2020 Administrative Guide/Care Provider Manual

Texas

Physician, Health Care Professional, Facility and Ancillary

Serving the following service delivery areas: Jefferson, Harris, Hidalgo, Nueces and Travis as well as Medicaid Rural Service Area (MRSA) Central and MRSA Northeast.

Customer Service: 888-887-9003

July 1, 2020

UHCprovider.com and Link
Welcome to the Community Plan manual. This complete and up-to-date reference PDF manual allows you and your staff to find important information such as processing a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Care provider tools are available online through Link at UHCprovider.com. Operational policy changes and other electronic tools are ready on our website at UHCprovider.com. Click the following links to access different manuals:

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to UHCprovider.com > Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select state.

Easily find information in the manual using the following steps:

1. Press CTRL+F.
2. Type in the keyword.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF.

If you have any questions about the information or material in this manual or about any of our policies, please call Provider Services.

We greatly appreciate your participation in our program and the care you offer our members.

**Important Information about the use of this manual**

In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise. In the event of a conflict between your agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.
# Table of Contents

- Welcome .....................................................................................................................................................2
- Chapter 1: About this Manual ...................................................................................................................5
- Chapter 2: About Us ..................................................................................................................................6
- Chapter 3: Texas Health Steps ..................................................................................................................9
- Chapter 4: Dental Home ..........................................................................................................................12
- Chapter 5: Early Childhood Intervention ................................................................................................13
- Chapter 6: Encouraging Programs ...........................................................................................................14
- Chapter 7: STAR+PLUS Service Coordination ......................................................................................16
- Chapter 8: End-of-Life Care ......................................................................................................................19
- Chapter 9: Long-Term Services and Support ..........................................................................................20
- Chapter 10: Value-Added Services ..........................................................................................................27
- Chapter 11: Pharmacy ...............................................................................................................................28
- Chapter 12: Behavioral Health ................................................................................................................32
- Chapter 13: Eligibility ...............................................................................................................................38
- Chapter 14: Eligibility Determination .....................................................................................................39
- Chapter 15: Access to Care .......................................................................................................................42
- Chapter 16: In Case of an Emergency .........................................................................................................45
- Chapter 17: Care Provider Responsibilities .............................................................................................47
- Chapter 18: Member Services ..................................................................................................................51
- Chapter 19: Abuse, Neglect and Exploitation ..........................................................................................53
- Chapter 20: Quality ......................................................................................................................................55
- Chapter 21: Prior Authorization ................................................................................................................58
- Chapter 22: Special Billing .........................................................................................................................59
- Chapter 23: Billing Members .....................................................................................................................62
- Chapter 24: Fraud, Waste and Abuse .........................................................................................................64
- Chapter 25: Claims and Submissions .......................................................................................................65
Chapter 26: Payments..........................................................................................................................68
Chapter 27: Complaints and Appeals........................................................................................................69
Chapter 28: Care Provider Support Programs..........................................................................................74

Appendices

Appendix A: CHIP Benefits ..........................................................................................................................75
Appendix B: STAR Benefits ............................................................................................................................94
Appendix C: STAR+PLUS Benefits ..................................................................................................................97
Appendix D: STAR and STAR+PLUS Member Rights and Responsibilities ...............................................101
Appendix E: CHIP Member Rights & Responsibilities ..................................................................................104
Appendix F: CHIP Perinate Member Rights & Responsibilities ......................................................................106
Appendix G: CHIP Cost-Sharing Schedule .................................................................................................108
Appendix H: Medicaid Client Acknowledgement Form ................................................................................109
Appendix I: STAR and STAR+PLUS Member Complaint and Appeal Processes ....................................111
Appendix J: CHIP Member Complaints and Appeals ..................................................................................113
Appendix K: Fraud Information ....................................................................................................................116
Appendix L: Claim Forms ..............................................................................................................................117
Appendix M: Medical Records Standards ....................................................................................................122
Appendix N: Member Identification (ID) Cards ..............................................................................................125
Appendix O: Reporting Abuse, Neglect or Exploitation (ANE) .....................................................................126
Appendix P: Community First Choice (CFC): Program Provider Responsibilities ....................................128
Appendix Q: Electronic Visit Verification ....................................................................................................129
Appendix R: Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment) ..................................................................................................................133
Appendix S: Adoption Assistance and Permanency Care Assistance ..........................................................135
Appendix T: Women with Breast or Cervical Cancer ....................................................................................137
Appendix U: Prescribed Pediatric Extended Care Centers and Private Duty Nursing ................................138
Appendix V: Breast Pump Coverage in Medicaid and CHIP ........................................................................139
Chapter 1: About this Manual

This provider manual is applicable for our CHIP, STAR and STAR+PLUS programs. It is designed as a comprehensive reference source for the information you and your staff need to conduct interactions and transactions with us in the most efficient manner possible. This manual, along with other resources, is available at our website UHCprovider.com.

We have separate manuals for Nursing Facility Long-Term Care, UnitedHealthcare Connected (Medicare-Medicaid Plan), STAR Kids and the UnitedHealthcare Administrative Guide for Commercial and Medicare Advantage Products. The following are other sources of important information when serving CHIP, STAR and STAR+PLUS members:

The Texas Medicaid Provider Procedure Manual at tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx

Texas Health and Human Services Commission (HHSC) Uniform Managed Care Manual at hhs.texas.gov > Services > Health > Medicaid and CHIP > Provider Information > Contracts and Manuals > Uniform Managed Care Manual

The Texas Administrative Code at sos.state.tx.us/tac/

The Texas Medicaid & Healthcare Partnership at tmhp.com

The Texas Department of State Health Services at dshs.texas.gov/thsteps > Provider Information (MEDICAL)

See also your UnitedHealthcare Community Plan Network Participation Agreement (Texas Medicaid and Chip Program Regulatory Requirement Appendix).

UnitedHealthcare Dual Complete Plans (HMO SNP and PPO)

For information about UnitedHealthcare Dual Complete, please see Chapter 4 of the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products. For state-specific information, go to UHCprovider.com > Menu > Health Plans by State.

Newsletters are a means of provider notification:

- **Practice Matters**: Quarterly edition posted to UHCprovider.com/TXCommunityPlan > Bulletins and Newsletters > Practice Matters Newsletters

Rehabilitative Services through the Texas Workforce Commission at twc.texas.gov.

A majority of our members are dependent on others for care and representation. References to members throughout this manual include any guardians or other member representatives.
Chapter 2: About Us

Background

UnitedHealthcare Community Plan has focused solely on the complex and dynamic public sector health care market for the past few decades. UnitedHealthcare Community Plan provides members, care providers and state partners with high value and quality services in a manner that delivers the right service at the lowest cost available in the market place.

Today, Texas Medicaid, which is administered by Texas HHSC, operates Medicaid managed care under the authority of federal waivers and state plan amendments that were approved by the Centers for Medicare & Medicaid Services (CMS). UnitedHealthcare Community Plan is contracted with HHSC to manage the following programs in the following service delivery areas.

<table>
<thead>
<tr>
<th>Program</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Health Insurance Program (CHIP)</td>
<td>Jefferson, Harris</td>
</tr>
<tr>
<td>CHIP and CHIP Perinate</td>
<td></td>
</tr>
<tr>
<td>State of Texas Access Reform (STAR)</td>
<td>Jefferson, Harris, Hidalgo</td>
</tr>
<tr>
<td>State of Texas Access Reform (STAR+PLUS)</td>
<td>Jefferson, Harris, Medicaid Rural Service Area</td>
</tr>
<tr>
<td></td>
<td>(MRSA) Central, MRSA Northeast, Nueces and Travis</td>
</tr>
</tbody>
</table>

Our focus is supporting the primary care provider (PCP)-led medical home in which health care services are accessible, family-centered, sensitive to cultural differences, comprehensive, coordinated, and compassionate. Care for every member integrates member choice, health education, wellness, and prevention.
Quick Reference Phone List

The following list contains phone numbers for UnitedHealthcare Community Plan as well as other resources in Texas: Numbers at-a-glance to aid you in serving our members. All numbers are toll-free.

<table>
<thead>
<tr>
<th>Contact</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Service</td>
<td>888-887-9003</td>
</tr>
<tr>
<td>STAR+PLUS Service Coordination Hotline</td>
<td>800-349-0550</td>
</tr>
<tr>
<td>STAR Care Management</td>
<td>888-887-9003</td>
</tr>
<tr>
<td>Prior Authorization (CHIP and STAR)</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Prior Authorization (STAR+PLUS)</td>
<td>866-604-3267</td>
</tr>
<tr>
<td>Prescription Prior Authorization</td>
<td>800-310-6826</td>
</tr>
<tr>
<td>Medicaid Transportation Program</td>
<td>877-633-8747</td>
</tr>
<tr>
<td>Language Interpreters</td>
<td>888-887-9003</td>
</tr>
<tr>
<td>Texas Department of State Health Services Laboratory Services</td>
<td>888-963-7111 ext. 7318</td>
</tr>
<tr>
<td>Vaccines for Children</td>
<td>888-777-5320</td>
</tr>
<tr>
<td>ImmTrac Customer Support</td>
<td>800-348-9158</td>
</tr>
<tr>
<td>Texas Department of State Health Services Case Management for Children and Pregnant Women</td>
<td>800-252-8023 ext. 2168</td>
</tr>
<tr>
<td>Optum (Behavioral Health) Referral and Crisis</td>
<td>888-887-9003</td>
</tr>
</tbody>
</table>

[^Contact]:

<table>
<thead>
<tr>
<th>Contact</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAXIMUS</td>
<td>800-964-2777</td>
</tr>
<tr>
<td>Early Childhood Intervention (ECI)</td>
<td>800-628-5115</td>
</tr>
<tr>
<td>Children with Special Health Care Needs</td>
<td>800-252-8023</td>
</tr>
<tr>
<td>THSteps Outreach Team</td>
<td>800-784-6999</td>
</tr>
<tr>
<td>THSteps Provider Outreach Referral Service</td>
<td>877-847-8377</td>
</tr>
<tr>
<td>Abuse, Neglect and Exploitation: Child and Elderly</td>
<td>800-252-6400</td>
</tr>
<tr>
<td>Abuse, Neglect and Exploitation: Disabled Adults</td>
<td>800-647-7418</td>
</tr>
<tr>
<td>Fraud, Waste and Abuse</td>
<td>800-436-6184</td>
</tr>
<tr>
<td>Credentialing</td>
<td>877-842-3210</td>
</tr>
<tr>
<td>UHCprovider.com Help Desk</td>
<td>866-842-3278</td>
</tr>
<tr>
<td>Physician Advocates</td>
<td>866-574-6088</td>
</tr>
<tr>
<td>Long-Term Services and Support (LTSS)</td>
<td>888-787-4107</td>
</tr>
<tr>
<td>Provider Advocates</td>
<td>888-787-4107</td>
</tr>
<tr>
<td>Optum Provider Services</td>
<td>800-873-4575</td>
</tr>
</tbody>
</table>

Your Contact Information

Help ensure members can find you and payments get to you by keeping your practice information current in our systems and directories. Is there a change in your demographic information?

- Name
- Service address
- Billing address
- Phone number
- National Provider Identification number (NPI)
- Texas Provider Identification number (TPI)
- Tax Identification Number (TIN)
- Group affiliation

Submit a form with your changes by visiting UHCprovider.com > Menu > Demographics and Profiles > Care Provider Paper Demographic Information Update Form.
Physicians and facilities should fax the form to:
United Health Network, 866-571-1060

- All other health care providers should fax the form to:
  UnitedHealthcare Community Plan, 855-500-3356

Or, call your physician or provider advocate. You may also call the credentialing number to report demographic changes at 877-842-3210.

The Texas Medicaid & Healthcare Partnership
Update your Medicaid Online Provider Lookup information with Texas Medicaid & Healthcare Partnership (TMHP) by visiting TMHP.com and completing the Provider Information Change Form.

Texas Medicaid provider types are required to revalidate their enrollment in Texas Medicaid every three or five years, depending on provider type, from the date of initial enrollment. Visit the TMHP Provider Re-enrollment page. For assistance with the re-enrollment process, contact a TMHP provider enrollment representative at 800-925-9126, Option 2.

Program Objectives

The following are principle objectives of Texas Medicaid managed care:

- Emphasize early intervention
- Promote improved access to quality care, thereby significantly improving health outcomes for the target population, with a special focus on prenatal and well-child care
- Promote member responsibility for their personal health care by helping them choose a health plan and PCP and by encouraging them to use preventive primary care services
- Reduce the higher use of medical services which occurs when members obtain non-urgent or emergent acute care through emergency rooms or access duplicate services for the same medical condition
- Encourage eligible members to choose a dental plan and a main dentist

This collaborative approach to health care delivery helps reduce costs by eliminating duplicate services and unnecessary emergency and inpatient care.

- For STAR+PLUS:
  - Improve access to care, provides care in the least restrictive setting
  - Provide more accountability and control on costs through service coordination
  - Integrate acute care and long-term services and supports (LTSS)

Our Programs

Children’s Health Insurance Program (CHIP)
CHIP is health insurance designed for families who earn too much money to qualify for Medicaid yet cannot afford to buy private health insurance. To qualify for CHIP, a child must be younger than age 19, a Texas resident, and a U.S. citizen or legal permanent resident.

Covered CHIP Perinate services must meet the definition of medically necessary covered services. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services. CHIP Perinate newborns are eligible for 12 months of continuous coverage, beginning with the month of enrollment as a CHIP Perinate. The CHIP Perinate mother is eligible for limited coverage during prenatal and postnatal periods.

State of Texas Access Reform (STAR)
The principal objectives of the STAR Program are to emphasize early intervention and to promote improved access to quality care, significantly improving health outcomes for the target populations. The special focus of the STAR Program is on prenatal and well-child care.

State of Texas Access Reform PLUS (STAR+PLUS)
This program is designed to improve access to care, provide care in the least restrictive setting, and provide more accountability and control on costs. STAR+PLUS integrates acute care and long-term care services. Service coordination is fundamental to managing the complex needs of these members.
Chapter 3: Texas Health Steps

The Texas Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for STAR and STAR+PLUS children through age 20 is Texas Health Steps (THSteps). These services need to be provided by a THSteps-enrolled care provider. Wellness care for these members is delivered in accordance with THSteps benefits and policies including the periodicity schedule and required elements of checkups. Visit the TMHP to enroll or use the provider look up to refer to a THSteps-enrolled care provider.

Corrective Action

THSteps receives oversight by the United States District Court per a 1996 lawsuit. Mothers of children eligible for state services in Texas successfully sought conjunctive relief against state agencies and various state officials in Frew, et al. v. Traylor, et al. claiming that the Texas program did not meet federal requirements. Several corrective actions were included in the order in 2007 as part of Frew, et al. v. Traylor, et al. Consent Decree. For a full list visit Texas HHSC at hhs.texas.gov > Laws & Regulations > Legal Information > Settlements > Frew et al vs. Phillips et al.

Documentation of Completed Texas Health Steps Components and Elements

Each of the six components and their individual elements according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual must be completed and documented in the medical record.

Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

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

1. **Comprehensive health and developmental history**, which includes nutrition screening, developmental and mental health screening, and TB screening
   - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.

2. **Comprehensive unclothed physical examination**, which includes measurements, height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening
   - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0 to 2 years), and blood pressure (3 to 20 years). Vision and hearing screenings are also required components of the physical exam. Document any referrals based on findings from the vision and hearing screenings.

3. **Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal, and HPV
   - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP “Recommended Childhood and Adolescent Immunization Schedule-United States,” unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
   - The screening care provider gives the immunization. They should not refer children to other immunizers, including Local Health Departments, to receive immunizations.
   - Include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
   - You may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit dshs.texas.gov/immunize/tvfc.
4. **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia
   - Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. You must include detailed identifying information for all screened newborn members and the member’s mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
   - Anemia screening at 12 months
   - Dyslipidemia screening at 9 to 12 years of age and again 18-20 years of age
   - HIV screening at 16-18 years
   - Risk-based screenings include:
     - dyslipidemia, diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia

5. **Health education** (including anticipatory guidance), is a federally mandated component of the medical checkup and is required to help parents, caregivers and clients understand what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.

6. **Dental referral** every six months until the parent or caregiver reports a dental home is established.
   - Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

The THSteps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Each checkup form includes all checkup components, screenings that are required at the checkup and suggested age appropriate anticipatory guidance topics. They are available online in the resources section at [txhealthsteps.com](http://txhealthsteps.com).

---

**Wellness Opportunity**

Members must receive timely health care services. Members new to UnitedHealthcare Community Plan should be offered a well checkup as soon as practicable but within than 90 days of enrollment and within 14 days for newborns. The THSteps annual medical checkup for an existing member age 36 months and older is due on the child’s birthday.

When a child comes in for a sick visit, you may accelerate THSteps by performing a wellness checkup for those members who are past due for their annual checkup. Members through age 20 can be seen in your office for both a sick and a well visit in the same day.

Sick and Well Visit – Occasionally, an abnormality is encountered or a pre-existing problem is addressed during the preventive visit, and significant elements of related Evaluation and Management (E/M) services are provided during the same visit. When this occurs, we reimburse the preventive medicine service plus the problem-oriented E/M service code when that code is appended with modifier 25. For more information, visit [UHCprovider.com/TXCommunityPlan](http://UHCprovider.com/TXCommunityPlan) > Policies and Clinical Guidelines > View Current Reimbursement Policies > Preventive Medicine and Screening Policy.

**Children of Migrant Farmworkers**

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

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

**Teens and Young Adults**

We encourage innovation to help ensure teens and young adults receive their THSteps services. THSteps extends through the age of 20. Special considerations for this age group include:

- Confidentiality
- PCP private consultation opportunities
- Transportation
- Transition to adulthood
- Treatment without adult consent
Please note that a parent must be present for members age 14 and younger for the visit to qualify as a THSteps medical checkup.

A useful tool available for you regarding adolescent health is the Texas Department of State Health Services located at [DSHS.texas.gov/THSteps > Provider Information (Medical) > Adolescent Health - A Guide for Providers.](http://DSHS.texas.gov/THSteps)

Refer to Chapter 18 for information about the Medical Transportation Program (MTP). This program provides non-emergency medical transportation to members who need help getting to their covered health care appointments.

### Missed Appointments

Assistance is available to you when a member misses an appointment. Fax the THSteps Provider Outreach Referral Form to your THSteps Health Service Regional Provider Relations Representative for member assistance to schedule a follow-up appointment and arrange for any necessary transportation. Visit The Texas Department of State Health Services for more information at [DSHS.texas.gov/THSteps > Provider Information (Medical) > Texas Health Steps Provider Outreach Referral Service.](http://DSHS.texas.gov/THSteps)

### For Additional Information

See the Case Management section of this manual for available programs including assistance for missed appointments.

For information about home health personal care for STAR members birth through age 20, refer to: Subsection 2.11, “Personal Care Services (PCS) (CCP)” in the Children’s Services Handbook (Vol. 2, Provider Handbooks). To provide CCP services, HCSSA providers must follow the enrollment procedures in subsection 5.2, “Enrollment” in the Children’s Services Handbook (Vol. 2, Provider Handbooks).

For Comprehensive care Program services, including private duty nursing, prescribed pediatric extended care centers, and therapies, go to [TMHP.com > Providers > Medicaid Provider Manual > Home Health Nursing and Private Duty Nursing Services Handbook.](http://TMHP.com)

For information about the Texas Health Steps environmental lead investigation (ELI) visit [TMHP.com > Providers > Reference Material > Texas Medicaid Provider Procedures Manual > Appendix C Lead Screening.](http://TMHP.com)

See the Dental Home section of this manual for additional information.

### Resources

- The Texas Medicaid & Healthcare Partnership THSteps Page [tmhp.com](http://tmhp.com)
- The Texas Department of State Health Services (DSHS) [DSHS.texas.gov](http://DSHS.texas.gov)
- The Texas DSHS Texas Health Steps Online Provider Education [txhealthsteps.com](http://txhealthsteps.com)
- The Texas Medicaid Provider Procedure Manual at [tmhp.com](http://tmhp.com)
Chapter 4: Dental Home

Help our members establish a dental home by six months of age. We aim to identify those at high risk of developing dental disease, start preventive services, treat decay early, and educate families about the importance of good oral health habits. More frequent dental checkups are available for children six through 35 months of age with semi-annual checkups available for children, adolescents and young adults three through 20 years of age. Dental plan members may choose their main dental homes. Dental plans assign each member to a main dental home if they do not timely choose one. Whether chosen or assigned, each member who is six months or older must have a designated main dental home.

Role of Main Dental Home

A main dental home serves as the member’s main dentist for all aspects of oral health care. The main dental home has an ongoing relationship with that member, to provide comprehensive, continuously accessible, coordinated, and family-centered care. The main dental home provider also makes referrals to dental specialists when appropriate. Federally qualified health centers and individuals who are general dentists and pediatric dentists can serve as main dental homes.

How to Help a Member Find Dental Care

The dental plan member ID card lists the name and phone number of a member’s main dental home provider. The member can contact the dental plan to select a different main dental home provider at any time. If the member selects a different main dental home provider, the change is reflected immediately in the dental plan’s system, and the member is mailed a new ID card within five business days. If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can call the Medicaid/CHIP Enrollment Broker’s at 800-964-2777.

Medicaid Non-emergency Dental Services

UnitedHealthcare Community Plan is responsible for paying for treatment and devices for craniofacial anomalies, and of Oral Evaluation and Fluoride Varnish benefits (OEFV) provided as part of a Texas Health Steps medical checkup for members aged 6 through 35 months.

OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a main dental home choice.

OEFV is billed by Texas Health Steps care providers on the same day as the Texas Health Steps medical checkup.

• OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
• Documentation must include all components of the OEFV.
• Texas Health Steps care providers must assist members with establishing a main dental home (see Attachment D) and document member’s main dental home choice in the members’ file.

CHIP Non-emergency Dental Services

UnitedHealthcare Community Plan is not responsible for paying for routine dental services provided to CHIP and CHIP Perinatal members. These services are paid through dental managed care organizations.

UnitedHealthcare Community Plan is responsible for paying for treatment and devices for craniofacial anomalies.

Resources

• The Emergency section of this manual contains information related to dental emergencies.
• For more information about Texas Health Steps dental (including orthodontia) see TMHP.com > Providers > Reference Material > Texas Medicaid Provider Procedures Manual > Chapter 7 Children’s Medicaid Dental Services.
• For more information about dental services see TMHP.com > Providers > Reference Material > Texas Medicaid Provider Procedures Manual.
Chapter 5: Early Childhood Intervention

The Texas Early Childhood Intervention (ECI) program is a statewide service for families with children, birth to 3 years of age, with disabilities and developmental delays. Families and professionals work as a team to plan appropriate services, based on the unique needs of the child and family. Services are provided in homes and community settings.

Specialized Skills Training (SST) is a rehabilitative service that promotes age-appropriate development by providing skills training to correct deficits and teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions. SST assists families with challenging behaviors such as tantrums, biting, picky eating, and sleep issues. For more information about specialized skills training visit TMHP.com > Provides > Reference Material > Texas Medicaid Provider Procedures Manual > Section 2.7.2.2 Specialize Skills Training (SST).

ECI case management helps families access and receive the services, resources, and supports they need to support their child’s development. Supports include helping the child and family transition to special education services as appropriate for children exiting ECI at age 3.

Referrals can be based on family concerns or professional judgment. You are responsible under federal law to identify and refer patients age 3 years and younger who are suspected of having a developmental disability, delay, or who are at risk of delay. A diagnosis at the time of referral is not necessary. Referral to ECI for screening and assessment should be done as soon as possible, but no longer than seven days after the child is identified, even if also referring to an appropriate specialist. For additional ECI information or to refer, visit hhs.texas.gov > Services > Disability > Early Childhood Intervention Services > ECI Information for Health and Medical Professionals.

You must cooperate and coordinate with local ECI programs to comply with federal and state requirements relating to the development, review, and evaluation of Individual Family Services Plans (IFSP). Any medically necessary health and behavioral health services identified and contained within an IFSP, or otherwise identified by a health care professional, must be provided to UnitedHealthcare Community Plan members in the amount, duration, scope, and setting established in the IFSP.

The designation “Program Provided (PP)” is used when the IFSP team identifies a need and the ECI contractor will be providing the service to address that need. The IFSP serves as service authorization and claims are submitted to the UnitedHealthcare Community Plan by the ECI contractor.

For more information about ECI case management/service coordination visit TMHP.com > Provides > Reference Material > Texas Medicaid Provider Procedures Manual > Section 8 Carved-out Services.

Children who are 3 years of age or older with a suspected developmental delay or disability should be referred to the local school district. Children in ECI at the time of turning 3 years of age are transitioned into the local school district.

School Health and Related Services

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as School Health and Related Services (SHARS). The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and HHSC. SHARS allows local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services provided to students in special education under Individuals with Disabilities Education Act (IDEA) that are documented in a student’s Individualized Education Program. For more information visit TMHP.com > Provides > Reference Material > Texas Medicaid Provider Procedures Manual > Children’s Services Handbook > Section 3 Texas School Health and Related Services (SHARS).
Chapter 6: Encouraging Programs

We have several programs to support member compliance to observe their wellness activities.

Baby Blocks

UnitedHealthcare created Baby Blocks, an interactive application to support the health of women and newborns before, during and after pregnancy. Members can access Baby Blocks through the free mobile web app on their iPhone®, Android® smartphones or any computer. This gives them opportunities to earn rewards as they follow a prenatal, postnatal and healthy-baby visit schedule. Members can register and receive more information at UHCBabyBlocks.com.

Healthy First Steps

Members through age 20 are referred to our Healthy First Steps when we learn they are pregnant or have recently given birth. This program is unique to Optum for UnitedHealthcare Community Plan. A nurse case manager works with members over the phone to encourage baby’s wellness toward the Well-child Visits in the first 15 months of life Healthcare Effectiveness Data and Information Set (HEDIS®) standard, as well as mom’s postpartum visit. Members continue to be followed by our Texas Health Steps Outreach team after eight weeks of this postpartum case management.

Texas Health Step Outreach Team

Our team works to help ensure that members see their primary care provider for THSteps Medical Checkups. We also work specifically with children of migrant farmworkers. To refer a member for assistance email texashealthsteps@uhc.com or call 800-784-6999.

Our Care Management Program

This program is available to CHIP and STAR members with chronic health conditions to have access to support, education and interventions based on their health care needs (such as living with asthma or diabetes). To refer a member, please call 888-887-9003.

Case Management for Children and Pregnant Women

STAR members who have medical-related needs that might affect their health care may be eligible for this assistance if either:

- A child through age 20 with a health condition or health risk
- A woman of any age who has a high-risk pregnancy

Services include assessing the needs of eligible clients, formulating a service plan, making referrals, problem-solving, advocacy, and follow-up regarding family and client needs. For more information about eligibility and client referral, visit TMHP.com > Provides > Reference Material > Texas Medicaid Provider Procedures Manual > Behavioral Health, Rehabilitation, and Case Management Services Handbook > Section 3.1.1 Eligibility or section 3.1.2 Referral Process or call 877-THSTEPS.

Blind Children’s Vocational Discovery and Development Program

These services are provided to help children who are blind and visually impaired to develop their individual potential. This program offers a wide range of services that are tailored to each child and their family’s needs and circumstances. By working directly with the entire family, this program can help children develop the concepts and skills needed to realize their full potential. For more information visit TMHP.com > Provides > Reference Material > Texas Medicaid Provider Procedures Manual > Behavioral Health, Rehabilitation, and Case Management Services Handbook > Section 2 Blind Children’s Vocational Discovery and Development Program. Or visit hhs.texas.gov > Services > Disability > Blind and Visually Impaired.
The Texas Health and Human Services Commission (HHSC)

Texas Medicaid provides the following service coordination services:

- Service coordination for people who have an intellectual disability or a related condition (adult or child). Persons who have a related condition are eligible if they are being enrolled into the home and community based waiver (HCS); the Texas Home Living Waiver; or an intermediate care facility for persons who have an intellectual disability (ICF/MR) facility.

- Service coordination for persons who have an intellectual disability or a related condition who are enrolled in HCS or Texas Home Living waiver programs.

For more information visit TMHP.com > Providers > Reference Material > Texas Medicaid Provider Procedures Manual > Behavioral Health, Rehabilitation, and Case Management Services Handbook > Section 5.2 Services, Benefits, Limitations, and Prior Authorization > 5.2.1 Service Coordination.

Pharmacist Assistance with Diabetes Control

The Diabetes Control Program (DCP) is an education coaching program available in Harris County, Texas at participating pharmacies. Four times a year, members are able to meet individually with a specially trained pharmacist who has received advanced instruction regarding diabetes control. Pharmacists support member’s self-management of their diabetes through help with medications, nutrition, blood glucose monitoring, goal setting, and education. This program is designed to complement a member’s PCP recommendations. The pharmacists are able to provide either at-home lab tests or may recommend members have their HbA1c test with their PCP.
Chapter 7: STAR+PLUS Service Coordination

Role of Service Coordinator

Our UnitedHealthcare Community Plan service coordination is specialized care management which includes but is not limited to the following services:

- Identification of needs, including physical, behavioral health social, financial, home environment
- Development of and necessary updates to a plan of care to address those identified needs
- Timely and coordinated access to an array of care providers and covered services
- Attention to addressing unique, person-centered needs of members
- Coordination of covered services with non-capitated services, as necessary and appropriate

Each member has a Service Coordination Team led by an assigned service coordinator whose role it is to develop and implement a person-centered plan for care. At its core, the team consists of the member and/or their legally authorized representative. The member is assured the choice of the care providers who will participate, as appropriate, in the coordination of their care, including the PCP and specialty care providers such as behavioral health and long-term services and supports (LTSS) care providers. The Service Coordination Team is person-centered built on member preferences and needs. It delivers services with transparency, individualization, respect, dignity, linguistic and cultural competence in the most appropriate, least restrictive environment.

Service coordinators contact members both telephonically and/or face-to-face based on member needs and preferences. An initial health risk assessment is performed within 30 days of enrollment into our health plan.

Higher risk members are considered level 1 service coordination category. They have complex medical needs and are in a STAR+PLUS waiver program. Their service coordination visits them at least twice a year and speaks with them on the phone at least once a year.

Lower risk members are in level 2 service coordination category may have a history of certain behavioral health issues. Members in this category also include those members receiving LTSS for personal assistance, community first choice or day activity health care. Their service coordinator visits them at a minimum once a year with and at least one phone call conversation.

STAR+PLUS members who do not qualify for service coordination levels 1 or 2 are considered to be in level 3. This includes members in nursing facilities for hospice care or in nursing facilities that are outside UnitedHealthcare Community Plan’s contracted service areas. These members do not have a personally dedicated service coordinator but receive at least two phone calls from a service coordinator annually.

Promoting Independence

We participate in the Promoting Independence initiative. The goal is to help aged and disabled individuals remain in their home in the community to the extent they are able to do so with the assistance of LTSS. Promoting Independence is the Texas response to the U.S. Supreme Court ruling in Olmstead v. L.C., which requires states to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services, when:

- Such placement is appropriate;
- The member does not oppose LTSS; and
- LTSS can be reasonably accommodated, taking into account the resources available and in consideration of the needs of others who are receiving state supported disability services.

Our service coordinators complete an assessment of the member within 30 days of a nursing facility admission. At that time, a plan of care is developed and if appropriate, includes plans to transition the member back into the community. If at this initial review, a return to the community is possible, the service coordinator works with the member and family to return the member to the community using Home and Community-based STAR+PLUS Waiver services to secure LTSS.

If the initial review does not support a return to the community, the service coordinator will conduct a second assessment 90 days after the initial assessment to determine any changes in the member’s condition or circumstances that may allow a return to the community.
Inpatient Concurrent Review: Clinical Information

Your cooperation is required with all UnitedHealthcare requests for information, documents or discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

Your cooperation is required with all UnitedHealthcare requests from the interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone.

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within four hours of receipt of our request if it is received before 1 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1 p.m. local time (but no later than 12 p.m. local time the next business day).

UnitedHealthcare uses MCG (formally Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

Discharge Planning

Discharge planning involves the member, attending physician, member’s PCP, the hospital, or nursing facility or other care settings discharge planner(s). Planning takes into consideration the next least restrictive level of care, necessary resources in the community and follow up. When a member is ready to return to community living, our service coordinator will develop and implement a member-centered transition plan which will include coordination with the following:

- Member’s PCP and other health care professionals
- Community resources

The plan will include utilization of appropriate and available resources, such as the following:

- Money Follows the Person Demonstration, which includes resources for activities of daily living, housing and behavioral health
- Transitional assistance service – a maximum of $2,500 is available on a one-time basis to help defray the costs associated with setting up a household. Transitional assistance services include but are not limited to: payment of security deposits to lease an apartment, purchase of essential furnishings and moving expenses.
- Centers for Independent Living – community-based organizations providing services and advocacy by and for persons with all types of disabilities to assist individuals with disabilities to achieve their maximum potential within their families and communities.
- The plan will include use of appropriate and available LTSS which are for individuals who have intellectual or developmental disabilities as appropriate.

The STAR+PLUS Preadmission Screening and Resident Review (PASRR) requires that all applicants to a Medicaid-certified nursing facility 1) be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services. For more information, they need in those settings see [TMHP.com > Providers > Reference Material > Texas Medicaid Provider Procedures Manual > Rehabilitative Services Limitations](https://www.tmhp.com/Providers/ReferenceMaterial/TexasMedicaidProviderProceduresManual/RehabilitativeServicesLimitations).

Transition Plan

Transition plans occur when:

- UnitedHealthcare Community Plan begins business in a new service area or a service area expansion
- We change locations
- We change our processing system, including changes in material subcontractors performing MIS or claims processing functions
- We initiate a contract to participate in any additional managed care programs
Discharge means a formal release of a member from an inpatient stay when the need for continued care at an inpatient level has concluded. Movement or transfer from one acute care hospital or long term care hospital or facility and readmission to another within 24 hours for continued treatment is not a discharge under this contract.

Transfer means the movement of the member from one acute care hospital or long term care hospital or facility and readmission to another acute care hospital, long term care hospital or facility within 24 hours for continued treatment.

We review any existing care plan and develop a transition plan for members who are newly transitioned into our health plan within 90 days of health plan start date or until the current authorization expires. For initial implementation of the STAR+PLUS program in a service area, we must honor existing LTSS authorizations for up to six months of start date. We pay for medically necessary prior authorized services for members who are new to us, even if their current care provider is out of network, until a network care provider can be secured. The exception being reimburse the continuation of services for a pregnant member past the 24th week of pregnancy for which established services may extend through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

Report any change in a member’s condition or circumstances to the service coordinator by calling 800-349-0550. You may also send an electronic message through CommunityCare, our online service coordination platform.
Chapter 8: End-of-Life Care

Advance Directives

Members have the right to refuse, withhold or withdraw medical treatment and mental health treatment through advance directives (see Social Security Act §1902(a)(57) and §1903(m)(1)(A)). Members are encouraged to discuss their wishes with their PCP. You must document, in a prominent part of the member medical record, whether or not the member has an executed advance directive. This is especially applicable to hospitals, critical access hospitals, skilled nursing facilities, home health agencies, providers of home health care, providers of personal care services and hospices. The provision of care cannot be conditioned, and a member may not be otherwise discriminated against, based on whether or not the member has executed an advance directive. Members have the right to:

- Receive medical care, even if the member does not have an advance directive.
- Change or cancel advance directives at any time
- Obtain clear and concise information with regard to the different types of advance directives available to them and when an advance directive will take effect
- Discuss advance directives with their PCP as well as family members, friends, and other individuals who are involved in their health care
- Make a written or non-written out of hospital Do Not Resuscitate (DNR) order
- Execute an advance written directive to doctors and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life sustaining treatment in the event of a terminal or irreversible condition
- Execute a Medical Power of Attorney; to appoint an agent to make health care decisions on the member’s behalf if the member becomes incompetent

Members must comply with state and federal laws regarding the witnessing and notarizing of advance directive documents. Members must keep advance directives in a safe place that is accessible to family members or other responsible individuals.

Hospice

HHSC manages the Hospice Program through care provider enrollment contracts with hospice agencies. These agencies must be licensed by the state and Medicare-certified as hospice agencies. Coverage of services follows the amount, duration, and scope of services specified in the Medicare Hospice Program. Hospice pays for services related to the treatment of the client’s terminal illness and for certain physician services (not the treatments).

Medicaid Hospice provides palliative care to all Medicaid-eligible members (no age restriction) who sign statements electing hospice services and are certified by physicians to have six months or less to live if their terminal illnesses run their normal courses. Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death.

Texas Medicaid members who are 21 years of age and older and who elect hospice coverage waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services that are unrelated to their terminal illness.

Texas Medicaid clients who are 20 years of age and younger and who elect hospice care are not required to waive their rights to concurrent hospice care and treatment of the terminal illness. They do not waive their rights to Medicaid services that are unrelated to their terminal illness.

Resources

For more information visit TMHP.com > Provides > Reference Material > Texas Medicaid Provider Procedures Manual > Section 4 Client Eligibility, 4.4 Restricted Medicaid Coverage, 4.4.3 Hospice Program.

For more information about STAR+PLUS Nursing Facility services visit TMHP.com > Provides > Reference Material > Texas Medicaid Provider Procedures Manual > Nursing Facility Services.
Chapter 9: Long-Term Services and Support

The STAR+PLUS Program is designed to improve access to care, provide care in the least restrictive setting and provide accountability and control on costs. The STAR+PLUS program integrates acute care and Long-Term Care Services and Supports (LTSS) into a Medicaid managed care delivery system for members who receive Supplemental Security Income (SSI). In the STAR+PLUS Program, we contract with care providers and delegated networks to create a health care provider delivery network. For more information visit TMHP.com > Provides > Reference Material > Texas Medicaid Provider Procedures Manual > section 4. STAR+PLUS PROGRAM.

Our contracted support services are delivered in the community thereby allowing members to live in a home environment when they would otherwise require nursing facility long-term care.

Authorization of Services

The authorization process begins when a service coordinator assesses the member’s needs. Then works with the member, family and health care providers to create a plan of care that specifies which services will be covered. The service coordinator then arranges for the services by contacting the care provider and entering an authorization into our system. Sometimes a plan of care may need to be adjusted during the year to accommodate a change in the member’s condition. A change in condition means a significant change in a member’s health, informal support or functional status that will not normally resolve itself without further intervention, and requires review and revision to the current person-centered care plan. At that time a service may be added, changed or deleted from the plan of care. The member can initiate this by calling Customer Service at 888-887-9003. Before providing services please make sure the service(s) you provide are authorized. Confirm that the authorization is for the correct member and includes the correct billing codes with modifiers and units. Please also verify the member’s eligibility at Link through UHCprovider.com > Eligibility & Benefits or by calling 888-887-9003.

Referral Information

PCPs may contact a service coordinator to obtain LTSS for your patient who is our member. This may be accomplished through Community Care, our online service coordination and health care management tool. Access is through Link at UHCprovider.com. You may also call the Service Coordination hotline at 800-349-0550.

Services

The following Medicaid services are available for STAR+PLUS Community Plan members. All STAR+PLUS members are eligible, based on need due to disabilities or aging, to Personal Attendant Services and Adult Day Healthcare. Members in the Home-and-Community-Based Service (HCBS) waiver program are additionally eligible for other LTSS services. All LTSS services are provided by HHSC-contracted, UnitedHealthcare Community Plan network care providers.

- Personal Attendant Services

  - Three types of Personal Attendant Services include:
    - Primary Home Care for non-waiver members. Includes an escort to medical appointments, housekeeping and personal care.
    - Protective Services for all STAR+PLUS members and may be appropriate for members at risk of injury due to a cognitive or memory impairment, and/or physical weakness. (This service is only available to eligible waiver members.)
    - Personal Attendant Services is an extensive list of support services for waiver members:
      - Respite Care
        Offers temporary relief for people who are caring for functionally-impaired adult members in their home, and not as a business. In-home respite is available only to waiver STAR+PLUS members. A value-added service benefit is available for limited respite for in-home care to non-waiver members. Assisted Living and Residential Care Facilities
        These facilities provide services in three types of living arrangements: assisted living apartments, residential care apartments and residential care non-apartment settings.
        An assisted living facility (ALF):
          a. Furnishes, in one or more facilities, food and shelter to four or more persons who are unrelated to the establishment proprietor;
**Chapter 9: Long-Term Services and Support**

b. Provides:
   1. Personal care services;
   2. Medication administration by a person licensed or otherwise authorized in this state to administer the medication; or
   3. Services described in this subparagraph clauses (1) and (2); and

c. May provide assistance with or supervision of the medication administration.

An assisted living facility may provide skilled nursing services for the following limited purposes:

a. Coordinate resident care with an outside home and community support services agency or health care professional;

b. Provide or delegate personal care services and medication administration, as described in this chapter;

c. Assess residents to determine the care required; and

d. Deliver temporary skilled nursing services for a minor illness, injury, or emergency, for a period not to exceed 30 days.

HHSC considers one or more facilities to be part of the same establishment and, therefore, subject to licensure as an assisted living facility, based on the following factors:

a. Common ownership;

b. Physical proximity;

c. Shared services, personnel, or equipment in any part of the facilities’ operations; and

d. Any public appearance of joint operations or of a relationship between the facilities.

The presence or absence of any one factor in subsection paragraph (3) is not conclusive.

To obtain a license, a person must follow the application requirements in 40 Tex. Admin Code §92.11 and meet the license criteria.

Residential care includes the following services: personal care, home management, social and recreational activities, supervision, transportation, and help with taking medications.

---

**Adult Foster Care**

Adult foster care (AFC) is a full-time living arrangement in a HHSC-contracted foster home for members who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes and qualify for waiver services, which may include meal preparation, housekeeping, minimal help with personal care, help with activities of daily living and provision of or arrangement for transportation.

**Day Activity and Health Services**

Normally provided Monday through Friday, services include lunch and snacks; nursing and personal care; physical rehabilitation; social, educational and recreational activities; and transportation. This is available for waiver and non-waiver members.

---

**Additional LTSS:**

**Emergency Response Services**

Electronic monitoring systems are for members who live alone or are isolated in the community. In an emergency, the member may press a call button to access around-the-clock help.

**Home-Delivered Meals**

One hot meal per day is delivered to a member’s home when they are unable to prepare their own meals and have no one available help. A value-added service allows for home-delivered meals for non-waiver members.

**Minor Home Modifications**

Minor home modifications allow a member to function better within their home. Modifications may include a wheelchair ramp, adjusted counter height and bathroom safety hardware. Minor home modifications do not include home renovations, remodeling or construction of additional rooms.

**Vehicle Modifications**

Mechanical or structural changes to a motor vehicle allow members with a disability to safely drive or ride as a passenger.

**Transitional Assistance Services**

A transitional assistance service helps members who have been discharged from a nursing home setting. A maximum of $2,500 is available on a one-time basis to help defray the costs associated with setting up a household. Transitional assistance services include but are not limited to payment of security deposits to lease an apartment, purchase of essential furnishings and moving expenses.
Employment Assistance and Supported Employment

We encourage employment in the general workforce for working age members with disabilities, regardless of level of disability. Employment Assistance helps members develop skills and aids in finding paid employment in the community. Supported Employment helps members with onsite work accommodations that may be necessary to maintain employment.

Consumer Directed Services/Financial Management

This service is for members who employ and retain their own attendants. They also direct the delivery of HCBS STAR+PLUS Waiver (SPW) personal assistance services and respite services. They do not handle the financial aspects of being an employer. Members are required to use a consumer-directed services agency for managing funds associated with these services, including hiring, training, supervising, processing timesheets and payroll and overall responsibilities of being an employer.

Community First Choice

This waiver program is for individuals with an intellectual disability or behavioral health diagnoses. It includes:

- Personal assistance with activities of daily living household chores and escorts, also known as personal care attendants, who accompany members to medical appointments when they cannot go alone.
- Habilitation: Allows an individual to reside successfully in a community setting by assisting the individual to acquire, maintain, and enhance self-help, socialization, and activities of daily living (ADL) skills, or assisting with and training the individual on instrumental daily living activities (IADLs). The six basic ADLs are eating, bathing, dressing, toileting, mobility, and grooming. Eating includes feeding oneself and getting all of the vitamins and nutrients needed to stay healthy. ADLs are more complex tasks such as housework and preparing meals. All qualified members may receive this service to help them accomplish ADLs, IADLs and health-related tasks.
- Emergency Response Services: Electronic monitoring systems are for functionally-impaired members who live alone or are isolated in the community. In an emergency, the member may press a call button to access around-the-clock help.

- Support Consultation involves voluntary member training on how to select, manage and dismiss attendants.

Role of LTSS Care Providers

LTSS care providers deliver a continuum of care and assistance. These services range from in-home to community-based services for the elderly and people with disabilities who need assistance in maintaining their independence. LTSS care providers are responsible to provide covered health services to members, within the scope of their UnitedHealthcare Community Plan agreement and within the scope of their specialty license.

LTSS Care Provider Responsibilities

- Notify a STAR+PLUS member’s UnitedHealthcare Community Plan service coordinator of any change in physical circumstances, physical condition or eligibility. Service coordinator contact information is located in the patient personal health section of the member’s record at UHCprovider.com. It is also listed in the STAR+PLUS CommunityCare online service coordination tool. You may also call the service coordination hotline at 800-349-0550 to inquire about a member’s assigned service coordinator so you can contact that person.
- Help ensure continuity of care, as members may be involved in several LTSS services at one time.
- Work with PCPs to coordinate the delivery of Medicare and Medicaid services and coordination of benefits for dual eligible members (if applicable).
- Verify member eligibility and help ensure the service coordinator secured authorization for services prior to your delivering services.
- Do not use physical restraint except in situations where the member’s behavior poses imminent danger of serious physical harm to self or others. Members have the right to not be restrained or secluded when it is at an LTSS care provider’s or someone else’s convenience, or is meant to force them to do something they do not want to do, or as a punishment. Seclusion is not acceptable as a form of restraint. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
• Train staff regarding the use and alternatives of restraint in accordance with §9.179 of the Texas Administrative Code.

• Train staff and volunteers on the identification and reporting of abuse, neglect, and exploitation.

• Help ensure, through initial and periodic training, the continuous availability of qualified service care providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies and any other needs specific to the member which are required to help ensure the member’s health, safety and welfare. The program provider must maintain documentation of this training in the member’s record.

• Coordinate care as appropriate with PCPs who may be out-of-network for UnitedHealthcare Community Plan, but in-network of another managed care organization to coordinate care for those members who are dually eligible for both Medicare and Medicaid.

• Employment assistance providers develop and update quarterly a plan for the delivery of employment assistance services.

• Supported employment providers develop and update quarterly a plan for delivering supported employment services.

• Help ensure member rights are protected, including privacy during visitation, the ability to send/receive sealed and uncensored mail, and make/receive telephone calls.

• Help ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the member which are required to help ensure the member’s health, safety, and welfare. The program provider must maintain documentation of this training in the member’s record.

• For the self-directed model with service budget, an individual has the option to permit family members, or any other individuals, to provide Community First Choice services and supports identified in the person-centered service plan, provided they meet the qualifications to provide the services and supports established by the individual, including additional training, per Code of Federal Regulations.

• Address complaints received from a member, or representative and have documentation showing the attempt(s) at resolution of the complaint. Members will be notified of how to file a complaint, including contact information for filing the complaint. Members may also file an appeal or complaint regarding a denial of service or a quality of service, respectively with UnitedHealthcare Community Plan by calling 888-887-9003 or sending the complaint to:

  UnitedHealthcare Community Plan
  Attn: Complaint and Appeals Dept.
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

**Credentialing**

Credentialing and re-credentialing every three years entails the submission of the following documentation and verification of the following provider requirements:

• Copy of current state license (if applicable)

• Copy of appropriate licensure (particularly for CFC, emergency response services)

• Internal Revenue Service (IRS) W-9 Form

• Copy of Medicare Participation Certification (if applicable)

• Copy of the Texas HHSC Participation Certification (if applicable)

• Copy of certification and/or accreditation certificates (e.g., JCAHO, Medicare)

• Copy of Declaration Sheet and/or Certificate of Insurance Policy for BOTH
  – Current professional malpractice insurance policy, and
  – Comprehensive general liability insurance policy

• Historical Underutilized Business Certification Number (if applicable)
Service Licensure, Certification, and other Minimum Qualification Requirements for Employment Assistance and Supported Employment Providers

You must meet all of the criteria in one of these three options.

Option 1:
• A bachelor’s degree in rehabilitation, business, marketing, or a related human services field; and
• Six months of documented experience providing services to people with disabilities in a professional or personal setting.

Option 2:
• An associate’s degree in rehabilitation, business, marketing, or a related human services field; and
• One year of documented experience providing services to people with disabilities in a professional or personal setting.

Option 3:
• A high school diploma or GED; and
• Two years of documented experience providing services to people with disabilities in a professional or personal setting.

Attendant Compensation Rate Enhancement

The Attendant Compensation Rate Enhancement is a legal provider agreement rider developed by HHSC that relates to the Texas HHSC additional reimbursement rate of compensation for attendants. Attendants are unlicensed caregivers who provide direct assistance with activities of daily living and instrumental activities of daily living. For example:

– Adult day care direct care workers
– Assisted living direct care workers
– Drivers
– Medication aides
– Personal attendant services direct care workers

Allowable compensation:
– Salaries and wages
– Attendant contract labor
– Payroll taxes
– Workers’ compensation
– Employer-paid health insurance
– Employer-paid life insurance
– Other employer-paid benefits not allowed
– Unrecovered cost of meals and room and board furnished to attendants
– Uniforms
– Hepatitis B vaccinations and TB testing/X-rays
– Job-related training reimbursements
– Job certification renewal fees

These are not all inclusive lists. For the full list of allowable compensation, visit the Texas Administrative Code. For provider training and instructions, visit UHCprovider.com/TXCommunityPlan > Training > Attendent Compensation Rate Enhancement or contact your provide advocate.

To request an amendment to your provider agreement: Ask for the amendment when you sign your first Provider Agreement with us. You may also request to add an amendment to your current Provider Agreement during the open enrollment period. We need your HHSC contract number so we can verify your rate enhancement level. Submit your amendment request and HHSC contract number to your provider advocate directly or fax to 855-500-3356. For questions you may call LTSS Provider Relations at 888-787-4107.

Federal Home and Community-Based Services Rules

LTSS settings that are in the community and considered outpatient, include:

- Adult day health care
- Foster care
- Assisted living and residential care
- Employment assistant services

**Choice**
The setting encourages member choice regarding services and supports, and who provides them.

Members may choose the setting in which they receive LTSS services. This choice is able to be made from a selection of setting options including non-disability specific settings and an option for a private unit in a residential setting, if available.

The setting optimizes, but does not regiment member initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact.

**Documentation**
Make a note of where the member is receiving services. Include a brief description in the member’s person-centered plan of care. Note whether and how the setting is appropriate based on the member’s needs, preferences, and for residential settings, resources available for room and board.

**Member Rights**
The LTSS provider, the owner and employees who carry out the services must help ensure a safe environment that:

- Encourages the greatest possible independence of every member
- Observes member rights related to:
  - Privacy
  - Dignity
  - Respect
  - Freedom from coercion and restraint

See the Appendix: Member Rights & Responsibilities of this manual for a complete list.

**Community**
The setting is integrated within its surrounding community and supports full access of members to the greater community. This includes the following opportunities for the member to:

- Seek employment and work in settings alongside employees not in special programs and to have the ability to earn a competitive salary.
- Engage in community life, such as go to the show, recreation center or the park.
- Control their personal resources, including personal belongings and monies.
- Receive services in the community, to the same degree of access as members not receiving Medicaid home and community-based (LTSS) services.

**Care Provider-owned Setting**
In a care provider-owned or controlled setting, in addition to the stated qualities, the following additional conditions must be met:

- Give members the same responsibilities and protections from eviction that tenants have under state and local law.
- Give members privacy in their sleeping or living unit, including member locking doors, choice of roommates, and freedom to furnish and decorate sleeping and living areas.
- Give members the freedom and support to control their own schedules and activities.

These setting guidelines do not apply to inpatient settings. These include:

- a nursing facility,
- an institution for mental diseases,
- an intermediate care facility for members with intellectual disabilities,
- a hospital, and
- any other locations that have qualities of an institutional setting.

**Resources**
• For information about the HHSC-contracted providers of long-term services and supports for individual who have intellectual or developmental disabilities, visit see TMHP.com > Providers > Reference Material > Texas Medicaid Provider Procedures Manual > Mental Health Rehabilitation, Mental Health Case Management, and Intellectual Disability Service Coordination.

• For information about the HHSC-contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities, visit see TMHP.com > Providers > Reference Material > Texas Medicaid Provider Procedures Manual > Mental Health Rehabilitation, Mental Health Case Management, and Intellectual Disability Service Coordination.

• LTSS providers please refer to the Abuse, Neglect and Exploitation section of this manual for additional information.

• See the Service Coordination section of this manual for information about the Texas Independence Initiative and community living.
Chapter 10: Value-Added Services

We offer additional services at no cost to the member. These special services are selected to address member needs and experiences in an effort to help them live healthier lives. Examples of value-added services include:

- Incentives for member annual wellness exams,
- Non-emergent transportation,
- 24-hour access to NurseLine, and
- Extra behavioral health support.

Members are informed of these services through their UnitedHealthcare Community Plan welcome packet. Value-added services are included in the member newsletter, listed in the member handbook and at UHCCommunityPlan.com. Information about services that are diagnosis-specific, such as diabetes and pregnancy, are mailed to the member’s home.

Members may directly access most of these services. Some services require assistance from your office. All are limited to in-network care providers. Please note that value-added services are available once per calendar year unless otherwise noted. These services may change in September of each year.

For the most current value-added services, please visit UHCprovider.com/TXCommunityPlan > Reference Guides and Value-Added Services. You may also call customer service at 888-887-9003.
Chapter 11: Pharmacy

The Pharmacy Help Desk for prescribers at 800-310-6826 is available for authorizations and prescription assistance. We adhere to the HHSC-approved formulary and preferred drug list for Texas members enrolled in UnitedHealthcare Community Plan. You may view the list of covered drugs at UHCprovider.com/TXCommunityPlan > Pharmacy Resources and Physician Administered Drugs, and at the Medicaid/CHIP Vendor Drug Program at txvendordrug.com > Formulary/PDL.

We also provide retail network contracting and management and clinical programs, such as step therapy, formulary management and disease/drug therapy management programs that assist customers in achieving a low-cost, high-quality pharmacy benefit.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>When to call</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Providers</td>
<td>Should you have any questions or require assistance, please contact the OptumRx Help Desk</td>
<td>877-305-8952</td>
</tr>
<tr>
<td>Pharmacy Benefits</td>
<td>Contact the OptumRx Help Desk for questions or inquiries on pharmacy benefits</td>
<td>877-305-8952</td>
</tr>
</tbody>
</table>
| Physician Prescribers | Questions on services requiring prior authorization may be made by calling our Pharmacy Prior Authorization Desk | Physician Prescribers: Phone: 800-310-6826 Fax: 866-940-7328
Pharmacies: Phone: 877-305-8952 For a list of all preferred drugs to go UHCprovider.com/TXCommunityPlan > Pharmacy Resources and Physician Administered Drugs |
| Pharmacy Providers  | Questions on how to join our network of participating pharmacies            | OptumRx Network Department Phone: 877-633-4701   |
Role of Pharmacy

Pharmacy responsibilities include a range of care for members, from dispensing medications to monitoring member health and progress to maximize their response to the medication. Pharmacists also educate members on the use of prescriptions and over-the-counter medications and advise physicians, nurses and other health professionals on drug decisions. Pharmacists also provide expertise about the composition of drugs, including their chemical, biological and physical properties. They help ensure drug purity and strength and make sure that drugs do not interact in a harmful way. Pharmacists are drug experts ultimately concerned about their patients’ health and wellness. Pharmacies may also contract for Limited Home Health Supplies (LHHS) with UnitedHealthcare Community Plan according to the Texas Vendor Drug Program Requirements.

Pharmacy providers have the following responsibilities:

• Adhere to the formulary,
• Adhere to the preferred drug list (PDL),
• Coordinate with the prescribing physician,
• Help ensure members receive all medication for which they are eligible, and
• Coordinate benefits when a member also receives Medicare Part D services or other insurance benefits.

Emergency Prescription Supply

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

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

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

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

- “Prior Authorization type Code “(Field 461-EU) = ‘8’
- “Prior Authorization Number Submitted” (Field 462-EV) = ‘801’
- “Day Supply” in the claim segment of the billing transaction (Field 405-D5) = ‘3’

Pharmacies can call our Pharmacy Provider Help Desk at 877-305-8952 for assistance with submission of information for a 72-hour emergency prescription supply.

Physician prescribers can call the pharmacy help desk for prescribers at 800-310-6826 for more information about the 72-hour emergency prescription supply policy.

Prior Authorization

Some drugs on the approved formulary and preferred drug list may require prior authorization. Pharmacists receiving prescriptions for drugs requiring PA should work with the prescribing physician for the prescribing care provider to request the prior authorization or to see if the prescription can be changed to a preferred alternative medication. If a preferred alternative is not appropriate, the physician should then contact the Pharmacy Help Desk at 800-310-6826 with questions concerning the prior authorization process. The drugs that are preferred and those that require prior authorizations are designated in the list of drugs at UHCprovider.com/TXCommunityPlan > Pharmacy Resources and Physician Administered Drugs.

Step Therapy

When a trial of an indicated first-line agent has been adequately tried and failed, these medications may also be requested through the prior authorization process. While lower-cost PDL alternatives may be appropriate in many instances; other non-PDL alternatives are available with prior authorization.

Days’ Supply Dispensing Limitation

UnitedHealthcare Community Plan members may receive up to a one-month supply (34 days) of a specific medication per prescription order or prescription refill. A medication may be reordered or refilled when 75 percent of the medication has been used. If a claim is submitted before 75 percent of the medication has been used, based on the original day supply
submitted on the claim, the claim will reject with a “refill too soon” message. Physician prescribers can call the Help Desk at 800-310-6826 with questions or for help with dosage change authorization. STAR and STAR+PLUS members age 21 years or older and not covered by Medicare are eligible to receive unlimited prescription benefits. CHIP members are eligible to receive an unlimited number of prescriptions per month and may receive up to 90-day supply of a drug.

New to Therapy Short-Acting Opioid Supply and Daily Dose Limits

UnitedHealthcare Community Plan will implement a short-acting opioid supply limit of three days and less than 50 Morphine Equivalent Dose (MED) per day for patients who are 19 or younger and new to opioid therapy. Requests for opioids beyond these limits will require prior authorization.

How This Affects You and Your Patients

Long-term opioid use can begin with the treatment of an acute condition. For this reason, we recommend you consider prescribing the following:

• The lowest effective dose of an immediate-release opioid; and
• The minimum quantity of an opioid needed for severe, acute pain that requires an opioid

By adhering to these guidelines, you’ll be working to help minimize unnecessary, prolonged opioid use.

Why We’re Making the Change

Studies have shown chronic opioid use often starts with a patient prescribed opioids for acute pain. The length and amount of early opioid exposure is associated with a greater risk of becoming a chronic user. For this reason, the Centers for Disease Control and Prevention recommends when a patient is prescribed opioids for acute pain, they receive the lowest effective dose for no more than the expected treatment time.

For more information on this change, call 888-362-3368.

Quantity Limitations

UnitedHealthcare Community Plan places quantity limitations on medications which may differ from limitations placed by the Texas Vendor Drug Program. Types of quantity limitations are:

• Unlimited prescriptions for adult STAR+PLUS members who are not also covered by Medicare
• Prescriptions for monthly quantities greater than the indicated limit require a prior authorization request
• Efficient mediation dosing
• The efficient medication dosing program, which helps consolidate medication dosage to the most efficient daily quantity to increase adherence to therapy and promote the efficient use of health care dollars

The limits for the program are established based on Federal Drug Administration approval for dosing and the availability of the total daily dose in the least amount of tablets or capsules daily. Quantity limits in the prescription claims processing system will limit the dispensing to consolidate dosing

• The pharmacy claims processing system prompting the pharmacist to request a new prescription order form the physician

Additions to the quantity limitations program drug list will be made from time to time. You will be notified accordingly. As always, we recognize that a number of patient-specific variables must be taken into consideration when drug therapy is prescribed. Overrides will be available through the medical exception (prior authorization) process. More information regarding drug-specific quantity limits can be found at UHCprovider.com/TXCommunityPlan > Pharmacy Resources and Physician Administered Drugs.

Formulary Information Available For Handheld Devices

This free service provides instant access, through a hand-held or other online device, to information on the drugs covered by Texas Medicaid. Supported platforms include Android, Palm, Blackberry, Windows Mobile, and iPhone. To register for the service, go to epocrates.com and sign up for free Epocrates Rx. After signing up, subscribe to the “Texas Medicaid” formulary. You can search by drug name to see which drugs are preferred or non-preferred and which products are subject to a clinical prior authorization edit.

E-Prescribing

Electronic prescribing (e-prescribing or eRx) is a prescribing physician’s ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy. It has the ability to verify eligibility and formulary data for a patient prior to and during the prescribing process. It also enables you to view medication history reports. This is enabled with the authorized exchange data from the PBM or payer and the
prescriber. We support surescripts. For more information visit surescripts.com. Please note that electronic prescribing of controlled substances (EPCS) is allowed and preferred.

UnitedHealthcare Community Plan supports e-prescribing for pharmacy claims. The NCPDP E1 transaction electronically verifies member eligibility.

For multisource drug prescription processing, enter the following information:

Submit “1” in “Dispense as Written” (DAW) (Field 408-D8) to override MAC pricing, when a physician wants a brand name dispensed and hand writes the phrase – “Brand Necessary,” “Brand Name Necessary,” or “Brand Name Medically Necessary” across the face of the prescription.

DAW “1” will reimburse at normal calculated cost including comparison to Usual & Customary and Gross Amount Due. Multi-source brand drugs will pay. The pharmacy submits a “5” in a “Dispense as Written” (DAW) Field 408-D8). The multi-source brand drug will be subject to Maximum Allowable Cost (MAC) Pricing.

Pharmacies should submit the “Prescription Origin Code” (Field 419-DJ) on all billing submissions in support for e-prescribing transactions. While the field is optional for National Council for Prescription Drug Programs (NCPDP) B1 transactions in version 5.1, it is required for D.0 B1 transactions.

Pharmacy Payment

Pharmacy providers are encouraged to participate in the Electronic Funds Transfer (EFT) Program. This service provides improved analysis, reporting and a cost-effective alternative to the traditional paper copy process. Follow these simple steps to enroll in the OptumRx Pharmacy EFT Program:

• Log on to optimrx.com > Health Care Professionals > Resources > Electronic Payment Solutions > EFT Enrollment. Select Learn More, to obtain detailed program information, a Pharmacy EFT Enrollment Form and an online EFT Trading Partner Information Request.
  – Print, complete and fax the enrollment form to:
    OptumRx
    P.O. Box 6104
    Cypress, CA 90630-6104
    Fax: 800-732-7601
  – Click on the online link to complete the EFT Trading Partner Information Request. This form will be used to set up the 835 electronic remittance advice file transfer Refer to the OptumRx Pharmacy Manual for EFT Program requirements and enrollment information or call the Help Desk at 877-305-8952.

References

Processor Information for UnitedHealthcare Community Plan Programs:

• Name of Processor: OptumRx™
• Bank Identification Number (BIN): 610494
• Processor Control Number (PCN): 9999
• Submitted Group: ACUTX

Pharmacy Claims Processing

Please refer to the OptumRx Pharmacy Provider Manual and payer specification documents for complete claims submission requirements and guidelines, including NCPDP format. Electronically submitted pharmacy claims are processed within 18 days, and all other claims are processed within 30 days. Pharmacy claims that are not submitted electronically are processed within 21 days.
Chapter 12: Behavioral Health

Behavioral health encompasses mental, emotional and substance use disorders. Behavioral health screening is included in a member’s annual wellness exam. We encourage you to be sensitive to postpartum and geriatric members as well as members experiencing a significant life stressor.

Preventive services are provided per the U.S. Preventive Services Task Force recommendations with grades A or B1, which you can view at the U.S. Department of Health & Human Services Agency for Healthcare Research and Quality at AHRQ.gov.com > Programs > Clinicians & Providers > Clinical Guidelines and Recommendations > Guide to Clinical Preventive Services. For CHIP, see also the periodicity schedule at the American Academy of Pediatrics at AAP.org > Professional Resources > Practice Transformation > Engaging Patients and Families > Periodicity Schedule.

The following recommendations are not reimbursed separately but must be provided, when applicable, as part of the routine preventive exam:

- Counseling to prevent tobacco use and tobacco-caused disease
- Behavioral counseling in primary care to promote healthy diet
- Behavioral interventions to promote breast feeding
- Screening, counseling and interventions for obesity
- Screening and behavioral counseling interventions to reduce alcohol misuse
- Screening for depression

A THSteps-enrolled care provider is required to perform behavioral health assessments for STAR and STAR+PLUS members through age 20 per the THSteps periodicity schedule. For information about conducting these screenings, see the THSteps online educational module, "Mental Health Screening," at txhealthsteps.com.

Assessment Instruments

The 2014 American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care, the THSteps Advisory Panel identified a work group to develop mental health screening tools for children. Tools include maternal and postnatal depression and psychological and behavioral screenings for children. Please visit Brightfutures, aap.org > Developmental, Behavioral, Psychosocial, Screening, and Assessment Forms.

Other recommended screening tools (scoring methodologies are included in the screening tools themselves):

- National Institute on Drug Abuse
- Patient Health Questionnaire (PHQ-9) for Depression
  Patient Health Questionnaire (PHQ) Screeners at Pfizer.com > Click here to access screeners > Select a Screener
- GAD 7 for Generalized Anxiety Disorder at Pfizer.com > Click here to access screeners > Select a Screener
- Children with Special Health Care Needs Screener from The Child and Adolescent Health Measurement Initiative at CAHMI.org > Resources > For Healthcare Providers and Organizations.

Texas Health Step Screenings

Mental health screening using one of the following validated, standardized mental health screening tools recognized by THSteps is required once for all clients who are 12 through 18 years of age:

- Pediatric Symptom Checklist (PSC-35)
- Pediatric Symptom Checklist for Youth (Y-PSC)
- Patient Health Questionnaire (PHQ-9)
- Car, Relax, Alone, Forget, Family, and Trouble Checklist (CRAFFT)

Procedure code 99420 is a benefit for members who are 12 through 18 years of age when services are provided by THSteps medical and federally qualified health center providers in the office setting. Procedure code 99420 must be submitted for mental health screenings when one of the validated, standardized mental health screening tools recognized by THSteps is used.

Mental health screenings at other checkups do not require the use of a validated, standardized mental health screening tool.

Procedure code 99420 must be submitted on the same date of service by the same provider as procedure code 99384, 99385, 99394, or 99395, and will be limited to once per lifetime.
Comorbidity

Physical diseases and chronic conditions are often accompanied by comorbid behavioral health conditions, such as depression, anxiety, and mood or substance use disorders. Consider a behavioral health specialist to be included in the members’ service coordination team for assessment and possible treatment. See the Referral segment of this chapter for referral numbers.

Member Access to Behavioral Health Services

United Behavioral Health, operating under the brand Optum, is the administrator of mental health and substance use disorder benefits for UnitedHealthcare Community Plan members. Prior authorization is not required for in-network specialists. Members may self-refer to any network behavioral health specialist. PCPs may also refer. It is the specialist’s responsibility to report back to the PCP their findings, recommendations and treatments for coordination between behavioral health and physical health services. Medical record documentation is documented using the current DSM classifications. A consent for disclosure of information accompanies any exchange of member information. You may also provide behavioral health-related services yourself if within the scope of its practice. The following appointment guidelines are from the time of referral to the time of the appointment:

- Initial outpatient behavioral health appointment – 14 days
- Post inpatient stay follow up – seven days
- Urgent care – within 24 hours
- Emergency – immediately upon presentation

Referral numbers are answered 24 hours a day. Face-to-face assessment for acute and crisis situations are available 24 hours a day, seven days a week. Behavioral health care providers will contact members who have missed an appointment within 24 hours to reschedule the appointment.

For a referral or crisis, call 888-887-9003.

Quality Services

- ADHD Medication and Treatment Management – Healthcare Effectiveness Data and Information Set (HEDIS®) 2016 addresses recommended follow-up visits for children ages six through 12 for whom a new prescription was filled for an Attention Deficit Hyperactivity Disorder (ADHD) medication when a prescription in the previous four months was not filled. Follow-up visits are divided into two phases:
  - Initiation Phase: At least one follow-up visit with practitioner with prescribing authority during the first 30 days
  - Continuation and Maintenance Phase: At least two follow-up visits within 270 days (nine months) after the end of the initiation phase. One of these three follow-up visits may be a telephone call, which is reimbursable using code: 98966-98968.

PCPs seeing children for follow-up visits after prescribing ADHD medications may bill for this particular service. The payable procedure codes for these visits can be found through the Texas Medicaid and Healthcare Partnership (TMHP) website search feature. The following table contains some examples of those procedure codes.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Presenting Problem(s)</th>
<th>Minutes Spent with Member and Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Minimal</td>
<td>5</td>
</tr>
<tr>
<td>99212</td>
<td>Self-limited or minor</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>Low to moderate</td>
<td>15</td>
</tr>
<tr>
<td>99214</td>
<td>Moderate to high</td>
<td>25</td>
</tr>
<tr>
<td>99215</td>
<td>Moderate to high</td>
<td>40</td>
</tr>
</tbody>
</table>
See the STAR and STAR+PLUS Benefit Appendixes of this manual for information about ADHD Covered Services for children including reimbursement for ADHD.

- **Antidepressants – Medication Management**
  Per HEDIS 2016 measure for adult patients diagnosed with major depression and prescribed antidepressants, patients must remain on an antidepressant drug for at least six months. Please explain to patients it may take 10 to 12 weeks to see the full effect of a medication and they should remain on the medication for at least six months to reduce the risk of recurrence.

  The HEDIS Antidepressant Medication Management measures for major depression focus on the percentage of members 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

  - **Effective Acute Phase Treatment.** The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
  - **Effective Continuation Phase Treatment.** The percentage of members who remained on an antidepressant medication for at least 180 days (six months).

  Please help educate members about:

  - The benefits of antidepressant treatment and potential risks of sudden cessation
  - The length of time it can take for medication to take effect
  - Ways to cope with side effects
  - Communicating with you prior to making any changes to their medication

**Hospitalization**

- Court-ordered inpatient admissions for members younger than 21 are not subject to admission and lengths of stay criteria. Admissions to freestanding and state psychiatric facilities must be medically necessary, unless they are court-ordered services for mental health commitments or they are a condition of probation. This type of court order is not covered if the member is given the choice of court-ordered admission vs. incarceration. Please note that modifier HZ, funded by Criminal Justice Agency, is not a covered benefit. These services will continue to be covered under the criminal justice system.

**Mental Health Condition Centers and Member Education**

These centers provide information and assessment tools for several mental health and substance use disorder diagnoses, symptoms, treatment options, prevention and other resources in one, easy-to-access area. They are available for PCP utilization as preliminary instruments. You will land on a section designated for care providers. Note the “Welcome Clinicians.” Through this site, you can access some of the same clinical content, self-assessment tools and other resources Optum makes available to its members. Access this resource through the Optum provider website at [providerexpress.com](http://providerexpress.com). > Clinical Resources > Live and Work Well clinician center.

**Medicaid Services for STAR+PLUS Members**

The following services are available in addition to behavioral health covered benefit services.

- **Mental Health Rehabilitative Services**
  Mental Health Rehabilitative Services help members with a serious and persistent mental illness or a serious emotional disturbance as defined in the current DSM who require rehabilitative services as determined by either the Adult Needs and Strengths Assessment or the Child and Adolescent Needs & Strengths. Services include Adult Day Program, Medication Training and Support, Crisis Intervention and Skills Training and Development. Members access these services through their service coordinator.

- **Targeted Case Management**
  This service helps members with a serious and persistent mental illness or a serious emotional disturbance as defined in the current DSM, to gain access to needed medical, social, educational,
developmental, and other appropriate services. Severe and persistent mental illness, or SPMI, describes mental illnesses with complex symptoms that require ongoing treatment and management, most often varying types and dosages of medication and therapy. SPMI typically does not level off and remain at a steady state. Rather, symptoms come and go in relation to stress. As a result, people with SPMI may be able to function independently for periods of time but may need intensive support with housing, school, work, social functioning, and other everyday life concerns when they experience a stressful event.

Serious emotional disturbances (SED) apply to children that experience functional impairment and are diagnosed for more than a year with a serious disorder such as pervasive developmental disorder, schizophrenia, conduct disorder, affective disorder, disorders with serious medical implications such as eating disorders, or persistent involvement with alcohol or drugs. Members access these case management services through their service coordinator and individual service plan.

• Care Providers of Targeted Case Management and Mental Health Rehabilitation
  These specialists are trained and certified to administer, the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) assessment tools to recommend a level of care when submitting a request for authorization by using the current the Texas Department of State Health Services Clinical Management for Behavioral Health Services (CMBHS) web-based system. The Texas Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG) is used when requesting services. These care providers have on file a signed attestation confirming the ability to provide, either directly or through sub-contract, the members with the full array of MHR and TCM services as outlined in the RRUMG. Texas HHSC established the following qualifications and supervisory protocols for providers of mental health rehabilitative services and mental health targeted case management.

• Mental Health Rehabilitative Services Qualified Providers
  Qualified Mental Health Professionals for Community Services (QMHP-CS)

  The requirement minimums for a QMHP-CS are as follows:
  • Demonstrated competency in the work to be performed; and
  • Bachelor’s degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
  • Registered nurse;
  • A licensed practitioner of the healing arts (LPHA) is automatically certified as a QMHP-CS;
  • A physician;
  • A licensed professional counselor;
  • A licensed clinical social worker;
  • A licensed psychologist;
  • An advanced practice nurse; or
  • A licensed marriage and family therapist
  • A community services specialist provider (CSSP) can be a QMHP-CS if acting under the supervision of an LPHA. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by an LPHA.

  For information about the Texas Department of State Health Services (DSHS) Mental Health Rehabilitation, see TMHP.com > Providers > Medicaid Provider Manual > Texas Medicaid Provider Procedures Manual > Behavioral Health and Case Management Services.
Mental Health Targeted Case Management
Qualified Care Providers
A qualified provider of mental health targeted case management must:

- Demonstrate competency in the work performed;
- Possess a bachelor’s degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
- Be a registered nurse.

Individuals authorized to provide case management services prior to August 31, 2004, may provide case management services without meeting the minimum qualifications if they meet the following criteria:

- High school diploma or high school equivalency;
- Three continuous years of documented full-time experience in the provision of mental health case management services as of August 30, 2004; and
- Demonstrated competency in the provision and documentation of case management services.
- A case manager must be clinically supervised by another qualified case manager who meets the criteria.

For information about the Texas Department of State Health Services (DSHS) Targeted Case Management (non-capitated service coordinated by the Local Behavioral Health Authorities [LBHA] until August 31, 2014) see TMHP.com > Providers > Texas Medicaid Provider Procedures Manual > Behavioral Health and Case Management Services.

Cognitive Rehabilitation Therapy
Cognitive rehabilitation therapy is a service that assists an individual in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry to enable the individual to compensate for the lost cognitive functions. Cognitive rehabilitation therapy is provided in accordance with the plan of care developed by the assessor, and includes reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. This service can be delivered by psychologists, occupational therapists (OT) or speech and language pathologists (SLP).

Health Behavioral Assessment and Intervention
Health Behavioral Assessment and Intervention (HBAI) services are for STAR and STAR+PLUS members who are 20 years of age and younger and have an underlying physical illness or injury, or a documented indication that a biopsychosocial factor may be significantly affecting the treatment, or medical management of an illness or injury. HBAI services may be a benefit when the client meets all of the following criteria:

- The member has an underlying physical illness or injury.
- There are documented indications that biopsychosocial factors may be significantly affecting the treatment or medical management of an illness or an injury.
- The member is alert, oriented and, depending on the client’s age, has the capacity to understand and to respond meaningfully during the in-person evaluation.
- The member has a documented need for psychological evaluation or intervention to successfully manage their physical illness, and activities of daily living.
- The assessment is not duplicative of other care provider assessment.
- HBAI services are provided by a LPHA who is co-located in the same office or building complex as the client’s PCP.

Services are designed to identify and address the psychological, behavioral, emotional, cognitive and social factors important to prevention, treatment or management of physical health symptoms.

The member must be referred for psychiatric or psychological counseling as soon as the need is identified. After the initial assessment (procedure code 96150), if the member’s PCP learns that the client is receiving psychiatric or psychological services from another health care provider, the PCP should contact the health-care provider to determine whether the client is already receiving any HBAI services. If HBAI services are not being provided, the PCP may consider referring the member for a more appropriate level of psychiatric or psychological treatment.
For re-assessment (procedure code 96151), maintain documentation in the member medical record that details the change in the mental or medical status that warrants reassessment of the member’s capacity to understand and cooperate with the medical interventions that are necessary to the member’s health and well-being. After the initial 180 days of HBAI services, the client may receive another episode of HBAI with the same medical diagnosis if there is a newly identified behavioral health issue. The member may have two episodes of HBAI per rolling year.

HBAI services (procedure codes 96150, 96151, 96152, 96153, 96154 or 96155) are a benefit when rendered by physician, NP, CNS, PA, LPC, LCSW, LMFT, CCP social worker, or psychologist in the office or outpatient hospital setting.

HBAI services will be included in the encounter rate for Rural Health Clinics and Federally Qualified Health Centers and will not be reimbursed separately. For more information visit TMHP.com > Providers > Reference Material > Texas Medicaid Provider Procedures Manual > 2.8 Health and Behavior Assessment and Intervention.

Optum Quality Improvement

Behavioral Health Services are monitored according to the following performance areas:

- Access to care
- Member satisfaction
- Utilization management
- Quality management patterns and quarterly summary reporting
- Coordination of care with member’s PCP

Optum’s Quality Improvement Department monitors the quality of care delivered to members and the outcomes of treatment through several clinical focus studies. Examples of focus studies completed are major depression, anxiety disorder, and medication management, substance use disorder treatment and PCP notification.

Local Behavioral Health Authority

Please note that we coordinate with the LBHA and state psychiatric facilities. Community mental health centers, also referred to as LBHAs, provide services to a specific geographic area of the state, called the local service area. DSHS requires each authority to plan, develop policy, coordinate, allocate and develop resources for mental health services in the local service area. LBHAs are individually owned and operated. Specific referral criteria differ so for program and referral information visit dshs.texas.gov/mhservices.

Resources

- See the CHIP, STAR and STAR+PLUS Benefits Appendixes of this manual for a complete list of covered behavioral health services.
- See the Pharmacy section of this manual about the available 72-hour emergency medicine supply and other drug information.
- See the Behavioral Health Toolkit for Primary Care Physicians available at UHCprovider.com/TXCommunityPlan > Reference Guides and Value-Added Services > Behavioral Health Toolkit for Primary Care Providers (PCPs).
- For more information for HHSC-contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities, visit TMHP.com > Providers > Reference Material > Texas Medicaid Provider Procedures Manual > Behavioral Health, Rehabilitation and Case Management Services Handbook > Mental Health Rehabilitation, Mental Health Case Management, and Intellectual Disability Service Coordination > 5.2.1 Service Coordination and 5.2.2 Case Management.
- Due to the nature of the contract with Optum, behavioral health specialists are referred to providerexpress.com guidelines, policies, billing, and the Optum network provider manual.
Chapter 13: Eligibility

You must verify member eligibility and any necessary authorizations at the time of service. This includes LTSS.

Verifying Member Medicaid Eligibility and MCO Enrollment

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

- Use TexMedConnect on the TMHP website at tmhp.com.
- Call Provider Services at the member’s medical or dental plan.

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

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

Your Texas Benefits Gives Access to Medicaid Health Information

See the Member Cards Appendix of this manual.

Verifying CHIP Eligibility

Verify the patient’s CHIP eligibility for the date of service prior to services being rendered. There are several ways to do this:

- Ask for the member’s UnitedHealthcare Community Plan CHIP ID Card.
- Call the UnitedHealthcare Community Plan Automated Eligibility Line at 888-887-9003.
- View member eligibility online at UHCprovider.com > Patient Eligibility & Benefits.
- Electronic eligibility verification e.g., NCPDP E1 Transaction (for pharmacies only).
- If a member loses their UnitedHealthcare Community Plan ID card, they should call Member Services right away at 888-887-9003. Member Services will send a new one.
Chapter 14: Eligibility Determination

STAR and STAR+PLUS

HHSC has selected an independent Texas company, MAXIMUS, to serve as the enrollment broker for STAR and STAR+PLUS. HHSC determines eligibility for Medicaid members and helps ensure members receive all the benefits of the Texas Medicaid programs. MAXIMUS maintains a call center with a toll-free telephone number for enrollment. MAXIMUS also assists members enrolling with a Manage Care Organization (MCO) or transferring from one MCO to another. MAXIMUS performs outreach, education, and enrollment functions to assist members in transferring from the traditional Medicaid system into the STAR and STAR+PLUS system. Outreach counselors are available to assist members with enrollment activities within their homes.

MAXIMUS assists Medicaid members in choosing an MCO and a PCP from the contracted health plans in Texas and their associated provider networks. UnitedHealthcare Community Plan is responsible for providing updates of its provider network to MAXIMUS for this reason. UnitedHealthcare Community Plan members may change their assigned PCP, as needed with UnitedHealthcare Community Plan.

If a member receives Medicare, Medicare is responsible for most primary, acute and behavioral health services. These services may or may not be covered by UnitedHealthcare Community Plan. The member receives LTSS through UnitedHealthcare Community Plan. You will notice the PCP’s name, address and telephone number are not listed on the member’s ID card which specifies “Long-Term Care Only.”

Mandatory MCO Participation

Supplemental Security Income (SSI), SSI-related, and Medical Assistance Only (MAO) members must select an MCO. The MCO provides acute and long-term care services.

If the member also has Medicare, the MCO provides long-term care services only. Mandatory participants are:

- Medicaid-only members
- STAR+PLUS waiver members
- Dual eligible long-term care members
- Dual eligible STAR+PLUS members
- STAR pregnant members
- Temporary Assistance for Needy Families recipients
- Supplemental Security Income recipients
- Medical Assistance Only recipients

Disenrollment

A member’s disenrollment request from UnitedHealthcare Community Plan will require medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment. Texas HHSC will make the final decision. You are strictly prohibited from taking any retaliatory action against a member for any reason, including reasons related to disenrollment.

Automatic Re-enrollment

Members who temporarily lose Medicaid eligibility and become disenrolled are automatically enrolled to the same MCO if they regain eligibility status within six months. After automatic re-enrollment, members may choose to change MCOs. You can check the TMHP Automated Inquiry Services (AIS) line to verify member eligibility status at 800-925-9126.

Newborn Enrollment

If a newborn is born to a Medicaid-eligible mother enrolled in the UnitedHealthcare Community Plan STAR or STAR+PLUS Program, MAXIMUS will enroll the newborn into the STAR Program. You can check the TMHP AIS line to verify the Medicaid number for the child.

You are required to call us immediately at 888-887-9003 when a pregnant STAR, STAR+PLUS or CHIP member is identified.
CHIP

CHIP program members are eligible for 12 months at a time. Re-enrollment is necessary at that time.

A CHIP Perinate (unborn child) who lives in a family with an income at or below Medicaid eligibility threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and moved to Medicaid for 12 months of continuous coverage (effective on the date of birth) after the birth is reported to MAXIMUS.

Newborn Enrollment

A CHIP Perinate mother in a family with an income at or below Medicaid eligibility threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under Medicaid eligibility threshold receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to MAXIMUS. For a copy of the form and instructions, visit Texas Health and Human Services online at hhs.texas.gov.

- CHIP Perinate newborns are eligible for 12 months of continuous coverage, beginning with the month of enrollment to CHIP Perinate. Services include mom’s initial visit and up to 20 prenatal visits, prescriptions and prenatal vitamins
- Delivery and two doctor visits for the mother after the baby is born (coverage ends 30 days post-delivery)
- Well baby check-ups, immunizations and prescriptions

Please note that CHIP is an insurance program for children through age 19. CHIP Perinate is for pregnant women age of 20 over. It is time-limited until through postpartum period. Non-CHIP Perinate members are enrolled for 12-month eligibility at a time.

A CHIP Perinate baby will continue to receive coverage through the CHIP program as a “CHIP Perinate Newborn” if born to a family with an income above Medicaid eligibility threshold, and the birth is reported to MAXIMUS.

A CHIP Perinate Newborn is eligible for 12 months continuous CHIP enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn maintains coverage in their CHIP Perinate health plan. Eligibility is determined by the administrative services contractor.

Plan Changes

A CHIP Perinate who lives in a family with an income at or below Medicaid eligibility threshold (an unborn child who will qualify for Medicaid once born) is deemed eligible for Medicaid and receives 12 months of continuous Medicaid coverage (effective on the date of birth) after the birth is reported to MAXIMUS.

A CHIP Perinate mother in a family with an income at or below Medicaid eligibility threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Members under Medicaid eligibility threshold receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the physician at the time of birth and returned to MAXIMUS.

CHIP Perinate mothers must select an MCO within 15 calendar days of receiving the enrollment packet or the CHIP Perinate membership is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.

When a member of a household enrolls in CHIP Perinate, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinate member’s health plan if the plan is different. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinate member’s enrollment period, or (2) the end of the traditional CHIP members’ enrollment period. In the 10th month of the CHIP Perinate Newborn’s coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn’s and the CHIP members’ information. Once the child’s CHIP Perinate coverage expires, the child will be added to their siblings’ existing CHIP case. CHIP Perinate members may request to change health plans under the following circumstances:

- For any reason within 90 days of enrollment in CHIP Perinate
- During the annual re-enrollment period
- If the member moves into a different service delivery area
- For cause at any time
Notice to Care Providers

All member disenrollment/reassignment requests by the PCP must be submitted to the UnitedHealthcare Community Plan Customer Service Department at 888-887-9003. They should include medical documentation indicating specific compelling circumstances that merit the disenrollment. You are strongly urged to talk to the member about their concerns prior to requesting reassignment and this cannot be done in a retaliatory manner. You are strictly not allowed to take any retaliatory action against a member for any reason, including related to enrollment.

Medical policies and coverage determination guidelines can be found at UHCprovider.com/TXCommunityPlan > Policies and Clinical Guidelines > UnitedHealthcare Community Plan Medical & Drug Policies and Coverage Determination Guidelines.
Chapter 15: Access to Care

A Primary Care Provider (PCP – Medical Home) has the responsibility to help ensure necessary health care services are available to members 24 hours a day/seven days a week. This includes the responsibility to return member after-hour phone calls within 30 minutes of the phone call. When unable to provide this level of care for the member, you must arrange with another in network PCP to cover this availability. You must adhere to the access standards when scheduling appointments.

Availability and Accessibility Standards

<table>
<thead>
<tr>
<th>Condition*</th>
<th>Description</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine*</td>
<td>Primary Care (including specialists such as behavioral health)</td>
<td>Within 14 days</td>
</tr>
<tr>
<td>Routine</td>
<td>Specialty Care Referrals</td>
<td>Within 21 days</td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>Adults and children</td>
<td>Within 90 days</td>
</tr>
<tr>
<td>Behavioral Health Post Hospitalization</td>
<td>Adults and children</td>
<td>Within seven days from the date of discharge from an inpatient behavioral health facility</td>
</tr>
<tr>
<td>First Prenatal Care</td>
<td>Routine (High-risk or new members in third trimester should be seen within five days or immediately if it is an emergency)</td>
<td>As soon as practicable but in no case longer 14 days of request or within five days if in the third trimester</td>
</tr>
<tr>
<td>Return Prenatal Care</td>
<td>In first 28 weeks</td>
<td>Every four weeks</td>
</tr>
<tr>
<td></td>
<td>28 – 36 weeks</td>
<td>Every two to three weeks</td>
</tr>
<tr>
<td></td>
<td>37 weeks plus</td>
<td>Weekly</td>
</tr>
<tr>
<td></td>
<td>Postpartum</td>
<td>Within 60 days</td>
</tr>
<tr>
<td>Well-Child Checkup</td>
<td>Routine (High-risk or new members in third trimester should be seen within five days or immediately if it is an emergency)</td>
<td>As soon as practicable but in no case longer 14 days of request or within five days if in the third trimester</td>
</tr>
<tr>
<td>New Member</td>
<td>Birth through age 20, overdue or upcoming well-child checkups, including Texas Health Steps medical checkups</td>
<td>As soon as practicable, but in no case longer than 90 days</td>
</tr>
<tr>
<td>Well Child Preventive Health Services</td>
<td>CHP. To be delivered in accordance with the American Academy of Pediatrics (AAP) periodicity schedule.</td>
<td>Within 60 days of enrollment; within 14 days of enrollment for newborns</td>
</tr>
<tr>
<td>Texas Health Steps Medical Checkups</td>
<td>The Texas Health Steps medical checkup for a member age 36 months and older is due on the child’s birthday. STAR and STAR+PLUS through age 20</td>
<td>As soon as practicable but in no case later than 14 days</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Including urgent specialty care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency</td>
<td>Including non-network and out-of-area facilities</td>
<td>Upon member presentation</td>
</tr>
</tbody>
</table>

* Routine Care means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.
Primary Care Provider

Though normally referred to as a PCP, in an effort to increase access for members, Texas HHSC recognizes the following provider types to be member PCPs while under the supervision of a physician:

- Advanced practice registered nurses
- Certified nurse-midwives
- Physician assistants

These care provider types and specialists willing to contract as a PCP should contact our network services at 866-574-6088.

After-Hour Access to Care

PCPs need to be available 24 hours, seven days a week. Or they must have coverage arranged to satisfy that same timeframe. After hours, the phone is a primary source of coverage support for members. Note that the telephone is not the end coverage but rather an avenue to channel member needs that occur after hours. The following the minimum requirements are outlined in our contract with Texas HHSC and ultimately our contract with you:

- All calls need to be answered by a live person or result in a return phone call from you or a designated representative within 30 minutes
- Office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP (i.e. an answering service), or to another designated medical provider (or that other designated medical provider’s messaging system that take enough of a message or otherwise enables a return phone call), who can return the call within 30 minutes.
- Office telephone is answered by someone who meets language requirements to communicate with the major populations served by your practice or has access to translation services of the major population groups and that can contact the PCP or another designated medical practitioner. An alternative is an answering system that offers language options for the languages spoken by the major population groups served by your practice.

The following business practices are not considered compliant after-hours arrangements:

- Office telephone is only answered during office hours.
- Office telephone is answered after-hours by a recording that tells patients to leave a message or send a page.
- Office telephone is answered after-hours by a recording that directs patients to go to an emergency room for services without providing an option to contact the care provider.
- Returning after-hour calls outside of the 30-minute timeline.

Member Accessibility Rights

Members have the following particular rights of access without a PCP referral:

- Obtain medication from any network pharmacy
- Select and have access to a network ophthalmologist or therapeutic to provide eye health care services other than surgery
- Members with special health care needs have direct access to specialists to a specialist, however appropriate to the member’s condition and identified needs; to have in place a standing order for a specialty physician
- For members with disabilities, special health care needs, and chronic or complex conditions, the right to designate a specialist as their PCP as long as the specialist agrees
- A referral to specialists and health-related services, including documentation of coordination of referrals and services provided between PCP and specialist
- Designate an OB/GYN as their PCP as long as the specialist agrees
- Access to a second opinion
- Self-referral to any network care provider
Network Referrals

UnitedHealthcare Community Plan has no network limitation on referrals to any in network care provider. Referrals should be made to care providers, facilities and contractors who are contracted in the UnitedHealthcare Community Plan and thereby in-network. Justification needs to be provided to UnitedHealthcare Community Plan for any referrals that would be considered out-of-network, including partners not contracted with UnitedHealthcare Community Plan. If the member accesses care through a non-contracted provider without prior authorization, the services may not be reimbursed unless the service is an emergency, urgently needed, post-stabilization or out-of-area renal dialysis.

We recognize network limitations in that referrals should be to contracted in-network providers, except under certain circumstances. For a list of participating providers, network facilities and contractors for referrals, visit UHCprovider.com > Find Dr. The list includes all provider types. Customer service is also a resource for identifying in-network referrals. Please call 888-887-9003.

Continuity of Care

Continuity of care is member involvement within the PCP Medical Home in ongoing health care management toward the shared goal of high quality, cost-effective medical care. Some particular issues which require continuity of care include members who are:

- Pregnant.
- Moving out of a UnitedHealthcare Community Plan contracted service area.
- Living with a preexisting condition that is not imposed.

If you are unable to secure an appropriate referral, please call customer service at 888-887-9003 to aid in the member’s transfer.

Resources

See the Emergency and Behavioral Health sections of this manual for additional access to care information.
Chapter 16: In Case of an Emergency

We provide for all medically necessary emergency services for inpatient, outpatient and ambulance transportation at network hospitals for our members at any time. Medically necessary emergency services do not require prior authorization. Medical records for emergency and inpatient services will be reviewed retrospectively for medical necessity by us prior to claims payment.

We adhere to the following definition of an emergency medical condition which manifests itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, whom possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- Placing the patient’s health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

For behavioral health (mental health or substance use) emergencies, call 888-887-9003, 24 hours a day/ seven days a week.

Potentially Preventable Episodes

A majority of our members live with chronic and complex medical conditions. We believe that the person-centered medical home maintained by their PCP is cornerstone to their medical management. We urge you to practice wellness by closing gaps in care per Effectiveness Data and Information Set (HEDIS®) and best practice guidelines. Our adopted best practice guidelines are posted to UHCprovider.com/TXCommunityPlan > Policies and Clinical Guidelines > Clinical Guidelines.

Please help teach our members to:

- Actively participate in health maintenance activities.
- Recognize worsening symptoms and their triggers.
- Have an emergency plan in place and to know when to:
  - Come to your office for a same-or next-day visit with you.

Medicaid (STAR and STAR+PLUS) Emergency Dental Services

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

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

CHIP Emergency Dental Services

UnitedHealthcare Community Plan is responsible for emergency dental services provided to CHIP members and CHIP Perinate Newborn members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

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

Emergency Transportation

We do not require prior authorization or notification for emergency transport, including emergency ambulance services.

Urgent Care

Urgent care is the treatment of a health condition, including behavioral, which is not an emergency. However, the condition is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that the person’s condition requires medical treatment or evaluation within 24 hours to prevent serious deterioration.

Please have a plan in place for those members for whom you can reasonably anticipate may require urgent care at some point due to their medical condition. Or make arrangements for a same or next-day appointment availability with you.
Emergency service claims should be directed to Link at UHCprovider.com. Become a registered user at UHCprovider.com and OptumRx to allow for a protected exchange of information when billing. Claims may be submitted by member. Payer ID is 87726. Go to Claims and Payments > Claim Submission > Sign In.

**Resources**

- See the Quality section of this manual for more information about potentially preventable episodes.
- See the Pharmacy section of this manual for more information about emergency 72-hour supply of medication.
- See the Behavioral Health section of this manual for more information about emergency treatment.
Chapter 17: Care Provider Responsibilities

Your responsibilities are outlined in the Medicaid/CHIP Regulatory Appendix to your UnitedHealthcare Community Plan Provider Agreement (Texas Medicaid/CHIP Regulatory Appendix).

Person-centered Medical Home and the Role of the PCP

The PCP role is that of the facilitator of the member’s medical home. This is a medical relationship between PCP and member in which the PCP provides comprehensive primary care to the member. It also involves facilitating partnerships between the member, our service coordinator (when applicable), the member’s other care providers, and, when appropriate, the patient’s family. A patient-centered medical home also must encompass the following primary principles:

- Members have an ongoing relationship with their PCP, who is the first contact for the patient and to provide continuous and comprehensive care to the patient.
- PCP leads a team of individuals at the practice level who are collectively responsible for the ongoing care of the member.
- PCP is responsible for providing all the care the member needs or for coordinating with other qualified providers to provide care to the member throughout the member’s life, including preventive care, acute care, chronic care, and end-of-life care.
- Coordination with non-CHIP covered services (non-capitated services): Including Texas agency-administered programs and, case management services and essential public health services.
- Member care is coordinated across health care facilities and the member’s community and is facilitated by information technology, and health information exchange systems to help ensure the member receives care when and where the member wants and needs the care and in a culturally and linguistically appropriate manner.

For additional information visit Patient-Centered Primary Care Collaborative at pcpcc.org.

Role and Responsibilities of Specialty Care Provider

Specialist consultations do not require authorization as long as the specialist is an in-network provider. Medical specialists are responsible for providing covered health services within the scope of their UnitedHealthcare Community Plan agreement and within the scope of their specialty license. You agree to render covered health services to members in the same manner as offered to other patients, in compliance with State regulations and as described within this provider manual. It is the responsibility of the specialist to report back to the PCP the specialist’s findings, recommendations and treatments.

Role of CHIP Perinate Provider

Providers of CHIP Perinate services are limited to physicians, community clinics and providers who provide prenatal care within their scope of practice. This includes obstetricians/gynecologists, family practitioners, general practitioners, nurse practitioners, internists, nurse midwives or other qualified health care providers. CHIP Perinate provides care to unborn children of pregnant women with household income up to 200 percent of the federal poverty level (FPL) and who are not eligible for Medicaid.

Delivery

Mothers eligible for CHIP Perinate coverage receive a bar-coded Emergency Medical Services Certification Form (Form H3038). The mother is instructed to bring the form to the hospital at the time of delivery. If the mother does not present the form, she can request a new one by calling 877-KIDS-NOW (877-543-7669) or a hospital-based eligibility worker can use a generic (non bar-coded) form. Do not copy/share bar coded Form H3038. The physician or a registered nurse with knowledge of the patient’s care, admission and discharge dates will typically complete the form before the mother is discharged. Specific training on the application process will be available to care providers before implementation of CHIP Perinate. If you want to supply applications in your office, you can order them in bulk at hhs.texas.gov.
Specialists as PCPs

A PCP for a member with disabilities, special health care needs, or complex conditions may be a specialist who agrees to provide PCP services to the member. The specialist must agree to perform all PCP duties required in the UnitedHealthcare Community Plan care provider manual and PCP duties must be within the scope of the specialist’s license. A specialist may apply to be classified as a PCP by contacting Network Management at 866-574-6088.

PCP Assignment

If a member does not select a PCP at the time of enrollment, MAXIMUS will automatically assign the member to a PCP based upon HHSC criteria. MAXIMUS advises us of all new members and their selected or assigned PCP on a monthly basis. PCPs should review the current monthly roster/panel of the members assigned to their practice to see if the member’s name and Medicaid number appear on the list. This list may be viewed through Link at UHCprovider.com.

Tuberculosis

Annually administer the Tuberculosis (TB) Questionnaire beginning at 12 months of age.

Find the TB Questionnaire in English (Form EF12-11494) and in Spanish (Form EF12-11494A), along with other TB assessment and treatment forms, at the Texas State Health Services at dshs.texas.gov > Disease Prevention > Infectious Disease Prevention > T-Z > Tuberculosis (TB) > TB Forms.

Administer a Tuberculin Skin Test (TST) when the screening tool indicates a risk for possible exposure. Bill this separately from the THSteps medical checkup.

Tuberculosis Services

Confirmed or suspected cases of tuberculosis (TB) require mandatory reporting to the local TB control program within one working day of identification. Use the most current DSHS forms and procedures for reporting TB and cooperate with member records investigation. For more information about mandatory reporting of infectious diseases to the Center for Disease Control, visit dshs.texas.gov > Disease Prevention > Infectious Disease Prevention > Disease Reporting > Notifiable Conditions. For TB prevention, detection, and treatment visit the World Wide Medical Association at wma.net > What We Do > Education > Tuberculosis Refresher Course for Physicians.

Please note that tuberculosis services are provided by DSHS-approved providers (directly observed therapy and contact investigation). For more information visit TMHP.com > Providers > Texas Medicaid Provider Procedures Manual > Clinics and Other Outpatient Facility Services Handbook.

Panel Roster

PCPs may print a monthly Primary Care Provider Panel Roster by visiting UHCprovider.com.

Sign in to UHCprovider.com. Select the UnitedHealthcare Online application on Link. Select Reports from the Tools & Resources. From the Report Search page, select the Report Type (PCP Panel Roster) from the pull-down menu. Complete additional fields as required. Click on the available report you want to view.

The PCP Panel Roster provides a list of UnitedHealthcare Community Plan members currently assigned to the provider.

Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, physician assistants, or nurse practitioners for women’s health care services and any non-women’s health care issues discovered and treated in the course of receiving women’s health care services. This includes access to ancillary services ordered by women’s health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

UnitedHealthcare Community Plan works with members and providers to ensure that all participants understand, support, and benefit from the primary care case management system. The coverage shall include availability of 24 hours, seven days per week. During non-office hours, access by telephone to a live voice (i.e., an answering service, physician on-call, hospital switchboard, PCP’s nurse triage) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems. Recorded messages are not acceptable.

Assignment to PCP Panel Roster

Once a member has been assigned to a PCP, panel rosters can be viewed electronically on the UnitedHealthcare Provider Portal at UHCprovider.com. The portal requires a unique user name and password combination to gain access.
Sign in to **UHCprovider.com**. Select the UnitedHealthcare Online application on Link. Select Reports from the Tools & Resources. From the Report Search page, Select the Report Type (PCP Panel Roster) from the pull-down menu. Complete additional fields as required. Click on the available report you want to view.

**Care Provider Plan Termination**

In the event of imminent harm of a member, actions against a license or the practice of fraud or malfeasance then UnitedHealthcare Community Plan can immediately terminate a provider contract with no recourse of an Advisory Review Panel. You must notify us, in writing, at the address stated in your provider agreement within 10 calendar days of your knowledge of any of the following occurrences:

- Material changes in, cancellation or termination of liability insurance
- Bankruptcy or insolvency
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program
- Loss or suspension of your license to practice

You are required to provide advanced written notice 90 days to UnitedHealthcare Community Plan and the affected members. For the purpose of the continuity of care, you will continue providing and coordinating care until either services are complete (if prior to anticipated termination date) or until the time of the termination date so long as that service provision is consistent with existing medical, ethical and legal requirements.

Members requiring services provision beyond the termination date need to be referred to another in-network care provider and that referral completed prior to the termination date. In some instances UnitedHealthcare Community Plan may make reasonable and medically appropriate provisions for the assumption of covered services to another in-network provider.

**PA Not Required**

After requesting a prior authorization, you may receive the message “PA Not Required”. When you receive this message, do not assume that the service is a benefit that happens to not request a prior authorization for you to deliver it. When you receive this message, re-check member benefits through **UHCCommunityPlan.com** > Just show me all plans in state > Texas > Select the program benefits you need to check to see if the service is a benefit for that member or you may call customer service at 888-887-9003.

**Resources**

- See the following sections of this manual for additional care provider roles and responsibilities:
  - Abuse, Neglect and Exploitation
  - Access to Care
  - Behavioral Health
  - Dental Home
  - Fraud, Waste and Abuse
  - Long-Term Services and Support
  - Quality
  - Pharmacy
  - Verifying Eligibility
  - Your Contact Information

**Durable Medical Equipment and Other Products Normally Found in a Pharmacy**

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

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must see the Prior Authorization section of this manual.

Call our Customer Service at 888-887-9003 for information about DME and other covered products commonly found in a pharmacy.

For more information about DME and medical supplies, visit TMHP.com > Providers > Reference Material > Texas Medicaid Provider Procedures Manual > Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook and the Children’s Services Handbook > Durable Medical Equipment (DME) Supplier (CCP).
Communicable Diseases

Members with communicable diseases require prompt appointment access and care, including confidentiality assurances. Minors may seek confidential treatment and give consent for these diseases. Prior authorization and/or a PCP referral are not necessary, members may self-refer. Find more information about infectious diseases mandatory reporting to the Center for Disease Control at dshs.texas.gov > Disease Prevention > Infectious Disease Prevention > Disease Reporting > Notifiable Conditions. Find additional information at the Texas Administrative Code Title 25, Part 1, Chapter 97 Communicable Diseases.

Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)/AIDS

Advise members about their risk reduction responsibility and partner notification if syphilis, cancrum, gonorrhea, chlamydia and/or HIV are confirmed.

You must have office policies and procedures, of which your staff is knowledgeable, to protect member confidentiality of those screened and treated for STD or HIV. These procedures must include, but are not limited to:

- The manner that medical records are safeguarded
- How employees should protect medical information
- The conditions information can be shared


Chapter 18: Member Services

Non-Emergent Transportation

Getting to your office or the pharmacy can be a challenge for some members. A member may not own a car due to finances, or they may not have the vehicle modifications necessary for a disability. Texas HHSC Medical Transportation Program (MTP) is available when STAR and STAR+PLUS members have no other means to get to a health care visit or pharmacy.

What is MTP?

MTP is a state-administered program that provides Non-Emergency Medical Transportation (NEMT) services statewide for eligible Medicaid clients who have no other means of transportation to attend their covered health care appointments. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place they get Medicaid services.

What services are offered by MTP?

• Passes or tickets for transportation such as mass transit within and between cities or states. It includes rail, bus, or commercial air

• Curb-to-curb service provided by taxi, wheelchair van, and other transportation vehicles

• Mileage reimbursement for a registered individual transportation participant (ITP) to a covered health care event. The ITP can be the responsible party, family member, friend, neighbor, or client

• Meals and lodging allowance when treatment requires an overnight stay outside the county of residence

• Attendant services (a responsible adult who accompanies a minor or an attendant needed for mobility assistance or due to medical necessity, who accompanies the client to a health care service)

• Advanced funds to cover authorized transportation services prior to travel

Call MTP

For more information about services offered by MTP, clients, advocates and you can call the toll-free line at 877-633-8747. To be transferred to the appropriate transportation provider, clients are asked to have either their Medicaid ID# or ZIP code available at the time of the call.

For more information see the Medical Transportation Program Handbook of the Texas Medicaid Provider Procedures Manual at TMHP.com > Provides > Reference Material > Texas Medicaid Provider Procedures Manual.

See the Value-Added Services section of this manual for available transportation for CHIP members.

Culturally Considerate Care

Personal consideration makes a world of difference when caring for members who are facing daily challenges with their disabilities or chronic illnesses. We appreciate your interactions should to be respectful of the member’s values in a manner that affirms and respects their personal worth while protecting and preserving their dignity. Services delivered by your office need to be without discrimination culture, race, ethnic background, and religion. Everyone has personal preconceptions based on beliefs and experiences; the key is to be as aware as possible of these and not to allow them to interfere with open-minded and respectful communications with and actions toward others. Please visit our new Cultural Competency Library at UHCprovider.com > Resource Library > Training > Impact of Cultural Competency and Americans with Disability Act.

Language Services

Members with a limited English proficiency or reading skills require an interpreter. Customer service can assist with accessing these services for them over the phone. Telephone interpreting service is also available for members who are deaf, hard-of hearing, deaf-blind or speech impaired. Hearing-impaired services are available at 888-685-8480 TDD/TTY. We can also assist with sign language and Braille. To arrange these services, call customer service at 888-887-9003. Written communication, such as patient education pages, referrals and consent forms should be at a sixth grade reading level, in Spanish, Chinese or another translation, and in larger print.

We have interpreter services to help ensure effective communication for our members regarding treatment, medical history or health condition. This is at no cost to you or our members and includes written, spoken, and sign language interpretation, when the member is receiving services from you in an office or other location, or accessing emergency services.
Over-the-phone (OPI) interpretation, including three-way calls facilitated between UnitedHealthcare Community Plan, you as the care provider and a telephone interpreter, does not require advance notification by you or the member.

You should request an in-person interpreter or schedule an appointment as quickly as possible, including for care in urgent conditions. Routine care in-person requests are scheduled according to the requested date and time, or to the next interpreter availability for the requested language, including American Sign Language (ASL). We will notify you if an in-person interpreter is not available for the requested date and time, and coordinate with you and the member to offer alternative interpretation options, such as OPI, Video Remote Interpretation, or the earliest availability of an in-person interpreter.

**Accommodated Services**

The American with Disability Act (ADA) 1990 is the result of people with disabilities challenging societal barriers to allow them to continue to reside in their community.

Your obligations to the ADA standards are to provide reasonable accommodations to those with hearing, vision, cognitive and/or physical disabilities. This commitment includes: Waiting room and exam room, an office along public transportation routes, adequate parking space to accommodate a wheelchair and other mobile devices, clear signage and way finding (e.g., color and symbol signage) throughout facilities. For additional information visit [ADA.gov](http://ADA.gov). Be sure to coordinate with us for any special access requirements necessary for any particular members to access your services.

**ImmTrac**

The ImmTrac registry offers you and other authorized entities secure, online access to the [Texas immunization registry](http://Texas immunization registry). In addition to online access to ImmTrac, an electronic data import (secure HTTPS or FTPAUTHSSl) process is available to providers who are currently entering data into a client encounter or Electronic Health Records (EHR) system. For more information, contact ImmTrac customer support at **800-348-9158**.

**Member Services**

Our member advocates support the member experience with UnitedHealthcare Community Plan. They are bilingual in English and Spanish and can secure other language translation as necessary. A member advocate becomes involved upon requested by calling Customer Service **888-887-9003**. Some of their services include the following:

- Secure a PCP that meets member cultural and language needs
- Locate a specialist, hospitals and other providers
- Obtain covered services, secure transportation
- Help file a complaint
Chapter 19: Abuse, Neglect and Exploitation

This section addresses the identification and reporting abuse, neglect and exploitation which you need to know as a mandatory reporter.

Abuse
The negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical, sexual, emotional harm or pain to a person by the person’s caretaker, family member, or other individual who has an ongoing relationship with the person.

Neglect
The failure to provide for the goods or services, including food, clothing, shelter and/or medical services, which are necessary to avoid physical, emotional harm or pain. This includes leaving someone who cannot care for themselves in a situation where they are at risk of harm due to situations such as starvation, dehydration, over or under medication, unsanitary living conditions, lack of heat, running water, electricity or personal hygiene.

Exploitation
The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with a person that involves using, or attempting to use, the resources of the person, including the person’s Social Security number or other identifying information, for monetary or personal benefit, profit, or gain without the informed consent of the person.

Reporting Abuse and Neglect
If you suspect that someone is being abused, neglected or exploited, you are obligated to report.

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

• Living in the community
• Receiving services from home and community support services agencies
• Residing in an unlicensed adult foster care provider with three or fewer beds
• Local authority, LBHAs, community center, or mental health facility operated by the Department of State Health Services

• An adult with a disability receiving services through the consumer-directed services option

Call 800-252-5400 or report online in non-emergency situations at txabusehotline.org

Local Law Enforcement if it is an emergency, call 911 or report to the Department of Family and Protective Services by calling 800-252-5400.

Failure to Report or False Reporting

• Not reporting suspected abuse, neglect and/or exploitation of a person is a criminal offense.
• Knowingly or intentionally reporting false information to DFPS or a law enforcement agency regarding abuse, neglect and/or exploitation is a criminal offense.
• Everyone has an obligation to report suspected abuse, neglect and/or exploitation. This includes reporting even when abuse, neglect or exploitation is committed by a family member, licensed foster parent or DFPS licensed general residential operation.

For life-threatening or emergency situations, call your local law enforcement agency or 911 immediately. Then make a report to DFPS.

LTSS providers must help ensure the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation). The LTSS provider must also provide the member, or representative with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline at 800-647-7418.

You must provide us with a copy of the abuse, neglect, and exploitation report findings from the DFPS within one business day of receipt.
For members who are receiving services from or have been placed in conservatorship of the Texas DFPS, we coordinate care with DFPS and foster parents for member care. You must respond to requests from DFPS including request for providing medical records and recognition of abuse and neglect with appropriate referral to DFPS.
Chapter 20: Quality

We adhere to the Triple Aim for the delivery of quality services for our membership:

- Improved individual experience
- Improved population health
- Bending the cost curve

We do this by promoting:

- Improve efficient and timely access to PCPs
  - Person-centered medical homes better manage member overall care
- Address open care opportunities
  - Observing quality measures helps prevent chronic complications
- Reduce Potentially Preventable Events (PPEs)
  - It is best to proactively manage complex conditions and educating members about to seek early treatment while having appointment access for these members when they are in need.

Clinical Practice Guidelines

We review and update the appropriateness of our adopted clinical practice guidelines in consideration of the needs of our members. We select the guidelines that most align with our expectations of care for our members. We focus on conditions predominately experienced by our members such as:

- Asthma
- Cardiovascular disease
- Chronic obstructive pulmonary disease
- Diabetes
- Major depression
- Prenatal care
- Postpartum care

These guidelines are intended to assist you in clinical decision making by describing a range of generally acceptable approaches to the diagnosis, management, and prevention of specific diseases or conditions. The guidelines attempt to define practices that meet the needs of most patients in most circumstances. The ultimate judgment about care of a particular member rests with you as the health care provider in light of all the circumstances presented by a particular member. A full listing of the guidelines is located at UHCprovider.com/TXCommunityPlan > Policies and Clinical Guidelines > Clinical Practice Guidelines.

Health Effectiveness Data and Information Set (HEDIS®)

HEDIS is a uniform tool designed to provide purchasers of health care and consumers with the information they need to reliably compare the performance of health care plans. It measures performance on important dimensions of care and service. In our accountability to these standards we look to you as the health care provider. Gaps in care are opportunities to satisfy wellness criteria. For example, a member gap in care could be a postpartum visit that has not yet occurred. Data is collected through claims and pharmacy utilization. Please note that these measures may change from year to year. For more information visit The National Committee for Quality Assurance (NCQA) which publishes HEDIS at NCQA.org > HEDIS Quality Measurement.

HEDIS Measures (not all inclusive)

- Adolescent Well-Care Visits
- Adults’ Access to Preventive/Ambulatory Health Services
- Antidepressant Medication Management
- Appropriate Treatment for Children With Upper Respiratory Infection
- Asthma Medication Ratio
- Childhood Immunizations (we commit to the Combo 4 series)
- Children’s and Adolescents’ Access to Primary Care Practitioners
- Comprehensive Diabetes Care
- Diabetes Monitoring for People With Diabetes and Schizophrenia
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
• Follow-Up After Hospitalization for Mental Illness
• Follow-Up Care for Children Prescribed ADHD Medication
• Frequency of Ongoing Prenatal Care
• Medication Management for People With Asthma
• Prenatal and Postpartum Care
• Use of Appropriate Medications for People With Asthma
• Well-Child Visits in the First 15 Months of Life
• Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Health Plan Performance Improvement Projects

HHSC maintains a program that identifies goals for us designed to improve the quality of care and reduce potentially preventable events. We then implement performance improvement projects throughout the year to help meet these goals. We follow the CMS Quality of Care External Quality Review, which include focus studies of these measures.

• Improve the utilization rate of well-child visits
  – in the first 15 months of life
  – for members three through six years of age
  – of adolescent well care visits for members ages 12 through 19
• Improve the compliance rate for Comprehensive Diabetes Care (CDC)
• Reduce Potentially Preventable Readmissions with a focus on
  – Chronic Obstructive Pulmonary Disease (COPD)
  – Asthma

For more information visit hhs.texas.gov > About HHS > Process Improvement > Medicaid and CHIP Quality and Efficiency Improvement > Performance Improvement Projects.

Utilization Management Reporting

We contract with Texas HHSC to which we are held accountable for the oversight of member care in a manner that improves quality and controls costs. We report the following dynamics on a regular basis, including for behavioral health services. Detailed information is located at the Uniform Managed Care Manual hhs.texas.gov > Services > Health > Medicaid and CHIP > Provider Information > Contracts and Manuals > Uniform Managed Care Manual.

Reporting Dynamics

• Financial (i.e. Third-Party Recovery, Out of Network Utilization)
• Provider Network Reporting (i.e. Credentialing, Capacity, Termination)
• Complaints and Appeals
• Hotlines (Call Centers)
• Historically Underutilized Business
• Long-Term Services and Supports Utilization
• Claims
• Pharmacy
• Geo Mapping for access to care

Maintaining Medical Record Documentation Standards

High-volume care providers are selected for record review no more frequently than every three years. Three charts per care provider will be reviewed to determine compliance with medical record documentation standards. In the event that you receive a score below 85% on your chart audit, an additional five charts will be reviewed to help ensure that a representative sample of charts was examined. If after further review results in a score below 85%, then you will be re-audited in six months. In the event that the re-audit does not receive a passing score, actions may include education and counseling, further audits, and recommendation for termination of contract for non-compliance with Medical Record Documentation Standards.

Clinical data needs to be provided to UnitedHealthcare Community Plan consistent with state and federal law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the American Recovery and Reinvestment Act of 2009 (ARRA) and the Clinical Laboratory Improvement Act (CLIA). Evidence of data provenance will be provided upon request by us to satisfy National Committee for Quality Assurance (NCQA) audits or other compliance requirements. You need to help ensure that the data submitted is accurate and complete, meaning all clinical data will represent the information received from the ordering physician and all results from the rendering care provider.
We verify that security measures, protocols, and practices are compliant with HIPAA regulation and our e-data usage, governance, and security policies and will be used for the lawful receipt of clinical data from care providers. Any clinical data received will be used only as allowed under applicable state and federal law. We use this data to perform treatment, payment or health care operations – as defined in HIPAA – for members. Our operations may include the following:

- Compliance with state and federal data collection and reporting requirements, including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS), NCQA accreditation, CMS Star Ratings, and CMS Hierarchical Condition Category Risk Adjustment System
- Care coordination and other care management and quality improvement programs including physician performance, pharmaceutical safety, customer health risks using predictive modeling and the subsequent development of disease management programs used by UnitedHealthcare Community Plan and other member and care provider health awareness programs
- Quality assessment and benchmarking data sets
- Any other lawful health care operations

HIPAA minimum necessary data requirements are defined in specific documents related to the method of clinical data acquisition, including HL7 companion guide(s) and process documentation related to proprietary file exchange, fax submissions, paper data submission and/or manual data collection by UnitedHealthcare Community Plan authorized personnel. The companion guides are available at UHCprovider.com > Resource Library > Electronic Data Interchange > EDI Companion Guides.

Protect Confidential Member Data

Medical records reflect all aspects of patient care, including ancillary services. Members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates that need that information to fulfill contractual service obligations and to facilitate improvements to member health care.

We require our associates and business associates to protect privacy and abide by privacy laws. If a member requests specific medical record information, we refer the member to you as the primary holder of the medical records. Applicable regulatory requirements need to be observed, including but not limited to those related to confidentiality of Medical information. Our care providers agree to comply in all relevant respects with the applicable HIPAA requirements and associated regulations, including applicable state laws and regulations.
Chapter 21: Prior Authorization

We use a prior authorization process to determine whether some services, prescribed procedures and medications will be covered prior to service delivery. For a complete list visit UHCprovider.com/TXCommunityPlan > Prior Authorization and Notification.

You may submit a request for prior authorization in the following ways:

**Online**
A request may be submitted on Link through UHCprovider.com. See the following details.

**Phone**
Call for prior authorization (24/7):
- 866-604-3267 CHIP, STAR and STAR PLUS members. Additional document would need to be faxed.

**Fax**
Faxing enables clinical information to be submitted at the same time as the request. A form is available on UHCprovider.com/TXCommunityPlan > Prior Authorization and Notification > Prior Authorization Forms.

Fax to 877-940-1972 STAR, STAR+PLUS and CHIP members.

Decisions are made within three business days from the time of a request as long as information is available to complete the review. For members younger than 21, up to seven days is allowed for any additionally requested information from the ordering physician. Lack of supporting documentation may result in denied authorizations.

**Online**
Visit Link at UHCprovider.com > Eligibility & Benefits to determine if Notification/Prior Authorization is required. Submit the Notification/Prior Authorization request through single sign-on to UHCprovider.com and upload supporting documentations (if prompted to do so).

You will receive a prompt in the event that a prior authorization is necessary when you check a member’s eligibility and benefits. You will further be prompted if the prior authorization request requires supplemental clinical documentation. For instructions visit UHCprovider.com > Prior Authorization and Notification.

For information on required clinical documentation to support prior authorization requests, visit UHCprovider.com > Tools & Resources > Policies, Protocols and Guides > Protocols > Medical Records Requirement for Pre-Service.

An authorization is not a guarantee of payment. Unauthorized services will not be reimbursed.

**Unique Prior Authorization Requests**

The following services involve unique avenues to request authorization.

- **Cardiology, Oncology and Radiology** – Information is posted to UHCprovider.com > Notifications/Prior Authorization (see separate listings for Cardiology, Oncology and Radiology)
- Prior authorization is required for outpatient injectable chemotherapy drugs when given for a cancer diagnosis.
- **Pharmacy** – See the Pharmacy section of this manual
- **Long-Term Services and Supports** – Please note that for these services the PCP and/or service coordinator determines the need and are solely secured and authorized as outlined in the member’s plan of care. Note: A change in member condition and services necessitates a new authorization.

**Prior authorization Resources**

- MCG Care Guidelines are followed for medical necessity criteria located at careguidelines.com
- See our Clinical Practice Guidelines (see Quality section of this manual)
- The Texas Medicaid Provider Procedures Manual (see About This Manual section of this manual)
- Covered CPT codes are located at UHCprovider.com/TXCommunityPlan > Policies and Clinical Guidelines > UnitedHealthcare Community Plan Medical & Drug Policies and Coverage Determination Guidelines.
- Reimbursement Policy considerations are located at UHCprovider.com/TXCommunityPlan > Policies and Clinical Guidelines > View Current Reimbursement Policies.
Chapter 22: Special Billing

National Drug Code

The National Drug Code (NDC) Unit of Measure and NDC calculated Quantity fields are required for all outpatient administered drugs. Inaccurate billing will result in the applicable drug line item being denied or subject to recoupment. Billing instructions are detailed in a training available at the Texas CHIP/Medicaid Vendor Drug Program.com > Clinician-Administered Drugs > Clinician-Administered Drugs Provider Training. Frequently Asked Questions are also available to you at the Texas CHIP/Medicaid Vendor Drug Program.com > Clinician-Administered Drugs > Clinician-Administered Drugs FAQ.

Present on Admission

All hospitals and inpatient rehabilitation facilities must report Present on Admission for in-patient claims. Use the UB-04 Data Specifications Manual and the ICD-10-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each “principal” diagnosis and “other” diagnoses codes reported on claim forms UB-04 and 837 Institutional. For more information visit the Centers for Medicare and Medicaid Services at CMS.gov > Outreach and Education > Medicare-Learning-Network > Facilities > Medicare Learning Network® (MLN) Suite of Products and Resources for Inpatient Hospitals Services > MLN Catalogue > Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision.

New Patients

According to CMS, a new patient is a patient who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years. Therefore, UnitedHealthcare Community Plan will reimburse a new patient E/M code only when the elements of that definition have been met. Visit UnitedHealthcare Community Plan (see Reimbursement Policies) for more information.

Well and Sick Visits

Preventive Medicine Services Current Procedural Terminology (CPT®) codes 99381-99387, 99391-99397, Healthcare Common Procedure Coding System (HCPCS) code G0402] include annual physical and well child examinations, usually separate from disease-related diagnoses. Occasionally, an abnormality is encountered or a pre-existing problem is addressed during the preventive visit, and significant elements of related Evaluation and Management (E/M) services are provided during the same visit. When this occurs, UnitedHealthcare Community Plan will reimburse the preventive medicine service plus the following problem-oriented E/M service codes when that code is appended with modifier 25. In cell 24d when billing a CMS Form 1500.

For specific codes and modifiers for medical checkups for STAR and STAR+PLUS members though age 20 see the THSteps Quick Reference Guide located at TMHP.com

A preventive medicine CPT or HCPCS code and a problem-oriented E/M CPT code may both be submitted for the same patient by the same physicians (and/or other health care professionals of the same group and same specialty reporting the same Federal Tax Identification number) on the same date of service. If the E/M code represents a significant, separately identifiable service and is submitted with modifier 25 appended, UnitedHealthcare Community Plan will reimburse the preventive medicine code plus the problem-oriented E/M code. UnitedHealthcare Community Plan will not reimburse a problem-oriented E/M code that does not represent a significant, separately identifiable service and that is not submitted with modifier 25 appended.
When a screening code is billed with a preventive medicine code on the same date of service for a member younger than 22, both the preventive medicine code and the screening code will be paid for members younger than age 22 in consideration of the Early Prevention, Screening, Diagnosis and Treatment (EPSDT) requirements.

CPT code 96110 represents developmental screening, with interpretation and report. It should be reported separate and distinct from the preventive medicine service only when the testing or screening results in an interpretation and report by the physician being entered into the medical record.

For additional information regarding reimbursement policies for preventive medicine and screening, visit UHCprovider.com/TXCommunityPlan > Policies and Clinical Guidelines > View Current Reimbursement Policies.

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

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

Please note that a parent must be present for members 14 years of age or younger to bill for THSteps Medical Checkup.

Value-added Services

To view the Value-added Services, see the reference guide located at UHCprovider.com/TXCommunityPlan > Reference Guides and Value-Added Services.

Social Service Needs

PCPs, emergency room care providers and behavioral health specialists need to submit claims for STAR+PLUS members that include information on the ICD-10 Z codes regarding socioeconomic and psychosocial circumstances and their related subcategories of these codes. This allows us to get this information to the member’s service coordinator so we can help meet the member’s needs. For more information about these codes, go to HHS.Texas.gov > Services > Health > Medicaid and CHIP > Provider Information > Contracts and Manuals > Texas Medicaid CHIP Uniform Managed Care Manual > Chapter 16.3.1.

Compound Medications

- **Reimbursement for Buy-and-Bill for Compounded 17P**
  If you administer compounded, preservative-free 17P in your office through the buy-and-bill process, then for billing instructions see UHCprovider.com/TXCommunityPlan > Pharmacy Resources and Physician Administered Drugs.

- **Network Specialty Pharmacies May Bill UnitedHealthcare Community Plan for Makena**
  You may obtain Makena from one of UnitedHealthcare Community Plan’s network specialty pharmacies. For billing instructions see UHCprovider.com/TXCommunityPlan > Pharmacy Resources and Physician Administered Drugs.

Long-Acting Reversible Contraception (LARC) Devices

Hospitals may receive reimbursement for the following procedure codes in addition to the hospital diagnosis related group (DRG) payment when a LARC device is inserted immediately postpartum: J7297 J7298 J7300 J7301 J7307. Federally Qualified Health Centers may also receive reimbursement for these codes in addition the encounter payment. When seeking reimbursement for an IUD or implantable contraceptive capsule, you must submit on the same claim the procedure code for the family planning service provided and the procedure code for the contraceptive device. The contraceptive device is not subject to FQHC limitations.

340B Providers Must Use Modifier U8 When Submitting Claims for 340B Clinician-administered Drugs.

Spell-of-Illness

STAR+PLUS Program benefits are subject to the same benefit limits and exclusions that apply to the traditional, fee-for-service Medicaid programs, with the following exception. For STAR+PLUS members reimbursement to hospitals for inpatient services is limited to the Medicaid spell-of-illness. A $200,000...
annual limit on inpatient services does not apply for STAR and STAR+PLUS members through age 20. Spell-of-illness does not apply for STAR members. There is no spell-of-illness limitation for CHIP and CHIP Perinate Newborn members.

**LTSS Billing Considerations**

- Community First Choice provider billing is held accountable to the Home and Community-based Services (HCS) Program Billing Guidelines. Visit [hhs.texas.gov](http://hhs.texas.gov) > Laws & Regulations > Handbooks > Long-term Care Waiver Programs: Home and Community-based Service Program Billing Guidelines. These standards address billable activities, what not to bill, units of service, provider qualifications and any necessary documentation.

- STAR and STAR+PLUS members may never be billed for any amount for any portion of a charge for service delivery that is benefit but was not paid by UnitedHealthcare Community Plan. These Medicaid members may not ever be billed, nor payment sought from them for any covered health care services rendered.

- Residential care providers should avoid any implications of a conflict of interest in serving members. To do this – never accept payment for goods or services provided to members, whether a covered health benefit or not, unless it is the allowable billing of room and board. Room and board billing may only be inclusive of acceptable room and board charges.

**Resources**

See the following sections of this manual for additional billing consideration: Behavioral Health, Emergency, LTSS and Pharmacy.

**Specialty Pharmacy Medications**

**Requirement of Specialty Pharmacy and Home Infusion Provider(s) to be a Network Care Provider**

We have contracted care providers for the distribution of specialty pharmacy and home infusion medications. They distribute specialty medications covered under a member’s medical benefit. This national network provides specialty medication fulfillment and distribution to meet the needs of our members and our participating care providers. The contracted specialty pharmacy or home infusion care provider’s agreement identifies their full program participation requirements.

We may deny, in whole or in part, any claim when you use a non-participating specialty pharmacy provider, wholesaler, or direct purchase from the manufacturers without prior approval from us. Hospitals may also be subject to other administrative actions based on their Agreement.

**Requirement to Use a Participating Specialty Pharmacy Provider for Certain Medications**

Hospitals contracted with UnitedHealthcare Community Plan are required to obtain certain specialty pharmacy medications from a participating specialty pharmacy when they are administered in an outpatient hospital setting, unless otherwise authorized by us. The specialty pharmacy will dispense these drugs in compliance with the corresponding drug policy and the member’s benefit plan and eligibility, and bill UnitedHealthcare Community Plan for the medication.

The hospital needs only to bill UnitedHealthcare Community Plan for medication administration and should not bill for the medication itself. **Members cannot be billed for the medication.**

For a list of the medications and participating specialty pharmacy care provider(s), go to: UHCprovider.com > Menu > Policies and Protocols > Community Plan Policies > Community Plan Drug Lists for Limited Supplier Protocol.

This requirement does not apply in situations in which the member has Medicare or another health benefit plan as the primary payer and UnitedHealthcare Community Plan is the secondary payer.

**Reminders:**

- Hospitals may only bill for the appropriate code to administer the medication.
- Hospitals may not bill for the medication.
- Hospitals may not bill members for the medication.

We anticipate that all hospitals should be able to procure the medications from a participating specialty pharmacy provider. **In the event a hospital does not obtain the specialty medication through the indicated specialty pharmacy, we will issue a denial of payment for the medication, in whole or in part, for failure to follow the protocol. Hospitals may not bill members for medication that is denied for failure to follow the protocol.**

If you have questions please contact your UnitedHealthcare Community Plan Provider Advocate.
Chapter 23: Billing Members

Balance Billing

The following members may never be billed, nor payment sought from them, for any balance amount of a charge for delivery of a service that is a covered health care benefit: STAR, STAR+PLUS, CHIP Perinate, CHIP Perinate Newborn members and CHIP members who are Native American or Alaskan Natives. Additionally, for CHIP members there is no cost-sharing on benefits for well-baby and well-child services, preventive services or pregnancy-related assistance.

UnitedHealthcare Community Plan only pays for services that are medically necessary or benefits of special preventive and screening programs such as family planning and THSteps. Hospital admissions denied by the Texas Medical Review Program (TMRP) also apply under this policy.

You may bill the member only if:

- A specific service or item is provided at the member’s request, and
- You have obtained and keep a written Member Acknowledgment Statement signed by the member, or member representative under informed consent, that states:

  English:
  "I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

  Spanish:
  “Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicaid no cubra los servicios o las provisiones que solicite (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el miembro solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud.”

Billing may occur without obtaining a signed Member Acknowledgment Statement in the following circumstances:

- Any service that is not a benefit of Texas Medicaid (for example, cellular therapy).
- All services incurred on non-covered days because of eligibility or spell of illness limitation. Total member liability is determined by reviewing the itemized statement and identifying specific charges incurred on the non-covered days. Spell of illness limitations do not apply to medically necessary stays for Medicaid members who are 20 years of age and younger.
- The reduction in payment that is due to the Medically Needy Program (MNP) is limited to children who are 18 years of age and younger and pregnant women. The member’s potential liability would be equal to the amount of total charges applied to the spend down. Charges to members for services provided on ineligible days must not exceed the charges applied to spend down.
- All services provided as a private pay patient. If you accept the member as a private pay patient, you must advise members they are accepted as private pay patients at the time the service is provided and are responsible for paying for all services received. In this situation, HHSC strongly encourages you to help ensure that the member signs written notification so there is no question how the member was accepted. Without written, signed documentation that the Texas Medicaid member has been properly notified of the private pay status, you cannot seek payment from an eligible Texas Medicaid member.
• The member is accepted as a private pay patient pending Texas Medicaid eligibility determination and does not become eligible for Medicaid retroactively. You may bill the member as a private pay patient if retroactive eligibility is not granted. If the member becomes eligible retroactively, the member notifies you of the change in status. Ultimately, you are responsible for filing timely Texas Medicaid claims. If the member becomes eligible, you must refund any money paid by the member and file Medicaid claims for all services rendered.

A care provider attempting to bill or recover money from a member in violation of the stated conditions may be subject to exclusion from Texas Medicaid.

See a sample Private Pay form in the appendix section of this manual.

Important: Ancillary services must be coordinated, and pertinent eligibility information must be shared. The PCP is responsible for sharing eligibility information with others (e.g., emergency room staff, laboratory staff, and pediatricians).

**CHIP Cost-sharing**

A CHIP cost-sharing table is included in the appendix of this manual. In the event that UnitedHealthcare Community Plan negotiated a lessor amount for a benefit than the identified copayment per a care provider’s network agreement, then the copayment must be capped at the lesser amount.

Pharmacies with questions about cost-sharing and claims processing can call the Pharmacy Help Desk at 877-305-8952.

Copayments do not apply, at any income level, for the following:

- Preventive services
- Pregnancy-related services
- Well-baby and well-child care services
- Services for Native Americans or Alaskan Natives
- Members of the CHIP Perinate subprogram (Perinates unborn children) and Perinate Newborns

UnitedHealthcare Community Plan is not responsible for payment of unauthorized non-emergency services provided to a CHIP member by an out-of-network care provider. In such circumstances, the CHIP member will be responsible for all costs. See the Appendix of the manual for the CHIP Cost Sharing Chart per the HHSC Uniform Managed Care Manual.

You may seek payment from CHIP members who are not perinate or perinate newborns for the difference in the cost of service delivery between your contract-allowed fee and the cost of service delivery. These are the only UnitedHealthcare Community Plan members for whom you are allowed to seek payment.
Chapter 24: Fraud, Waste and Abuse

Everyone bears a responsibility to help ensure public monies are used in a manner keeping with the public trust. UnitedHealthcare Community Plan is a Medicaid program in STAR and STAR+PLUS and Texas State funds for CHIP. Anyone knowing of actions resulting in questionable billing or utilization of these funds is obligated to report for investigation.

**Fraud** is the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true, when that individual knows that the deception could result in some unauthorized benefit to them or some other person.

**Abuse** is defined as practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to UnitedHealthcare Community Plan or that fail to meet professionally recognized standards for health care.

**Waste** means practices that a reasonably prudent person would deem careless allow inefficient use of resources, items or services.

It is your obligation to report knowledge or suspicion of fraud, waste or abuse.

- The Federal False Claims Act prohibits knowingly submitting false or fraudulent claims or claims-related information to the federal government. The act permits any person who knows of fraud against the United States government to file a lawsuit on behalf of the government against the person or business that committed the fraud.

- The Texas False Claims Act, a person may also be liable if he presents a claim for payment under the Medicaid program for a product or service that was rendered by an unlicensed Provider or that has not been approved by a health care practitioner. The civil penalty under the act is greater than the Federal False Claims Act for unlawful acts that result in injury to an elderly person, a disabled person, or someone under the age of 18. The act includes provisions to prevent employers from retaliating against employees who report their employer’s false claims.

- The Whistleblower Act provides protection to an employee who is retaliated against by an employer because of the employee’s participation. The protection is available to any employee who is fired, demoted, threatened, harassed or otherwise discriminated against by their employer because the employee investigates, files, or participates in a qui tam action. The protections includes reinstatement and damages of double the amount of lost wages if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against. Any of the following avenues may be used to report the suspected fraud, waste, and/or abuse.

Report online to the HHSC Office of Inspector General at [oig.hhsc.texas.gov > Report fraud, waste or abuse](oig.hhsc.texas.gov) or call 800-436-6184. Visit [UHC.com/fraud](https://UHC.com/fraud), call us at 844-359-7736 or 888-887-9003, or mail to the following address:

UnitedHealthcare Community Plan
Attn: Compliance
14141 Southwest Freeway, Ste. 800,
Sugar Land, TX 77478

**Resource**

See the Fraud Appendix of this manual for a message from Texas HHSC for reporting fraud, waste or abuse by a or member.
Chapter 25: Claims and Submissions

There are three methods to submit electronic outpatient claims and encounter data to UnitedHealthcare Community Plan, through a clearinghouse of your choice and the Texas Medicaid & Healthcare Partnership online. Postmarked claims are also accepted. Claims and encounter data are to be submitted within 95 days from date of service.

Electronic Claims:

**UHCprovider.com**
Become a registered user at [UHCprovider.com](http://UHCprovider.com) to allow for a protected exchange of information when billing. Claims may be submitted by member. Payer ID is 87726. Go to Claims & Payments > Claim Submission > Sign In.

Education and guidance for submitting claims to [UHCprovider.com](http://UHCprovider.com):
- Quick reference guides (with screen shots) and step-by-step instructions are available at Link through [UHCprovider.com](http://UHCprovider.com) > Help > Electronic Solutions.
- Online education is available by visiting Link at [UHCprovider.com](http://UHCprovider.com) > Tools & Resources > Training & Education. There you will find interactive demos, tours, quick reference cards and registration for facilitator-led trainings throughout the year.
- The Help Desk is available toll-free at 866-842-3278, option 2.
- Contact your provider advocate for further assistance or call customer service at 888-887-9003 for contact information to reach your provider advocate.

**Claims Attachments**
Texas UnitedHealthcare Community Plan care providers may submit claims electronically through Link at [UHCprovider.com](http://UHCprovider.com). You may also submit attachments. For instructions visit [UHCprovider.com](http://UHCprovider.com) > Claims and Payments.

**Claims Batching**
Connectivity Director is our free direct connection allows you to batch claims submissions to UnitedHealthcare. For more information visit [UHCprovider.com](http://UHCprovider.com). Ingenix EDI Solutions – All-Payer Gateway is a seamless, low-cost connection from [UHCprovider.com](http://UHCprovider.com) to Ingenix, where you may upload and submit batch claim files, verify eligibility, check claim status, track claims, and make referrals and authorizations. Claims must be submitted in CMS 1500 or claim form UB-04. For more information visit [UHCprovider.com](http://UHCprovider.com).

**Claims Management**
Registered users can use Claims Management Application through link at [UHCprovider.com](http://UHCprovider.com). For registration and training visit [UHCprovider.com](http://UHCprovider.com).

**A Clearinghouse**
You may select an office software vendor or a clearinghouse through which to submit your claims to [UHCprovider.com](http://UHCprovider.com). The information is transferred from your terminal to a secure clearinghouse, where it is checked for errors and data omissions. If there is a problem with the submission, the information is immediately sent back to the office software vendor or clearinghouse and you for correction. This significantly reduces your wait time for claims that are denied due to errors or missing information. The office software vendor or clearinghouse then submits the corrected data to us, and you receive a report of the electronic activity, including confirmation of information. For information about submitting claims through clearinghouses, please visit Link at [UHCprovider.com](http://UHCprovider.com) > Tools & Resources > EDI Education for Electronic Transactions.

**Texas Medicaid & Healthcare Partnership**
You may submit claims regardless of a member’s managed care organization (MCO) membership to the TMHP, and the claims will be forward to the appropriate MCO. TMHP will not forward the following claims, which must be submitted directly to UnitedHealthcare Community Plan:
- Paper claim forms
- Electronic submissions for CHIP, Pharmacy, LTSS

After transmitting a claim, a message will be sent indicating whether the claim was transmitted successfully. If the claim is unsuccessful, please correct the submission and resubmit the claim. If the claim is accepted, you will receive no more transmissions from TMHP. Notices for all payment determinations for our members will be sent by UnitedHealthcare Community Plan or the dental plan.
Mailed Claims

Claims need to be submitted on approved claims forms:
In-patient claims need to be on a Centers for Medicare and Medicaid Services (CMS) Institutional paper claim form CMS 1450 (UB-04) form. All others should be on a CMS 1500 form. See the Claims Forms Appendix of this manual for additional information about completing these forms.

Claims and encounter data may be mailed to the following addresses:

<table>
<thead>
<tr>
<th>STAR+PLUS</th>
<th>STAR and CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Community Plan</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>STAR</td>
</tr>
<tr>
<td>P.O. Box 31352</td>
<td>P.O. Box 5270</td>
</tr>
<tr>
<td>Salt Lake City, UT 84131-0352</td>
<td>Kingston, NY 12402-5270</td>
</tr>
</tbody>
</table>

Deadlines

Claims must be received by UnitedHealthcare Community Plan within 95 days of the date of service to be considered for payment.

Clean Claims

We abide by the following TMHP claims adjudication requirements for clean claims:

- You must be in good standing for the dates of service billed (i.e., not on vendor payment hold for any reason).
- The member must be Medicaid eligible for the dates of service billed
- Medical necessity determination (prior authorization as applicable) must be in place for the dates of service billed
- Professional and institutional claims need to include the taxonomy code, National Provider Identifier (NPI) and address exactly as enrolled or attested in Texas Medicaid, whether through TMHP or HHSC. This applies to both rendering and billing care providers, as well as electronic or paper claims. For example, if attested as your business address at 100 Main Street, submitting claims with 100 Main St. will result in denials.
- Professional claims need to add qualifiers to the taxonomy code.

The 110-Day Rule

Medicaid is the payer of last resort. When a Medicaid member has other health insurance, you must bill the other insurance before submitting a CHIP, STAR or STAR+PLUS claim to UnitedHealthcare Community Plan. If a third-party resource has not responded to or has delayed payment on a claim for more than 110 days from the date the claim was billed, we will consider the claim for reimbursement. Submit the claim to us as soon as a disposition is received from the third party, or once the 110 days has elapsed, to help ensure the payment deadlines are not missed. The following information is required when re-submitting the claims:

- Name and address of the third-party review (TPR)
- Date the TPR was billed
- Statement signed and dated by the care provider that no disposition has been received from the TPR within 110 days of the date the claim was billed

A home health services provider or any other similar long-term care services provider that is Medicare-certified is not required to seek reimbursement from Medicare before billing Texas Medicaid for a person who is Medicare-eligible and has been determined to not be homebound.

Fee Schedules

Fee schedules are located at the Texas Medicaid & Healthcare Partnership at [TMHP.com > Providers > Fee Schedules](http://TMHP.com). You may request a paper copy of your fee schedule by calling customer service at 888-887-9003.

Capitation Rates

Services part of a monthly capitation are included in the provider network agreement for applicable care providers. For additional information speak with your physician advocate or call customer service at 888-887-9003.

Corrected Claims

- Electronic corrected claims can be submitted online through Link at [UHCprovider.com > Claim Reconsideration](http://UHCprovider.com). Application by selecting Corrected Claim in the “Reason for Request” drop down. You may send attachments with a corrected claim.
• You may also submit a corrected claim through a clearinghouse or in the mail with a reconsideration form. Please do not submit hand written claims. If submitting a paper CMS Form 1500, please use box #22 (Medicaid Resubmission Code) to enter the original claim number. Our claim system will then read this number and not deny for a duplicate claim.
Chapter 26: Payments

We have a 30-day clean claim payment for professional and institutional claims submissions. Paper pharmacy clean claims are paid within 21 days of submission. Clean electronic pharmacy claims are paid within 18 days of claim submission. Original claims submissions and adjustments processed after the thirtieth day will include interest payments according to Texas HHSC.

Electronic Payments and Statements

We use this Optum platform to manage electronic payments. You can access the following functions:

- View your electronic payments
- Receive confirmation of successful deposits into your bank account (or when a successful check is issued)
- View electronic remittance advices that you can print

For registration and additional information visit Link at UHCprovider.com > Electronic Payments and Statements.

Speak with your physician or provider advocate if you are unable to participate in EPS or call customer service at 888-887-9003 to obtain the contact information or your advocate.

Overpayments

If you identify an overpayment of a claim, you must refund the overpayment within 30 days. Send the credit balance to:

UnitedHealth Group Recovery Services
P.O. Box 740804
Atlanta, GA 30374

Please include the appropriate documentation that explains the overpayment, including member ID, check number, date of services and amount paid.

Adjustments

If you believe a claim should not have been denied, call customer service at 888-887-9003. If the claim was denied incorrectly, you will be given a tracking number while the adjustment is processing and the claim should be corrected in 15 business days. You will be contacted to confirm processing.

Reconsiderations

You can electronically re-submit a claims reconsideration online. Visit Link at UHCprovider.com, click on Link, then select Claim Reconsideration from the Claims & Payments drop down menu.

To mail a claim reconsideration, a form is available at UHCprovider.com/TXCommunityPlan > Claims and Payments > Claim Reconsideration.
Chapter 27: Complaints and Appeals

Care Provider Complaints

You have the opportunity to complain to UnitedHealthcare Community Plan regarding any aspect of the health plan. You are encouraged to submit complaints by completing the Provider Complaint/Grievance Form located at UHCprovider.com/TXCommunityPlan > Claims and Payments > Claim Administrative Disputes/Appeals. Customer Service is available to provide assistance by calling 888-887-9003.

Complaints may also be mailed to:
UnitedHealthcare Community Plan
Attn: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131-0364

Providers also have the right to complain to the appropriate regulatory agency regarding issues concerning the health plan.

STAR and STAR+PLUS providers have the right to submit complaints to Texas HHSC after completing the complaint process through UnitedHealthcare Community Plan.

Written complaints may be mailed to:
Texas Health and Human Services Commission
Provider Complaints
Health Plan Operations, H320
P.O. Box 85200
Austin, TX 78708

Complaints may also be emailed to:
HPM_complaints@hhsc.state.tx

CHIP care providers have the right to submit complaints to the Texas Department of Insurance (TDI). Written complaints may be mailed to:
Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149091
Austin, TX 78714 -9091

You may also fax or email complaints to:
Fax: 512-490-1007
Online: tdi.state.tx

Complaints may also be emailed to:
ConsumerProtection@tdi.texas.gov

In person:
Texas Department of Insurance
Consumer Protection (111-1A)
333 Guadalupe St.
Austin, TX 78701

Retaliation will not be tolerated against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint, presents an appeal, grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation. Retaliation is an action, including refusal to renew or termination of a contract, against a care provider because the care provider filed a complaint against the MCO or appealed a MCO action on behalf of a member.

Care Provider Appeals

Appeals are submitted under two categories:

1. Determinations – services not yet rendered
   - a denial or limited authorization of a member or care provider requested services, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit

2. Claims/Administrative Denials – services rendered for which payment has been sought

Determination Appeals

You may appeal on behalf of the member with regard to determination appeals. You must have written consent from the member to file the appeal on their behalf. See the member appeal section of this manual for additional information regarding the member appeal process.

Claims/Administrative Denial Appeals

UnitedHealthcare Community Plan adheres to TMHP claims payment and appeals deadlines.
Claims/Administrative Appeals must be filed within 120 calendar days from the date of disposition. This applies to both electronic and paper submissions. The date of disposition refers to the date of the Remittance and Status (R&S) Report on which the last action on the claim appears.

Claims/Administrative Appeals include, but are not limited to, timely filing denials, and denials due to lack of notification/authorization claims not paid in accordance with your contract. Claims appeals must be completed or post marked no later than 120 calendar days from the date on the provider remittance advice (PRA).

- **Electronic**
  You can electronically submit an appeal by visiting [UHCProvider.com](http://UHCProvider.com) > Claims and Payments > Submit a Corrected Claim, Claim Reconsideration/Begin Appeal Process

- **Paper**
  Mail a completed Appeal Request Form to the address shown on the back of the member’s ID card. Find more information at [UHCProvider.com](http://UHCProvider.com) > Menu > Claims, Billing and Payments > Submit a Corrected Claim, Claim Reconsideration/Begin Appeal Process.

Claims/administrative appeals are processed within 30 calendar days from receipt of the appeal. If the original decision to deny the claim is reversed, the claim is reprocessed and a PRA is re-issued with the claim detail. If, after review, the claim is still not approved, in whole or in part, a written explanation is sent to the provider.

**Specialty Review** – For claims/adverse benefit determination appeals which continue to be denied and for which you believe the service was medically necessary, you have the option to request a specialty review. You must request a specialty review within 10 calendar days of the appeal decision date. Notification of receipt of request will be given within five days. The review is performed by an independent physician of the same or similar specialty. The process will be completed within 15 calendar days after the request is received.

CHIP care providers also have the right to submit appeals to the Texas Department of Insurance. See Provider Complaints section of this manual for information regarding where to submit.

Call Customer Service at 888-887-9003 with any questions regarding claims or appeals.

**Member Complaints**

Retaliation will not be tolerated against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint, presents an appeal, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation. Retaliation is an action, including refusal to renew or termination of a contract, against a care provider because the care provider filed a complaint against the MCO or appealed a MCO action on behalf of a member.

All members have the right to file a complaint regarding any aspect of the health plan. There is no time limitation for filing a complaint.

Complaints may be filed orally or through written correspondence. For oral complaints, members are requested to call member services at 888-887-9003. Written complaints may be mailed to:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131-0364

If a member needs assistance filing a complaint, we have member advocates available to assist the member. Member advocates may be reached by calling our customer service toll-free at 888-887-9003 and requesting to speak to a member advocate.

Members may have a representative file their complaint for them. To become a member representative, written consent must be received from the member designating another individual to act on their behalf.

Members will receive a letter acknowledging their complaint within five business days of receipt of the complaint. Members will receive a letter detailing the results of the investigation into their complaint within 30 calendar days of resolution.
CHIP members have the option to request complaint appeal panel should they disagree with the resolution of their complaint. A panel is assigned to decide or recommend a decision of the member’s appeal. Members have the right to appear in person, or through correspondence.

Complaint appeal request are acknowledged within five business days of receipt. The process is completed no later than 30 calendar days after the date of receipt.

Members may also file complaints to the appropriate regulatory agency.

STAR and STAR+PLUS members may also file a complaint with Texas HHSC after going through the complaint process at UnitedHealthcare Community Plan.

Written complaints may be mailed to:
Texas Health and Human Services Commission
Attn: Resolution Services
Health Plan Operations, H320
P.O. Box 85200
Austin, TX 78708-5200

Complaints may also be emailed to:
HPM_complaints@hhsc.state.tx

CHIP members also have the right to submit complaints and appeals to the Texas Department of Insurance (TDI).

Written complaints may be mailed to
Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149091
Austin, TX 78714-9091

Fax: 512-490-1007

Online at tdi.state.tx
Email: ConsumerProtection@tdi.texas.gov

In person:
Texas Department of Insurance
Consumer Protection (111-1A)
333 Guadalupe St.
Austin, TX 78701

STAR and STAR+PLUS Member Appeals

If the health plan denies or limits a member’s request for a covered service, members will receive written correspondence informing them of the denial and the reason the service was denied. Members may also request an appeal for the denial of payment for services in whole or in part.

The member or the member’s representative can file an appeal requesting the case be reviewed again. Member appeals may be filed by contacting member services at 888-887-9003 or through written correspondence. Written correspondence should be mailed to the following address:
UnitedHealthcare Community Plan
Attn: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131-0364

Should the member need assistance in filing their appeal, the health plan has member advocates available to assist the member. Member advocates may be reached by calling Customer Service at 888-887-9003 and requesting to speak to a member advocate.

Oral appeals for STAR and STAR+PLUS members must be confirmed by a written, signed appeal by the member or their representative, unless the member or their representative requests an expedited resolution. This process does not apply to CHIP.

Member appeals for STAR and STAR+PLUS members must be filed within 60 calendar days of the date of the notice of denial.

STAR and STAR+PLUS members may continue to receive current authorized services if their appeal is filed on or before the later of 10 days following the MCO’s mailing of the notice of the action or the intended effective date of the proposed action.

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

Standard Appeals

Once received, the member is forwarded an acknowledgment letter within five business days of receipt. A physician of the same or a similar specialty performs the review of member’s appeal. Once completed, the member receives written correspondence containing the appeal decision.
Expedited Appeals
Expedited appeals can be requested when the health plan determines (for a request from a member) or the care provider indicates (in making the request on the member’s behalf or supporting the member’s request) that taking the time for a standard resolution could seriously jeopardize the member’s life or health.

As with standard appeals, an independent physician of the same or similar specialty performs the review. A decision will be made within 72 hours for expedited appeals. For appeals related to ongoing emergencies or continued hospitalization, we make a decision within one business day.

To request an expedited appeal, and or to get help to file an expedited appeal, contact Customer Service to request the expedited appeal at 888-887-9003. The request may also be written and sent to:

UnitedHealthcare Community Plan
Attn: Appeals and Grievances
14141 Southwest Freeway, Ste. 800
Sugar Land, TX 77478.

Every oral appeal received must be confirmed by a written, signed appeal by the member or their representative, unless an expedited appeal is requested.

Upon review of the circumstances surrounding the expedited appeal, the health plan determines if the request meets the expedited appeal criteria. Should the request not meet the criteria, the appeal is downgraded to a standard appeal. The member or the member’s representative receives written correspondence stating that the appeal has been downgraded and will follow the standard appeal guidelines.

Extensions
Members or their representative may request up to an additional 14 calendar days for the decision to be made for an appeal. Additionally, UnitedHealthcare Community Plan can request up to 14 calendar days for an extension if able to show that there is a need for additional information and how the delay is in the member’s best interest.

For CHIP Member Appeals, see Appendix J in this provider manual.

External Reviews
STAR, STAR+PLUS – Request for a State Fair Hearing
If a member, as a member of the health plan, disagrees with the health plan’s decision after completing the entire appeal process, the member has the right to ask for a state fair hearing. A member also has the right to request a State Fair Hearing if UnitedHealthcare Community Plan does not make a decision on the member’s appeal within the required time frame. The member may name someone to represent them by writing a letter to the health plan telling us the name of the person the member wants to represent them. You may be the member’s representative. The member or the member’s representative must ask for the state fair hearing within 120 days of the date on the health plan’s letter that tells of the appeal decision being challenged. If the member does not ask for the state fair hearing within 120 days, the member may lose their right to a state fair hearing.

To ask for a state fair hearing, the member or the member’s representative should either send a letter to the health plan at:

UnitedHealthcare Community Plan
Attn: Fair Hearings/IRO
14141 Southwest Freeway
Sugar Land, TX 77478

or call 800-288-2160

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

If the member asks for a state fair hearing, the member will get a packet of information letting the member know the date, time, and location of the hearing. Most fair hearings are held by telephone. At that time, the member or the member’s representative can tell why the member needs the service the health plan denied. HHSC will give the member a final decision within 90 days from the date the member asked for the state fair hearing.
CHIP – Request for an Independent Review Organization (IRO) review

CHIP members have the opportunity to request an IRO which is totally independent of UnitedHealthcare Community Plan. Members must have first appealed through the UnitedHealthcare Community Plan the original denial unless the member has a life-threatening condition and services have not been received.

Form LHL009 is provided with each denial letter. It is also sent with each upheld decision in appeals. The member must complete and sign the LHL009 and return it to us. We will then forward the request to the Texas Department of Insurance which assigns an IRO to review the member’s case.

The member will receive correspondence from the TDI as to which IRO has been assigned. The IRO assigned will render a decision and notify the member and the UnitedHealthcare plan.

The IRO has 20 days for non-life-threatening cases and eight days for life-threatening to make its decision. There is no cost to the member. We are responsible for any administrative fees CE related to the IRO review.
Chapter 28: Care Provider Support Programs

Network Management

UnitedHealthcare Community Plan agreement begins in Network Management. This is your resource for contractual issues and helping ensure that your contact information is correct. Your information should match your claims submission. If you have any changes or updates, please contact Network Management immediately at 866-574-6088.

Physician and Provider Advocates

Our provider advocates are in the community working with our network providers. Provider advocates are responsible for education and guidance when interfacing with UnitedHealthcare Community Plan. Provider advocates are available by phone at 888-303-6162. They can also be reached by email (providerservicesTX@uhc.com). They conduct town halls, host webinars and are available for office visits. LTSS providers should call 888-787-4107 or email uhc_cp_prov_relations@uhc.com.

Provider Engagement Consultants

The Provider Engagement team is part of an innovative approach by UnitedHealthcare Community Plan to engage our high-volume PCPs, federally qualified health centers and rural health clinics to offer a concierge experience and a high level of customer service. The team focuses on providing a thorough explanation of health plan attributes processes, health education programs and outcomes to the care provider community.

Customer Service

A segment of our toll-free telephone support is dedicated to providers. Care provider-specific assistance is available such as how to reach your assigned physician or provider advocate, claims adjustments or general “where to go” inquiries. Member-specific information for you is also available such as eligibility and benefits, arranging language assistance and transportation as well as referrals to services such as vision and dental. This service is available Monday – Friday, 8 a.m. – 5 p.m. CT, closed New Year’s Day, Martin Luther King Jr Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving and the day after, and Christmas Day. You may call the toll-free number at 888-887-9003.
Appendix A: CHIP Benefits

The covered CHIP service benefit package must meet the CHIP definition of Medically Necessary Covered Services. There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Copays apply until a family reaches the specific cost-sharing maximum.

Copays do not apply to CHIP Perinate members. CHIP Perinate Newborns are eligible for 12 months continuous coverage, beginning with the month of enrollment as a CHIP Perinate. The following includes benefit information from the Newborn Evidence of Coverage (EOC).

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient General Acute and Inpatient Rehabilitation Hospital Services</td>
<td>Services include, but are not limited to, the following:</td>
<td>For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit.</td>
</tr>
<tr>
<td></td>
<td>• Hospital-provided physician or care provider services</td>
<td>For CHIP Perinates in families with income above the Medicaid eligibility threshold (perinates who do not qualify for Medicaid once born), benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy.</td>
</tr>
<tr>
<td></td>
<td>• Semi-private room and board (or private if medically necessary as certified by attending)</td>
<td>Services include:</td>
</tr>
<tr>
<td></td>
<td>• General nursing care</td>
<td>• Operating, recovery and other treatment rooms</td>
</tr>
<tr>
<td></td>
<td>• Special duty nursing when medically necessary</td>
<td>• Anesthesia and administration (facility technical component)</td>
</tr>
<tr>
<td></td>
<td>• ICU and services</td>
<td>Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).</td>
</tr>
<tr>
<td></td>
<td>• Patient meals and special diets</td>
<td>Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:</td>
</tr>
<tr>
<td></td>
<td>• Operating, recovery and other treatment rooms</td>
<td>• Dilation and curettage (D&amp;C) procedures;</td>
</tr>
<tr>
<td></td>
<td>• Anesthesia and administration (facility technical component)</td>
<td>• Appropriate provider-administered medications;</td>
</tr>
<tr>
<td></td>
<td>• Surgical dressings, trays, casts, splints</td>
<td>• Ultrasounds, and</td>
</tr>
<tr>
<td></td>
<td>• Drugs, medications and biologicals</td>
<td>• Histological examination of tissue samples.</td>
</tr>
<tr>
<td></td>
<td>• Blood or blood products that are not provided free-of-charge to the patient and their administration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• X-rays, imaging and other radiological tests (facility technical component)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Laboratory and pathology services (facility technical component)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Machine diagnostic tests (EEGs, EKGs, etc.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Oxygen services and inhalation therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Radiation and chemotherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• In-network or out-of-network facility and care provider services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section</td>
<td></td>
</tr>
</tbody>
</table>
### Covered Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
</table>
| • Hospital, care provider and related medical services, such as anesthesia, associated with dental care | • Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:  
  – Dilation and curettage (D&C) procedures  
  – Appropriate provider-administered medications  
  – Ultrasounds  
  – Histological examination of tissue samples  
  – Surgical implants  
  – Other artificial aids including surgical implants  
• Inpatient services for a mastectomy and breast reconstruction include:  
  – All stages of reconstruction on the affected breast  
  – External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed  
  – Surgery and reconstruction on the other breast to produce symmetrical appearance  
  – Treatment of physical complications from the mastectomy and treatment of lymphedemas  
  – Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit | • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:  
  – Cleft lip and/or palate; or  
  – Severe traumatic skeletal and/or congenital craniofacial deviations; or  
  – Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.                                                                                                                                                                                                 |
## Covered Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
</table>
| Skilled Nursing Facilities (Includes Rehabilitation Hospitals) | Services include, but are not limited to, the following:  
- Semi-private room and board  
- Regular nursing services  
- Rehabilitation services  
- Medical supplies and use of appliances and equipment furnished by the facility | Not a covered benefit. |
| Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center | Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:  
- X-ray, imaging, and radiological tests (technical component)  
- Laboratory and pathology services (technical component)  
- Machine diagnostic tests  
- Ambulatory surgical facility services  
- Drugs, medications and biologicals  
- Casts, splints, dressings  
- Preventive health services  
- Physical, occupational and speech therapy  
- Respiratory services – radiation and chemotherapy  
- Renal dialysis  
- Blood or blood products that are not provided free-of-charge to the patient and the administration of these products  
- Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:  
  - Dilation and curettage (D&C) procedures;  
  - Appropriate provider-administered medications;  
  - Ultrasounds, and  
  - Histological examination of tissue samples. | Services include, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting:  
- X-ray, imaging, and radiological tests (technical component)  
- Laboratory and pathology services (technical component)  
- Machine diagnostic tests  
- Drugs, medications and biologicals that are medically necessary prescription and injection drugs  
Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:  
- Dilation and curettage (D&C) procedures;  
- Appropriate provider-administered medications;  
- Ultrasounds, and  
- Histological examination of tissue samples. |
### Covered Benefits

<table>
<thead>
<tr>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility.</td>
<td>2. Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or non-viable pregnancy.</td>
</tr>
<tr>
<td>• Surgical implants</td>
<td></td>
</tr>
<tr>
<td>• Other artificial aids including surgical implants</td>
<td>3. Amniocentesis, cordocentesis, fetal intrauterine transfusion (FIUT) and ultrasonic guidance for cordocentesis, FIUT are covered benefits with an appropriate diagnosis.</td>
</tr>
<tr>
<td>• Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include:</td>
<td>4. Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.</td>
</tr>
<tr>
<td>– All stages of reconstruction on the affected breast;</td>
<td>5. Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.</td>
</tr>
<tr>
<td>– External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed</td>
<td></td>
</tr>
<tr>
<td>– Surgery and reconstruction on the other breast to produce symmetrical appearance; and</td>
<td></td>
</tr>
<tr>
<td>– Treatment of physical complications from the mastectomy and treatment of lymphedemas.</td>
<td></td>
</tr>
<tr>
<td>• Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit</td>
<td></td>
</tr>
<tr>
<td>• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:</td>
<td></td>
</tr>
<tr>
<td>– Cleft lip and/or palate; or</td>
<td></td>
</tr>
<tr>
<td>– Severe traumatic skeletal and/or congenital craniofacial deviations; or</td>
<td></td>
</tr>
<tr>
<td>– Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
<td></td>
</tr>
</tbody>
</table>

### Physician/Physician Extender Professional Services

<table>
<thead>
<tr>
<th>Services include, but are not limited to, the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations)</td>
</tr>
<tr>
<td>• Physician office visits, inpatient and outpatient services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services include, but are not limited to the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth</td>
</tr>
<tr>
<td>• Physician office visits, inpatient and outpatient services</td>
</tr>
<tr>
<td>• Laboratory, X-rays, imaging and pathology services including technical component and/or professional interpretation</td>
</tr>
</tbody>
</table>
## Covered Benefits

### CHIP Members and CHIP Perinate Newborn Members
- Laboratory, X-rays, imaging and pathology services, including technical component and/or professional interpretation
- Medications, biologicals and materials administered in Physician’s office
- Allergy testing, serum and injections
- Professional component (in/outpatient) of surgical services, including:
  - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care
  - Administration of anesthesia by physician (other than surgeon) or CRNA
  - Second surgical opinions
  - Same-day surgery performed in a hospital without an over-night stay
  - Invasive diagnostic procedures such as endoscopic examinations
- Hospital-based physician services (including Physician performed technical and interpretive components)
- Physician and professional services for a mastectomy and breast reconstruction include:
  - All stages of reconstruction on the affected breast;
  - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed
  - Surgery and reconstruction on the other breast to produce symmetrical appearance; and
  - Treatment of physical complications from the mastectomy and treatment of lymphedemas.

### CHIP Perinate Members (Unborn Child)
- Medically necessary medications, biologicals and materials administered in physician’s office
- Professional component (in/outpatient) of surgical services, including:
  - Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth.
  - Administration of anesthesia by physician (other than surgeon) or CRNA
  - Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.
  - Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).
- Hospital-based physician services (including Physician performed technical and interpretive components)
- Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation
- Professional component of amniocentesis, cordocentesis, fetal intrauterine transfusion (FIUT) and ultrasonic guidance for amniocentesis, cordocentesis, and FIUT
- Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to:
  - Dilation and curettage (D&C) procedures;
  - Appropriate provider-administered medications;
  - Ultrasounds, and
  - Histological examination of tissue samples.
### Covered Benefits

<table>
<thead>
<tr>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section</td>
<td></td>
</tr>
<tr>
<td>• Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>- Dilation and curettage (D&amp;C) procedures;</td>
<td></td>
</tr>
<tr>
<td>- Appropriate provider-administered medications;</td>
<td></td>
</tr>
<tr>
<td>- Ultrasounds, and</td>
<td></td>
</tr>
<tr>
<td>- Histological examination of tissue samples.</td>
<td></td>
</tr>
<tr>
<td>• Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation</td>
<td></td>
</tr>
<tr>
<td>• Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:</td>
<td></td>
</tr>
<tr>
<td>- Cleft lip and/or palate; or</td>
<td></td>
</tr>
<tr>
<td>- Severe traumatic skeletal and/or congenital craniofacial deviations; or</td>
<td></td>
</tr>
<tr>
<td>- Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.</td>
<td></td>
</tr>
</tbody>
</table>
## Covered Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
</table>
| Prenatal Care and Pre-Pregnancy Family Services and Supplies                     | Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services. Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care. | Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include:  
1. One visit every four weeks for the first 28 weeks of pregnancy;  
2. One visit every two to three weeks from 28 to 36 weeks of pregnancy; and  
3. One visit per week from 36 weeks to delivery.  
More frequent visits are allowed as medically necessary. Benefits are limited to 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician’s files and is subject to retrospective review.  
Visits after the initial visit must include:  
• Interim history (problems, marital status, fetal status);  
• Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities); and  
• Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client). |
## Appendix A: CHIP Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthing Center Services</td>
<td>Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) &lt;br&gt;Limitation: Applies only to CHIP members</td>
<td>Covers birthing services provided by a licensed birthing center. Limited to facility services related to labor with delivery. &lt;br&gt;Applies only to CHIP Perinate members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).</td>
</tr>
<tr>
<td>Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center</td>
<td>CHIP members: Covers prenatal services and birthing services rendered in a licensed birthing center. &lt;br&gt;CHIP Perinate Newborn members: Covers services rendered to a newborn immediately following delivery.</td>
<td>Covers prenatal services and birthing services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (antepartum) care visits that include: &lt;br&gt;1. One visit every four weeks for the first 28 weeks or pregnancy; &lt;br&gt;2. One visit every two to three weeks from 28 to 36 weeks of pregnancy; and &lt;br&gt;3. One visit per week from 36 weeks to delivery. &lt;br&gt;More frequent visits are allowed as medically necessary. Benefits are limited to 20 prenatal visits and two postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. &lt;br&gt;Visits after the initial visit must include: &lt;br&gt;• Interim history (problems, marital status, fetal status); &lt;br&gt;• Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) and &lt;br&gt;• Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).</td>
</tr>
<tr>
<td>Covered Benefits</td>
<td>CHIP Members and CHIP Perinate Newborn Members</td>
<td>CHIP Perinate Members (Unborn Child)</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies | $20,000, 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including:  
  • Orthotic braces and orthotics  
  • Dental devices  
  • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses  
  • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease  
  • Hearing aids  
  • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. | Not a covered benefit, with the exception of a limited set of disposable medical supplies, published at txvendordrug.com > Formulary > Limited Home Health Supplies and only when they are obtained from a CHIP-enrolled pharmacy provider. |
## Appendix A: CHIP Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and Community Health Services</td>
<td>Services provided in the home and community, including, but not limited to:</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td></td>
<td>• Home infusion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Respiratory therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Visits for private duty nursing (R.N., L.V.N.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Home health aide when included as part of a plan of care during a period that skilled visits have been approved</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Speech, physical and occupational therapies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Services are not intended to replace the child’s caretaker or to provide relief for the caretaker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Services are not intended to replace 24-hour inpatient or skilled nursing facility services</td>
<td></td>
</tr>
</tbody>
</table>
## Covered Benefits

<table>
<thead>
<tr>
<th>Inpatient Mental Health Services</th>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to:</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td></td>
<td>• Neuropsychological and psychological testing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• As part of provider capitation payment, inpatient mental health services for adults and children provided in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting are limited to no more than 15 days per month for individuals age 21-64. There is no day limitation for services provided in a free standing psychiatric hospital to members younger than age 21 or age 65 and older.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Inpatient mental health services for children are a covered benefit for members birth through age 20 or age 65 and older, and do not need to be provided in lieu of an acute care inpatient hospital setting.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Inpatient psychiatric hospital services provided in a free-standing psychiatric hospital to members younger than age 21 or ages 65 and older are a covered Medicaid benefit and are not provided in lieu of, and there is no day limitation for services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Does not require PCP referral.</td>
<td></td>
</tr>
</tbody>
</table>
## Covered Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Mental Health Services</td>
<td>Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to:</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td></td>
<td>• The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Neuropsychological and psychological testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medication management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rehabilitative day treatments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Residential treatment services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Skills training (psycho-educational skill development)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A qualified mental health provider – community services (QMHP-CS) is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted local behavioral health authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Does not require a PCP referral</td>
<td></td>
</tr>
<tr>
<td>Covered Benefits</td>
<td>CHIP Members and CHIP Perinate Newborn Members</td>
<td>CHIP Perinate Members (Unborn Child)</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient Substance Use Disorder Treatment Services</strong></td>
<td>Services include, but are not limited to:</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td></td>
<td>• Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Does not require a PCP referral</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Substance Use Disorder Treatment Services</strong></td>
<td>Services include, but are not limited to, the following:</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td></td>
<td>• Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Intensive outpatient services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Partial hospitalization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Does not require PCP referral</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation Services</strong></td>
<td>Services include, but are not limited to, the following:</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td></td>
<td>• Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rehabilitation services, which include, but are not limited to, physical, occupational, and speech therapy and developmental assessment</td>
<td></td>
</tr>
</tbody>
</table>
### Covered Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care Services</td>
<td>Services include, but are not limited to:</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td></td>
<td>• Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Treatment services, including treatment related to the terminal illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Up to a maximum of 120 days with a six-month life expectancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patients electing hospice services may cancel this election at any time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Services apply to the hospice diagnosis</td>
<td></td>
</tr>
<tr>
<td>Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services</td>
<td>MCO cannot require authorization as a condition for payment for emergency conditions or labor and delivery.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Covered services include, but are not limited to, the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emergency services based on prudent layperson definition of emergency health condition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hospital emergency department room and ancillary services and physician services 24 hours a day, seven days a week, both by in-network and out-of-network care providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medical screening examination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stabilization services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emergency ground, air and water transportation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MCO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emergency services based on prudent layperson definition of emergency health condition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stabilization services related to the labor with delivery of the covered unborn child.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emergency ground, air and water transportation for labor and threatened labor is a covered benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.</td>
<td></td>
</tr>
</tbody>
</table>
## Covered Benefits

<table>
<thead>
<tr>
<th>Covered Benefits</th>
<th>CHIP Members and CHIP Perinate Newborn Members</th>
<th>CHIP Perinate Members (Unborn Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants</td>
<td>Services include, but are not limited to, the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td>Vision Benefit</td>
<td>The health plan may reasonably limit the cost of the frames/lenses.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Services include:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• One pair of non-prosthetic eyewear per 12-month period</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Services do not require physician prescription and are limited to spinal subluxation.</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td>Tobacco Cessation Program</td>
<td>Covered up to $100 for a 12-month period limit for a plan-approved program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health plan defines plan-approved program.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• May be subject to formulary requirements.</td>
<td>Not a covered benefit.</td>
</tr>
<tr>
<td>Case Management and Care Coordination Services</td>
<td>These services include outreach informing, case management, care coordination and community referral.</td>
<td>Covered benefit.</td>
</tr>
</tbody>
</table>
### Covered Benefits

**Covered Benefits**

**CHIP Members and CHIP Perinate Newborn Members**

- **Drug Benefits**
  - Services include, but are not limited to, the following:
    - Outpatient drugs and biologicals, including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and
    - Drugs and biologicals provided in an inpatient setting.

**CHIP Perinate Members (Unborn Child)**

- Services include, but are not limited to, the following:
  - Outpatient drugs and biologicals, including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and
  - Drugs and biologicals provided in an inpatient setting.

Services must be medically necessary for the unborn child.

### CHIP Exclusions from Covered Services

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care; labor and delivery; and care related to disease, illnesses, or abnormalities related to the reproductive system
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e., cannot be prescribed for family planning)
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by health plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the health plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the health plan
Appendix A: CHIP Benefits

- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (This does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails.)
- Replacement or repair of prosthetic devices and DME due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based specialty therapy (physical therapy, speech therapy, or occupational therapy) services are not covered except when ordered by a physician(PCP)
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)

Exclusions from Covered Services for CHIP Perinates

- For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (perinates who qualify for Medicaid once born), inpatient facility charges are not a covered benefit if associated with the initial Perinate Newborn admission. “Initial Perinatal Newborn admission” means the hospitalization associated with the birth.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth
- Inpatient mental health services
- Outpatient mental health services
• DME or other medically related remedial devices.
• Disposable medical supplies, with the exception of a limited set of disposable medical supplies, published at txvendordrug.com > Formulary > Limited Home Health Supplies when they are obtained from an authorized pharmacy provider
• Home and community-based health care services
• Nursing care services
• Dental services
• Inpatient substance use disorder treatment services and residential substance use disorder treatment services
• Outpatient substance use disorder treatment services
• Specialty Therapy (physical therapy, speech therapy, or occupational therapy) and services for individuals with speech, hearing, and language disorders
• Hospice care
• Skilled nursing facility and rehabilitation hospital services
• Emergency services other than those directly related to the labor with delivery of the covered unborn child
• Transplant services
• Tobacco cessation programs
• Chiropractic services
• Medical transportation not directly related to labor or threatened labor, miscarriage or non-viable pregnancy, and/or delivery of the covered unborn child
• Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or post-partum care
• Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
• Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
• Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
• Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)
• Mechanical organ replacement devices including, but not limited to artificial heart
• Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
• Prostate and mammography screening
• Elective surgery to correct vision
• Gastric procedures for weight loss
• Cosmetic surgery/services solely for cosmetic purposes
• Out-of-network services not authorized by the health plan, except for emergency care related to the labor with delivery of the covered unborn child
• Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
• Medications prescribed for weight loss or gain
• Acupuncture services, naturopathy and hypnotherapy
• Immunizations solely for foreign travel
• Routine foot care such as hygienic care
• Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
• Corrective orthopedic shoes
• Convenience items
• Over-the-counter medications
• Orthotics primarily used for athletic or recreational purposes
• Custodial Care (Care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
• Housekeeping
• Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
• Services or supplies received from a nurse, which do not require the skill and training of a nurse
• Vision training, vision therapy, or vision services
• Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
• Donor non-medical expenses
• Charges incurred as a donor of an organ
Appendix B: STAR Benefits

The following is a non-exhaustive, high-level listing of Acute Care Covered Services included under the Medicaid STAR Program.

STAR Program benefits are subject to the same benefit limits and exclusions that apply to the traditional, fee-for-service Medicaid programs, with the following three exceptions. Adult STAR Members are provided with three enhanced benefits compared to the traditional, fee-for-service Medicaid coverage:

- 1 waiver of the three prescription per-month limit;
- 2 waiver of the 30-day spell-of-illness limitation; and
- 3 waiver of the $200,000 individual annual limit on inpatient services.

For a complete listing of the limitations and exclusions that apply to each Medicaid benefit category, please refer to the current Texas Medicaid Provider Procedures Manual, which can be accessed online at: tmhp.com. The services are subject to modification based on changes in Federal and State laws, regulations, and policies.

STAR Covered Services include Medically Necessary Emergency and Non-Emergency Ambulance Services:

- Audiology services, including hearing aids, for adults and children
- Behavioral health services, including:
  - Inpatient mental health services for children (birth through age 20)
  - Acute inpatient mental health services for adults
  - Outpatient mental health services
  - Psychiatry services
  - Mental health rehabilitative services
  - Counseling services for adults (21 years and older)
- Member reimbursement for members for Attention Deficit Hyperactivity Disorder (ADHD) and follow-up care for children prescribed ADHD medications
- Outpatient substance use disorder treatment services including:
  - Assessment
  - Detoxification services
  - Counseling treatment
  - Medication assisted therapy
- Residential substance use disorder treatment services including:
  - Detoxification services
  - Substance use disorder treatment (including room and board)
- Birthing services provided by a physician and certified nurse midwife (CNM) in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Early childhood intervention (ECI) services
- Emergency services
- Family planning services, available through Healthy Texas Women, Family Planning, and primary health care programs
- Home health care services
- Hospital services, including inpatient and outpatient
  - We may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.
  - As part of provider capitation payment, inpatient mental health services for adults and children may be provided in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting, and are limited to no more than 15 days per month for individuals age 21-64. There is no day limitation for services provided in a free standing psychiatric hospital to members younger than age 21 or ages 65 and older.
  - Inpatient mental health services for children are a covered benefit for members birth through age 20 or ages 65 and older, and do not need to be provided in lieu of an acute care inpatient hospital setting.
  - Inpatient psychiatric hospital services provided in a free-standing psychiatric hospital to members younger than age 21 or ages 65 and older are a covered Medicaid benefit and are not provided “in lieu of” and there is no day limitation for services.
  - We may provide substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting.
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
  - Inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    - All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
    - Surgery and reconstruction on the other breast to produce symmetrical appearance;
    - Treatment of physical complications from the mastectomy and treatment of lymphedemas; and
    - Prophylactic mastectomy to prevent the development of breast cancer
  - External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
- Medical checkups and Comprehensive Care Program (CCP) Services for children (birth through age 20) through the Texas Health Steps Program
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children six months through 35 months of age
- Outpatient drugs and biologicals, including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Drugs and biologicals provided in an inpatient setting
- Podiatry
- Prenatal care
- Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS),
and physician assistant (PA) in a licensed birthing center

- Primary care services
- Preventive services including an annual adult well check for patients 21 years and older
- Radiology, imaging, and X-rays
- Specialty physician services
- Mental health targeted case management
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)
- Telemedicine
- Telemonitoring, to the extent covered by Texas Government Code §531.01276
- Telehealth
Appendix C: STAR+PLUS Benefits

The following is a non-exhaustive, high-level listing of acute care covered services included under the Medicaid STAR+PLUS Program.

STAR+PLUS Program benefits are subject to the same benefit limits and exclusions that apply to the traditional, fee-for-service Medicaid programs, with the following three exceptions. Adult STAR+PLUS members are provided with three enhanced benefits compared to the traditional, fee-for-service Medicaid coverage:

1. Waiver of the three prescription per month limit, for members not covered by Medicare
2. Waiver of the $200,000 individual annual limit on inpatient services
3. Waiver of spell of illness limitation for Medicaid-only members who are admitted to an inpatient facility with a primary diagnosis of bipolar disorder, major depressive disorder, recurrent depressive disorder schizoaffective disorder, or schizophrenia as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V). These diagnoses will remove the SOI limitation for the entire inpatient hospital stay.

Please refer to the UMCM, Section 16.1.2.10.1 “Spell of Illness Guidance for STAR+PLUS Members” for additional mental illness waiver requirements. For a complete listing of the limitations and exclusions that apply to each Medicaid benefit category, go to tmhp.com > providers > Medicaid Provider Manual > Texas Medicaid Provider Procedures Manual.

The services listed in this attachment are subject to modification based on changes in federal and state laws, regulations, and policies.

**Services included under the MCO capitation payment**
- Emergency and non-emergency ambulance services
- Audiology services, including hearing aids, for adults and children
- Behavioral health services, including:
  - Inpatient mental health services for adults and children. We may provide these services in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.
  - As part of provider capitation payment, inpatient mental health services for adults and children may be provided in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting, and are limited to no more than 15 days per month for individuals age 21-64. There is no day limitation for services provided in a free standing psychiatric hospital to members younger than age 21 or ages 65 and older.
  - Inpatient mental health services for children are a covered benefit for members birth through age 20 or ages 65 and older, and do not need to be provided in lieu of an acute care inpatient hospital setting.
  - Inpatient psychiatric hospital services provided in a free-standing psychiatric hospital to members younger than age 21 or ages 65 and older are a covered Medicaid benefit and are not provided “in lieu of” and there is no day limitation for services.
  - Outpatient mental health services for adults and children
  - Psychiatry services
  - Counseling services for adults (21 years and older)
  - Substance use disorder treatment services, including
    - Outpatient services, including:
      - Assessment
– Detoxification services
– Counseling treatment
– Medication assisted therapy

• Residential services, which may be provided in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting, including:
  – Detoxification services
  – Substance use disorder treatment (including room and board)

• Member reimbursement for members for Attention Deficit Hyperactivity Disorder (ADHD) and follow-up care for children prescribed ADHD medications

• Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center

• Birthing services provided by a physician and CNM in a licensed birthing center

• Birthing services provided by a licensed birthing center

• Cancer screening, diagnostic, and treatment services

• Chiropractic services

• Dialysis

• Durable medical equipment and supplies

• Early childhood intervention (ECI) services

• Electronic visit verification

• Emergency services

• Family planning services

• Home health care services

• Hospital services, inpatient and outpatient

• Laboratory

• Mastectomy, breast reconstruction, and related follow-up procedures, including:
  – Outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    • All stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
    • Surgery and reconstruction on the other breast to produce symmetrical appearance;
    • Treatment of physical complications from the mastectomy and treatment of lymphedemas; and
    • Prophylactic mastectomy to prevent the development of breast cancer.
  – External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.

• Medical checkups and Comprehensive Care Program (CCP) services for children (birth through age 20) through the Texas Health Steps Program

• Mental health rehabilitative services and mental health targeted case management for individuals who are not dually enrolled in Medicare and Medicaid

• Nursing facility services
Appendix C: STAR+PLUS Benefits

- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children six months through 35 months of age
- Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals
- Drugs and biologicals provided in an inpatient setting
- Podiatry
- Prenatal care
- Primary care services
- Preventive services including an annual adult well check for patients 21 years and older
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)
- Telemedicine
- Telemonitoring, to the extent covered by Texas Government Code §531.01276
- Telehealth

The following is a non-exhaustive, high-level listing of community-based long-term care covered services included under the STAR+PLUS Medicaid managed care program. Please refer to Texas Health and Human Services Commission for a more inclusive listing of limitations and exclusions that apply to each benefit.

- Community-based long-term care services for all members
  - Personal attendant services (PAS) – All members of a STAR+PLUS MCO may receive medically and functionally necessary PAS.
  - Day activity and health services (DAHS) – All members of a STAR+PLUS MCO may receive medically and functionally necessary DAHS.
- HCBS STAR+PLUS waiver services for those members who qualify for these services. The state provides an enriched array of services to clients who would otherwise qualify for nursing facility care through a Home and Community-Based Medicaid Waiver. In traditional Medicaid, this is known as the Community-Based Alternatives (CBA) waiver. The STAR+PLUS MCO must also provide medically necessary services that are available to clients through the CBA waiver in traditional Medicaid to those clients that meet the functional and financial eligibility for the HCBS STAR+PLUS Waiver.
  - PAS (including the three service delivery options: Self Directed, Agency, and Service Responsibility)
  - In-home or out-of-home respite services
  - Nursing services (in home)
  - Emergency response services (emergency call button)
  - Home-delivered meals
  - Minor home modifications
  - Adaptive aids and medical equipment
  - Medical supplies not available under the Texas Medicaid State Plan/ Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 Waiver
Appendix C: STAR+PLUS Benefits

- Specialty Therapy (physical therapy, speech therapy, or occupational therapy)
- DAHS (for members in 217-Like STAR+PLUS eligibility group, as identified in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, whose income exceeds 150% FPL)
- Adult foster care
- Assisted living
- Transition assistance services: These services are limited to a maximum of $2,500.00. If the MCO determines that no other resources are available to pay for the basic services/items needed to assist a member, who is leaving a nursing facility, with setting up a household, the MCO may authorize up to $2,500 for Transition Assistance Services (TAS). The $2,500 TAS benefit is part of the expense ceiling when determining the Total Annual Individual Service Plan (ISP) Cost.
- Dental services: The annual cost cap of this service is $5,000 per waiver plan year. The $5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.
- Cognitive rehabilitation therapy (effective March 6, 2014)
- Financial management services
- Support consultation
- Employment assistance (effective September 1, 2014)
- Supported employment (effective September 1, 2014)

- Community First Choice services for those members who qualify for these services. The state provides an enriched array of services to members who would otherwise qualify for care in a nursing facility, an ICF/IDD, or an institution for mental diseases (IMD).
  - Habilitation
  - PAS - CFC - All qualified members may receive medically and functionally necessary PAS under CFC.
  - Acquisition, maintenance and enhancement of skills - All qualified members may receive this service to enable the member to accomplish ADLs, IADLs and health-related tasks.
  - Emergency response service - CFC - (Emergency call button) - All qualified members may receive necessary Emergency Response Services under CFC.
  - Support management - All qualified members may receive voluntary training on how to select, manage and dismiss attendants.
Note: The following information is intended for UnitedHealthcare Community and State members.

**MEMBER RIGHTS:**

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.

2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your primary care provider.
   b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   c. Change your primary care provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your primary care provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   b. Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your care provider.

5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:
   a. Make a complaint to your health plan or to the state Medicaid program about your health care, your care provider, or your health plan.
   b. Get a timely answer to your complaint.
   c. Use the plan’s appeal process and be told how to use it.
   d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, seven days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider’s office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else’s convenience, or is meant to force you to do something you do not want to do, or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

10. You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

11. You have the right to make recommendations regarding the organization’s member rights and responsibilities policy.

MEMBER RESPONSIBILITIES:

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

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

3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your primary care provider about your health.
   b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
   c. Help your providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
   a. Work with your care provider in deciding what health care is best for you.
   b. Understand how the things you do can affect your health.
   c. Do the best you can to stay healthy.
   d. Treat providers and staff with respect.
   e. Talk to your care provider about all of your medications.

5. You have a responsibility to follow plans and instructions for care that you have agreed to with your practitioners.
MEMBER’S RIGHT TO DESIGNATE OB/GYN

UnitedHealthcare Community Plan DOES NOT LIMIT TO NETWORK

UnitedHealthcare Community Plan allows the member to pick any OB/GYN, whether that doctor is in the same network as the member’s Primary Care Provider or not.

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their primary care provider. An OB/GYN can give the member:

• One well-woman checkup each year
• Care related to pregnancy
• Care for any female medical condition
• A referral to a specialist doctor within the network
Note: The following information is intended for UnitedHealthcare Community and State members.

MEMBER RIGHTS:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child’s health plan, doctors, hospitals, and other care providers.

2. Your health plan must tell you if they use a “limited provider network.” This is a group of doctors and other care providers who only refer patients to other doctors who are in the same group. “Limited provider network” means you cannot see all the doctors who are in your health plan. If your health plan uses “limited networks,” you should check to see that your child’s primary care provider and any specialist doctor you might like to see are part of the same “limited network.”

3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.

4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.

5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.

6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.

7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child’s primary care provider. Ask your health plan about this.

8. Children who are diagnosed with special health care needs or a disability have the right to special care.

9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.

10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.

11. Your child has the right to emergency services if you reasonably believe your child’s life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copayment, depending on your income. Copayments do not apply to CHIP Perinate members.

12. You have the right and responsibility to take part in all the choices about your child’s health care.

13. You have the right to speak for your child in all treatment choices.

14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.

15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other care providers.

16. You have the right to talk to your child’s doctors and other providers in private, and to have your child’s medical records kept private. You have the right to look over and copy your child’s medical records and to ask for changes to those records.

17. You have the right to a fair and quick process for solving problems with your health plan and the plan’s doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child’s doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
Appendix E: CHIP Member Rights & Responsibilities

18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child’s health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

20. You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

21. You have the right to make recommendations regarding the organization’s member rights and responsibilities policy.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in seeing your child’s health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.

2. You must become involved in the doctor’s decisions about your child’s treatments.

3. You must work together with your health plan’s doctors and other providers to pick treatments for your child that you have all agreed upon.

4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan’s complaint process.

5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.

6. If you make an appointment for your child, you must try to get to the doctor’s office on time. If you cannot keep the appointment, be sure to call and cancel it.

7. If your child has CHIP, you are responsible for paying your doctor and other providers copayments that you owe them. If your child is getting CHIP Perinate services, you will not have any copayments for that child.

8. You must report misuse of CHIP or CHIP Perinate services by health care providers, other members, or health plans.

9. Talk to your child’s provider about all of your child’s medications.

10. You have a responsibility to follow plans and instructions for care that you have agreed to with your practitioners.

MEMBER’S RIGHT TO DESIGNATE AN OB/GYN:

UnitedHealthcare Community Plan DOES NOT LIMIT TO NETWORK

UnitedHealthcare Community Plan allows the member to pick any OB/GYN, whether that doctor is in the same network as the member’s primary care provider or not.

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their primary care provider. An OB/GYN can give the member:

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

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child’s health plan, doctors, hospitals, and other providers.

2. You have a right to know how the perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.

3. You have a right to know how the health plan decides whether a perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.

4. You have a right to know the names of the hospitals and other perinatal providers in the health plan and their addresses.

5. You have a right to pick from a list of health care providers large enough so that your unborn child can get the right kind of care when it is needed.

6. You have a right to emergency perinatal services if you reasonably believe your unborn child’s life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.

7. You have the right and responsibility to take part in all the choices about your unborn child’s health care.

8. You have the right to speak for your unborn child in all treatment choices.

9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.

10. You have the right to talk to your perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.

11. You have the right to a fair and quick process for solving problems with the health plan and the plan’s doctors, hospitals, and others who provide perinatal services for your unborn child. If the health plan says it will not pay for a covered perinatal service or benefit that your unborn child’s doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

12. You have a right to know that doctors, hospitals, and other perinatal care providers can give you information about your or your unborn child’s health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

13. You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

14. You have the right to make recommendations regarding the organization’s member rights and responsibilities policy.

MEMBER RESPONSIBILITIES:

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.

2. You must become involved in the doctor’s decisions about your unborn child’s care.

3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan’s complaint process.

4. You must learn about what your health plan does and does not cover. Read your CHIP Member Handbook to understand how the rules work.

5. You must try to get to the doctor’s office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinate services by health care providers, other members, or health plans.
7. Talk to your provider about all of your medications.
8. You have a responsibility to follow plans and instructions for care that you have agreed to with your practitioners.

MEMBER’S RIGHT TO DESIGNATE AN OB/GYN:

UnitedHealthcare Community Plan **DOES NOT LIMIT** TO NETWORK

UnitedHealthcare Community Plan allows the member to pick any OB/GYN, whether that doctor is in the same network as the member’s primary care provider or not.

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their primary care provider. An OB/GYN can give the member:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- A referral to a specialist doctor within the network
Appendix G: CHIP Cost-Sharing Schedule

Members are required to pay copayments for medical services or prescription drugs at the time of service. Copayment requirements are found at hhs.texas.gov.
Texas Medicaid/CHIP/CHIP Perinate
Private Pay Form
SAMPLE FORM

Date:__________ Member’s Name:___________________________________

Medicaid #:_______________________ Provider’s Name:____________________

Texas Medicaid reimburses only for services that are medically necessary or benefits of special preventive
and screening programs such as family planning and THSteps.

Specify Services

☐ “I understand that, in the opinion of ________________________________ that the services
or
items that I have requested to be provided to me on ________________________ may not be
(date of service)
covered under the Texas Medicaid/CHIP/CHIP Perinate Program as being reasonable and medically
necessary for my care. I understand that Texas Medicaid determines the medical necessity of the services
or items that I request and receive. I also understand that I am responsible for payment of the services or
items I request and receive if these services or items are determined not to be reasonable
and medically necessary for my care.”

________________________  ______________________________________________
Date                            Signature of member or member representative
____________________            ______________________________________________
Date                             Signature of Witness
INSTRUCTIONS

1. Review the Medicaid Client Acknowledgment Statement with the member or member representative prior to delivering services, while they are in the office.
   a. Advise the patient that Medicaid does not cover the test(s) or service(s).
   b. Review the options on the Medicaid Client Acknowledgment Statement with the member.
   c. Make sure the member understands their obligation to pay for testing if they agree to the test or service.

2. Complete the forms.
   a. Enter the date of service, member’s name, Medicaid number and physician/provider.
   b. Document the item(s) or service(s) to be provided.
   c. Document the reason the test(s) or service(s) is needed.

3. Member’s signature or person acting on behalf of the member.
   a. Select only one option.
   b. Sign and date the Medicaid Acknowledgment Client Form.

4. Retain in member’s medical record.
Appendix I: STAR and STAR+PLUS Member Complaint and Appeal Processes

Note: The following information is intended for UnitedHealthcare Community and State STAR and STAR+PLUS members.

What should I do if I have a complaint?
We want to help. If you have a complaint, please call us toll-free at 888-887-9003 to tell us about your problem. A UnitedHealthcare Community Plan member services advocate can help you file a complaint. Just call 888-887-9003. Most of the time, we can help you right away or at the most within a few days.

Once you have gone through the UnitedHealthcare Community Plan complaint process, STAR and STAR+PLUS members can complain to Texas Health and Human Services Commission (HHSC) by calling toll-free 866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission Health Plan Operations - H-320
P.O. Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

If you can get on the internet, you can send your complaint in an email to HPM_Complaints@hhsc.state.tx.us.

Who do I call?
Call UnitedHealthcare Member Services for help 888-887-9003.

Where can I mail a complaint?
For written complaints, please send your letter to UnitedHealthcare Community Plan. You must state your name, your member ID, your telephone number and address, and the reason for your complaint. Please send your letter to:
UnitedHealthcare Community Plan Attn: Complaint and Appeals Department
P.O. Box 31364
Salt Lake City, UT 84131-0364

Can someone help me file a complaint?
UnitedHealthcare Community Plan members can access an independent ombudsman through our new internal complaints unit. Referrals can be made by a member advocate based on interaction with members that appear to need an independent advocate to work through their concerns. In addition, the ombudsman may make referrals to UnitedHealthcare Community Plan complaints unit concerning members of their organization needing help. UnitedHealthcare Community Plan has contracts with several non-profit entities to provide support for members.

What are the requirements and timeframes for filing a complaint?
There is no time limit on filing a complaint with UnitedHealthcare Community Plan. UnitedHealthcare Community Plan will send you a letter telling you what we did about your complaint.

How long will it take to process my complaint?
Most of the time we can help you right away or at the most within a few days. You will get the letter within 30 days from when your complaint got to UnitedHealthcare Community Plan.

Can someone from UnitedHealthcare Community Plan help me file a complaint?
Yes, a UnitedHealthcare Community Plan Member Services representative can help you file a complaint, just call 888-887-9003. Most of the time, we can help you right away or at the most within a few days.
Appendix I: STAR and STAR+PLUS Member Complaint and Appeal Processes

What can I do if my doctor asks for a service or medicine that is covered but UnitedHealthcare Community Plan denies or limits it (if UnitedHealthcare Community Plan denies or limits my patient’s request for a covered service)?

UnitedHealthcare Community Plan will send you a letter if a covered service you requested is not approved or if payment is denied in whole or in part. If you are not happy with our decision, call UnitedHealthcare Community Plan within 60 days from the date on the adverse benefit determination notice. If you ask for an appeal within 10 days from the date on the denial letter, you may be able to keep your services that are being denied. You can appeal by sending a letter to UnitedHealthcare Community Plan or by calling UnitedHealthcare Community Plan. You can ask for up to 14 days of extra time for your appeal. UnitedHealthcare Community Plan can take extra time on your appeal if it is better for you. If this happens, UnitedHealthcare Community Plan will tell you in writing the reason for the delay.

You can call Member Services and get help with your appeal. When you call Member Services, we will help you file an appeal. Then we will send you a letter and ask you or someone acting on your behalf to sign a form so we can have it in writing.

How will I find out if services are denied?

UnitedHealthcare Community Plan will send a letter if a covered service requested by your child’s PCP is denied, delayed limited or stopped to you, any person representing you in the appeal and the provider for whom the service was denied.

What are the timeframes for the appeal process?

UnitedHealthcare Community Plan has up to 30 calendar days to decide if your request for care is medically needed and covered. We will send you a letter of our decision within 30 days. In some cases you have the right to a decision within one business day. If your provider requests, we must give you a quick decision. You can get a quick decision if your health or ability to function could be seriously hurt by waiting.

What are the timeframes for an expedited appeal?

UnitedHealthcare Community Plan must decide this type of appeal in 72 hours and one business day for those related to ongoing emergency and continued hospitalization. This time frame begins when we get the information and request.

What happens if UnitedHealthcare Community Plan denies the request for an expedited appeal?

If UnitedHealthcare Community Plan denies an expedited appeal, the appeal is processed through the normal appeal process, which will be resolved within 30 days. You will receive a letter explaining why and what other choices you may have.

Who can help me file an expedited appeal?

If your child is in the hospital, ask someone to help you mail, fax, or call in your request for this type of appeal. You may also call UnitedHealthcare Community Plan Member Services at 888-887-9003 and ask someone to help you start an appeal or ask your child’s doctor to do it for you. Expedited appeals can be made verbally and do not have to be in writing.

What documentation should I keep after filing a complaint or appeal?

Keep a copy of any forms or attachments that you mail or fax in or receive (including cover pages or cover letters), as well as copies of any emails. In addition, please keep a log of any telephone communications related to/from UnitedHealthcare Community Plan that may be related to a complaint or appeal.
Appendix J: CHIP Member Complaints and Appeals

The following information is intended for UnitedHealthcare Community and State CHIP members.

What should I do if I have a complaint? Who do I call?
We want to help. If you have a complaint, please call us toll-free at 888-887-9003 to tell us about your problem. A UnitedHealthcare Community Plan Member Services representative can help you file a complaint. Most of the time, we can help you right away, or at the most within a few days.

If I am not satisfied with the outcome, who else can I contact?
If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll-free to 800-252-3439. If you would like to make your request in writing, send it to:

Texas Department of Insurance Consumer Protection
P.O. Box 149091
Austin, TX 78714-9091

If you can get on the internet, you can find additional contact information at tdi.texas.gov/consumer/complfrm.html.

Can someone from UnitedHealthcare Community Plan help me file a complaint?
Yes, a UnitedHealthcare Community Plan Member Services representative can help you file a complaint, just call 888-887-9003. Most of the time, we can help you right away, or at the most within a few days.

How long will it take to process my complaint?
Most of the time, we can help you right away, or at the most within a few days. You will get a response letter within 30 days from when your complaint got to UnitedHealthcare Community Plan.

What are the requirements and timeframes for filing a complaint?
There is no time limit on filing a complaint with UnitedHealthcare Community Plan. UnitedHealthcare Community Plan will send you a response letter telling you what we did about your complaint.

Do I have the right to meet with a complaint appeal panel?
If you make a complaint for you/your child, and it is not worked out the way you thought it should, you have the right to appeal. When you appeal, you will get information about having your concern heard by a complaint appeal panel. This panel is made up of doctors, other care providers, and UnitedHealthcare Community Plan members.

Where can I mail a complaint?
For written complaints please send your letter to UnitedHealthcare Community Plan. Your letter must state your name, your member ID number, your telephone number and address, and the reason for your complaint. Please send your letter to:

UnitedHealthcare Community Plan Attn: Complaint and Appeals Department
P.O. Box 31364
Salt Lake City, UT 84131-0364
Ombudsman program
UnitedHealthcare Community Plan members can access a UnitedHealthcare Community Plan independent ombudsman to assist them with resolving their complaint.

UnitedHealthcare Community Plan contracts with several non-profit organizations to provide this service to you. You can be referred to a UnitedHealthcare Community Plan independent ombudsman through our Member Services department by calling 888-887-9003.

What can I do if my child’s doctor asks for a service for my child that is covered, but UnitedHealthcare Community Plan denies or limits it?
UnitedHealthcare Community Plan will send you a letter if a covered service requested by your child’s PCP is denied, delayed, limited or stopped. If you are not happy with the decision, you can call Member Services at 888-887-9003 and ask for an appeal. We will record your verbal request. Your recording will then be made into a written request. We will send a form to you to complete, sign and return as soon as possible.

How will I find out if services are denied?
UnitedHealthcare Community Plan will send a letter if a covered service requested by your child’s PCP is denied, delayed, limited or stopped to you, anyone representing you and the care provider for whom the services are denied.

What are the timeframes for the appeal process?
UnitedHealthcare Community Plan has up to 30 calendar days to decide if your request for care is medically needed and covered. We will send you a letter of our decision within 30 days. In some cases you have the right to a decision within one business day. If your provider requests, we must give you a quick decision. You can get a quick decision if your health or ability to function could be seriously hurt by waiting. You also have the right to choose a quick review from an independent review organization (IRO).

When do I have the right to request an appeal?
You may request an appeal whenever you do not agree with UnitedHealthcare Community Plan’s decision to deny services or care for you/your child.

Does my request have to be in writing?
An appeal form will be included in each letter you receive when UnitedHealthcare Community Plan denies a service to you. This form may be signed and returned. You may also request an appeal by phone by calling Member Services at 888-887-9003.

How will I find out if services are denied?
UnitedHealthcare Community Plan will send a letter if a covered service requested by your child’s PCP is denied, delayed, limited or stopped to you, anyone representing you in the appeal and the provider for whom the service was denied.

No retaliation is allowed.
UnitedHealthcare Community Plan will not punish a member, doctor or care provider for filing a complaint or appeal against UnitedHealthcare Community Plan.

Can someone from UnitedHealthcare Community Plan help me file an appeal?
Member Services is available to help you file an appeal. You can ask them to help you when you call 888-887-9003. They will send you an appeal request form and ask that you return it before your appeal request is taken.

What is an expedited appeal?
An expedited appeal is when the health plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health.
How do I ask for an expedited appeal?
You may ask for this type of appeal in writing or by phone. Make sure you write “I want a quick decision or an expedited appeal,” or “I feel my child’s health could be hurt by waiting for a standard decision.” To request a quick decision by phone, call UnitedHealthcare Community Plan Member Services at 888-887-9003.

Does my request for an expedited appeal have to be in writing?
We can accept your request orally or in writing. Mail written requests to:

UnitedHealthcare Community Plan Attn: Complaint and Appeals Department
P.O. Box 31364
Salt Lake City, UT 84131-0364.

What are the timeframes for an expedited appeal?
UnitedHealthcare Community Plan must decide this type of appeal within 72 hours.

What happens if UnitedHealthcare Community Plan denies the request for an expedited appeal?
If UnitedHealthcare Community Plan denies an expedited appeal, the appeal is processed through the normal appeal process, which will be resolved within 30 days. You will receive a letter explaining why and what other choices you may have.

Who can help me in filing an appeal or an expedited appeal?
If you/your child is in the hospital, ask someone to help you mail or call in your request for this type of appeal. You may also call UnitedHealthcare Community Plan Member Services at 888-887-9003 and ask someone to help you start an appeal or ask your/your child’s doctor to do it for you.

What Is an IRO?
If you are not satisfied with the outcomes of the appeal with UnitedHealthcare Community Plan, you can file and an independent review organization (IRO). This is an outside organization that the Texas Department of Insurance (TDI) picks to review your health plan’s denial of a service you and your doctor feel is medically necessary. This organization is not related to your doctor or your health plan. There is no cost to you for this independent review. You can ask for a review by an IRO after you complete the appeal process. An IRO is the final level of appeal for a Determination.

How do I request an IRO?
If you choose an IRO, you may contact UnitedHealthcare Community Plan Member Services at 888-887-9003.

What are the timeframes for this process?
When UnitedHealthcare Community Plan gets your request, we send it to the Texas Department of Insurance (TDI) within five calendar days.

We work with TDI and the IRO to give them all the information about your case. The IRO will let UnitedHealthcare Community Plan and you know what they decide. This decision is final, and UnitedHealthcare Community Plan will work with you and your child’s care providers to do what the IRO says must be done.
Appendix K: Fraud Information

FRAUD INFORMATION: A MESSAGE FROM HHSC REPORTING WASTE, ABUSE, OR FRAUD BY A PROVIDER OR CLIENT MEDICAID MANAGED CARE AND CHIP

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

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

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

• Call the OIG Hotline at 800-436-6184;
• Visit oig.hhsc.texas.gov Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form; or
• You can report directly to your health plan:
  – UnitedHealthcare Community Plan
    14141 Southwest Freeway, Suite 800
    Sugar Land, TX 77478
    – Toll-free 888-887-9003

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

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

• When reporting about someone who gets benefits, include:
  – The person’s name
  – The person’s date of birth, Social Security number, or case number if you have it
  – The city where the person lives
  – Specific details about the waste, abuse, or fraud
## Appendix L: Claim Forms

### Outpatient Services

Outpatient services use an approved CMS form 1500, which is directly available for download from CMS to process a claim on a CMS Form 1500. Any missing or invalid data will result in a claim not being paid. Claim information must match referral information. For more information, go to [CMS.gov](https://www.cms.gov) > Regulations & Guidance > Guidance > Manuals > Internet Only Manuals (IOMs) > Medicare Claims Processing Manual.

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
</table>
| 19        | Reserved for local use                           | Transfers of Multiple Clients  
If the claim is part of a multiple transfer, indicate the other client’s complete name and Medicaid number.  
Ambulance Hospital-to-Hospital Transfers  
Indicate the services required from the second facility and unavailable at the first facility. |
| 20        | Outside lab                                      | Check the appropriate box. The information may be requested for retrospective review. If “yes”, enter the provider identifier of the facility that performed the service in block 32. |
| 21        | Diagnosis or nature of illness or injury         | Enter up to four ICD-10-CM diagnosis codes to the highest level of specificity available. |
| 22        | Re submissions                                   | Enter original claim number.                                             |
| 23        | Prior authorization number                       | Use authorization number issued by UnitedHealthcare Community Plan. For workers compensation and other property and casualty claims, this is required when prior authorization, referral, concurrent review, or voluntary certification was received. |
| 24        | (Various)                                        | General notes for blocks 24a through 24j:  
• Unless otherwise specified, all required information should be entered in the unused portion.  
• If more than six line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28-line items for the entire claim.  
• For multi-page claim forms, indicate the page number of the attachment. |
| 24a       | Date(s) of service                               | Enter the date of service for each procedure provided in a MM/DD/YYYY format. If more than one date of service is for a single procedure, each date must be given on a separate line. National Drug Code (NDC) in the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered).  
Do not enter hyphens or spaces within this number. Example: N400409231231. |
| 24b       | Place of service                                 | Select the appropriate POS code for each service from the table under subsection 6.3.1.1, “Place of Service (POS) Coding” located at TMHP. |
| 24c       | EMG (THSteps medical checkup condition indicator) | Enter the appropriate condition indicator for THSteps medical checkups. |
| 24d       | Fully describe procedures, medical services, or supplies furnished for each date given | Enter the appropriate procedure codes and modifier for all services billed.  
If a procedure code is not available, enter a concise description.  
NDC: In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit. |
<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>24e</td>
<td>Diagnosis pointer</td>
<td>Enter the line item reference (1, 2, 3, or 4) of each diagnosis code identified in block 21 for each procedure. Indicate the primary diagnosis only. Do not enter more than one diagnosis code reference per procedure. This can result in denial of the service.</td>
</tr>
<tr>
<td>24f</td>
<td>Charges</td>
<td>Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.</td>
</tr>
<tr>
<td>24g</td>
<td>Days or units</td>
<td>If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). Note: The maximum number of units per detail is 9,999. NDC Optional: In the shaded area, enter the NDC unit of measurement code.</td>
</tr>
<tr>
<td>24j</td>
<td>Rendering provider ID# (performing)</td>
<td>Enter the provider identifier of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Enter the TPI in the shaded area of the field. Entered the NPI in the unshaded area of the field.</td>
</tr>
<tr>
<td>26</td>
<td>Patient's account number</td>
<td>Optional: Enter the client identification number if it is different than the subscriber/insured’s identification number. Used by provider’s office to identify internal client account number.</td>
</tr>
<tr>
<td>27</td>
<td>Accept assignment</td>
<td>All providers of Texas Medicaid must accept assignment to receive payment by checking</td>
</tr>
<tr>
<td>28</td>
<td>Total charge</td>
<td>Enter the total charges. For multi-page claims enter “continue” on initial and subsequent claim forms. Indicate the total of all charges on the last claim.</td>
</tr>
<tr>
<td>29</td>
<td>Amount paid</td>
<td>Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.</td>
</tr>
<tr>
<td>30</td>
<td>Balance due</td>
<td>If appropriate, subtract block 29 from block 28 and enter the balance.</td>
</tr>
<tr>
<td>31</td>
<td>Signature of physician or supplier</td>
<td>The physician, supplier, or an authorized representative must sign and date the claim. Billing services may print “Signature on File” in place of the provider’s signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.</td>
</tr>
<tr>
<td>32</td>
<td>Service facility location information</td>
<td>If services were provided in a place other than the client’s home or the provider’s facility, enter name, address, and ZIP code of the facility where the service was provided.</td>
</tr>
<tr>
<td>33</td>
<td>Billing provider info &amp; PH #</td>
<td>Enter the billing provider’s name, street, city, state, ZIP+4 code, and telephone number.</td>
</tr>
<tr>
<td>33a</td>
<td>NPI</td>
<td>Enter the NPI of the billing provider.</td>
</tr>
<tr>
<td>33b</td>
<td>Other ID #</td>
<td>Enter the TPI number of the billing provider.</td>
</tr>
</tbody>
</table>
Facility and Inpatient Services

Facility and Inpatient Services use an approved Center for Medicare and Medicaid Services (CMS) UB-04 Form available at [CMS.gov](https://www.cms.gov) (Home > Medicare > CMS Forms > CMS Forms Items > Details for title: CMS 1450). The following list contains the minimum amount of information required to process a claim on a CMS UB-04 Form. Any missing/invalid data will result in the claim not being paid. Claim information must match referral information. For more information, go to [CMS.gov](https://www.cms.gov) > Regulations & Guidance > Guidance > Manuals > Internet Only Manuals (IOMs) > Medicare Claims Processing Manual.

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unlabeled</td>
<td>Enter the hospital name, street, city, state, ZIP+4 Code, and telephone number.</td>
</tr>
<tr>
<td>3a</td>
<td>Patient control number</td>
<td>Optional: Any alphanumeric character (limit 16) entered in this block is referenced on the R&amp;S Report.</td>
</tr>
<tr>
<td>3b</td>
<td>Medical record number</td>
<td>Enter the patient’s medical record number (limited to ten digits) assigned by the hospital.</td>
</tr>
<tr>
<td>4</td>
<td>Type of Bill (TOB)</td>
<td>Enter a TOB code. See TMHP for codes listing.</td>
</tr>
<tr>
<td>6</td>
<td>Period covered</td>
<td>Enter the beginning and ending dates of service billed.</td>
</tr>
<tr>
<td>8a</td>
<td>Patient identifier</td>
<td>Optional: Enter the patient identification number if it is different than the subscriber/insured’s identification number. Used by providers office to identify internal patient account number.</td>
</tr>
<tr>
<td>8b</td>
<td>Patient name</td>
<td>Enter the patient’s last name, first name, and middle initial as printed on the Medicaid identification form.</td>
</tr>
<tr>
<td>9a–9b</td>
<td>Patient address</td>
<td>STAR and STAR+PLUS in 9a, enter the patient’s complete address as described (street, city, state, and ZIP+4 Code).</td>
</tr>
<tr>
<td>10</td>
<td>Birthdate</td>
<td>Enter the patient’s date of birth (MM/DD/YYYY).</td>
</tr>
<tr>
<td>11</td>
<td>Sex</td>
<td>Indicate the patient’s gender by entering an “M” or “F”.</td>
</tr>
<tr>
<td>12</td>
<td>Admission date</td>
<td>Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or STAR and STAR+PLUS of care (SOC) for home health claims. Providers that receive a transfer patient from another hospital must enter the actual dates the patient was admitted into each facility.</td>
</tr>
<tr>
<td>13</td>
<td>Admission hour</td>
<td>Military time for the time of admission for inpatient claims or time of treatment for outpatient claims.</td>
</tr>
<tr>
<td>14</td>
<td>Type of admission</td>
<td>Enter the appropriate type of admission code for inpatient claims (code 1-5).</td>
</tr>
<tr>
<td>15</td>
<td>Source of admission</td>
<td>Enter the appropriate source of admission code for inpatient claims.</td>
</tr>
<tr>
<td>16</td>
<td>Discharge hour</td>
<td>For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of “30”), leave the block blank.</td>
</tr>
<tr>
<td>17</td>
<td>Patient Status</td>
<td>For inpatient claims, enter the appropriate two-digit code to indicate the patient’s status as of the statement “through” date.</td>
</tr>
<tr>
<td>18–28</td>
<td>Condition codes</td>
<td>Enter the two-digit condition code “05” to indicate that a legal claim was filed for recovery of funds potentially due to a patient.</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>29</td>
<td>ACDT state</td>
<td>Optional: Accident state.</td>
</tr>
<tr>
<td>31—34</td>
<td>Occurrence codes and dates</td>
<td>Enter the appropriate occurrence code(s) and date(s).</td>
</tr>
<tr>
<td>35–36</td>
<td>Occurrence span codes and dates</td>
<td>For inpatient claims, enter code “71” if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay.</td>
</tr>
<tr>
<td>39–41</td>
<td>Value codes</td>
<td>Accident hour – For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6.</td>
</tr>
<tr>
<td>42–43</td>
<td>Revenue codes and description</td>
<td>For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate.</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/rates</td>
<td>Inpatient: Enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. <strong>Home Health Services:</strong> Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. <strong>Outpatient:</strong> Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code.</td>
</tr>
<tr>
<td>45</td>
<td>Service date</td>
<td>Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims.</td>
</tr>
<tr>
<td>45 (line 23)</td>
<td>Creation date</td>
<td>Enter the date the bill was submitted.</td>
</tr>
<tr>
<td>46</td>
<td>Service units</td>
<td>Provide units of service, if applicable. For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation.</td>
</tr>
</tbody>
</table>
### Block No. | Description | Guidelines
---|---|---
47 | Total charges | Enter the total charges for each service provided.
47 (line 23) | Totals | Enter the total charges for the entire claim.
48 | No covered charges | If any of the total charges are no covered, enter this amount.
50 | Payer Name | Enter UnitedHealthcare Community Plan.
51 | Health Plan ID | Enter the health plan identification number.
54 | Prior payments | Enter amounts paid by any TPR, and complete Blocks 32, 61, 62, and 80 as required.
56 | NPI | Enter the NPI of the billing provider. (Must match NPI on file with UnitedHealthcare Community Plan for our claims.)
57 | Other identification (ID) number | Enter the TPI number (non-NPI number) of the billing provider.
58 | Insured’s name | If other health insurance is involved, enter the insured’s name.

Additional claims information is located in the Behavioral Health, Emergency and Pharmacy sections of this manual.
Appendix M: Medical Records Standards

Medical Record Documentation Standards

All participating primary care providers are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care. Participating practitioners are subject to UnitedHealthcare Community and State’s periodic quality review of medical records to determine compliance to the following medical record keeping requirements.

Confidentiality of Records

Office policies and procedures exist for the following:

- Confidentiality of the patient medical record
- Initial and periodic training of office staff concerning medical record confidentiality
- Release of information
- Record retention
- Availability of medical record when housed in a different office location (as applicable)

Record Organization

An office policy exists that addresses a process to respond to and provide medical records upon request of patients to include a provision to provide copies within 48 hours in urgent situations. Medical records are maintained in a current, detailed, organized and comprehensive manner.

Organization should include evidence of:

- Identifiable order to the chart assembly
- Papers are fastened in the chart
- Each patient has a separate medical record

Medical records are:

- Stored in a manner that helps ensure protection of confidentiality
- Released only to entities as designated consistent with federal requirements
- Kept in a secure area accessible only to authorized personnel
- Filed in a manner for easy retrieval
- Readily available to the treating practitioner where the member generally receives care
- Promptly sent to specialty providers upon patient request and within 48 hours in urgent situations

Procedural Elements

- Medical records are legible*
- All entries are signed and dated
- Patient name/identification number is located on each page of the record
- Linguistic or cultural needs are documented as appropriate
- Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the patient’s first language is something other than English
• Mechanism for monitoring and handling missed appointments is evident
• An executed advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information regarding advance directives.
• A problem list includes a list of all significant illnesses and active medical conditions*
• A medication list includes prescribed and over-the-counter medications and is reviewed annually*
• Documentation of the presence or absence of allergies or adverse reactions is clearly documented*
• History
  • An initial history (for patients seen three or more times) and physical is present to include:
    – Medical and surgical history*
    – A family history that minimally includes pertinent medical history of parents and/or siblings
    – A social history that minimally includes pertinent information such as occupation, living situations, education, smoking, ETOH, and/or substance use/history beginning at age 11
    – Current and history of immunizations of children, adolescents and adults
  • Screenings of/for:
    – Recommended preventive health screenings/tests
    – Depression
    – High risk behaviors such as drug, alcohol and tobacco use; and if present, advise to quit
    – Medicare patients for functional status assessment and pain
    – Adolescents on depression, substance use, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Problem Evaluation and Management
• Documentation for each visit includes:
  – Appropriate vital signs (measurement of height, weight, and BMI annually)
  – Chief complaint*
  – Physical assessment*
  – Diagnosis*
  – Treatment plan*

• Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines
• Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)
• Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets.
• Treatment plans are consistent with evidence-based care and with findings/diagnosis
  – Timeframe for follow-up visit as appropriate
  – Appropriate use of referrals/consults, studies, tests
  – X-rays, labs consultation reports are included in the medical record with evidence of practitioner review
  – There is evidence of practitioner follow-up of abnormal results
– Unresolved issues from a previous visit are followed up on the subsequent visit

• There is evidence of coordination with behavioral health provider. Education, including lifestyle counseling is documented. Patient input and/or understanding of treatment plan and options is documented. Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies, as ordered by the practitioner are documented.

* Critical element
Appendix N: Member Identification (ID) Cards

To view a sample of member ID cards, go to UHCprovider.com/TXCommunityPlan > Member Information: Current Medical Plans, ID Cards, Provider Directories, Dental & Vision Plans.
Appendix O: Reporting Abuse, Neglect or Exploitation (ANE)

Reporting Abuse, Neglect or Exploitation

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

Report to the Health and Human Services Commission (HHSC) if the victim is an adult or child who resides in or receives services from:

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

Call HHSC at 800-458-9858.

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

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

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

Report to Local Law Enforcement:

- If a care provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.
- Dial 911 for assistance if you believe the person is in immediate danger.

Additional Care Provider Responsibilities:

- You must provide UnitedHealthcare Community Plan with a copy of the Abuse, Neglect, and Exploitation report findings within one business day of receipt of the findings from the Department of Family and Protective Services. This is the responsibility of all
care provider types, including care providers of long term services and supports.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHSC, or a law enforcement agency (see: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).

- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHSC, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).

- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.
Appendix P: Community First Choice (CFC): Program Provider Responsibilities

- The CFC services must be delivered in accordance with the member’s service plan.
- The program provider must have current documentation which includes the member’s service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable).
- The HCS or TxHmL program provider must ensure that the rights of the members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls).
- The program provider must help ensure, through initial and periodic training, the continuous availability of qualified service care providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the member that are required to ensure the member’s health, safety, and welfare. The program provider must maintain documentation of this training in the member’s record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation). The program provider must also provide the member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline (800-647-7418).
- The program provider must address any complaints received from a member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver’s license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must help ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must help ensure that any additional training requested by the member/LAR of CFC PAS or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to the MCO financial accountability standards.
- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a member, including unauthorized disclosure of information related to a member’s finances and the purchase of goods that a member cannot use with the member’s funds.
Appendix Q: Electronic Visit Verification

What is EVV?
- Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends.
- EVV is a method by which a person, including but not limited to a personal care attendant, who enters a STAR+PLUS, STAR Kids, Medicare-Medicaid Plan (MMP), or Community First Choice Member’s home to provide a service will document their arrival time, services and departure time using a telephonic application system. This visit information will be recorded and used as an electronic version of a paper time sheet for an attendant and used to support claims to the MCO for targeted EVV services.

Can a care provider elect not to use EVV?
All Medicaid-enrolled service providers (provider agencies) who provide STAR+PLUS, STAR Kids, Medicaid and Medicare Program (MMP) and CFC services that are subject to EVV are required to use a HHSC-approved EVV system to record onsite visitation with the individual/member. Those services include:
- Personal assistance services (PAS)
- In-Home Respite
- Community First Choice – PAS/Habilitation
- Flexible family support services (for STAR Kids only)

Is EVV required for CDS employers?
No. CDS Employers have the option to choose from the following 3 options:
- Phone and Computer (Full Participation): The telephone portion of EVV will be used by your Consumer Directed Services (CDS) employee(s) and you will use the computer portion of the system to perform visit maintenance.
- Phone Only (Partial Participation): This option is available to CDS employers who can participate in EVV, but may need some assistance from the FMSA with visit maintenance. You will use a paper time sheet to document service delivery. Your CDS employee will call in when they start work and call out when they end work. Your FMSA will perform visit maintenance to make the EVV system match your paper time sheet.
- No EVV Participation: If you do not have access to a computer, assistive devices, or other supports, or you do not feel you can fully participate in EVV, or do not wish to participate in EVV, you may choose to use a paper time sheet to document service delivery.

How do care providers with assistive technology (ADA) needs use EVV?
If you use assistive technology, and need to discuss accommodations related to the EVV system or materials, please contact the HHSC-approved EVV vendor.

DataLogic (Vesta) Software, Inc.
Contact Information:
Website: [vestaevv.com](http://vestaevv.com)
Sales & Training
  Email: [info@vestaevv.com](mailto:info@vestaevv.com)
  Phone: (888) 880-2400
Tech Support
  Email: [support@vesta.net](mailto:support@vesta.net)
Appendix Q: Electronic Visit Verification

EVV use of small alternative device (SAD) process and required SAD forms

• The SAD process is found at hhs.texas.gov
• Order SAD devices electronically directly from DataLogic Vesta. Contact them at info@vestaevv.com with questions about the ordering process.
• Equipment provided by an EVV contractor to a care provider, if applicable, must be returned in good condition within their control.

What is the HHSC Compliance Plan?

• The HHSC Compliance Plan is a set of requirements that establish a standard for EVV usage that must be adhered to by provider agencies under the HHSC EVV initiative.
• You must achieve and maintain an HHSC EVV Initiative Provider Compliance Plan Score of at least 90% per review period. Reason codes must be used each time a change is made to an EVV visit record in the EVV system.

EVV Compliance

All care providers providing the mandated services must use the EVV system and must maintain compliance with the following requirements:

• You must enter member information, provider information, and service schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual process. You must ensure that all required data elements, as determined by HHSC, are uploaded or entered into the EVV system completely and accurately upon entry, or they will be locked out from the visit maintenance function of the EVV system.
• You must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.
• You must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
• You must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
• You should notify the appropriate MCO, or HHSC, within 48 hours of any ongoing issues with EVV vendors or issues with EVV Systems.
• You must complete any and all required visit maintenance in the EVV system within 60 days of the visit (date of service). Visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. You must submit claims in accordance with their contracted entity claim submission policy. No visit maintenance will be allowed more than 60 days after the date of service and before claims submission, unless an exception is granted on a case-by-case basis.
• You must use the reason code that most accurately explains why a change was made to a visit record in the EVV System. The MCOs, will review reason code use by their contracted provider agencies to ensure that preferred reason codes are not misused.
• If it is determined that you have misused preferred reason codes, the provider agency HHSC EVV Initiative Provider Compliance Plan Score may be negatively impacted, and you may be subject to the assessment of liquidated damages, imposition of contract actions, implementation of the corrective action plan process, and/or referral for a fraud, waste, and abuse investigation.
• You must ensure that claims for services are supported by service delivery records that have been verified by the provider agency and fully documented in an EVV System
• Claims are subject to recoupment if they are submitted before all of the required visit maintenance has been completed in the EVV System.
• Claims that are not supported by the EVV system will be subject to denial or recoupment.
  – With the exception of HHSC-identified Displaced CM2000 providers, all provider agencies must use the EVV system as the system of record by September 1, 2015.
Appendix Q: Electronic Visit Verification

- HHSC-identified Displaced CM 2000 providers must use the EVV system as the system of record by February 1, 2015.

- Adherence to the Provider Compliance Plan
  - The MCO Compliance Plan at UHCprovider.com/EVV > Electronic Visit Verification > Your Plan Compliance.
  - The HHSC Compliance Plan is located at hhs.texas.gov.

- Any Corrective action plan required by an MCO is required to be submitted by the Network Provider to the MCO within 10 calendar days of receipt of request.

- MCO Provider Agencies may be subject to liquidated damages and termination from the MCO network for failure to submit a requested corrective action plan in a timely manner.

**Will there be a cost to the provider for the access and use of the selected EVV vendor system?**
There is no cost to the care provider associated with the use of EVV.

**Do providers of Home Health Services have EVV responsibilities?**
- Provider Compliance Plan (excluding Consumer-Directed Services [CDS]) (hhs.texas.gov > Doing Business with HHS > Provider Portals > Long-term Care Providers > Resources > Electronic Visit Verification > Provider Compliance Plans).
- Non-CDS EVV providers must adhere to the Provider Compliance plan found at UHCprovider.com/EVV > Electronic Visit Verification > Your Plan Compliance, or by calling UnitedHealthcare Community Plan 888-787-4107 for the most current version.
- Use of reason codes
  Any change to the prior authorized services and the actual service delivery (for example, a missed visit) need to be justified with a reason code. To review the list of reason codes, visit UHCprovider.com/EVV > Electronic Visit Verification > Training.

**Will training be offered to care providers?**
Training (including for CDS employers) is available online at UHCprovider.com/EVV > Electronic Visit Verification > Training. You may also consult your Provider Advocate directly for personal training. Community First Choice care providers are included in these training opportunities.

**Will claim payment be affected by the use of EVV?**
Providers must adhere to EVV guidelines in the provider compliance plan when submitting a claim. Claims must be submitted within 95 calendar days of the EVV Visit.

**What if I need assistance?**
Contact your provider advocate directly for assistance with EVV issues or call LTSS Customer Service to help you reach your provider advocate 888-787-4107.

**What if I have a complaint related to the EVV process?**
To submit a complaint to UnitedHealthcare Community Plan, How to File a Complaint

To file a complaint, go to UHCprovider.com/TXCommunityPlan > Claims and Payments > Claim Administrative Disputes/Appeals, complete and send the Provider Complaint/Grievance Form to:
UnitedHealthcare Community Plan
Attn: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131-0364
Appendix Q: Electronic Visit Verification

You may also submit a complaint to the Texas HHSC Provider Resolution Services. Written complaints may be mailed to:

- Texas Health and Human Services Commission
  Provider Complaints
  Health Plan Operations, H320
  P.O. Box 85200
  Austin, TX 78708

- Email to: HPM_complaints@hhsc.state.tx
Appendix R: Care Provider Appeal Process to HHSC (related to claim recoupment due to member disenrollment)

Re-check member eligibility after receiving a claims payment recoupment notification, to determine if a member eligibility change was made to Fee-for-Service or to a different managed care organization on the service date.

1. If member eligibility changed to Fee-for-Service on the service date:

   Appeal claim payment recoupment by submitting the following information to HHSC:
   - A letter indicating the appeal is about a managed care disenrollment/recoupment and that you are requesting an Exception Request.
   - The explanation of benefits (EOB) showing the original payment. Use when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items approved by the health plan.
   - The EOB showing the recoupment and/or the health plan’s “demand” letter for recoupment. The demand letter must identify the client name, identification number, DOS, and recoupment amount, and the information should match the payment EOB.
   - Completed clean claim. Paper claims must include both the valid NPI and TPI number. When you need a prior authorization (PA), you will be contacted with the authorization number and you will need to submit a corrected claim containing the valid authorization number.
   - Note: label the request “Expedited Review Request” at the top of the letter to help ensure the appeal request is reviewed prior to 18 months from the service date.

   Mail Fee-for-Service related appeal requests to:
   Texas Health and Human Services Commission
   HHSC Claims Administrator Contract Management
   Mail Code-91X
   P.O. Box 204077
   Austin, TX 78720-4077

   Prepare a new paper claim for each recouped claim. Insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing the recouped claims payment.

   A new claim submission is not required before sending the administrative appeal letter. However, if you appeal before submitting a new claim, you must include the new claim with the administrative appeal.

   HHSC Claims Administrator Contract Management only reviews appeals received within 18 months from the service date. Based on 1 TAC § 354.1003, you must adhere to all filing and appeal deadlines for HHSC Claims Administrator Contract Management to review an appeal. All claims must be finalized within 24 months from the service date.

2. If member eligibility changed from one Managed Care Organization (MCO) to another on the service date:

   You may appeal claims payment recoupments and service denials by submitting the following information to the appropriate MCO, to which the member eligibility was changed on the service date:
   - A letter indicating the appeal is about a managed care disenrollment/recoupment and that you are requesting an Exception Request.
   - The explanation of benefits (EOB) showing the original payment. The EOB showing the recoupment and/or the MCO’s “demand” letter for recoupment must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
• Documentation must identify the client name, identification number, DOS, recoupment amount, and other claims information.

• Note: label the request “Expedited Review Request” at the top of the letter to help ensure the appeal request is reviewed prior to 18 months from the service date.

Submit appeals online at UHCprovider.com/TXCommunityPlan > Provider Complaints and Appeals.

You can mail Fee-for-Service related appeals to:
  Texas Health and Human Services Commission
  HHSC Claims Administrator Contract Management
  Mail Code-91X
  P.O. Box 204077
  Austin, TX 78720-4077
The Adoption Assistance Program is for members who have been adopted. The Permanency Care Assistance Program is for members that live with a foster family that has committed to be a permanent placement. Members in both these programs are considered Members with Special Health Care Needs (MSHCN) and are in our STAR program. Other MSHCN STAR members include farmworker children who travel for seasonal harvesting work. Children in the Early Childhood Intervention (ECI) program are also MSHCN.

We provide Service Management to MSHCN, including the development of a service plan and ensuring access to treatment by a multidisciplinary team when necessary. We include primary care and specialty care providers who are experienced in patients with MSHCN. Sometimes, it makes sense to have a standing referral to a specialty care provider so that the member has ready access when he or she needs it.

We explore the availability to community resources to help support a holistic approach to meeting member needs and encouraging the attainment of their aspirations. Samples include:

1. Local school districts (Special Education)
2. Texas HHSC Medical Transportation Program (MTP)
3. Civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy

See more in the Encouraging Programs section of this manual.

Service Coordination
Service management is an included benefit for members in the Adoption Assistance and Permanency Care Assistance programs.

Our service coordinators work with a care planning team to develop a person-centered service plan that centers around the member and their family or legally authorize representative (LAS). The team includes a primary care provider, specialty providers, including behavioral health clinicians as well as provider of LTSS. We use our online care coordination tool, CommunityCare, to plan and coordinate ongoing care.

Unique to each member, the service plan includes, but is not limited to, the following:

- Member history
- Member’s service preferences
- Short and long-term member needs and goals
- Member natural strengths and supports, such as the member’s abilities or family members
- Member current medical and social needs and concerns including:
  - Behavioral health: mental health and/or substance use disorders
  - Physical, occupational, speech, or other specialized therapy services
  - Durable medical equipment and medical supplies
  - Nursing services including home health skilled nursing, private duty nursing
  - Nursing services offered through a prescribed pediatric extended care center
  - Prescription drugs including psychotropic medications
Appendix S: Adoption Assistance and Permanency Care Assistance

- Non-covered services, community supports, and other resources that the member already receives or that would be beneficial to the member, such as assistance with housing.
- Component of other existing service plans such as the school Individual Family Service Plan (IFSP) or the ECI

To help ensure members, care is coordinated and meeting their ongoing needs, we continue to work with them throughout the year based on their level of need.

Members with High-Risk Needs
Members with this level of need include those members in the home and community-based waiver programs, nursing facility (except for nursing facility members listed under Level 3), individuals with serious and persistent mental illness (SPMI) or other members with complex medical needs.

These members have an assigned service manager. Members in a nursing facility receive quarterly face-to-face visits, including nursing facility care planning meetings or other interdisciplinary team meetings. All other Level 1 members receive a minimum of two face-to-face visits with their service manager every year. Members with SPMI also receive one telephone call from their service manager every year in addition to the minimum of two annual face-to-face service coordination contacts.

Members with Lower Risk Needs
Members receive annually at least one in-person visit and one phone call from their service managed when:
  - They are receiving LTSS, such as Personal Assistance Services, Day Activity and Health Services, Community First Choice Services
  - They are experiencing behavioral health issues that do not qualify as SMI
  - They are in the Breast Cancer and Cervical Cancer Program

Members who are eligible for both Medicare and Medicaid and who do not meet eligibility as a level one high risk member, is considered a Level 2 member and so will receive at least two phone calls from a service manager during the year to help ensure their needs are met.

Members Not of High-Risk or Lower-Risk Needs
Members who do not have needs that place them at high-risk or low-risk, can still receive service management. These members may request service management or may automatically receive it if they are living in a nursing facility to receive hospice or are living in a nursing facility that is outside of our service area.

To see more about how we coordinate member care, please see the service coordination section of this manual.

To help us make sure our members continue receive the services they need even as they experiences changes, let us know if you see a change in circumstances or member condition. Please call our service coordination hotline at 877-352-7798.
Appendix T: Women with Breast or Cervical Cancer

Women with breast cancer or cervical cancer may be eligible for full Medicaid STAR+PLUS benefits and services. The goal of the program is to improve timely access to breast and cervical cancer treatment for uninsured women who are screened and identified by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) of the Centers for Disease Control and Prevention (CDC).

To qualify, a woman needs to have at least one of the following diagnoses:

- Grade 3 cervical intraepithelial neoplasia (CIN III)
- Severe cervical dysplasia
- Cervical carcinoma in situ
- Primary cervical cancer
- Ductal carcinoma in situ
- Primary breast cancer
- Metastatic or recurrent breast or cervical cancer

Other qualifying indicators include:

- Younger than 65
- U.S. citizen or eligible immigrant
- Uninsured or otherwise not eligible for Medicaid
- Texas resident

Eligibility is determined by Texas HHSC. A woman who is eligible to receive Texas Medicaid receives full Medicaid benefits beginning the day after she received a qualifying diagnosis and for the duration of her cancer treatment. Services are not limited to the treatment of breast and cervical cancer.

**Continued Eligibility**

A woman may continue to receive Medicaid benefits as long as she meets the eligibility criteria and provides proof that she is receiving active treatment for breast or cervical cancer, receiving hormonal treatment or receiving disease surveillance. Being under a physician’s care for routine health screening, does not qualify to membership in this program. Women who are not eligible may reapply if diagnosed with a new breast or cervical cancer or a metastatic or recurrent breast or cervical cancer.

If the patient’s cancer is in remission and the physician determines that the patient requires only routine health screening for a breast or cervical condition (e.g., annual breast examinations, mammograms, and Pap tests as recommended by the American Cancer Society and the U.S. Preventative Services Task Force), the patient is not considered to be receiving treatment; MBCC coverage will not be renewed.

A patient who is subsequently diagnosed with a new, metastatic, or recurrent breast or cervical cancer may re-apply for MBCC benefits.
A member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services and must be coordinated to prevent duplication. A member may receive both in the same day but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless:

- The member’s medical condition changes
- The authorized hours are not commensurate with the member’s medical needs.

Per 1 Tex. Admin. Code §363.209 (c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.
Appendix V: Breast Pump Coverage in Medicaid and CHIP

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

<table>
<thead>
<tr>
<th>Coverage in prenatal period</th>
<th>Coverage at delivery</th>
<th>Coverage for newborn</th>
<th>Breast pump coverage and billing</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR</td>
<td>STAR</td>
<td>STAR</td>
<td>STAR covers breast pumps and supplies when medically necessary for mothers or newborns. Bill breast pumps and supplies under the mother’s Medicaid ID or the newborn’s Medicaid ID.</td>
</tr>
<tr>
<td>CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*</td>
<td>Emergency Medicaid</td>
<td>Medicaid fee-for-service (FFS) or STAR**</td>
<td>Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn’s Medicaid ID.</td>
</tr>
<tr>
<td>CHIP Perinatal, with income above 198% FPL</td>
<td>CHIP Perinatal</td>
<td>CHIP Perinatal</td>
<td>CHIP covers breast pumps and supplies when medically necessary for CHIP Perinatal newborns. Bill breast pumps and supplies under the newborn’s CHIP Perinatal ID.</td>
</tr>
<tr>
<td>STAR Kids</td>
<td>STAR Kids</td>
<td>Medicaid FFS or STAR**</td>
<td>Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when medically necessary for mothers or newborns. Bill breast pumps and supplies under the mother’s Medicaid ID or the newborn’s Medicaid ID.</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>STAR+PLUS</td>
<td>Medicaid FFS or STAR**</td>
<td>Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for the newborn when the mother does not have coverage. Bill breast pumps and supplies under the newborn’s Medicaid ID.</td>
</tr>
<tr>
<td>STAR Health</td>
<td>STAR Health</td>
<td>STAR Health</td>
<td>Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for the newborn when the mother does not have coverage. Bill breast pumps and supplies under the newborn’s Medicaid ID.</td>
</tr>
<tr>
<td>None, with income at or below 198% FPL</td>
<td>Emergency Medicaid</td>
<td>Medicaid FFS or STAR**</td>
<td>Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for the newborn when the mother does not have coverage. Bill breast pumps and supplies under the newborn’s Medicaid ID.</td>
</tr>
</tbody>
</table>

*CHIP Perinatal members with household incomes at or below 198% FPL must apply for emergency Medicaid coverage for labor and delivery services. HHSC mails the pregnant woman an emergency Medicaid application 30 days before her reported due date. When emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

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