of equipment or devices expected to withstand repeated use, which have been previously purchased by TCMAP, is limited to one replacement every three years due to loss or breakage under normal use and requires pre-authorization (e.g., DME, blood glucose monitors, braces, orthotics, etc.)
- (AJ) Replacement or exchange of existing, functional equipment is limited to items ordered by a physician/provider with appropriate medical rationale.
- (AK) Sheepskin pads (or synthetic facsimile) except for use in treatment or prevention of pressure sores (requires pre-authorization).
- (AL) Shower extension, handheld.
- (AM) Thermometers.
- (AN) Vocational, educational, and recreational equipment.
- (AO) Waist/gait belts.
- (AP) Whirlpool baths and saunas.

74.005 Dental Policies²

(a) Forward. The Travis County Rural Dental Assistance Program (TCRDAP) provides limited dental services to eligible Enrollees in the Travis County Medical Assistance Program (MAP). TCRDAP is a maintenance dentistry program established to provide urgent and emergency services.

(b) Eligibility for Services

- (1) Dental benefits are provided to an individual who
- (A) enrolls in the Travis County Medical Assistance Program (Enrollee) and
 - (B) qualifies for dental benefits.

An Enrollee must live within the boundaries of Travis County and outside the city limits of the City of Austin.

An Enrollee must be enrolled in MAP for four (4) months before he/she qualifies for dental benefits, except for medical care.

- (2) All Enrollees may receive emergency dental care immediately upon enrollment in MAP.
- (3) A lapse in an Enrollee's coverage of forty-five (45) days or more will result in the Enrollee having to wait another four (4) months from the new enrollment date to again qualify for dental benefits. During this 4-month waiting time, the Enrollee may receive emergency dental care.
- (4) A lapse in an Enrollee's coverage of less than forty-five (45) days will not affect an Enrollee's eligibility for dental services. However, any services provided to an Enrollee on dates of lapsed coverage will not be reimbursed by TCRDAP.
- (5) Each TCRDAP Enrollee is provided a copy of the Travis County Medical Assistance Program (MAP) Handbook at the time of enrollment.

(c) Covered Services

- (1) Informed Consent. The Enrollee should be advised of treatment options and risks associated with the performance or non-performance of the proposed treatment prior to the performance of authorized services, including information concerning the following:
- (A) Dentition

² Section 74.005 was amended on 8/19/1997, 8/8/2000, 9/10/2002, and 9/30/2003. However, only the amended text from 8/8/2000 is incorporated here because the text changes due to later amendments could not be ascertained. Please contact Commissioners Court Minutes for copies of the agenda backup documentation for this chapter.

- (B) Ability to maintain teeth, dentures, partials, bridges, etc.
 - (C) Compliance for dental hygiene, maintenance, and treatment
 - (D) Ability to eat, including chewing with current teeth
 - (E) Disclaimer regarding potential problems with partial or full mouth dentures, including, but not limited to:
 - (i) inability or decreased ability to chew
 - (ii) cosmetic changes in appearance of mouth and teeth
 - (iii) care required for bridge, partial, or denture
 - (iv) permanence of dental appliance when teeth are removed
 - (v) pain, break-in period
 - (vi) use of special cleansers, adhesives, etc.
 - (F) Instruction on dietary practices and oral hygiene.
- (2) Emergency Care is defined as those emergency dental services which are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, or severe discomfort, or to prevent the imminent loss of teeth. Prior authorization for treatment is required.
- (A) If a dental emergency occurs as a result of dental treatment, the Dentist will provide treatment to resolve the dental emergency as a part of the pre-approved services.
 - (B) In the event dental services result in a life threatening emergency, the Dentist is to call 911 for transporting the Enrollee to Brackenridge Emergency Room.
 - (C) Referrals to other dental providers to resolve complications of dental treatment (such as teeth broken at the root) require prior authorization.
- (3) Urgent Care is defined as the least costly medically necessary care to treat acute dental disease that likely will relieve pain and discomfort. Prior authorization for treatment is required. Limitations of urgent care include:
- (A) Urgent restorative treatment should be provided for teeth with a good prognosis when the patient's current hygiene practices are considered.
 - (B) Urgent oral surgical procedures should be provided to symptomatic teeth that have a poor or hopeless prognosis. Removal of asymptomatic teeth is not considered medically necessary.
 - (C) Placement of plastic or stainless steel crowns may be covered by TCRDAP to restore broken and/or endodontically treated teeth.
 - (D) Replacement of existing fixed bridgework, partials, and full dentures may be covered by TCRDAP if the prosthesis is over

five (5) years old and is unable to be made serviceable by relining or rebasing the prosthesis.

- (4) Follow-up Care is defined as an annual oral exam with bitewings and cleaning given an Enrollee who has undergone dental treatment in the Travis County Rural Dental Assistance Program. Prior authorization for treatment is required.
- (5) Dentures, partial and complete, are allowed once every five (5) years for the Enrollee, if appropriate. The Enrollee should be advised of all options, including potential problems with bridges and dentures. After receipt of the denture or partial, the Travis County Rural Dental Assistance Program will cover adjustments and repairs only. Replacement of the denture or partial prior to the five (5) year period will be at the expense of the Enrollee unless medical documentation is provided for a condition necessitating such replacement (such as weight loss which is medically excessive).
- (6) An Enrollee who is a child not eligible for Medicaid dental benefits is allowed one dental check-up (bitewings and cleaning) by age five (5).
- (7) Panorex is limited to one every three (3) years, for diagnostic purposes such as fractured jaws, tumors, cysts, and impacted wisdom teeth.
- (8) Exclusions. The following services are not covered by the Travis County Rural Dental Assistance Program:
 - (A) Any services or supplies not pre-approved by TCRDAP pursuant to applicable procedures.
 - (B) All orthodontic procedures, appliances and adjustments.
 - (C) Cosmetic procedures.
 - (D) Any treatment of the temporomandibular joint and associated musculature with splints, restorations, mouthguards, equilibrations, physical therapy or any dental procedures.
 - (E) All procedures that have a professionally acceptable less expensive treatment modality.
 - (F) Intraoral and extraoral appliances or devices.
 - (G) Any services that are covered by another payer, including, but not limited to, Medicaid, Medicare, Veterans Administration, dental assistance plans, dental HMO's, employer reimbursement plans, indemnity plans, and other third party payers.
 - (H) Implants, precision attachments and overdentures.
 - (I) Appliances or restorations used to increase vertical dimension or correct occlusion.
 - (J) Services or supplies that do not meet the acceptable standard of care, including charges for procedures that are experimental

or investigational in nature or not fully approved by the Council of the American Dental Association.

- (K) Charges specific to dietary instructions, oral hygiene instruction, consultations and plaque control programs.
- (L) Splinting of teeth.
- (M) Any procedure or supply not meeting the definition of "emergency," "urgent," or "follow-up" care as defined herein.
- (N) Services or supplies deemed "not medically necessary" by TCRDAP.

(d) Loss of Dental Benefits

- (1) Enrollees are responsible for notifying the Dentist at least twenty-four (24) hours before an appointment if she/he will not be able to keep her/his appointment. "No Show" (also known as "Did Not Keep Appointment") is defined as the Enrollee not notifying the Dentist within 24 hours of the appointment that she/he will not be able to keep her/his appointment.
- (2) An Enrollee may lose dental benefits and be denied dental services if she/he demonstrates a record of missed appointments. An Enrollee may lose dental benefits if, on two documented occasions, she/he fails to keep a dental appointment or fails to notify the Dentist at least 24 hours prior to an appointment that the appointment cannot be kept.

(e) Transportation. It is the responsibility of the Enrollee to arrange her/his transportation for the dental appointment. The Enrollee may contact the Rural Neighborhood Center nearest to her/him to arrange transportation with Capitol Area Rural Transportation Services (CARTS) to her/his dental appointment if private transportation is not available.

(f) Dentist Assignment. When feasible, an Enrollee is given an appointment with a Dentist close to where the Enrollee resides. All Dentists in the Travis County Rural Dental Assistance Program network will, to the best of the ability of TCRDAP, be given equal opportunity to provide dental services to Enrollees requiring dental services.

(g) Dentist Responsibilities

- (1) The Dentist will verify on the date of service an Enrollee's eligibility for the Travis County Rural Dental Assistance Program. If an Enrollee is not eligible on the date of service and dental services are provided, the Travis County Rural Dental Assistance Program will not reimburse the Dentist for services provided.
- (2) Prior Authorization for Treatment
 - (A) The Dentist will request and obtain authorization from the TCRDAP prior to providing any services to Enrollees. The Dentist may be asked to submit a treatment plan on the

TCRDAP dental claim form. X-rays and documentation may be required as part of the pre-authorization process.

- (B) The Dentist acknowledges and agrees that services not pre-authorized will not be reimbursed. The original treatment plan will become the basis for reimbursement unless the plan has been modified by the Dentist and the modifications approved by TCRDAP; then, the modified plan is to be submitted for payment.
- (C) Treatment which has been pre-authorized is to be completed within sixty (60) days of the authorization. If work is not completed within sixty (60) days, the Dentist may verbally request and obtain from TCRDAP an additional thirty (30) day extension, for a total maximum of ninety (90) days in which to complete the treatment plan. In the event work has not been completed at the conclusion of the thirty day extension, the Dentist must resubmit to TCRDAP for authorization.
- (D) Emergency Care. The Dentist will call TCRDAP to obtain verbal pre-authorization for a one-time visit in the event emergency care is needed. If more than one visit is needed, the Dentist will be required to request pre-authorization for additional visits by submitting a written treatment plan on the TCRDAP dental claim form.
- (E) If an Enrollee desires services which are not covered by the TCRDAP, terms and payments may be agreed upon by the Dentist and the Enrollee; TCRDAP will not be responsible for payment of these services.

(h) Reimbursement

- (1) Exhibit 1 attached to these policies is the fee schedule effective March 1, 2000. All services performed on or after March 1, 2000, will be reimbursed at rates in this Exhibit. Travis County Commissioners Court is the only entity that can alter this fee schedule. Services not listed on the fee schedule and which are medically necessary will be reimbursed at sixty percent (60%) of usual customary and reasonable rates for the Austin/Travis County community when pre-authorized. Exhibit 1-A contains the fee schedule for standard covered dental services. Exhibit 1-B contains the fee schedule for covered dental services performed by an Oral Surgeon.
- (2) Any services for which pre-authorization was obtained prior to October 1, 1996, will be reimbursed at the rates in effect for fiscal year 1995-96.
- (3) Services not pre-authorized will not be reimbursed.
- (4) An Enrollee must be eligible for dental services on the date treatment is provided in order for services to be reimbursed.

74.005 Exhibit I. Fee Schedule for Covered Dental Services

| Dental Procedure | Description | Fee |
|------------------|---|-------|
| 00110 | Initial Exam (no charge) | None |
| 00120 | Periodic oral evaluation (inc. comprehensive evaluation, bitewings, prophylaxis) | \$ 75 |
| 00210 | Radiograph intraoral - complete series (inc. bitewings) (no charge with initial exam) | \$ 38 |
| 00220 | Radiograph intraoral - periapical - first film (no charge with initial exam) | \$ 6 |
| 00270 | Radiograph bitewing - single film (no charge with initial exam) | \$ 12 |
| 00274 | Radiograph bitewings - four films (no charge with initial exam) | \$ 18 |
| 00330 | Panorex (fee for material only) | \$ 25 |
| 01110 | Prophylaxis - adult | \$ 34 |
| 01120 | Prophylaxis - child | \$ 25 |
| 01203 | Topical application of fluoride - child | \$ 15 |
| 01351 | Sealant - per tooth | \$ 18 |
| 01510 | Space maintainer - fixed - unilateral | \$ 80 |
| 01515 | Space maintainer - fixed bilateral | \$ 80 |
| 01520 | Space maintainer - removable - unilateral | \$ 80 |
| 01525 | Space maintainer - removable - bilateral | \$ 80 |
| 02110 | Amalgam - one surface, primary | \$ 42 |
| 02120 | Amalgam - two surfaces, primary | \$ 52 |
| 02130 | Amalgam - three surfaces, primary | \$ 63 |
| 02131 | Amalgam - four or more surfaces, primary | \$ 75 |
| 02140 | Amalgam - one surface, permanent | \$ 48 |
| 02150 | Amalgam - two surfaces, permanent | \$ 62 |
| 02160 | Amalgam - three surfaces, permanent | \$ 80 |
| 02161 | Amalgam - four or more surfaces, permanent | \$ 95 |
| 02330 | Resin - one surface, anterior | \$ 52 |
| 02331 | Resin - two surfaces, anterior | \$ 72 |
| 02332 | Resin - three surfaces, anterior | \$ 94 |
| 02335 | Resin - four or more surfaces, anterior | \$ 94 |
| 02380 | Resin - one surface, posterior - primary | \$ 52 |

| | | |
|-------|---|--------|
| 02381 | Resin - two surfaces, posterior - primary | \$ 72 |
| 02382 | Resin - three or more surfaces, posterior - primary | \$ 94 |
| 02385 | Resin - one surface, posterior - permanent | \$ 52 |
| 02386 | Resin - two surfaces, posterior - permanent | \$ 72 |
| 02387 | Resin - three or more surfaces, posterior - permanent | \$ 94 |
| 02710 | Crown - resin | \$ 197 |
| 02920 | Recement crown | \$ 33 |
| 02930 | Prefabricated stainless steel crown - primary tooth | \$ 95 |
| 02931 | Prefabricated stainless steel crown - permanent tooth | \$ 95 |
| 02940 | Temporary restoration intended to relieve pain | \$ 35 |
| 02951 | Pin retention | \$ 15 |
| 03110 | Pulp cap, direct (excluding final restoration) | \$ 26 |
| 03120 | Pulp cap, indirect (excluding final restoration) | \$ 24 |
| 03220 | Therapeutic pulpotomy (excluding final restoration) | \$ 62 |
| 03310 | Endodontic therapy, anterior (inc. treatment plan, clinical procedures, follow-up care) | \$ 249 |
| 03320 | Endodontic therapy, bicuspid (inc. treatment plan, clinical procedures, follow-up care) | \$ 296 |
| 03330 | Endodontic therapy, molar (inc. treatment plan, clinical procedures, follow-up care) | \$ 360 |
| 04220 | Gingivectomy or gingivoplasty - per quadrant with anesthesiology | \$ 75 |
| 04260 | Osseous surgery - per quadrant | \$ 250 |
| 04321 | Provisional splinting - extracoronal, 1-6 teeth | \$ 180 |
| 04910 | Periodontal maintenance procedures (following active therapy) | \$ 65 |
| 05110 | Complete denture - maxillary | \$ 585 |
| 05120 | Complete denture - mandibular | \$ 585 |
| 05210 | Partial, Acrylic | \$ 350 |
| 05211 | Maxillary partial denture - resin base | \$ 595 |
| 05212 | Mandibular partial denture - resin base | \$ 595 |
| 05281 | Removable unilateral partial denture | \$ 336 |
| 05410 | Adjust complete denture - maxillary | \$ 35 |
| 05411 | Adjust complete denture - mandibular | \$ 35 |
| 05421 | Adjust partial denture - maxillary | \$ 35 |

| | | |
|-------|--|--------|
| 05422 | Adjust partial denture - mandibular | \$ 35 |
| 05610 | Repair resin denture base | \$ 70 |
| 05620 | Repair cast framework | \$ 105 |
| 05630 | Repair or replace broken clasp | \$ 47 |
| 05640 | Replace broken teeth (for one, two or three teeth) | \$ 105 |
| 05750 | Reline complete maxillary denture | \$ 180 |
| 05751 | Reline complete mandibular denture | \$ 180 |
| 05760 | Reline maxillary partial denture | \$ 180 |
| 05761 | Reline mandibular partial denture | \$ 180 |
| 06545 | Retainer - cast metal for resin bonded fixed prosthesis (Maryland Bridge) | \$ 567 |
| 07110 | Extraction, single tooth - permanent | \$ 52 |
| 07112 | Extraction, single tooth - primary | \$ 25 |
| 07120 | Extraction, each additional tooth | \$ 52 |
| 07210 | Surgical removal of erupted tooth | \$ 52 |
| 07220 | Removal of impacted tooth - soft tissue | \$ 81 |
| 07230 | Removal of impacted tooth - partially bony | \$ 135 |
| 07240 | Removal of impacted tooth - completely bony | \$ 165 |
| 07250 | Surgical removal of residual tooth roots | \$ 45 |
| 07310 | Alveoloplasty in conjunction with extractions - per quadrant | \$ 115 |
| 07320 | Alveoloplasty not in conjunction with extractions - per quadrant | \$ 175 |
| 07960 | Frenectomy | \$ 85 |
| 09110 | Palliative (emergency) treatment of dental pain - minor procedure | \$ 40 |
| 09240 | Intravenous sedation | \$ 105 |
| 09930 | Treatment of complications (post-surgical) | \$ 40 |

OTHERS Services not listed on the fee schedule which are medically necessary and pre-authorized will be reimbursed at sixty percent (60%) of the usual customary and reasonable rates for the Austin/Travis County community.