2025 Care Provider Manual

Physician, Care Provider, Facility and Ancillary Care Provider Manual

Texas

CHIP: Harris, Jefferson, and Nueces
STAR: Harris, Hidalgo, Jefferson, and Nueces
STAR Kids: Harris, Hidalgo, and Jefferson, as well as Medicaid Rural Service Area (MRSA) Central and MRSA Northeast
STAR+PLUS: Bexar, Dallas, Harris, Hidalgo, Tarrant and Travis, as well as MRSA Central and MRSA Northeast
UnitedHealthcare Connected (Medicare-Medicaid Program) (MMP): Harris County

CHIP | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS STAR Kids Your Health Plan ★ Your Choice | TEXAS STAR PLUS Your Health Plan ★ Your Choice | TEXAS Medicare Medicaid PLAN Your Health Plan ★ Your Choice | TEXAS Health and Human Services

Provider Services: **1-888-887-9003**

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UHCprovider.com and
UnitedHealthcare Provider Portal

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United Healthcare® Community Plan

Welcome

Welcome to the UnitedHealthcare Community Plan® care provider manual. This up-to-date reference PDF allows you and your staff to find important information, such as how to process a claim and submit prior authorization requests. It features important phone numbers and websites in the **How to Contact Us** section.

Click to access different care provider manuals

- **Administrative guide** – **UHCprovider.com/guides**
  - Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans), click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **A different Community Plan care provider manual** – **UHCprovider.com/guides**
  - Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on Texas

View the **Medicaid glossary** for definitions of terms commonly used throughout the care provider manuals.

For state specific glossary information, see **Glossary** section of this manual.

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

Using this care provider manual

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it, instead. If there is 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 care provider manual will be amended as policies change.

Participation agreement

Terms and definitions as used in this care provider manual:

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement
- "You," "your" or "care provider" refers to any health care provider subject to this manual, including physicians, clinicians, facilities and ancillary care providers, except when indicated
- "Community Plan" refers to the UnitedHealthcare Medicaid plan
- "Your Agreement," "Provider Agreement" or "Agreement" refers to your Participation Agreement with us
- "Us," "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this care provider manual
- Any reference to "ID card" includes a physical or digital card

Thank you for your participation in our program and the care you offer our members.

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Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com** Live chat available at **UHCprovider.com/contactus**	**1-888-887-9003**
Training	**UHCprovider.com/training**	**1-888-887-9003**
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal** New users: **UHCprovider.com/access**	**1-855-819-5909**
CommunityCare Provider Portal Training	**UnitedHealthcare CommunityCare Provider Portal user guide**	
One Healthcare ID support	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**	**1-855-819-5909**
Resource Library	**UHCprovider.com/resourcelibrary**	
Provider advocate	email: **uhc_cp_prov_relations@uhc.com**	**1-888-303-6162** For help with health plan and care provider coordination

UnitedHealthcare Community Plan of Texas supports increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following members:

- Children and youth, from birth through 18 years of age, eligible for Medicaid
- Pregnant women
- Children eligible for the Children's Health Insurance Program (CHIP)
- Adults who qualify for Texas Medicaid due to chronic conditions and financial eligibility
- Children and young adults through age 20 with disabilities, including those in the Medically Dependent Children Program (MDCP)

Program objectives

The principle objectives of Texas Medicaid managed care are to:

- Emphasize early intervention
- Promote improved access to quality care, thereby significantly improving health outcomes for the target population, with a special focus on pre-natal and well-child care
- Promote member responsibility for their personal health care by helping them choose a health plan and primary care provider (PCP) and by encouraging them to use of 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

Children's Health Insurance Program (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

The State of Texas Access Reform (STAR) Program emphasizes early intervention and promotes improved access to quality care, significantly improving health outcomes for the target populations. The special focus of the STAR Program is on pre-natal and well-child care.

STAR+PLUS

The STAR+PLUS program improves access to care, provides care in the least restrictive setting, and provides 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.

STAR Kids

The STAR Kids program provides Medicaid benefits to children and young adults with disabilities, including those in the Medically Dependent Children Program (MDCP). STAR Kids improves access to care, provides care in the least restrictive setting, and provides more accountability and control on costs. Service coordination is fundamental to managing the complex needs of these members.

The Texas Health and Human Services Commission (HHSC) determines enrollment eligibility of our members.

UnitedHealthcare Connected Medicare-Medicaid plan

UnitedHealthcare Connected serves members who are dually eligible for Medicare and Medicaid within the UnitedHealthcare Connected service area. These members must be eligible and enrolled in Medicare Part A, Medicare Part B and Texas Medicaid.

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com** or call **Provider Services** at **1-888-887-9003**

Program	Service area
Children's Health Insurance Program (CHIP) and CHIP Perinate	Harris, Jefferson, Nueces
State of Texas Access Reform (STAR)	Harris, Hidalgo, Jefferson, Nueces
STAR Kids	Harris, Hidalgo, Jefferson, Medicaid Rural Service Area (MRSA) Central, MRSA Northeast
STAR+PLUS	Bexar, Dallas, Harris, Hidalgo, Tarrant, and Travis, as well as MRSA Central and MRSA Northeast
UnitedHealthcare Connected (MMP)	Harris County only

How to join our network

Learn how to join the UnitedHealthcare Community Plan care provider network at **UHCprovider.com/join**. There you will find guidance on our credentialing process, how to sign up for self-service and other helpful information.

Already in network and need to make a change?

To change an address or phone number, add or remove physicians from your TIN, or make other changes, go to My Practice Profile at **UHCprovider.com/attestation**.

Approach to health care

Care Model

The Care Model program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, care providers and our community to improve care coordination and elevate outcomes. Targeting UnitedHealthcare Community Plan members with chronic complex conditions who often use health care, the program helps address their needs holistically. Care Model examines medical, behavioral and social/environmental concerns to help members get the right care from the right care provider in the right place and at the right time.

The program provides interventions to members with complex medical, behavioral, social, pharmacy and specialty needs, resulting in better quality of life, improved access to health care and reduced expenses. Care Model provides a care management/coordination team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan serves. Care Model provides:

- Market-specific care management encompassing medical, behavioral and social care
- Extended care team including primary care provider PCP, pharmacist, medical and behavioral director, and peer special
- Engage members, connecting them to needed resources, care and service
- Individualized and multidisciplinary care plan
- Assistance with appointments with PCP and coordinating appointments. The Clinical Care Team refers members to a specialist as required for complex needs.
- Education and support with complex condition.
- Tools for helping members engage with care providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage members

The goals of the Care Model program are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames
- Identify and discuss behavioral health needs, measured by number of BH care provider visits within identified time frames
- Improve access to pharmacy
- Identify and remove social and environmental barriers to care
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics
- Empower the member to manage their complex/chronic illness or problem and care transitions
- Improve coordination of care through dedicated staff resources and to meet unique needs
- Engage community care and care provider networks to help ensure access to affordable care and the appropriate use of services

To refer your patient who is a UnitedHealthcare Community Plan member to the Care Model program, call **Provider Services** at **1-888-887-9003** or the number that is on the back of the member's ID card

Compliance

HIPAA mandates National Provider Identifier (NPI) usage in all standard transactions (claims, eligibility, remittance advice, claims status request/response, and authorization request/response) for all health care providers who handle business electronically.

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support UnitedHealthcare Community Plan's Cultural Competency Program. For more information, go to **UHCprovider.com/resourcelibrary** > Health Equity Resources > **Cultural Competency**.

- **Cultural competency training and education**

  Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources.

  Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.

UnitedHealthcare Community Plan provides the following:

- **Language interpretation line**
  - We provide oral interpreter services Monday–Friday from 8 a.m.–8 p.m. ET
  - To arrange for interpreter services, please call **1-877-842-3210** TTY **711**
  - **I Speak language assistance card**

  This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.
- **Materials for limited English-speaking members**

  We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

For more information, go to **uhc.com** > **Language Assistance**.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual ® for medical care determinations.

Network management department

Within UnitedHealthcare Community Plan, the Network management department can help you with your contract, credentialing and in-network services. The department has network account managers and provider advocates who are available for visits, contracting, credentialing and other related issues.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster.

Learn the differences by viewing the **digital solutions comparison guide**.

This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents. This includes appeals prior authorization requests and decisions. Using electronic transactions is fast and efficient and supports a paperless work environment. Use Application Programming Interface (API), electronic data interchange (EDI) or the UnitedHealthcare Provider Portal for maximum efficiency in conducting business electronically.

You may find additional guidance in the program-specific provider manuals. Go to **UHCprovider.com/manuals** > Texas > CHIP, STAR, and STAR+PLUS Provider Administrative Manual or the Nursing Facility Provider Manual. Within 5 days of inclusion into our network, we will notify new care providers how to find and access this care provider manual. 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 at **UHCprovider.com/manuals** > UnitedHealthcare Administrative Guide.

Application Programming Interface

Application programming interface (API) is a free digital solution that allows health care professionals to automate administrative transactions. API is designed to help your organization improve efficiency, reduce costs and increase cash flow. Automatic data feeds are created to share information between your organization and UnitedHealthcare on a timetable you set, and transfer the data to your practice management

system, proprietary software, portal, spreadsheets or any application you prefer.

This can help you create a smoother workflow with fewer interruptions. We have API functionality for many of your day-to-day transactions. For more information, visit **UHCprovider.com/api**.

Electronic Data Interchange

Electronic data interchange (EDI) is an online resource using your internal practice management or hospital information system to exchange transactions with us through a clearinghouse.

The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging into different payer websites to manually request information. This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions.

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses
- EDI transactions available to care providers are:
  - Claims (837),
  - Eligibility and benefits (270/271),
  - Claims status (276/277),
  - Referrals and authorizations (278),
  - Hospital admission notifications (278N), and
  - Electronic remittance advice (ERA/835)

Visit **UHCprovider.com/edi** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/optimizeedi.**

Getting Started

- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system
- Contact clearinghouses to review which electronic transactions can interact with your software system

Read our **Clearinghouse Options** page for more information.

Point of Care Assist

When made available by UnitedHealthcare Community Plan, you will do business with us electronically. Point of Care Assist® integrates members' UnitedHealthcare health data within the Electronic Medical Record (EMR) to provide real-time insights of their care needs, aligned to their specific member benefits and costs. This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to **UHCprovider.com/poca**.

UHCprovider.com

This **public website** is available 24/7 and does not require registration to access. You'll find valuable resources including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.

UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal.**

You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information – all at no cost without calling.

See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

- If you already have a One Healthcare ID, simply go to the **UnitedHealthcare Provider Portal** to access
- If you need to set up an account on the portal, follow **these steps** to register
- **Eligibility and benefits**

  View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims**

  Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **Prior authorization and notification**

Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/priorauth**.

- **Specialty pharmacy transactions**
  Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile**
  View and update your provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **Document Library** Access reports and claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, and can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.

See **UnitedHealthcare Provider Portal** to learn more about the available self-paced user guides for various tools/tasks.

Direct Connect

Direct Connect is a free online portal that lets you securely communicate with payers to address errant claims. This portal can replace previous methods of letters, faxes, phone calls and spreadsheets. It also helps:

- Manage overpayments in a controlled process
- Create a transparent view between care provider and payer
- Avoid duplicate recoupment and returned checks
- Decrease resolution timeframes
- Real-time reporting to track statuses of inventories in resolution process
- Provide control over financial resolution methods

All users will access Direct Connect using the **UnitedHealthcare Provider Portal**. On-site and online training are available.

Email **directconnectsupport@optum.com** to get started with Direct Connect.

Privileges

To help our members access appropriate care and minimize out-of-pocket costs, primary care providers and specialists must have privileges at applicable in-network facilities or arrangements with an in-network care provider to admit and provide facility services. This includes full admitting hospital privileges, ambulatory surgery center privileges and/or dialysis center privileges.

Provider Services

Provider Services is the primary contact for care providers who need help. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan.

Provider Services at **1-888-887-9003** works closely with all departments in UnitedHealthcare Community Plan and can answer your questions about Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more.

How to contact us

Topic	Contact	Information
Behavioral, mental health & substance use disorder	Optum® **providerexpress.com** **1-877-614-0484** Claims mailing address: **Optum Behavioral Health** P.O. Box 30660 Salt Lake City, UT 84130-0760	Eligibility, claims, benefits, authorization, and appeals. Refer members for behavioral health services. A PCP referral is not required.
Benefits	**UHCprovider.com/benefits** **1-888-887-9003**	Confirm a member's benefits and/or prior authorization.
Cardiology prior authorization	**UHCprovider.com/cardiology** > Sign In **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Care model (care management/disease management)	CHIP & STAR: **1-888-887-9003** STAR Kids: **1-877-352-7798** STAR+PLUS: **1-800-349-0550**	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
Claims	**UHCprovider.com/claims** **1-888-887-9003** Mailing address: **UnitedHealthcare Community Plan STAR and CHIP** P.O. Box 5270 Kingston, NY 12402-5270 **UnitedHealthcare Community Plan STAR+PLUS** and **UnitedHealthcare Connected (MMP)** P.O. Box 31352 Salt Lake City, UT 84131-0352 **UnitedHealthcare Community Plan STAR Kids** P.O. Box 5290 Kingston, NY 12402-5290	Verify a claim status or get information about proper completion or submission of claims.
Electronic billing (code: 87726) (MMP)	**UHCprovider.com** > **Claims & Payments** Help desk: **1-866-842-3278**	
Medical and LTSS paper claims (MMP)	**UnitedHealthcare Connected** P.O. Box 31352 Salt Lake City, UT 84131-0352	

Topic	Contact	Information
Claim overpayments	Sign in to **UHCprovider.com/claims** to access the UnitedHealthcare Provider Portal. **1-800-727-6735** Mailing address: **UnitedHealthcare Community Plan** Attn: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments. See the **Overpayment** section for requirements before sending your request. **Provider Services** line is available 7:30 a.m. to 5:00 p.m. CT, Monday-Friday.
Dental	1-877-378-5301	**Provider Services** line is available 8:00 a.m. to 5:00 p.m. CT, Monday-Friday.
Early childhood intervention (ECI)	1-800-628-5115	
Electronic data intake (EDI) issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions
Electronic visit verification	**1-888-787-4107**	**UHCprovider.com/evv**
Eligibility	To access eligibility information: **UHCprovider.com/eligibility** **1-888-887-9003**	Confirm member eligibility.
Fraud, waste and abuse (payment integrity	Payment integrity information: **UHCprovider.com/TXcommunityplan** > Integrity of Claims, Reports, and Representations to the Government Reporting: **uhc.com/fraud** **1-844-359-7736** or **1-877-401-9430** Office of Inspector General: 1-800-436-6184 https://oig.hhs.texas.gov/report-fraud-waste-or-abuse	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Laboratory services	**UHCprovider.com/findprovider** > **Preferred Lab Network** Labcorp 1-800-833-3984 Quest Diagnostics: 1-866-697-8378	Labcorp and/or Quest Diagnostics are network laboratories. Certain lab work for Texas Health Steps must be submitted through the Department of State Health Services Lab.
Medicaid [Texas Medicaid & Healthcare Partnership (TMHP)]	Medicaid.gov TMHP.com	Contact Medicaid directly.

Topic	Contact	Information
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** **1-888-887-9003** Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations and appeals, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at one of the following addresses: Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 Appeals mailing address: **UnitedHealthcare Community Plan** **Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	CHIP, STAR, STAR+PLUS: **1-888-887-9003** STAR Kids: **1-866-919-4381** MMP: **1-800-256-6533** TTY **711**	Helps assist members with issues or concerns. Available 7 a.m.–7 p.m. CT, Monday-Friday 8 a.m. – 8 p.m. (CHIP, STAR, STAR+PLUS) 8 a.m. – 5 p.m. (STAR Kids) 8 a.m. – 8 p.m. (MMP)
Member appeals (Medicare-Medicaid Plan)	Part C & D grievances and Part C appeals: **UnitedHealthcare Community Plan** **Attn: Complaint and Appeals Department** P.O. Box 31364 Salt Lake City, UT 84131- 0364 Part D appeals **UnitedHealthcare Community Plan** **Attn: Part D Standard Appeals** P.O. Box 6103 Cypress, CA 90630- 9998	
Multilingual/ telecommunication device for the deaf (TDD) services	**1-888-887-9003** TDD **711**	Available 8 a.m.–5 p.m. CT, Monday-Friday, except state-designated holidays.
National Credentialing Center (VETTS line)	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**	Self-service functionality to update or check credentialing information.

Topic	Contact	Information
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203	Apply for a National Provider Identifier (NPI).
Network management	**UHCprovider.com/findprovider**	A team of provider relation advocates. Ask about contracting and care provider services.
Network management support	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**	Self-service functionality for medical network care providers to update or check credentialing information.
NurseLine	CHIP: **1-800-850-1267** STAR: **1-800-535-6714** STAR Kids: **1-844-222-7326** STAR+PLUS: **1-877-839-5407** UnitedHealthcare Connected (Medicare-Medicaid Plan): **1-877-303-2422** Dual Eligible members: **1-877-596-3258**	Available 24 hours a day, 7 days a week.
Obstetrics/pregnancy and baby care	Healthy First Steps® Pregnancy Notification Form at **UHCprovider.com**, then Sign In for the UnitedHealthcare Provider Portal. **1-800-599-5985** **uhchealthyfirststeps.com**	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer members to **uhchealthyfirststeps.com** to sign up for Healthy First Steps Rewards.
Oncology prior authorization	**UHCprovider.com/oncology** **1-888-397-8129** Monday–Friday 7 a.m.–7 p.m. CT	For current list of CPT codes that require prior authorization for oncology
OneHealthcare ID support center	Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat** **1-855-819-5909**	Contact if you have issues with your ID. Available 7 a.m.–9 p.m. CT, Monday–Friday 6 a.m.–6 p.m. CT, Saturday 9 a.m.–6 p.m. CT, Sunday
Pharmacy services	**professionals.optumrx.com** **1-877-305-8952** MMP: **1-800-711-4555** (urgent) Pharmacists MMP **1-877-889-6510** Pharmacy mail order MMP **1-877-889-5802**	Optum Rx ® oversees and manages our network pharmacies, and supports prescribing care providers.

Topic	Contact	Information
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** **1-800-310-6826** **1-800-711-4555** (urgent)	Request authorization for medications as required. Use the UnitedHealthcare Provider Portal to access the PreCheck MyScript® tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred Check coverage and price, including lower-cost alternatives.
Prior authorization requests/ advanced and admission notification	To notify us or request a medical prior authorization: • EDI: Transactions 278 and 278N • **UHCprovider.com/priorauth** Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications."	Use the **Prior Authorization and Notification Tool** online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status Information and advance notification/ prior authorization lists: **UHCprovider.com/ TXCommunityplan** > Prior Authorization and Notification.
Provider complaints (MMP)	**UnitedHealthcare Connected** P.O. Box 31364 Salt Lake City, UT 84131-0364	
Provider Services	**UHCprovider.com/TXCommunityPlan** **1-888-887-9003**	Available 8 a.m. - 6 p.m. CT, Monday-Friday.
Provider Services (MMP)	**1-888-887-9003**	Available 8 a.m. - 6 p.m., Monday-Friday.
Radiology prior authorization	**UHCprovider.com/radiology** > Sign In **1-866-889-8054**	TX CHIP STAR PLUS Kidseview or request prior authorization, see basic requirements, guidelines, CPT code list and more information.
Referrals	**UHCprovider.com/referrals** Provider Services **1-888-887-9003**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/TXCommunityPlan** > **Policies and Protocols**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.

Topic	Contact	Information
STAR migrant farmworkers	**1-888-887-9003** email: **uhctxstaraapca@uhc.com**	Please report any health plan members that you identify as children of migrant farmworkers.
STAR and CHIP members with special healthcare needs	**1-888-887-9003** email: **uhctxstaraapca@uhc.com**	To refer a member who might qualify as having special health care needs.
Technical support	**UHCprovider.com/contactus** Chat with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. **1-866-209-9320** for Optum support or **1-866-842-3278**, Option 1 for web support	Call if you have issues logging in to the **UnitedHealthcare Provider Portal**, you cannot submit a form, etc.
Texas Vaccines for Children (TVFC) Program	**UHCprovider.com/contactus** Chat with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**	Care providers must participate in the TVFC Program administered by the Department of Health and Senior Services (DHSS) and must use the free vaccine when administering vaccine to qualified eligible children. Providers must enroll as TVFC providers with DHSS to bill for the administration of the vaccine.
Tobacco Free Quit line	**1-866-209-9320** for Optum support or **1-866-842-3278**, Option 1 for web support	Ask about services for quitting tobacco/smoking.
Transportation	ModivCare Members: CHIP, STAR, STAR+PLUS: **1-866-528-0441** STAR Kids: **1-866-529-2117** For providers and facilities: **1-877-564-9835**	To arrange nonemergent transportation, please contact ModivCare at least 3 business days in advance.
Vision Services	1-844-976-2724	Prior authorization is required for all routine eye exams and hardware. Authorizations must be obtained from MARCH® Vision Care. Submit claims directly to your contractor.
Website for Texas Community Plan	**UHCprovider.com/TXCommunityPlan**	Access your state specific Community Plan information on this website.

Chapter 2: Care provider standards & policies

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com**	**1-888-887-9003**
General care provider assistance	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**	
Eligibility	**UHCprovider.com/eligibility**	**1-888-887-9003**
Referrals	**UHCprovider.com/referrals**	**1-888-887-9003**
Provider Directory	**UHCprovider.com/findprovider**	**1-888-887-9003**

General care provider responsibilities

Refer to your UnitedHealthcare Community Plan Network Participation Agreement (Texas Medicaid and CHIP Program Regulatory Requirement Appendix) for a full list of your responsibilities.

Non-discrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them solely based on age, sex, race, physical or mental handicap, national origin, religion, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members as patients or with UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

UnitedHealthcare Community Plan members and/or their representative(s) may take part in the planning and implementation of their care. To help ensure members and/or their representative(s) have this chance, UnitedHealthcare Community Plan requires you:

1. Educate members, and/or their representative(s) about their health needs.
2. Share findings of history and physical exams.
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.
4. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care manager in developing a specific care plan for members enrolled in High Risk Care Management.

Care provider compliance to standards of care Medicare-Medicaid plan

You must comply with the UnitedHealthcare Community Plan and payer's protocols, including those contained in this care provider manual. You may view protocols at **UHCprovider.com/protocols.**

UnitedHealthcare Connected participating care providers must comply with all applicable laws and licensing requirements. In addition, participating care providers must offer covered services in a manner consistent with standards related to generally accepted medical and surgical practices at the time of treatment. Participating care providers must also comply with UnitedHealthcare Connected standards, which include but are not limited to:

- Guidelines established by the federal Center for Disease Control (CDC) or any successor entity
- All federal, state and local laws regarding the conduct of their profession

Participating care providers must also comply with UnitedHealthcare Connected policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and cost of care
- Prior authorization requirements and time frames
- Credentialing requirements
- Referral policies
- Care management program referrals
- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of member medical record information to fulfill the business and clinical needs of UnitedHealthcare Connected
- Cooperating with efforts to assure appropriate levels of care
- Maintaining a mutual and professional relationship with UnitedHealthcare Connected personnel and fellow participating care providers
- Providing equal access and treatment to all Medicare and Medicaid members

Marketing

CHIP and Medicaid care providers are required to comply with the following HHSC marketing policies:

1. Care providers can tell their patients about the CHIP and Medicaid programs in which they participate.
2. Care providers may inform their patients of the benefits, services, and specialty care services offered through managed care programs in which they participate. However, providers must not recommend one managed care organization (MCO) over another, offer patients incentives to select one MCO over another, or assist the patient in deciding to select a specific MCO.
3. At the patients' request, providers may give patients the information necessary to contact a particular MCO or refer the patient to an MCO member orientation.
4. Care providers must distribute or display health-related materials for all contracted MCOs or choose not to distribute or display for any contracted MCO. Materials must follow these guidelines:
   - **a.** Health-related posters cannot be larger than 16" x 24".
   - **b.** Health-related materials may have the MCO's name, logo, and contact information.
   - **c.** Care providers are not required to distribute or display all health-related materials provided by each MCO with whom they contract. A care provider can choose which items to distribute or display as long as the care provider distributes or displays one or more items from each contracted MCO that distributes items to the care provider and the care provider does not give the appearance of supporting one MCO over another.
5. Care providers must display stickers submitted by all contracted MCOs or choose not to display stickers for any contracted MCOs. MCO stickers indicating the care provider participates with a particular MCO cannot be larger than 5" x 7" and cannot indicate anything more than "MCO is accepted or welcomed here." Care providers may choose whether to display items such as children's books, coloring books, and pencils provided by each contracted MCO. Care providers can choose which items to display as long as they display one or more from each contracted MCO. Items may only be displayed in common areas.
6. Care providers may distribute applications to families of uninsured children and assist with completing the application.
7. Care providers may direct patients to enroll in the CHIP and Medicaid Managed Care Programs by calling the Medicaid Helpline at 1-800-335-8957 or visiting www.yourtexasbenefits.com.
8. Bargains, premiums, or other considerations on prescriptions may not be advertised in any manner in order to influence a member's choice of pharmacy or promote the volume of prescriptions provided by the pharmacy. Advertisement may only convey participation in the program.

UnitedHealthcare Connected (MMP) care providers may not develop and use any materials that market UnitedHealthcare Connected (MMP) without the

prior approval of UnitedHealthcare Connected in compliance with Medicare Advantage requirements. UnitedHealthcare Connected will not prohibit you from informing members of your affiliation or change in affiliation.

Tell our members about the benefits, services and specialty care services offered through UnitedHealthcare Connected. However, you may not recommend one managed care organization (MCO) over another, offer patients incentives to select one MCO over another or help select a specific MCO. For more information, see the HHSC Uniform Managed Care contract at hhs.texas.gov > Services > Health > Medicaid & CHIP > Managed Care Contract Management > Uniform Managed Care Contract. Also look in the UnitedHealthcare Community Plan contract amendment to serve Medicaid members.

A gift of minimal value may be exchanged with a vendor or business associate if it is a common business courtesy, such as coffee or a similar token. However, even small gifts to government officials are prohibited under most circumstances. If you have questions about whether you can accept a small gift from a member, go to oig.hhs.gov > Compliance > Special Fraud Alerts, Bulletins, and Other Guidance > Other Guidance > Policy Statement Regarding Gifts of Nominal Value To Medicare and Medicaid Beneficiaries.

Provide official notice

Write to us within 10 calendar days if any of the following events happen:

1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.
4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.
7. Material changes in, cancellation or termination of liability insurance.

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate. **Provider Services** is available to help you and our members with the transition.

Care provider plan termination

UnitedHealthcare Community Plan can immediately terminate a care provider contract with no recourse of an Advisory Review Panel in the event of imminent harm of member health, actions against a license or the practice of fraud or malfeasance.

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

Members requiring service provision beyond the termination date should be referred to another in-network care provider, and that referral completed before 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 care provider.

Notification to members of care provider termination Medicare-Medicaid plan

If the subcontractor involved is a PCP, UnitedHealthcare Connected must notify, in writing, all members who use the subcontractor as a PCP. Notice will be sent at least 45 days prior to the termination of the care provider.

If UnitedHealthcare Connected receives less than 45 days notice, UnitedHealthcare Connected will issue the notice within 1 business day of becoming aware of the PCP's termination.

Transfer and termination of members from participating care provider's panel

UnitedHealthcare Connected members have the right to privacy and confidentiality regarding their health care records and information in accordance with the UnitedHealthcare Connected program. Participating care providers and each staff member will sign an Employee Confidentiality Statement to be placed in the staff member's personnel file.

UnitedHealthcare Connected will determine reasonable cause for a transfer based on written documentation submitted by the PCP. PCPs may not transfer a member to another PCP due to the costs associated with the member's covered services.

PCPs may request termination of a member due to fraud, disruption of medical services or repeated failure to make the required reimbursements for services.

Closing of care provider panel

When closing a practice to new UnitedHealthcare Connected members or other new patients, you are expected to:

- Give UnitedHealthcare Connected prior written notice that the practice will be closing to new members as of the specified date
- Keep the practice open to UnitedHealthcare Connected members who were members before the practice closed
- Uniformly close the practice to all new patients including private payers, commercial or governmental insurers.
- Give UnitedHealthcare Connected prior written notice of the reopening of the practice, including a specified effective date

Out-of-network care providers delivering care

When a member changes MCOs, they may continue to receive previously authorized services from their current care provider, even if that care provider is out-of-network. This can happen until the care provider becomes in-network or we are able to assess the member and create a new person-centered service plan of care that includes services from an in-network care provider.

Members who, at the time of enrollment into UnitedHealthcare Community Plan, are diagnosed with and receiving treatment for a terminal illness may remain with their established care provider, even if that care provider is out-of-network.

Members may receive services from an out-of-network care provider on a case-by-case basis when medically necessary, if covered services are not available from an available in-network care provider.

If you are unable to secure an appropriate referral, please call **Provider Services** at **1-888-887-9003** to aid in the member's transfer.

Selection and retention of participating care providers

The UnitedHealthcare Community Plan of Texas is responsible for arranging covered services provided to thousands of members through a comprehensive care provider network of independent practitioners and facilities that contract with UnitedHealthcare Community Plan.

The network includes health care professionals, such as PCPs, specialist physicians, medical facilities, allied health professionals and ancillary providers.

The UnitedHealthcare Community Plan of Texas network has been carefully developed to include those participating health care professionals who meet certain criteria, such as availability, geographic service area, specialty, hospital privileges, quality of care and acceptance of our managed care principles and financial considerations.

UnitedHealthcare Community Plan of Texas continuously reviews and evaluates participating care provider information and recredentials you every 3 years. The credentialing guidelines are subject to change based on industry requirements and our standards.

Arrange substitute coverage

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare

Community Plan care provider. For the most current list of network professionals, review our Provider Directory at **UHCprovider.com/findprovider**.

Administrative terminations for inactivity

Up-to-date directories are a critical part of providing our members with the information they need to take care of their health. To accurately list care providers who treat UnitedHealthcare Community Plan members, we:

1. End Agreements with care providers who have not submitted claims for UnitedHealthcare Community Plan members for one year and have voluntarily stopped participation in our network.
2. Inactivate any tax identification numbers (TINs) with no claims submitted for one year. This is not a termination of the Provider Agreement. Call UnitedHealthcare Community Plan to reactivate a TIN.

Changing an existing TIN or adding a health care provider

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Updating your practice or facility information

You can update your practice information through the UnitedHealthcare Provider Portal on **UHCprovider.com**. Go to **UHCprovider.com**, then Sign In > My Practice Profile. Or submit your change by:

- Visiting **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data electronically
- Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**
- Visit TMHP.com > Providers > select My Account and log in to update your profile

Changes involving identification numbers, such as tax identification numbers, or a name need to be submitted to TMHP using a Provider Information Change Form.

Mail the completed form to:

TMHP Provider Enrollment
P.O. Box 200795
Austin, TX 78720-0795

Texas Medicaid providers are required to re-validate their enrollment in Texas Medicaid every 3 or 5 years, depending on care 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 1-800-925-9126, Option 3.

After-hours care

Life-threatening situations require the immediate services of an emergency department. Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu.

You must follow the minimum requirements outlined in your contract with Texas HHSC:

- Your office phone is accessible 24 hours a day
- The office telephone is answered after-hours by an answering service that meets language requirements of the Major Population Groups and that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
- The office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the Member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable
- The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, or another designated medical provider, who can return the call within 30 minutes

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

- Office phone is only answered during office hours
- Office phone is answered after hours by a recording directing members to leave a message, text, page, or go to an ER for services without providing an option to contact the care provider
- Returning after-hours calls outside of the 30-minute timeframe

If a member calls you after hours asking about urgent care, and you can't fit them in your schedule, refer them to an urgent care center.

Participate in quality initiatives

You must help our quality assessment and improvement activities. You must also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by United States government agencies and professional specialty societies.

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud, waste and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 6 years or longer if required by applicable statutes or regulations.

Performance data

You must allow the plan to use care provider performance data.

Care provider evaluation Medicare-Medicaid plan

When evaluating the performance of a participating care provider, UnitedHealthcare Connected reviews the following areas:

- **Quality of care** - Measured by clinical data related to the appropriateness of member care and member outcomes
- **Efficiency of care** - Measured by clinical and financial data related to a member's health care costs
- **Member satisfaction** - Measured by the members' reports regarding accessibility, quality of health care, member-care provider relations and the comfort of the practice setting
- **Administrative requirements** - Measured by the care provider's methods and systems for keeping records and transmitting information
- **Participation in clinical standards** - Measured by the care provider's involvement with panels used to monitor quality of care standards

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

Coordination with Texas Department of Family and Protective Services

You must coordinate with the Texas Department of Family and Protective Services (DFPS) and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS. You must respond to DFPS requests, including providing medical records, recognition and appropriate referral to DFPS of abuse and neglect.

Inform members of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to members on state law about advance treatment directives, about members' right to accept or refuse treatment, and about your own policies regarding advance directives. To comply with this requirement, we inform members of state laws on advance directives through Member Handbooks and other communications.

Your agreement

If you have a concern about your Agreement with us, send a letter with the details to the address in your contract. A representative will look into your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the Member's Handbook at **UHCCommunityPlan.com/TX** > select a plan > Member handbook.

Also reference Chapter 13 of this manual for information on provider claim reconsiderations, appeals, and grievances.

Arbitration Medicare-Medicaid plan

Any arbitration proceeding under your agreement will be conducted in Texas under the auspices of the American Arbitration Association (AAA), as further described in our agreement.

For more information on the AAA guidelines, go to adr.org.

Appointment standards (access and availability standards)

Office hours

Provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

Comply with the appointment availability standards on the following page.

Pregnant members

You are required to call us immediately at **1-888-887-9003** when a pregnant CHIP, STAR, STAR Kids or STAR+PLUS member is identified. For complete information on appointment availability and access to care standards, go to **UHCprovider.com/TXcommunityplan** > Reference Guides and Value Added Services > Texas Community Plan Access and Availability Standards Quick Reference Guide.

Appointment availability: Access to care standards

These timelines show the calendar days from which our members need to be seen from the point of calling or otherwise making contact with you. Some appointment needs are based on conditions the following conditions:

Condition	Condition description	Details	Timeframe
Annual wellness	Preventive health care (Annual wellness exam for CHIP, STAR+PLUS [age 21 and older] and MMP as well as for sick visits for all members.)	Adults 21 and over	90 days
		• Children/youth 6 months through 20	60 days
		STAR Kids members	14 days
		• Children less than 6 months	14 days
		Newborn	No more than 7 days from birth
		Initial appointment (Member with high risk pregnancy and/or new to health plan need to be seen within 5 days. In case of an emergency, members need to be seen immediately for treatment.)	14 days
	Pre- and post-natal (Changes may apply due to medical necessity; see contract for details.)	First 28 weeks of pregnancy or 28-36 weeks of pregnancy	One visit every 4 weeks or one visit every 2-3 weeks
		36 weeks until delivery	One visit per week
		2 mom postpartum visits	Within 60 days of birth
		Newborn members new to our health plan	Within 14 days of enrollment
	Texas Health Steps (THSteps) Early and periodic screening diagnosis and testing (EPSDT) for STAR, STAR Kids, STAR+PLUS members through age 20 Not sure when your patient needs a THSteps medical checkup? You may contact the Texas Medicaid & Healthcare Partnership at tmhp.com or call 1-800-925-9126 to verify that the client is due for a checkup.	• Newborn • Newborn–5 days Weeks 2, 4, 6, 9, 12, 15, 18, 24 and 30	These checkups are timely if received within 60 days beyond the periodic due date based on the members birth date.
		• STAR Kids less than 6 months	14 within days
		Ages 3 through 20	Annually – within 364 calendar days after the child's birthday in a non-leap year. (365 calendar days after the child's birthday in a leap year.)
		*STAR Kids less than 6 months	
		New members through age 20 other than newborns	Within 90 days from enrollment
		Initial visit for most members (with any referral from PCP to be made within 5 days from awareness of need for referral.)	21 days

Condition	Condition description	Details	Timeframe
Specialists		Initial visit for STAR Kids members	14 days (with any referral from PCP to be made within 5 days from awareness of need for referral.)
	Behavioral health clinician	When a member is discharged from an inpatient stay for mental health or substance use disorder treatment. (Excludes CHIP Perinate) Initial outpatient visit and routine care (excludes CHIP Perinate)	7 days from discharge date. Timeframe: Within 14 days (Any PCP referral must be made to the specialist on a timely basis, based on the urgency of the Member's medical condition, but no later than 5 days after the PCP identifies the need for the care.)
	Case management for children and pregnant women	Medicaid members with medical-related needs that might affect their health care may be eligible for this assistance if they are either: • A child through age 20 with a health condition or health risk. • A woman of any age who has a high-risk pregnancy.	Within 14 days.
	Long-Term Services and Supports (LTSS) Including mental health or substance use disorder crisis.	When it is determined by the person-centered treatment team that these services are necessary to help members stay in their home.	7 days from the start date in the member's individualized service plan, unless otherwise stated.
	Specialists may include providers such as pediatric cardiologists, neurologists and vision and dental care providers.	Members can self-refer.	21 days (Any PCP referral must be made to the specialist on a timely basis, based on the urgency of the Member's medical condition, but no later than 5 days after the PCP identifies the need for the care.)
	Specialty care providers for occupational, physical and speech therapies.	Any medically necessary evaluation or assessment required for authorization of services should be scheduled to allow the actual specialty therapy services to begin within 21 days from date of request for services.	Within 21 days of referral for therapy to begin.
Urgent	A condition so severe or painful enough that requires medical treatment or evaluation within 24 hours to prevent serious deterioration.	Includes mental health or substance use disorder crisis.	Within 24 hours.
Emergency	A condition with acute symptoms the severity of which could cause serious impairment of body or organ functions, in whole or in part.	Includes mental health or substance use disorder crisis.	Immediately upon presentation.

Provider directory and your contact information

You are required to tell us, within 5 business days, if there are any changes to your ability to accept new patients. If a member, or potential member, contacts you, and you are no longer accepting new patients, report any inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional assistance in finding a care provider.

We are required to contact all participating care providers annually and independent physicians every 6 months. We require you to confirm your information is accurate or provide us with applicable changes.

If we do not receive a response from you within 30 business days, we have an additional 15 business days to contact you. If these attempts are unsuccessful, we notify you that if you continue to be non-responsive we will remove you from our care provider directory after 10 business days.

If we receive notification the directory information is inaccurate, you may be subject to corrective action.

In addition to outreach for annual or bi-annual attestations, we are required to make outreach if we receive a report of incorrect provider information. We are required to confirm your information. You must also make sure the information matches what is on record with TMHP. To update your information, use the Provider Enrollment Management System (PEMS) at tmhp.com > Provider Enrollment > PEMS > File Maintenance.

To help ensure we have your most current information:

- **Delegated care providers** – submit changes to your designated submission pathway
- **Nondelegated care providers** – visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data

Find the medical, dental and mental health care provider directory at **UHCprovider.com/findprovider.**

Care provider attestation

Confirm your data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-888-887-9003.** If you have received the upgraded My Practice Profile and have editing rights, access the **UnitedHealthcare Provider Portal** for My Practice Profile to make many of the updates required in this section.

When you submit demographic updates, list only those addresses where a member may make an appointment and see the health care provider. On-call and substitute health care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

Prior authorization request

Prior authorization request is the process of requesting approval from UnitedHealthcare Community Plan to cover costs. Prior authorization is one of the tools we use to monitor the medical necessity and cost-effectiveness of the health care members receive. Prior authorization requests may include procedures, services, and/or medication. To see the list, go to **UHCprovider.com/TXCommunityPlan** > Prior Authorizations and Notifications > **Prior Authorization Requirements.**

Coverage may only be provided if the service or medication is deemed medically necessary, or meets specific requirements provided in the benefit plan.

For MMP, you are required to comply with UnitedHealthcare Connected prior authorization policies and procedures. Non-compliance may result in delay or denial of reimbursement. Because the PCP coordinates most services provided to a member, they usually initiate requests for prior authorization. However, specialists and ancillary care providers may also request prior authorization for services within their specialty areas.

Take the following steps before providing medical services and/or medication to UnitedHealthcare Community Plan members:

- Verify eligibility using the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-888-887-9003**. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- UnitedHealthcare Connected uses medical review criteria based on CMS/Medicaid program requirements, applicable policies and procedures, contracts and law.
- Get prior authorization from the **UnitedHealthcare Provider Portal**:
  1. To access the Prior Authorization app, go to **UHCprovider.com**, then Sign In.
  2. Select the **Prior Authorization and Notification app.**

3. View notification requirements.
4. Request prior authorization via phone by calling the number on the back of the member's ID card.
5. Find the Texas Standard Prior Authorization Request Form for Health Services at **UHCprovider.com/TXCommunityPlan** > Prior Authorization and Notification > Prior Authorization Forms and Documentation Supporting Medical Necessity > Texas Standard Prior Authorization Request Form for Health Services.
6. Find other pharmacy forms at **UHCprovider.com/TXCommunityPlan** > **Pharmacy Resources and Physician-Administered Drugs**
7. Long-Term Services and Supports (LTSS) authorizations cannot be requested, but can be secured by the person-centered care planning service coordinator.
8. Identify and bill other insurance carriers when appropriate and verify other insurance for coordination of benefits.

If you have questions, please call UnitedHealthcare Web Support at **1-866-842-3278**, option 3, 7 a.m. – 9 p.m. CT, Monday-Friday.

Denial of requests for prior authorization

Denials of authorization requests occur only after a UnitedHealthcare Connected medical director has reviewed the request. A UnitedHealthcare Connected medical director is always available to speak to you and review a request.

Prior authorization request are often denied due to lack of medical documentation. You are encouraged to call or submit additional information for reconsideration. If more information is requested and not received within 5 business days, the request is denied.

The prior authorization department, under the direction of licensed nurses and medical directors, documents and evaluates requests for authorization. This includes:

- Verification that the member is enrolled with UnitedHealthcare Connected at the time of the request for authorization and on each date of service
- Verification that the requested service is a covered benefit for the member
- Assessment of the requested service's medical necessity and appropriateness
- UnitedHealthcare Connected medical review criteria based on CMS/Medicaid program requirements, applicable policies and procedures, contracts and law
- Verification that the service is being provided by a PCP and in the appropriate setting
- Verification of other insurance for coordination of benefits

Culturally considerate care

Everyone has the right to receive culturally and linguistically appropriate services (CLAS). The care delivered needs to be respectful of the person's beliefs, practices and unique needs. For more information, including national standards and training, visit thinkculturalhealth.hhs.gov.

Timeliness standards for notifying members of test results

After receiving results, notify members within:

- Urgent: 24 hours
- Non-urgent: 10 business days

Role and requirements for primary care providers and specialists serving in primary care provider role

Specialists include: internal medicine, pediatrics, or obstetrics/gynecology

The primary care provider PCP led medical home is the base of care for our Texas HHSC programs. The PCP works closely with the member and their family to observe wellness and to anticipate future health care needs. A person-centered approach addresses the varied needs of the patient, and the PCP coordinates referrals and on-going communication any other professionals as necessary to serve the member. This care model entails care that is:

- Accessible
- Continuous
- Comprehensive

- Family-centered
- Coordinated
- Compassionate
- Culturally effective

The PCP plays a vital role by improving health care delivery in 4 critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24 hours a day, 7 days a week coverage and backup coverage when they are not available.

The PCP is responsible for providing or requesting authorization for covered services for members of UnitedHealthcare Connected when an authorization is not otherwise obtained by the member's service coordinator.

PCPs can be medical doctors (M.D.s) and doctors of osteopathy (DOs) from any of the following practice areas:

- General practice
- Internal medicine
- Family practice
- Pediatrics
- Obstetrics/gynecology
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs), and similar community clinics
- Specialist physicians who are willing to contract as a PCP to selected members with special needs and conditions

Additional primary care provider responsibilities

To increase access for members, the Texas Health and Human Services Commission 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 call **Network Services** at **1-866-574-6088** to contract as a primary care provider.

Members may change their assigned primary care provider by contacting **Provider Services** at **1-888-887-9003** any time during the month.

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

Members have the right to designate an OB/GYN as their PCP, as long as the specialist agrees. This PCP designation does not apply to STAR Kids dual eligible members since they do not need a designated PCP.

Members with disabilities, special health care needs, and chronic or complex conditions have the right to designate a specialist as their PCP as long as the specialist agrees. STAR Kids dual-eligible members, who are eligible for both Medicare and Medicaid services, are not required to designate a PCP.

Members with qualifying complex care needs may be assigned a health home. A member may also request a health home responsible for providing comprehensive services and supports, including member service coordination. The difference between a PCP who provides a medical home and a Health Home is that the role of a specially contracted Health Home is to coordinate a comprehensive set of services, including service coordination services.

We ask members who don't select a PCP during enrollment to select one. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process. Members may change their assigned PCP by contacting **Provider Services** at **1-888-887-9003** any time during the month.

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 care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage

will include availability of 24 hours a day, 7 days a week.

During non-office hours, access by telephone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services. The person answering need to be able meet the language requirements of the major population served. All calls answered by an answering service must be returned within 30 minutes by the PCP or other designated medical provider. **Recorded messages are not acceptable.**

Consult with other appropriate health care professionals to develop individualized treatment plans for UnitedHealthcare Community Plan members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing
- Submit all accurately coded claims or encounters timely
- Provide all well baby/well-child services
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a one MD practice and at least 30 hours per week for a two or more MD practice
- Be available to members by telephone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

Responsibilities of primary care providers and specialists serving in primary care provider role

Specialists include internal medicine, pediatrics, and/or obstetrics/gynecology

A PCP may refer a member to a specialist as medically necessary. Specialty care providers deliver covered health services to members in the same manner as offered to other patients. They comply with state regulations and as described in this manual. In addition to general care provider responsibilities, specialty care providers communicate findings, recommendations and treatment information to the member's PCP. The report should be created after the initial assessment and quarterly thereafter.

A specialist may contract as a PCP provided they meet the qualifications and are willing to assume the PCP responsibilities for the member. Members with special health care needs or who are determined to need a course of treatment or regular care monitoring need direct access to a specialist as appropriate for the member's condition and identified needs. Specialists are responsible for coordinating their findings and treatment back to the PCP. Specialists are an integral part of the service coordinated integrated team plan and treatment.

Members with disabilities, special health care needs and chronic or complex conditions may choose a specialist as their PCP as long as the specialist agrees. Members may select and access a network ophthalmologist or therapeutic physician to provide eye health care services other than surgery.

In addition to meeting the requirements for all care providers, PCPs must:

- Maintain current Medicaid enrollment and re-enroll when scheduled at TMHP.com > providers
- Follow member access criteria for care
- Notify us and TMHP of changes to your contact information, such as address, telephone number or group affiliation
- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs. Use nationally recognized clinical practice guidelines. Observe Texas Health Steps for wellness and screening.
- Render services to members who are diagnosed as being infected with the Human Immunodeficiency Virus (HIV) or having Acquired Immune Deficiency
- Syndrome (AIDS) in the same manner and to the same extent as other members, and under the compensation terms set forth in their contract
- Meet all applicable ADA requirements when providing services to members who may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility

- Request prior authorization for applicable services to the Prior Authorization Department, UnitedHealthcare Community Plan, or Pharmacy Department as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether or not a member has an advance directive form.
  - Adhere to advance directives (Patient Self-Determination Act). The federal Patient Self-Determination Act requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult members (age 21 and older) written information about their right to have an advance directive. Advance directives are oral or written statements either outlining a member's choice for medical treatment or naming a person who should make choices if the member loses the ability to make decisions. You must maintain policies and procedures regarding advance directives and document in individual medical records whether they have executed an advanced directive.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Make available and transfer medical records upon request. Provide copies of medical records to members upon request at no charge
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS® or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities Act (ADA) standards
- Complying with the Texas HHSC Access and Availability standards for scheduling emergency urgent care and routine visits. Appointment Standards are covered in **Chapter 2** of this manual.
- Coordinate with non-CHIP covered services (non-capitated services), including Texas agency-administered programs and case management services and essential public health services.

The following providers should see their additional responsibilities in this manual:

- Long-Term Services and Supports in **Chapter 5**
- Community First Choice in **Appendix D**
- Behavioral Health in **Chapter 8**
- Pharmacists in **Chapter 4**

A specialist may apply to be contracted as a PCP by contacting Network management support team at **1-866-574-6088.**

Your contract requirements

One barrier to health care services is when a PCP does not have an adjustable examination table or a Hoyer lift to assist a member dependent on a wheelchair. This prevents the member from getting onto the table for a thorough examination. Your Medicaid contract specifies your obligation to adhere to the ADA to help ensure that all members have access to receive services without physical, communication or practical barriers. Many of our members require special accommodations to access the services they need. See more about the Americans with Disabilities Act at ada.gov > Title III: Materials Specifically for Business and Non-profits. See also at Health and Human Services – hhs.gov > Access to Medical Care for Individuals with Mobility Disabilities.

Rural health clinic, federally qualified health center or primary care clinic

Members may choose a care provider who meets the PCP requirements and performs PCP-type services within a Rural Health Clinic or Federally Qualified Health Center as their PCP.

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be located in rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:

  - Preventive (wellness) health services from a care provider, physician assistant, nurse practitioner and/or social worker
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits
- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a primary care clinic that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Member access to health care guidelines Medicare-Medicaid plan

The following appointment availability goals should be used to help ensure timely access to both medical and behavioral health care:

- Routine follow-up or preventive care – within 30 days
- Routine/symptomatic – within 7 days
- Routine specialty care – 21 days
- Non-urgent care – within 7 days
- Urgently needed services – within 24 hours
- Emergency – immediately

Provide specialty therapy evaluations (e.g., occupational therapy, physical therapy, speech therapy) within 21 days of a signed referral submission. Schedule any additional required evaluations or assessments (e.g., audiology testing) to allow the specialty therapy services evaluation to occur within 21 days of the referral.

Adherence to member access guidelines will be monitored through the office site visits, long-term care visits and the tracking of complaints/complaints related to access and/or discrimination. Variations from the policy will be reviewed by the network management for educational and/or counseling opportunities and tracked for participating care provider re-credentialing. UnitedHealthcare Community Plan/provider coordination of care is something we coordinate directly with you when special or unique member care services are necessary.

All participating care providers and hospitals will treat all UnitedHealthcare Connected members with equal dignity and consideration as their non-UnitedHealthcare Connected patients. All participating care providers and hospitals will help ensure the hours of operation of all of its network providers – including medical, behavioral and LTSS – are convenient to the population services and do not discriminate against MMP enrollees (e.g., hours of operation may be no less than those for commercially insured or public Fee-For-Service insured individuals), and plan services are available 24 hours a day, 7 days a week, when medically necessary.

Primary care provider checklist

1. Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-888-887-9003.**
2. Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
3. Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
4. Refer patients to UnitedHealthcare Community.
5. Identify and bill other insurance carriers when appropriate.
6. All services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form.

Specialist role and responsibilities

In addition to applicable requirements for all care providers, specialists must:

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer
- Verify the eligibility of the member before providing covered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Specialist consultations do not require authorization if the specialist is an in-network care provider
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
  - STAR Kids member reports should be after the initial assessment and quarterly thereafter.

- Maintain staff privileges at one UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the Texas HHSC Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual
- Provide anytime coverage. PCPs and specialists serving in the PCP role must be available to members by phone 24 hours a day, 7 days a week, or they must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for after-hours access. PCPs and obstetricians serving in the PCP role must take part in all survey-related activities.

Long-Term Services and Supports care providers

Long-Term Services and Supports (LTSS) care providers deliver In-Home and Community-Based Services for the elderly and people with disabilities who need assistance in maintaining their independence. As a result, these care providers enable members to live in their homes, in their communities rather than a nursing home. Services are delivered as outlined in your agreement, this manual and any other referenced guidelines, with special focus on person-centered care. This includes participating as part of the member's care coordination team. LTSS care providers provide covered health services to members within the scope of their UnitedHealthcare Community Plan agreement and their specialty license.

Settings Requirements for Home and Community-Based Services

Home and Community-Based Services (HCBS) settings requirements changed on March 1, 2023.

Federal regulations now require participating UnitedHealthcare Community Plan of Texas health care professional-owned or controlled settings to meet the following conditions for our members:

- Access to the community
- Employment
- Adult living facilities and adult foster care (AFC) settings
- Setting choice
- Privacy, dignity and respect, and freedom from coercion and restraint
- Initiative, autonomy, and independence
- Choice regarding services, support and who provides them
- Residential agreement
- Door locks – see HHSC LTCR
- Technical Memorandum 20-01
- Choice of room and roommate
- Room furnishings and decorations
- Control of daily schedule and access to food
- Visitation
- Physical accessibility
- Modifications to HCBS settings rule requirements
- Specific details about each setting condition can be found in the Code of Federal Regulations Title 42, Section 441.301(c)(4)(i-v) and Section 441.530(a)(1)(i-v)

Affected Home and Community-Based Services

The following HCBS services you provide are affected by the settings requirements:

- Community First Choice (CFC) personal assistance services
- CFC habilitation
- Respite
- Nursing
- Physical therapy
- Occupational therapy
- Cognitive rehabilitation therapy
- Speech therapy
- Supported employment
- Employment assistance
- Support consultation
- Assisted living
- AFC

Prenatal care responsibilities

CHIP perinate care provider role

CHIP perinate provides care to unborn children of pregnant women with household income up to 202

percent of the federal poverty level (FPL) and who are not Medicaid-eligible.

CHIP perinate provider services are limited to physicians, community clinics and care providers who provide prenatal care within their practice scope. This includes obstetricians/gynecologists, family practitioners, general practitioners, nurse practitioners, internists, nurse midwives or other qualified health care providers.

Delivery

Mothers eligible for CHIP Perinate coverage receive a bar-coded Emergency Medical Services Certification Form (Form H3038). The mother must bring the form to the hospital at the time of delivery. If the mother does not have the form, she can request a new one by calling 1-877-KIDS-NOW (1-877-543-7669). Or a hospital-based eligibility worker can use a generic (non bar-coded) form.

Do not copy or share bar coded Form H3038. The physician or a registered nurse with knowledge of the member's care, admission and discharge dates usually completes it before discharging the mother. Application process training will be available to you before CHIP Perinate implementation. If you want to supply applications in your office, you can order them in bulk at hhs.texas.gov.

Ancillary care provider responsibilities

Ancillary care providers include freestanding radiology, freestanding clinical labs, home health, hospice, dialysis, durable medical equipment, infusion care, therapy, ambulatory surgery centers, freestanding sleep centers and other non-care providers. PCPs and specialist care providers must use the UnitedHealthcare Community Plan ancillary network.

UnitedHealthcare Community Plan participating ancillary providers should maintain sufficient facilities, equipment, and personnel to provide timely access to medically necessary covered services.

Ancillary care provider checklist

Take the following steps when providing services to members:

- Use Medicaid web-based eligibility verification system
- Use TexMedConnect at tmhp.com
- Call your Texas Benefits care provider help line at 1-855-827-3747

1. Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-888-887-9003.**
2. Check the member's ID card at the time of service.
3. Verify member with photo identification.
4. Get prior authorization from UnitedHealthcare.
5. Community Plan, if required. Visit **UHCprovider.com/priorauth**.
6. Identify and bill other insurance carriers when appropriate.

Chapter 3: Care provider office procedures and member benefits

Key contacts

Topic	Link	Phone number
Member benefits	**UHCCommunityPlan.com/TX**	CHIP, STAR, STAR+PLUS: **1-866-314-0025** STAR Kids **1-888-384-1680**
Member handbook	**UHCCommunityPlan.com/TX**	Go to Plan Details, then Member Resources, View Available Resource
Provider Services	**UHCprovider.com**	**1-888-887-9003**
Prior authorization	**UHCprovider.com/priorauth**	**1-888-887-9003**
D-SNP	**UHCprovider.com/TX** > Medicare > **Dual Complete Special Needs Plan**	See back of member's ID card

Benefits

Go to **UHCCommunityPlan.com/TX** or **UHCprovider.com/eligibility** for more information.

Assignment to primary care provider panel roster

Once a member is assigned a PCP, view the panel rosters electronically by signing on to **UnitedHealthcare Provider Portal**.

The **UnitedHealthcare Provider Portal** requires a unique user name and password combination to gain access.

Each month, PCP panel size is monitored by reviewing PCP to member ratio reports. When a PCP's panel approaches the max limit, it is removed from auto-assignment. The state requires PCPs to send notice when their panels reach 85% capacity. To update the PCP panel limits, send a written request.

1. Go to **UHCprovider.com**.
2. Select Sign In on the top right.
3. Log in.
4. Click on Community Care.

The Community Care Roster has member contact information, clinical information to include HEDIS measures/Gaps in Care, is in an Excel format with customizable field export options, and can be pulled at the individual practitioner or TIN level. **Document Library** for member contact information in a PDF at the individual practitioner level.

View the **Document Library Interactive User Guide** to see the basic steps you'll take to access letters and secure reports.

HEDIS measures may change from year to year. For more information, visit NCQA.org > HEDIS.

Primary care provider assignment

HHSC has selected an independent Texas company, MAXIMUS, to serve as the enrollment broker for the Medicare/Medicaid program. HHSC determines eligibility for Medicaid members and ensures members

receive all the benefits of the Texas Medicaid programs. MAXIMUS maintains a call center with a toll-free phone number for enrollment. MAXIMUS also assists members enrolling with an 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 MMP system.

Outreach counselors are available to assist members with enrollment activities within their homes.

Mandatory Managed Care Organization participation

As recipients of Supplemental Security Income (SSI), STAR Kids members are mandated to select an MCO and a primary care provider PCP.

Choosing a primary care provider

Each enrolled UnitedHealthcare Community Plan member either chooses or is assigned a PCP. The assignment considers the distance to the PCP, the PCP's capacity and if the PCP is accepting new members. UnitedHealthcare Community Plan will assign members to the closest and appropriate PCP.

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the member changes the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the request date.

UnitedHealthcare Connected is responsible for managing the member's care from the date the member is enrolled with the plan until the member is disenrolled.

Members receive a letter notifying them of the name of their PCP, the office location, the telephone number and the opportunity to select a different PCP should they prefer someone other than the PCP assigned.

Members using UnitedHealthcare Connected must choose a PCP to coordinate their care. PCPs are the basis of the managed care philosophy. UnitedHealthcare Connected works with participating PCPs who help manage the health care needs of members and arrange for medically necessary covered medical services. If a member asks UnitedHealthcare Connected to change the PCP at any other time, the change will be made effective the first day of the following month.

To help ensure coordination of care, members must coordinate with their PCPs before seeking care from a specialist. We make exceptions for specified services (such as women's routine preventive health services, routine dental, routine vision and behavioral health). Participating health care professionals are required to coordinate member care within the UnitedHealthcare Connected care provider network. If possible, all member referrals should be directed to UnitedHealthcare Connected network care providers. Referrals outside of the network are permitted but only with prior authorization from UnitedHealthcare Connected.

The form to request this authorization is available at **UHCprovider.com/TXCommunityPlan** > Prior Authorization and Notification > **Prior Authorization Forms.**

Continuity of care is member involvement within the PCP medical home in ongoing health care management. It strives toward the shared goal of delivering high-quality, cost-effective medical care. Some issues requiring continuity of care include members who are:

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

If you are unable to secure an appropriate referral, please call **Provider Services** at **1-888-887-9003** to aid in the member's transfer.

The referral and prior authorization procedures explained in this manual are important to the UnitedHealthcare Connected program. Understanding and adhering to these procedures are essential for successful participation as a UnitedHealthcare Connected care provider.

Deductibles/copayments

Because members get assistance from Medicaid, they generally pay nothing for the covered services explained in this chapter. However, members may be responsible for paying a "patient liability" for nursing facility or waiver services covered through their Medicaid benefit. Texas HHSC will determine if a member's income and certain expenses require you to have a patient liability.

Issues requiring continuity of care include members moving out of the contracted service area.

For a complete list of current services, including dental services, go to **UHCCommunityPlan.com/TX** > See Plans in Texas > UnitedHealthcare Connected (Medicare-Medicaid Plan).

Medically necessary service

UnitedHealthcare Community Plan only pays for medically necessary services.

Medically necessary definition

Medically necessary health care services or supplies are medically appropriate and:

- Necessary to meet members' basic health needs
- Cost-efficient and appropriate for the covered services

Member assignment

Assignment to UnitedHealthcare Community Plan

MAXIMUS, Texas HHSC's enrollment broker, assists Medicaid members in choosing an MCO and a PCP from the contracted health plans in Texas and their associated care provider networks. UnitedHealthcare Community Plan is responsible for providing updates of its care 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."

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
- TANF recipients
- Supplemental Security Income recipients
- Medical Assistance Only recipients

At enrollment time, each member receives a welcome packet that includes a copy of the UnitedHealthcare Community Plan Member Handbook. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

Download a copy of the Member Handbook online by contacting at **UHCCommunityPlan.com/TX** Go to Plan Details > Member Resources > View Available Resources.

Disenrollment

Disenrollment/reassignment requests must be submitted to the UnitedHealthcare Community Plan **Provider Services** at **1-888-887-9003**

A member's disenrollment request from UnitedHealthcare Community Plan requires medical documentation from the PCP or 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 6 months. Members may choose to change MCOs after automatic re-enrollment.

Check member eligibility status by calling the TMHP Automated Inquiry Services (AIS) line at 1-800-295-9126.

Unborn enrollment changes

Encourage your members to notify the Texas HHSC when they know they are expecting. HHSC notifies Managed Care Organizations (MCOs) daily of an unborn when Texas Medicaid learns a woman associated with the MCO is expecting. The MCO or you may use the online change report through the Texas website to report the baby's birth. With that information, HHSC verifies the birth through the mother. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify HHSC when the baby is born.

Members may call **1-800-252-8263.**

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Check eligibility daily until the mother has enrolled her baby in a managed care plan.

Wraparound services

Medicaid provides services to help cover treatment that Medicare does not completely cover. These are called "wraparound services." Examples include some Medicaid durable medical equipment (DME) and certain medications. Also included are LTSS when necessary to help members to have their basic needs met in their home and community when they would otherwise need to go into a nursing facility for that level of care.

Primary care provider selection

Although unborn children cannot be enrolled with an MCO until birth, ask your members to select and contact a PCP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PCP selections.

UnitedHealthcare Community Plan Members can go to **myuhc.com/communityplan** > Find a Doctor > Texas > Select Plan to look up a care provider.

Newborn enrollment

If a Medicaid-eligible mother enrolled in the UnitedHealthcare Community Plan gives birth, MAXIMUS enrolls the newborn into the STAR Program. You can check the TMHP AIS line to verify the child's Medicaid number.

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. Services include:

- Mom's initial visit and up to 20 prenatal visits, prescriptions and prenatal vitamins
- Delivery and 2 doctor visits for the mother after the baby is born (coverage ends 30 days post-delivery)
- Well baby check-ups, immunizations and prescriptions

CHIP member eligibility

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, is eligible for Medicaid and moved to Medicaid for 12 months (effective on the date of birth) after the birth is reported to MAXIMUS.

Plan changes

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. The physician must fill out Form H3038 at the time of birth and return it to MAXIMUS.

CHIP Perinate mothers must select an MCO within 15 calendar days of receiving the enrollment packet. If they don't, the CHIP Perinate membership is defaulted into an MCO. The mother is notified of the plan choice and has 90 days to select another MCO.

When a household member enrolls in CHIP Perinate, all traditional CHIP members in the household are disenrolled from their current health plans. They are prospectively enrolled in the CHIP Perinate member's health plan if the plan is different. All household members 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 receives a CHIP renewal form. The family must complete and submit the renewal form, which includes the CHIP Perinate newborn's and the CHIP members' information.

Once the child's CHIP Perinate coverage expires, the child is added to their siblings' 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

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with Texas HHSC, Texas's Medicaid program. The Texas HHSC determines program eligibility. An individual who becomes eligible for the Texas Medicaid program either chooses or is assigned to one of the Texas HHSC-contracted health plans.

STAR Kids membership

Medicaid populations who must participate in the STAR Kids program include children and young adults age 20 and younger who receive:

- Supplemental Security Income (SSI) and SSI-related Medicaid
- SSI and Medicare
- Nursing Facility services are in the ICF-IID Program, or an HCBS waiver not integrated into STAR Kids (LTSS services only)
- Medically Dependent Program (MDCP) waiver services

We do not provide HCBS Waiver services for members in the following programs who will continue to receive services from Medicaid Texas state plans: Home and Community-Based Services (HCBS), Community Living Assistance and Support Services (CLASS), Texas Home Living (TxHmL), Deaf Blind with Multiple Disabilities (DBMD), and Youth Empowerment Services (YES). Our STAR Kids members will receive all their healthcare and Long-Term Services and Supports or HCBS through UnitedHealthcare Community Plan.

UnitedHealthcare Connected Medicare-Medicaid member eligibility and enrollment

Medicare and Medicaid (MMP) members who elect to become members of UnitedHealthcare Connected must meet the following qualifications:

1. Entitled to Medicare Part A and be enrolled in Medicare Part B.
2. Entitled and enrolled in Medicaid Title XIX benefits.
3. Reside in a UnitedHealthcare Connected Service Area: Harris County.
4. Maintain a permanent residence within the service area, and must not reside outside the service area for more than 6 months.
5. Members of all ages who do not have end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant) at time of application.

Women with breast or cervical cancer eligibility

Women with breast cancer or cervical cancer may be eligible for full Medicaid STAR+PLUS benefits and

services. 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 years
- U.S. citizen or eligible immigrant
- Uninsured or otherwise not eligible for Medicaid
- Texas resident

Texas HHSC determines eligibility. A woman 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 keep getting Medicaid benefits as long as she meets the eligibility criteria and can prove she is receiving treatment for breast or cervical cancer, hormonal treatment or disease surveillance. 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 member's cancer is in remission and the physician determines the member 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 member is not considered to be receiving treatment.

As a result, MBCC coverage will not be renewed.

A member diagnosed with a new, metastatic, or recurrent breast or cervical cancer may re-apply for MBCC benefits.

For guidance on Title XIX visit **UHCprovider.com/training** > State Specific Training > Texas > Completing the Title XIX DME/Medical Supplies Form For Texas Medicaid.

Member ID card

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage.

Check the member's ID card at each visit, and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license, if this is your office practice.

The member's ID card also shows the PCP assignment on the front of the card. If a member does not bring their card, call Provider Services. Also document the call in the member's chart.

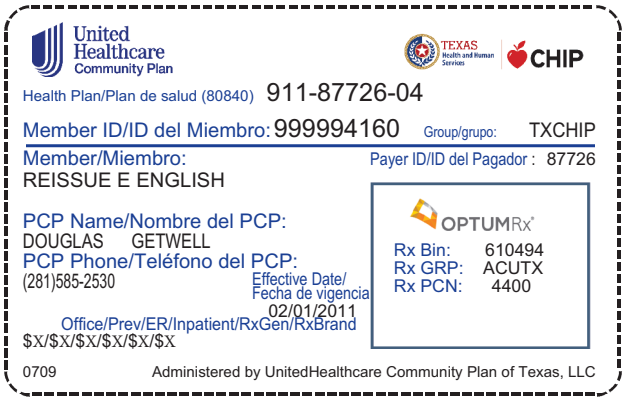
If a fraud, waste and abuse event arises from a care provider or a member's ID card, go to **uhc.com/fraud** to report it. Or call the **Fraud, waste and abuse hotline**.

Member identification numbers

Each member receives a nine-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The Texas HHSC Medicaid Number is also on the member ID card.

Sample health member ID card

CHIP


United Healthcare Community Plan

TEXAS Health and Human Services | CHIP

Health Plan/Plan de salud (80840) 911-87726-04

Member ID/ID del Miembro: 999994160 Group/grupo: TXCHIP

Member/Miembro:
REISSUE E ENGLISH

Payer ID/ID del Pagador : 87726

PCP Name/Nombre del PCP:
DOUGLAS GETWELL

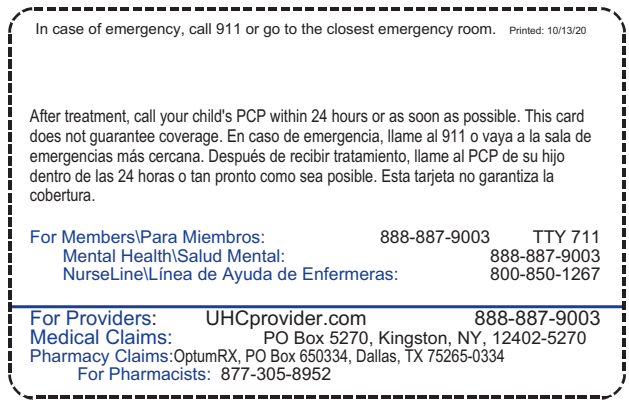
PCP Phone/Teléfono del PCP:
(281)585-2530

Effective Date/ Fecha de vigencia
02/01/2011

Office/Prev/ER/Inpatient/RxGen/RxBrand
$X/$X/$X/$X/$X/$X

OPTUMRx
Rx Bin: 610494
Rx GRP: ACUTX
Rx PCN: 4400

0709 Administered by UnitedHealthcare Community Plan of Texas, LLC

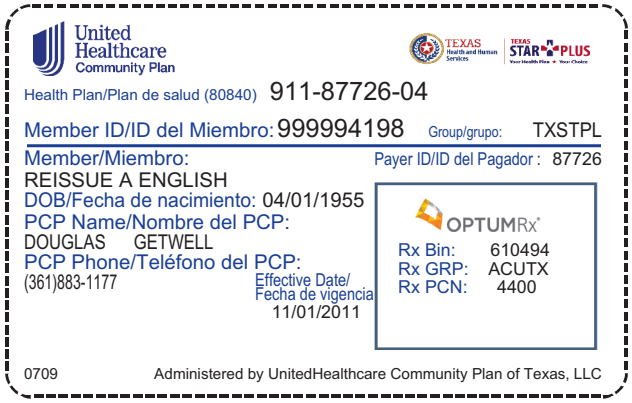

In case of emergency, call 911 or go to the closest emergency room. Printed: 10/13/20

After treatment, call your child's PCP within 24 hours or as soon as possible. This card does not guarantee coverage. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de las 24 horas o tan pronto como sea posible. Esta tarjeta no garantiza la cobertura.

For Members\Para Miembros: 888-887-9003 TTY 711
Mental Health\Salud Mental: 888-887-9003
NurseLine\Línea de Ayuda de Enfermeras: 800-850-1267

For Providers: UHCprovider.com 888-887-9003
Medical Claims: PO Box 5270, Kingston, NY, 12402-5270
Pharmacy Claims:OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952

STAR+PLUS


United Healthcare Community Plan

TEXAS Health and Human Services | STAR+PLUS

Health Plan/Plan de salud (80840) 911-87726-04

Member ID/ID del Miembro: 999994198 Group/grupo: TXSTPL

Member/Miembro:
REISSUE A ENGLISH

Payer ID/ID del Pagador : 87726

DOB/Fecha de nacimiento: 04/01/1955

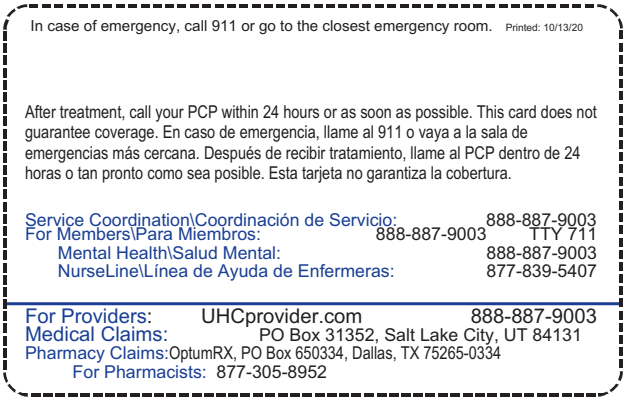
PCP Name/Nombre del PCP:
DOUGLAS GETWELL

PCP Phone/Teléfono del PCP:
(361)883-1177

Effective Date/ Fecha de vigencia
11/01/2011

OPTUMRx
Rx Bin: 610494
Rx GRP: ACUTX
Rx PCN: 4400

0709 Administered by UnitedHealthcare Community Plan of Texas, LLC

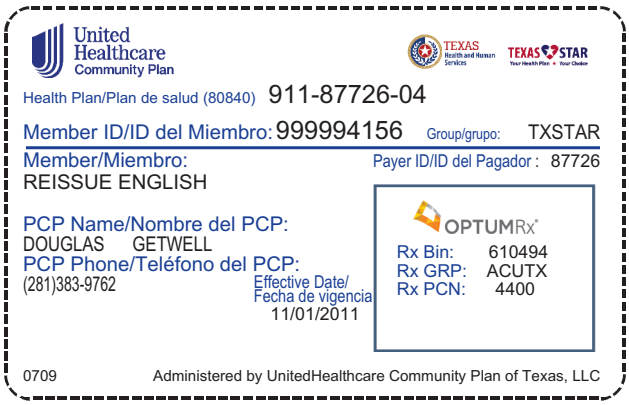

In case of emergency, call 911 or go to the closest emergency room. Printed: 10/13/20

After treatment, call your PCP within 24 hours or as soon as possible. This card does not guarantee coverage. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible. Esta tarjeta no garantiza la cobertura.

Service Coordination\Coordinación de Servicio: 888-887-9003
For Members\Para Miembros: 888-887-9003 TTY 711
Mental Health\Salud Mental: 888-887-9003
NurseLine\Línea de Ayuda de Enfermeras: 877-839-5407

For Providers: UHCprovider.com 888-887-9003
Medical Claims: PO Box 31352, Salt Lake City, UT 84131
Pharmacy Claims:OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952

STAR


United Healthcare Community Plan

TEXAS Health and Human Services | TEXAS STAR

Health Plan/Plan de salud (80840) 911-87726-04

Member ID/ID del Miembro: 999994156 Group/grupo: TXSTAR

Member/Miembro:
REISSUE ENGLISH

Payer ID/ID del Pagador : 87726

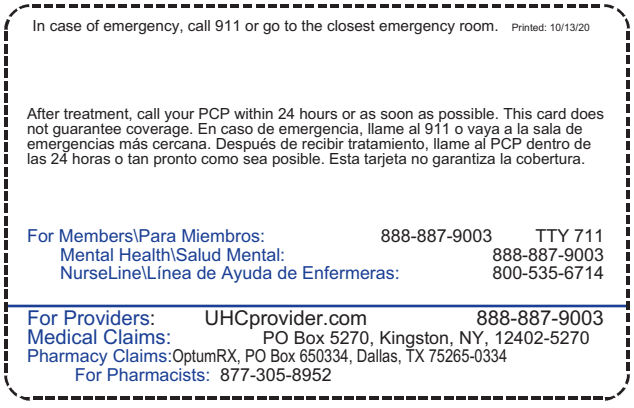
PCP Name/Nombre del PCP:
DOUGLAS GETWELL

PCP Phone/Teléfono del PCP:
(281)383-9762

Effective Date/ Fecha de vigencia
11/01/2011

OPTUMRx
Rx Bin: 610494
Rx GRP: ACUTX
Rx PCN: 4400

0709 Administered by UnitedHealthcare Community Plan of Texas, LLC

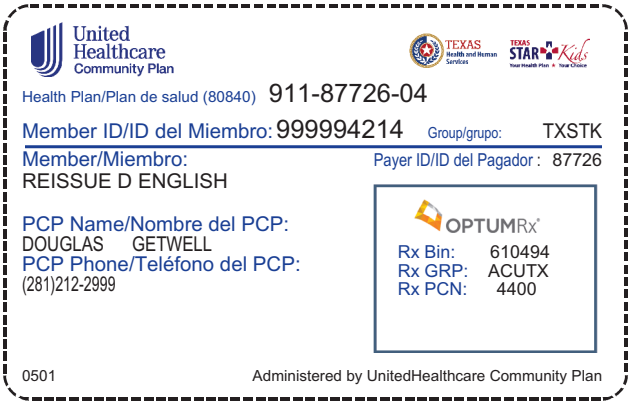

In case of emergency, call 911 or go to the closest emergency room. Printed: 10/13/20

After treatment, call your PCP within 24 hours or as soon as possible. This card does not guarantee coverage. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP dentro de las 24 horas o tan pronto como sea posible. Esta tarjeta no garantiza la cobertura.

For Members\Para Miembros: 888-887-9003 TTY 711
Mental Health\Salud Mental: 888-887-9003
NurseLine\Línea de Ayuda de Enfermeras: 800-535-6714

For Providers: UHCprovider.com 888-887-9003
Medical Claims: PO Box 5270, Kingston, NY, 12402-5270
Pharmacy Claims:OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952

STAR Kids


United Healthcare Community Plan

TEXAS Health and Human Services | STAR Kids

Health Plan/Plan de salud (80840) 911-87726-04

Member ID/ID del Miembro: 999994214 Group/grupo: TXSTK

Member/Miembro:
REISSUE D ENGLISH

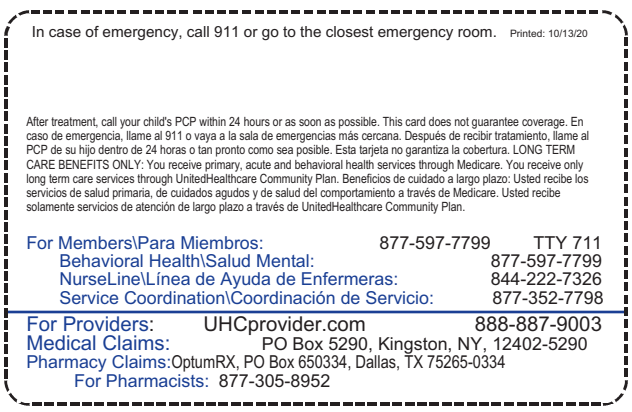
Payer ID/ID del Pagador : 87726

PCP Name/Nombre del PCP:
DOUGLAS GETWELL

PCP Phone/Teléfono del PCP:
(281)212-2999

OPTUMRx
Rx Bin: 610494
Rx GRP: ACUTX
Rx PCN: 4400

0501 Administered by UnitedHealthcare Community Plan

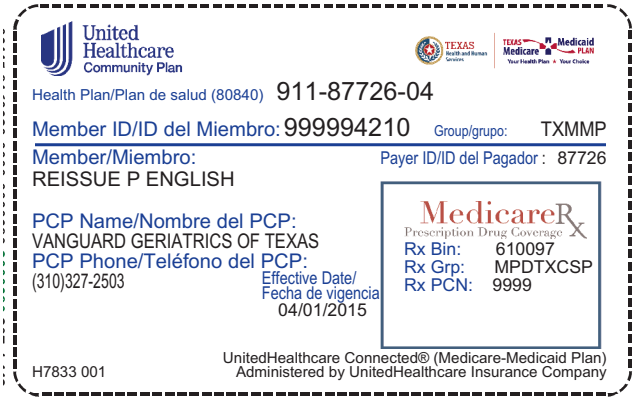

In case of emergency, call 911 or go to the closest emergency room. Printed: 10/13/20

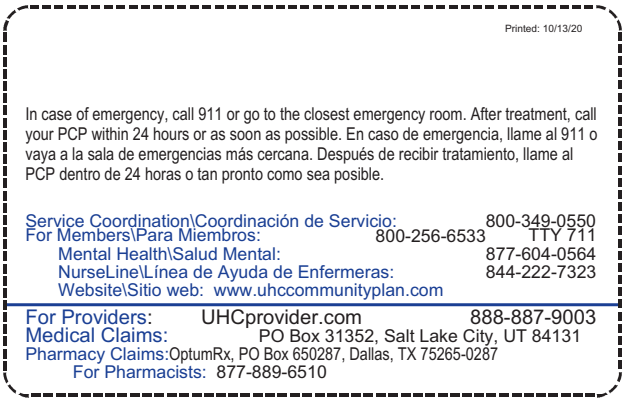
After treatment, call your child's PCP within 24 hours or as soon as possible. This card does not guarantee coverage. En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible. Esta tarjeta no garantiza la cobertura. LONG TERM CARE BENEFITS ONLY: You receive primary, acute and behavioral health services through Medicare. You receive only long term care services through UnitedHealthcare Community Plan. Beneficios de cuidado a largo plazo: Usted recibe los servicios de salud primaria, de cuidados agudos y de salud del comportamiento a través de Medicare. Usted recibe solamente servicios de atención de largo plazo a través de UnitedHealthcare Community Plan.

For Members\Para Miembros: 877-597-7799 TTY 711
Behavioral Health\Salud Mental: 877-597-7799
NurseLine\Línea de Ayuda de Enfermeras: 844-222-7326
Service Coordination\Coordinación de Servicio: 877-352-7798

For Providers: UHCprovider.com 888-887-9003
Medical Claims: PO Box 5290, Kingston, NY, 12402-5290
Pharmacy Claims:OptumRX, PO Box 650334, Dallas, TX 75265-0334
For Pharmacists: 877-305-8952

Medicare-Medicaid plan





Disenrollment

A member's disenrollment request from UnitedHealthcare Community Plan requires medical documentation from the PCP, or documentation indicating sufficiently compelling circumstances meriting disenrollment. Texas HHSC will make the final decision. You may not retaliate against a member for any reason, including disenrollment-related reasons.

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 6 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 1-800-925-9126.

Verifying member Medicaid eligibility and Managed Care Organization enrollment

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. You should verify the patient's Medicaid eligibility and Managed Care Organization (MCO) enrollment for the date of service prior to services being rendered. There are several ways to do this:

- Use TexMedConnect on the TMHP website at tmhp.com
- Log into your TMHP user account and accessing Medicaid Client Portal for care providers
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at 1-800-925-9126 or 1-512-335-5986
- Call Provider Services at the patient's medical or dental plan

Important: Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling 1-800-252-8263. Medicaid members also can go online to order new cards or print temporary cards.

Important: Request and keep hard copies of any Medicaid Eligibility Verification (Form 1027-A) submitted by patients. A copy is required during the appeal process if the patient's eligibility becomes an issue.

Care provider access to Medicaid medical and dental health information

Log into the TMHP user account and access the Medicaid Client Portal for care providers. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). This information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details.

The specific functions available are:

- Access to a Medicaid patient's medical and dental health information including medical diagnosis, procedures, prescription medicines and vaccines on the Medicaid Client Portal through My Account
- Enhances eligibility verification available on any device, including desktops, laptops, tablets, and smart phones with print functionality
- Texas Health Steps and benefit limitations information

- A viewable and printable Medicaid Card
- Display of the Tooth Code and Tooth Service Code for dental claims or encounters
- Display of the Last Dental Anesthesia Procedure Date
- Additionally, an online portal is available to patients at YourTexasBenefits.com where they can;
- View, print, and order a Your Texas Benefits Medicaid card
- See:
  - medical and dental plans
  - benefit information
  - Texas Health Steps Alerts
  - broadcast alerts
  - diagnosis and treatments
  - vaccines
  - prescription medicines
- Choose whether to let Medicaid doctors and staff see their available medical and dental information

Note: The YourTexasBenefits.com Medicaid Client Portal displays information for active patients only. Legally authorized representatives can view anyone who is part of their case.

Medicare enrollment for STAR+PLUS

When a STAR+PLUS member turns 21, they are enrolled into UnitedHealthcare Connected (MMP) if they also have Medicare Parts A, B and D. Members receive a letter within 60 days of this enrollment. Eligibility is determined by HHS.

Members are notified of their right to opt out. They may also choose to disenroll from UnitedHealthcare Connected (MMP) at any time and then enroll in:

- MMP with another MCO
- Any MCO's STAR+PLUS program (Medicaid-only) AND any qualifying Medicare Advantage plan with a separate Part D prescription drug plan
- Any qualifying Medicare Advantage plan that also has a Part D prescription drug plan (MAPD)
- Medicare FFS and a Part D prescription drug plan
- A Program of All-inclusive Care for the Elderly (PACE)

This disenrollment may be given orally or written. The new enrollment will be effective on the first calendar day of the following month.

UnitedHealthcare Dual Complete - Dual special needs plan

Dual special needs plan (D-SNP) is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For general information about D-SNP, go to **uhc.com/medicaid/dsnp**.

For information about UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP. For Texas-specific D-SNP information, go to **UHCprovider.com/en/health-plans-by-state/texas-health-plans.html**.

UnitedHealthcare connected Medicare-Medicaid plan care provider performance standards and compliance obligation

Laws regarding federal funds

Payments you receive for furnishing services to UnitedHealthcare Connected members are, in whole or part, from Federal funds. Therefore, you and any of your subcontractors, must comply with certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

Key contacts

Topic	Link	Phone number
Referrals	**UHCprovider.com/referrals**	**1-888-887-9003**
Prior authorization	**UHCprovider.com/priorauth**	**1-888-887-9003**
Pharmacy	**UHCprovider.com/priorauth**	**1-877-305-8952**
Dental	**UHCdental.com**	**1-877-378-5301**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**

Medical management improves the quality and outcome of healthcare delivery. We offer the following services as part of our medical management process.

Ambulance services

Air ambulance

Air ambulance is covered only when the services are medically necessary and transportation by ground ambulance is not available. It is also only covered when:

- Great distances or other obstacles keep members from reaching the destination
- Immediate admission is essential
- The pickup point is inaccessible by land

Emergency ambulance transportation

An emergency is a serious, sudden medical or behavioral condition that may include severe pain. Without immediate attention, the affected person could suffer major:

- Injury to their overall health
- Impairment to bodily functions
- Dysfunction of a bodily organ or part

Emergency transports (in- and out-of-network) are covered. They do not require an authorization.

If a member is eligible and enrolled in a home- and community-based waiver program, they may also use waiver transportation benefits.

Members receive all medically necessary Medicaid covered services at no cost to them. These services may or may not require prior authorization before the member receives them.

For authorization, go to **UHCprovider.com/priorauth** or call **Provider Services** at **1-888-887-9003**.

Bill ambulance transport as a non-emergency transport when it doesn't meet the definition of an emergency transport. For more information about special billing considerations, please see **Chapter 12** of this manual.

Ambulance and wheelchair van services

Covered emergency ambulance transport services include fixed-wing, rotary-wing and ground ambulance services. The ambulance takes a member to the nearest place that can provide care. A member's condition must be serious enough that other transportation could risk their or their unborn baby's health. In non-emergencies, ambulance or wheelchair van transport services are covered when medically necessary.

Non-emergent ambulance transportation

UnitedHealthcare Community Plan members may get non-emergency transportation services through ModivCare for covered services. Covered transportation includes sedan, taxi, wheelchair-equipped vehicle, public transit, mileage repayment and shared rides. Members may get transportation when:

- They are bed-confined before, during and after transport; and
- The services cannot be provided at their home (including a nursing facility or ICF/MR)

Ambulance services for a member receiving inpatient hospital services are not included in the payment to the hospital. They must be billed by the ambulance provider. This includes transporting the member to another facility for services (e.g., diagnostic testing) and returning them to the first hospital for more inpatient care.

Make urgent non-emergency trips, such as when a member is sent home from the hospital, through our Member Call Center at **1-888-887-9003**, after 6 p.m. CT

- CHIP, STAR, STAR+PLUS and MMP: Call ModivCare's Ride Assist at 1-866-528-0443
- STAR Kids: Call 1-866-529-2120

Schedule rides up to 30 days in advance. Members must call between 8 a.m. - 5 p.m. CT, Monday-Friday, to schedule transportation.

If they have questions about their order, they may call Modivcare.

- CHIP, STAR, STAR+PLUS and MMP: 1-866-528-0441
- STAR Kids: 1-866-529-2117

What are non-emergency medical transportation services?

Non-emergency medical transportation (NEMT) services provide transportation to covered health care services for patients who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips or transportation while receiving LTSS.

What do non-emergency medical transportation services include?

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

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

Children 14 years and younger must be accompanied by a parent, guardian or other authorized adult. Children 15-17 years of age must be accompanied by, or have consent on file to travel alone, from a parent, guardian or other authorized adult. Parental consent is not required if the covered health care service is confidential in nature.

Contact Us

If you have a member you think would benefit from receiving NEMT services, please refer them to us for information. They can call Provider Services at **1-888-887-9003**. For inquiry follow-ups that surpass 3 days or escalation requests, send an email to Tx.Transportation@modivcare.com.

When a patient misses an appointment

Please call the patient to reschedule and, if necessary, assist them in securing Medicaid transportation. UnitedHealthcare Community Plan **Provider Services** is available at **1-888-887-9003**.

Complete online the Provider Outreach Referral Service Form at dshs.texas.gov > Texas Health Steps and fax to THSteps at **1-512-533-3867.**

The THSteps Provider Outreach Referral Service is administered by the THSteps program and provides necessary outreach and follow-up with THSteps patients, such as contacting a patient to:

- Schedule a follow-up appointment
- Reschedule a missed appointment
- Assist with scheduling transportation to the appointment

Blind children's vocational discovery and development program

These services provide children who are blind or visually impaired with a range of services 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 THMP.com > Medicaid Provider Manual > Behavioral Health and Case Management Services Handbook > Chapter 2: Blind Children's Vocational Discovery and Development Program (BCVDDP).

Or visit the Texas Health and Human Services Commission at hhs.texas.gov > Services > Disability > Blind and Visually Impaired or call 1-877-787-8999, select a language, then Option 3.

Communicable diseases

Members with communicable diseases require prompt appointment access and care for their condition, including confidentiality assurances. Minors are able to seek confidential treatment and give their own consent for these diseases. Neither a prior authorization or a PCP referral are necessary.

For more information about infectious disease mandatory reporting to the Center for Disease Control, visit dshs.texas.gov > Resources > Disease Reporting.

Find more information at the Texas Administrative Code Title 25, Part 1, Chapter 97 Communicable Diseases.

Comprehensive care program

Newborns covered by Medicaid have access to diagnosis and treatment services through the Medicaid Children's Services Comprehensive Care Program (CCP), available for children and adolescents. These services provide any medically necessary health care service that corrects or improves the ember's disability, physical or mental illness, or chronic condition, even if the service may not be available as a covered benefit in the health plan.

For more information, go to TMHP.com > providers > Medicaid Provider Manual.

Continuity of care

Members may receive services from their existing care provider, even if you are not contracted in our network. The authorization will remain in place until our service coordinators are able to assess the member and establish a person-centered plan of care, or until we secure a comparable service care provider contracted in our network and able to meet the complex needs of the member.

When a new member has an approved authorization in place, service may continue under that authorization for the same amount, duration, and scope until our service coordinators are able to assess the member, medical necessity is determined and new authorization(s) are secured. This will occur no longer than 90 calendar days after the patient becomes a member of our health plan, or until the end of the current authorization period.

Some particular issues which require continuity of care include:

- Pregnant women past the 24th week of pregnancy are allowed to remain under their current OB/GYN

care through delivery of the child and post-partum checkup, immediate postpartum care and the follow-up checkup within the first 6 weeks of delivery. This is the case even if the OB/GYN is, or becomes an out-of-network care provider.
- Members who have a pre-existing condition that is not imposed
- Members moving out of a UnitedHealthcare Community Plan contracted service area

Dental home

Dental plan members may choose their main dental homes. Dental plans will assign each member to a main dental home if he/she does not timely choose one. Whether chosen or assigned, each member who is 6 months or older must have a designated main dental home.

Role of main dental home

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

For more information on PASRR screenings, evaluations and specialized services for MMP members, go to TMHP.com > Medicaid Provider Manual.

Help a member find dental care

The dental plan member ID card lists the member's main dental home provider name and phone number. The member can contact the dental plan at any time to select a different main dental home provider. If the member selects a different main dental home provider, the change is reflected immediately in the dental plan's system. The member is mailed a new ID card within 5 business days. If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can call the Medicaid/CHIP enrollment broker at 1-800-964-2777.

Medicaid non-emergency dental services

Routine dental services provided to Medicaid members are paid through dental MCOs. UnitedHealthcare Community Plan is not responsible for payment of these services.

UnitedHealthcare Community Plan pays 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.

UnitedHealthcare aligns with the Texas Medicaid Provider Procedures Manual (TMPPM) with regards to billing and documentation requirements, as follows. 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 OEFV components
- Texas Health Steps care providers must assist members with establishing a main dental home and document member's main dental home choice in the members' file

For more information about Texas Health Steps dental (including orthodontia), visit TMHP.com > Medicaid Provider Manual > Children's Services Handbook > Chapter 4: Texas Health Steps (THSteps) Dental > Section 4.3.13.1 Oral Evaluation and Flouride Varnish (OEFV) in the Medical Home.

CHIP non-emergency dental services

UnitedHealthcare Community Plan is not responsible for paying for routine dental services provided to CHIP and CHIP Perinate members. These services are paid through dental MCOs. UnitedHealthcare Community Plan pays for treatment and devices for craniofacial anomalies.

For more information about Texas Health Steps dental (including orthodontia), visit TMHP.com > Medicaid Provider Manual > Children's Services Handbook > Chapter 4: Texas Health Steps (THSteps) Dental.

Durable medical equipment

Durable medical equipment (DME) is equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses. DME consists of items that are:

- Primarily used to serve a medical purpose
- Not useful to a person in the absence of illness, disability, or injury
- Ordered or prescribed by a care provider
- Reusable
- Repeatedly used
- Appropriate for home use
- Determined to be medically necessary

See our Coverage Determination Guidelines at **UHCprovider.com/policies** > For Community Plans > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.

Durable medical equipment care provider enrollment and common pharmacy products

We reimburse for covered durable medical equipment (DME) commonly found in pharmacies. For 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, diapers, disposable or expendable medical supplies, and some nutritional products.

For DME reimbursement or other products normally found in pharmacy products for children (birth through age 20), a pharmacy must enroll as a DME provider. See the Billing and Submission chapter of this manual.

For more information, visit TMHP.com > Medicaid Provider Manual > Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook and Children's Services Handbook > Durable Medical Equipment (DME) Supplier (CCP).

To participate as a Durable Medical Equipment (DME) provider, pharmacies must complete the enrollment application available at THMP.com.

For assistance, call the Texas Medicaid and Healthcare Partnership (TMHP) Contact Center at 1-800-925-9126, or email TMHP Provider Relations to request assistance from the local TMHP provider relations representative in your area.

In addition to enrolling through TMHP, call UnitedHealthcare Community Plan at **1-866-574-6088** to amend your contract as a DME care provider.

Cite durable medical equipment exceptional circumstances provision in prior authorization requests

UnitedHealthcare Community Plan of Texas complies with the federal requirement to deliver medically necessary durable medical equipment (DME) under the Home Health DME and Supplies Exceptional Circumstances Provision.

- This provision may be needed when equipment or supplies are not covered under the Texas Medicaid Provider Procedures Manual (TMPPM)
- There is no exhaustive list of DME, and supplies covered under the exceptional circumstances provision
  - Federal regulations provide general guidance on allowed equipment that typically wouldn't be needed by someone without a disability, illness, or injury, or supplies that are consumable and disposable items to address an individual's need

How to request services under the provision

You must request the exceptional circumstances provision when you submit a prior authorization:

- Submit a prior authorization online (submission instructions provided below)
- Under Comments, cite you're requesting the exceptional circumstances provision and list the justification for the specific home health service(s)

- If the exceptional circumstances provision is cited, you must include a reference and explain the member's need for the requested home health care service(s)

Examples of what may be covered under the exceptional circumstances provision are, but are not limited to:

- Augmentative communication device (ACD) systems
- Bath and bathroom equipment
- Bone growth stimulators
- Diabetic equipment and supplies
- Hospital beds and equipment Incontinence supplies
- IV supplies and equipment
- Mobility aids
- Nutritional (enteral) products, supplies and equipment
- PT/INR monitors and related testing supplies
- Wound care equipment and supplies

How to submit a prior authorization request

You can submit a prior authorization request online.

Online: Sign in to the **UnitedHealthcare Provider Portal** and select Prior Authorizations

Early Childhood Intervention program

The Texas Early Childhood Intervention (ECI) program is a statewide service for families with children, birth to 3 years of age, with developmental delays, disabilities or certain medical diagnoses. Services are provided in homes and community settings. The goal is to help ensure children with developmental delays are ready for preschool and kindergarten.

You are required to help refer children to this program in an effort to offset any developmental delays that may affect their education. You do not need to have a diagnosis to refer. You do need parent or guardian permission. Refer a patient whom you suspect as having a developmental delay or who otherwise meets eligibility criteria for ECI services within 7 days of your suspicion. Members may also self-refer without a PCP referral to this program.

For more information abut ECI-qualifying diagnoses, go to diagsearch.hhsc.state.tx.us.

Eligibility evaluation

ECI determines eligibility using the Battelle Developmental Inventory (BDI-2). An evaluation may include medical and developmental history, and interviews with parents, other primary caregivers and medical care providers. A team of professionals determines medical necessity for covered health and behavioral health services.

Referrals

ECI care providers are in our UnitedHealthcare Community Plan network. 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 suspected of having a developmental disability, delay or who are at risk of delay. A medical diagnosis or a confirmed developmental delay is not necessary to refer a child. However, you will need parental consent.

If a previously referred member was found ineligible, a change in the child's development may result in another referral.

Refer a patient to ECI for screening and assessment within 7 days of suspecting a developmental delay, even if also referring to an appropriate specialist.

For more ECI information or to refer, visit Texas Health and Human Services at hhs.texas.gov > Services > Disability > Early Childhood Intervention Services, use the ECI Physician Referral Form, or call 1-877-787-8999.

Services

The team creates an Individualized Family Services Plan (IFSP) after the child is determined eligible for ECI services. The IFSP becomes part of the plan of care, and outlines ECI services by amount, duration, scope and practice setting for delivery. The IFSP services determine authorization for medically needed services.

ECI services may include:

- Assistive technology
- Audiology and vision
- Case management

- Family education and training
- Nursing and nutrition
- Physical, occupational, speech therapy
- Specialized skills training

Specialized Skills Training (SST) is a rehabilitative service promoting age-appropriate development by providing skills training to correct deficits and teach compensatory skills for deficits directly resulting 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 > Medicaid Provider Manual > Children's Services Handbook > Section Specialize Skills Training (SST).

Case management

ECI service coordinators help families access and receive the services, resources and supports they need to support their child's development. Supports include helping the member and family transition to special education services or other options, as appropriate for children exiting ECI at 3 years of age.

For more information about ECI case management/service coordination, visit TMHP.com > Medicaid Provider Manual > Children's Services Handbook > Early Childhood Intervention (ECI) Services: Targeted Case Management

When a child receives ECI services, their UnitedHealthcare Community Plan ECI service provider shares their IFSP with the member's coordinator and PCP through CommunityCare, our online coordination capability.

You may access CommunityCare through the Provider Portal at **UHCprovider.com** by signing in with your One Healthcare ID and password.

The amount a family pays for ECI services is determined using a sliding fee scale, and is based on family size and income after allowable deductions. No child or family is turned away because of an inability to pay.

Refer children 3 years of age or older with a suspected developmental delay or disability to the local school district. The ECI program transitions children receiving ECI services at the time of turning 3 years old into the local school district.

School health and related services

School health and related services (SHARS) are Medicaid services provided by Texas school districts to Medicaid-eligible students. SHARS oversight 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 (that are documented in a student's Individualized Education Program) provided to students in special education under Individuals with Disabilities Education Act (IDEA).

For more information, visit TMHP.com > Medicaid Provider Manual > Children's Services Handbook > Section 3 School Health and Related Services (SHARS).

For more ECI information, visit:

- Sec.303.303 (a)(2)(i): For more information about federal laws on child find and referral procedures, look at 34 CFR (Code of Federal Regulations)
- The Center for Health Care Services: chcsbc.org
- For a list of conditions: diagsearch.hhsc.state.tx.us
- Our policies: **UHCprovider.com/policies > For Community Plans**

Emergency/urgent care services

Emergency and urgent care services are available only in the U.S. and its territories. Emergency services do not require prior authorization.

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate ER use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fever, cough and colds, and sore throats. Urgent care centers are useful for conditions not requiring an ER level of care.

Covered services include:

- Hospital emergency department room, ancillary and other care by in- and out-of-network care providers
- Medical examination
- Stabilization services
- Access to designated Level I and Level II trauma centers or hospitals meeting the same levels of care for emergency services

- Emergency ground, air and water transportation
- Emergency dental services, limited to broken or dislocated jaw, traumatic damage to teeth and supporting structures, and cyst removal. Also includes treatment of oral abscess of tooth or gum origin, and treatment and devices for correction of craniofacial anomalies and drugs.

We pay out-of-network care providers for emergency services at the current program rates at the time of service. We try to negotiate acceptable payment rates with out-of-network care providers for covered post-stabilization care services for which we must pay.

Emergency room care

For an emergency, the member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No referral is needed. Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services.

Before they are treated, UnitedHealthcare Community Plan members who visit an ER are screened to determine whether they have a medical emergency. Prior authorization is not required for the medical screening. UnitedHealthcare Community Plan covers these services regardless of the emergency care provider's relationship with UnitedHealthcare Community Plan.

After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable. If the hospital needs to appeal the decision or if does not receive a decision within one hour and/or they need to speak with a peer (medical director), call **1-800-955-7615**. The treating care provider may continue with care until the medical director is reached, or when one of these guidelines is met:

1. A plan care provider with privileges at the treating hospital takes over the member's care.
2. A plan care provider takes over the member's care by sending them to another place of service.
3. An MCO representative and the treating care provider reach an agreement about the member's care.
4. The member is released.

Depending on the need, the member may be treated in the ER, in an inpatient hospital room, or in another setting. This applies whether the member receives emergency services in or outside their service area.

Urgent care (non-emergent)

Urgent care services are covered. For a list of urgent care centers, contact **Provider Services** at **1-888-887-9003.**

Dental emergencies

UnitedHealthcare Community Plan is responsible for emergency dental services provided to Medicaid, CHIP and CHIP Perinate members in a hospital, free-standing ER, 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 supporting structures, and removal of cysts
- Treatment of oral abscess of tooth or gum origin
- Treatment and devices for correction of craniofacial anomalies and drugs

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

Nurses in the Health Services Department review emergency admissions within one business day of notification.

Deliver emergency care without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal at **UHCprovider.com/priorauth**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services at 1-888-887-9003**.

UnitedHealthcare Community Plan makes

utilization management determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally-developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize Utilization Management staff to support service underutilization. Care determination criteria is available upon request by contacting the Prior Authorization Department (UM Department, etc.)

For policies and protocols, go to **UHCprovider.com/policies** > **For Community Plans.**

If a member meets an acute inpatient level of stay, admission starts at the time you write the order.

Family planning

Family planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. UnitedHealthcare Community Plan members may access these services without a referral for any in-network or out-of-network care provider. They may also seek family planning services at the care provider of their choice. The following services are included:

- Annual gynecological examination
- Annual pap smear
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling
- Laboratory services
- Pregnancy planning and perinatal health promotion and education for reproductive-age women and adolescents
- Perinatal risk assessment of non-pregnant women, pregnant, and postpartum women, and infants up to 1 year of age
- Access to appropriate levels of care based on risk assessment, including emergency care
- Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary
- Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems
- Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems
- Education and care coordination for members who are at high-risk for preterm labor, including education on the availability of medication regimens to prevent preterm birth, such as hydroxyprogesterone caproate

Parental consent is not required for minors to purchase non-prescription contraceptives (e.g., condoms) or to receive information about family planning. Minors must get a parent's permission to receive prescription contraception unless they are on Medicaid, legally emancipated or age 16 and living on their own. For more information go to the Adolescent Health Guide for Providers.

Blood tests to determine paternity are covered **only** when the claim indicates tests were necessary for legal support in court.

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
  - GIFT (Gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy **Note:** Diagnosis of infertility is covered. Treatment is not.
  - Morning-after pill. Contact the state of Texas to verify state coverage.

Parenting/child birth education programs

- Child birth education is covered
- Parenting education is not covered

Other family planning services

Members requesting contraceptive services or family planning services are also provided counseling and education about the family planning and family planning services available to them. We have outreach programs available to increase community support for family planning and encourage members to use available family planning services.

We will notify care providers involved in the care of pregnant/ delivering women and newborns (including out-of-network care providers and hospitals) of our prior authorization requirements. We do not require a

prior authorization for services provided to a pregnant/delivering member or newborn member for a medical condition that requires emergency services, regardless of when the emergency condition arises.

We develop, implement, monitor, and maintain standards, policies and procedures for providing information regarding family planning to care providers and members, specifically regarding state and federal laws governing member confidentiality, including minors. We do require, through contractual provisions, that our network care providers have mechanisms in place to help ensure member confidentiality for family planning services.

View prior authorization requirements for these services at **UHCprovider.com/Eligibility**

Or, visit **UHCprovider.com/TXCommunityPlan** > Prior Authorization and Notification.

Voluntary Sterilization

In-network treatment with consent is covered. The member needs to give consent 30 days before surgery, be mentally competent and be at least 21 years old at the time of consent for:

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the HHSC Regulations for more information on sterilization.

Care coordination/health education

Our care coordination program is led by our qualified, full-time care coordinators. You are encouraged to collaborate with us to ensure care coordination services are provided to members. This program is a proactive approach to help members manage specific conditions and support them as they take responsibility for their health.

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes
- Support member empowerment and informed decision making
- Effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

Our program makes available population-based, condition-specific health education materials, websites, interactive mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based upon evidence-based guidelines or standards of care, directly to members that address topics that help members manage their condition. Our program provides personalized support to members in case management. The case manager collaborates with the member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the care coordination program.

Programs are based upon the findings from our Health Education, Cultural and Linguistic Group Needs Assessment (GNA) and will identify the health education, cultural and linguistic needs.

Care management program STAR, CHIP

This program is available to CHIP and STAR members with chronic health conditions or special health care needs to access support, education and interventions based on their health care needs (such as living with asthma or diabetes). To refer a member, call **1-888-887-9003**.

Case management for children and pregnant women

Medicaid members with medical-related needs that might affect their health care may be eligible for this assistance if they are either:

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

Case managers contracted with UnitedHealthcare work with eligible members by assessing their needs, formulating a service plan, making referrals, problem-solving, advocacy and follow-up.

We do not require prior approvals or requests for follow-up visits to the Texas Medicaid and Healthcare Partnership (TMHP) Children and Pregnant Women (CPW) program services.

For CPW claims, you'll need to upload documentation for each comprehensive claim using the following approved health and human services commission (HHSC) documents:

- CM-01A, Referral and Intake
- CM-02, Family Needs Assessment
- CM-03E-S, Service Plan
- CM-03ConE-S, Service Plan Consent

To learn more about claim submissions, click here **https://chameleoncloud4.io/review/prod/3e583cef-bdf9-43f6-b1cc-fe33abf105ed.**

For more information about eligibility, visit TMHP.com > Medicaid Provider Manual > Behavioral Health, and Case Management Services Handbook > Section 3.1.1 Eligibility or section 3.1.2 Referral Process or call **1-877-THSTEPS**. For referrals, call **1-888-887-9003** or email **CPW@uhc.com**.

Prescribed pediatric extended care centers and private duty nursing

A member has a choice of private duty nursing (PDN), prescribed pediatric extended care (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.

Potentially preventable episodes

Some of our members live with chronic and complex medical conditions. The person-centered medical home maintained by you as their PCP is a cornerstone to their medical management. We urge you to practice wellness by closing gaps in care per the Healthcare 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 Practice Guidelines.

Please work with our members to:

- Actively participate in health maintenance activities, such as an Asthma Action Plan
- Recognize worsening symptoms and their triggers
- Have an emergency plan in place and know when to:
  - Come to your office for a same- or next-day visit with you
  - Visit an urgent care center, and/or the ER

Hearing services

Monaural and binaural hearing aids are covered, including fitting, follow-up care, batteries and repair. Bilateral cochlear implants, including implants, parts, accessories, batteries, charges and repairs are covered. Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts and batteries are covered for members 20 years or younger.

Hospice

Hospice, also called end-of-life care, helps people diagnosed with a terminally illness to live their remaining days with dignity.

When a member qualifies for end-of-life hospice care, a Home and Community Support Services Agency (HCSSA) can provide home health, hospice or personal

attendant services (PAS) in the member's home or independent living environment as prescribed by a physician or individualized service plan (ISP). The HCSSA develops an integrated plan of care, including specific services the agency agrees to perform and the member agrees to receive. HCSSAs are licensed and monitored by Texas Health and Human Services.

Our members receiving hospice care leave our managed care and become fee-for-service through the Texas HHSC. Members receiving hospice within a nursing facility will continue to receive our service coordination services.

Members 20 years or younger, in Medicaid or enrolled in CHIP, may receive curative treatment and hospice services at the same time.

For more information, go to TMHP.com > Medicaid Provider Manual > Vol. 1 Client Eligibility > Section 4.3.3 Hospice Program.

For more information about STAR+PLUS and MMP Nursing Facility services, go to TMHP.com > Medicaid Provider Manual.

Laboratory, x-rays, imaging procedures

Advanced outpatient imaging procedures

Advanced outpatient imaging procedures must be prior authorized by UnitedHealthcare Community Plan. Diagnostic imaging procedures requiring the injection or ingestion of radiopaque chemicals are performed only under the direction of physicians qualified to perform those procedures. To get prior authorization, go to **UHCprovider.com/priorauth** > click on the Radiology tab, or call UnitedHealthcare Community Plan Radiology.

Laboratory services

Labcorp and Quest Diagnostics are our in-network lab providers. Contact Labcorp directly at 1-800-833-3984 and Quest Diagnostics directly at 1-866-697-8378.

Use UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by PCPs, other care providers or dentists in one of these laboratories do not require prior authorization except as noted on our prior authorization list.

For more information on our in-network labs, go to **UHCprovider.com/findprovider** > **Preferred Lab Network**.

Genetic testing

For Genetic Testing, go to **UHCprovider.com/priorauth** > click on the Genetic and Molecular Testing tab. Prior authorization may be required.

When submitting claims, have a Clinical Laboratory Improvement Amendment number (CLIA #). Otherwise, claims will deny. CLIA standards are national and not Medicaid-exclusive. CLIA applies to all care providers rendering clinical laboratory and certain other diagnostic services.

See the **Billing and Submission** chapter for more information.

For Medicaid members through age 20, Texas Health Steps requires the use of the Texas Department of State and Health Services (DSHS) Laboratory Services for specimens obtained as part of a Texas Health Steps medical checkup, including newborn screens; blood lead testing; hemoglobin electrophoresis; and total hemoglobin tests that are processed at the Austin Laboratory; and pap smear, gonorrhea, and chlamydia screening processed at the Women's Health Laboratories in San Antonio. Specimens for glucose, cholesterol, HDL, lipid profile, HIV, and RPR may be submitted to the DSHS Laboratory or Labcorp. Hematocrit may be performed at the care provider's clinic if the care provider needs an immediate result for anemia screening.

For more information about screenings and procedures for submitting to the DSHS Laboratory, go to tmhp.com > providers > Medicaid Provider Manual, and dshs.texas.gov/lab.

Or visit the Texas Health Steps Online Provider Training Modules at txhealthsteps.com/courses.

Maternity/pregnancy/ well-child care

Pregnancy/maternity

You may bill global days if the mother has been a UnitedHealthcare Community Plan member for 3 or more consecutive months or had 7 or more prenatal visits.

Medicaid does not consider ultrasounds medically necessary if they are done only to determine the fetal sex or provide parents with a photograph of the fetus. We allow the first 3 obstetrical ultrasounds per pregnancy. The fourth and subsequent obstetrical ultrasound procedures will only be allowed for identified high-risk members. High-risk member claims must include the corresponding diagnosis code.

For prior authorization maternity care, including out-of-plan and continuity of care, call **1-888-887-9003** or go to or go to **UHCprovider.com/priorauth**. Complete the online Risk Assessment form to initiate case management outreach.

Pregnant UnitedHealthcare Community Plan members should receive care from UnitedHealthcare Community Plan care providers only. UnitedHealthcare Community Plan considers exceptions to this policy if:

1. The woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and
2. If she has an established relationship with a non-participating obstetrician.

UnitedHealthcare Community Plan must approve all out-of-plan maternity care.

A UnitedHealthcare Community Plan member does not need a referral from her PCP for OB/GYN care. Perinatal home care services are available for UnitedHealthcare Community Plan members when medically necessary.

Maternity admissions

All maternity admissions require notification. Days in excess of 48 hours for vaginal deliveries and 96 hours for C-section require clinical information and medical necessity review.

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/priorauth**, or call Prior Authorization Department at **1-888-887-9003.**

Provide the following information within one business day of the admission:

- Date of admission
- Member's name and Medicaid ID number
- Obstetrician's name, phone number, care provider ID
- Facility name (care provider ID)
- Vaginal or cesarean delivery

If available at time of notification, provide the following birth data:

- Date of delivery
- Gender
- Birth weight
- Gestational age
- Baby name

Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after mother's discharge require separate notification and will be subject to medical necessity review. The midwife (CNM) must be a licensed registered nurse recognized by the Board of Nurse Examiners as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives.

A CNM must identify a licensed care provider or group of care providers with whom they have arranged for referral and consultation if complications arise.

Furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through a nurse practitioner, physician's assistant or licensed professional nurse. If handled through supervision, the services must be within the staff's scope of practice or licensure as defined by state law.

You do not have to be present when services are provided. However, you must assume professional responsibility for the medical services provided and help ensure approval of the care plan.

For additional pregnant member and baby resources, see Healthy First Steps in **Chapter 7**.

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the mother and her newborn. Post-discharge care consists of a minimum of two visits, at least one in the home, according to accepted maternal and neonatal physical assessments. A registered professional nurse, with experience in maternal and child health nursing, or a care provider must conduct these visits. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date. Prior authorization is required for home health care visits for post-partum follow-up. The attending care provider decides the location and post-discharge visit schedule.

Newborn enrollment

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members (provided the mother was admitted using her ID card).

If the mother delivers out of state, the member would need to contact the Enrollment Department to provide birth notification. The Enrollment Department would then add the baby to the health plan.

The hospital provides enrollment support by providing required birth data during admission.

Bright Futures Assessment

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics. It is supported by the U.S. DHHS, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

The Bright Futures Guidelines informs all preventive care screenings and well-child visits. You may incorporate Bright Futures into health programs such as home visits, child care and school-based health clinics. Materials developed for families are also available.

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care based on **Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents**.

Settings for Bright Futures implementation include:

- Private practices
- Hospital-based or hospital-affiliated clinics
- Resident continuity clinics
- School-based health centers
- Public health clinics
- Community health centers
- Indian Health Service clinics
- Other primary care facilities

A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the Bright Futures Guidelines. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.

Home care and all prior authorization services

The discharge planner ordering home care should call the Prior Authorization Department at **1-888-887-9003** to arrange for home care.

Pregnancy termination services

Allowable pregnancy termination services do not require a referral from the member's primary care provider. Members must use the UnitedHealthcare Community Plan care provider network.

Neonatal intensive care unit case management

The neonatal intensive care unit (NICU) management program manages inpatient and post-discharge neonatal intensive care unit (NICU) cases to improve outcomes and lower costs. Our dedicated team of NICU case managers, social workers and medical directors offer both clinical care and psychological services.

The NICU Case Management program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth. High risk newborns placed in the NICU are eligible upon birth for NICU Case Management services.

The NICU Case Management team works closely with Neonatal Resource Services (NRS) team neonatologist and Utilization Management nurses, health plan registered nurses and social worker care managers to support and coordinate needed care for NICU infants and their families, as appropriate.

Inhaled nitric oxide

Use the guidelines for inhaled nitric oxide (iNO) therapy at **UHCprovider.com/policies** > For Community Plans > Medical and Drug Policies for Community Plan. Search for "Inhaled Nitric Oxide Therapy."

Oncology

Prior authorization

For information about our oncology prior authorization program, including radiation and chemotherapy guidelines, requirements and resources, go to **UHCprovider.com/oncology** or call **1-888-397-8129** Monday–Friday, 7 a.m.–7 p.m. CT.

Pharmacy

Role of pharmacy (ALL)

Pharmacy providers dispense medications and monitor members' health and progress to maximize their response to the medication. They also educate members on how to use prescriptions and over-the-counter medications. Pharmacy providers advise physicians, nurses and other health professionals on drug decisions. Pharmacists coordinate with prescribing care providers to help ensure comprehensive member care.

Pharmacy providers offer expertise about drug composition. They make sure that drugs do not interact in a harmful way.

Pharmacies may also contract for Limited Home Health Supplies (LHHS) with UnitedHealthcare Community Plan according to the Texas Vendor Drug Program Requirements.

Pharmacy care 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 eligible medication
- Coordinate benefits when a member also receives Medicare Part D services or other insurance benefits

Pharmacies serving our members are enrolled with the Texas Health and Human Services Commission (HHSC) Vendor Drug Program.

To enroll, visit txvendordrug.com > Providers > Pharmacy Provider Enrollment.

Preferred drug list (All)

UnitedHealthcare Community Plan determines and maintains its prescription drug list (PDL) of covered medications. This list applies to all UnitedHealthcare Community Plan of Texas members. Specialty drugs on the PDL are identified by a "SP" in the "Requirements and Limits" section of each page.

You must prescribe Medicaid members drugs listed on the PDL. We may not cover brand-name drugs not on the PDL if an equally effective generic drug is available and is less costly unless prior authorization is followed.

If a member requires a nonpreferred medication, call Pharmacy Prior Authorization at **1-800-310-6826** or use the online Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal.

We provide you PDL updates before the changes go into effect. Change summaries are posted on **UHCprovider.com**. Find the PDL and Pharmacy Prior Notification Request form at **UHCprovider.com/priorauth**.

Formulary (All)

A formulary is a list of all the drugs the plan covers. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription

is filled at a network pharmacy or through our network mail order pharmacy service, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on coverage.

The drugs on the formulary are selected by our plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program. Both brand name drugs and generic drugs are included on the formulary. A generic drug has the same active ingredient formula as the brand name drug but usually costs less and is rated by the Food and Drug Administration (FDA) to be as safe and effective.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. In other cases, we have decided not to include a particular drug. We may also add or remove drugs from the formulary during the year. If we change the formulary, we will notify the member of the change at least 60 days before the effective date of change. If we don't notify the member of the change in advance, the member will get a 60-day supply of the drug when they request a refill. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will NOT give 60-days' notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

To find out what drugs are on the formulary or to request a copy of our formulary, please contact UnitedHealthcare Connected Member Services. The number can be located on the back of the member's ID card.

View the formulary, list of covered drugs and preferred drug list at:

- **UHCprovider.com/TXCommunity Plan** > Pharmacy Resources and Physician Administered Drugs > Prescription Drug Lists/ Formulary Lists, Drug Search and Updates
- Medicaid/CHIP Vendor Drug Program: txvendordrug.com > Formulary/PDL

Review the formulary to see if a drug you are prescribing is subject to requirements or limits. If the drug is subject to requirements or limits, you can ask us to make an exception to our coverage rules.

The pharmacist must coordinate benefits when a member also receives Medicare Part D services or other insurance benefits.

Formulary information for handheld devices (All)

Epocrates Rx is a free service providing instant access, through a hand-held or other online device, to information on the drugs covered by Texas Medicaid. To register for the service, go to epocrates.com and sign up for free Epocrates Rx, or download the Epocrates RX app on your hand held device.

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.

Out-of-network pharmacies Medicare-Medicaid plan

Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Out-of-network prescriptions may be covered in the following circumstances:

- The prescriptions are related to care for a medical emergency or urgent care. In this situation, members will pay the full cost (rather than paying just the copayment). UnitedHealthcare Connected members can ask for reimbursement by submitting a paper claim form.
- If a UnitedHealthcare Connected member requires prescription drugs, and they are outside of the plan's service area but still in the U.S., we will cover prescriptions filled at an out-of-network pharmacy. In this situation, members will pay the full cost (rather than paying just the copayment). UnitedHealthcare Connected members can ask for reimbursement by submitting a paper claim form.
- A UnitedHealthcare Connected member is unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service
- A member is trying to fill a covered prescription drug not regularly stocked at an eligible network retail pharmacy. (This may include orphan drugs or other specialty pharmaceuticals.)

Before filling a prescription at an out-of-network pharmacy, please contact Member Services to see if a network pharmacy is available. If there aren't, our Member Services may be able to make arrangements

for the member to get their prescriptions from an out-of-network pharmacy. Prescription medication information is available under Medicare Part B and at TXVendorDrug.com > Formulary > Formulary > Preferred Drugs > Preferred Drug Lists Both the Texas Medicaid formulary and preferred drug list are available in a mobile format.

e-prescribing (All)

Electronic prescribing (e-prescribing or eRx) allows prescribing providers to electronically send an accurate, error-free and understandable prescription directly to a pharmacy. You can view medication history reports, and it can verify eligibility and formulary data for a patient before and during the prescribing process.

UnitedHealthcare Community Plan supports pharmacy claims e-prescribing. Pharmacies should submit the "Prescription Origin Code" (Field 419-DJ) on all billing submissions in support for e-prescribing transactions. The field is optional for National Council for Prescription Drug Programs (NCPDP) B1 transactions in version 5.1, but required for D.0 B1 transactions.

We support Surescripts. Surescripts connects pharmacies, care providers, benefit managers, and technology partners to get the right information to the right place at the right time. For more information, visit surescripts.com. Electronic prescribing of controlled substances (EPCS) is allowed and preferred.

Comprehensive Care Program (STAR and STAR Kids)

The Medicaid Comprehensive Care Program (CCP) can cover medically necessary drugs and supplies not available through a member's benefits for members younger than 21 years old. Examples include some over-the-counter drugs, nutritional products, and disposable or expendable medical supplies commonly found in pharmacies.

Enroll by completing an application at tmhp.com. For assistance, contact the TMHP Contact Center at **1-800-925-9126**, or email TMHP Provider Relations to request assistance from the local TMHP provider relations representative in your area.

Learn more about DME and the Comprehensive Care Program at txvendordrug.com > Providers >Pharmacy DME enrollment.

Prior authorization (All)

Some drugs on the formulary and preferred drug list (PDL) may require prior authorization.

View the formulary and PDL at txvendordrug.com > Formulary/PDL.

See the Medical Management Guidelines in this chapter of the manual for more information, or call the Pharmacy Help Desk at **1-800-310-6826** for questions about the prior authorization process.

Submit prior authorization for Medicaid-only medications with a paper form. This form is at **UHCprovider.com/TXCommunityPlan** > Prior Authorization and Notification Resources. Under Need More Help?, click the **Pharmacy Resources** link. Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**.

Step therapy (CHIP, STAR, STAR+PLUS, Medicare-Medicaid plan)

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 cases, other non-PDL alternatives are available with prior authorization.

Emergency prescription supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and 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 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 may call our Pharmacy Help Desk at **1-877-305-8952** for questions or assistance with submission information for a 72-hour emergency prescription supply.

You may call the **1-800-310-6826** for more information about the 72-hour emergency prescription supply policy.

Special notes for STAR Kids members

For second-generation antiviral drugs to treat Hepatitis C, you should not use a 72-hour emergency rule. These medications require strict prior authorization review.

We assess a member's medical and drug claim history to determine whether the member's medical condition satisfies the applicable criteria for dispensing a drug without an additional prior authorization request (see Texas Government Code § 531.073(h)).

In follow up to a 72 - hour emergency request override, UnitedHealthcare Community Plan may require a prescribing provider to request a PA as a condition of coverage or pharmacy payment, if the PA request is approved or denied within 24 hours of receipt.

Days' supply dispensing limitation

CHIP, STAR, STAR+PLUS members may receive up to a one-month supply (34 days) of a specific medication per prescription order or prescription refill. You may reorder or refill a medication when the member uses 75 percent of the medication. If you submit a claim before the member uses 75 percent of the medication, based on the original day supply submitted on the claim, the claim will reject with a "refill too soon" message.

Contact the Help Desk at **1-800-310-6826** 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 a 90-day drug supply.

Days' supply dispensing limitation (STAR Kids)

STAR Kids members may receive up to a one-month supply (31 days) of a specific medication per prescription order or prescription refill. You may reorder or refill a medication when the member uses 75 percent of the medication. If you submit a claim before the member uses 75 percent of the medication, based on the original day supply submitted on the claim, the claim will reject with a "refill too soon" message. Contact the Help Desk at **1-800-310-6826** with questions or for help with dosage change authorization.

Quantity limitations

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

The following are quantity limitation types:

- Monthly prescription quantities greater than the indicated limit require a prior authorization
- Quantity limits based on 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 program limits are established based on Federal Drug Administration dosing approval and the availability of the total daily dose in the least amount of daily tablets or capsules. Quantity limits in the prescription claims processing system will limit the dispensing to consolidate dosing. The pharmacy claims processing system will prompt the pharmacist to request a new prescription order from the prescribing provider.

We will notify you of any quantity limitations program drug list additions that are made.

We recognize you must consider patient specific variables when drug therapy is prescribed, and therefore overrides are available through the medical exception (prior authorization) process.

More information about drug specific quantity limits can be found at **UHCprovider.com/TXCommunityPlan** > Pharmacy Resources and Physician Administered Drugs.

Members not in the dual eligibility program can have unlimited prescriptions.

New to therapy short-acting opioid supply and daily dose limits (All)

UnitedHealthcare Community Plan has implemented a short-acting opioid supply limit of 3 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 **1-888-362-3368.**

Member choice (All)

Members have the right to obtain medication from any pharmacy contracted within the UnitedHealthcare Community Plan network.

Product order cancellation CHIP, STAR, STAR Kids, STAR+PLUS

If you offer service delivery for covered products, such as DME, home health supplies, or outpatient drugs or biological products, you are required to reduce, cancel, or stop delivery at the member's or the member's authorized representative's written or verbal request. You must maintain records documenting the request.

Confirm with the member that you should deliver an automated, covered refill order or a new prescription. You should also have a policy for and complete a drug regimen review on all prescriptions filled as a result of the auto-refill program. The goal of drug regimen review is to help ensure optimal patient outcomes are achieved from the drug therapy. This includes consideration of the indication, effectiveness, and safety of each medication and the patient's compliance with drug therapy. It also includes the identification, resolution and prevention of medication-related problems. Members must have the option to withdraw from an automated refill delivery program at any time, so ensure you have a policy in place to allow the member to do so.

Pharmacy claims processing (All)

Please refer to **Optum RX Pharmacy Provider Manual** and payer specification documents for complete claims submission requirements and guidelines.

UnitedHealthcare Community Plan Programs' Processor Information:

- Processor name: Optum Rx™
- Bank Identification Number (BIN): 610494
- Processor Control Number (PCN): 9999
- Submitted Group: ACUTX

Also see the Texas Uniform Managed Care Manual, Chapter 2.2 Pharmacy Claims Manual.

Psychotropic medication utilization parameters for foster children CHIP, STAR, STAR Kids, STAR+PLUS

CHIP, STAR, STAR Kids and STAR+PLUS members may not be in foster care. However, PCPs treating a CHIP, STAR, STAR Kids and STAR+PLUS member must contractually comply with the Psychotropic Medication Utilization Parameters for Foster Children found at dshs.texas.gov > mental health programs > Psychotropic Medication Utilization Parameters for Foster Children.

Radiology prior authorization program

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for radiology procedures.

You must obtain prior authorization for the following advanced imaging procedures if you provide them in an office or outpatient setting:

- Computerized Tomography (CT)

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron-Emission Tomography (PET)
- Nuclear Medicine
- Nuclear Cardiology

Advanced imaging procedures do not require prior authorization if performed in the following places of service:

- ER
- Observation unit
- Urgent care
- Inpatient stay

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone at:

- **Online: UHCprovider.com/radiology** > Sign In
- **Phone: 1-866-889-8054** from 8 a.m. - 5 p.m. CT, Monday-Friday. Make sure the medical record is available. An authorization number is required for each CPT code

For a list of Advanced Outpatient Imaging Procedures that require prior authorization, a prior authorization crosswalk, and/or the evidence-based clinical guidelines, use the search option at **UHCprovider.com/radiology** > Specific Radiology Programs.

Screening, brief interventions, and referral to treatment services

Screening, brief interventions, and referral to treatment services (SBIRT) are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed healthcare professional within the scope of their practice
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed
- SBIRT screening will occur during an Evaluation and Management (E/M) exam and is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to 4 sessions per patient, per provider per calendar year.

What is included in screening, brief interventions, and referral to treatment services?

Screening: With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other drug (substance) use problems and determine how severe those problems already are. 3 of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

Brief intervention: If screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences and motivates them to change their behavior.

Referral to treatment: Refer members whose screening indicates a severe problem or dependence s to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. This includes coordinating with the Alcohol and Drug Program in the County where the member resides for treatment.

SBIRT services will be covered when all of the following are met:

- The billing and servicing providers are SBIRT certified
- The billing provider has an appropriate taxonomy to bill for SBIRT
- The diagnosis code is V65.42
- The treatment or brief intervention does not exceed the limit of 4 encounters per client, per provider, per year

The SBIRT assessment, intervention, or treatment takes places in one of the following places of service:

- Office
- Urgent care facility
- Outpatient hospital
- ER – hospital
- Federally qualified health center (FQHC)
- Community mental health center
- Indian health service – free standing facility
- Tribal 638 free standing facility
- Homeless Shelter

For more information about E/M services and outreach,

see the Department of Health and Human Services Evaluation and Services online guide at cms.gov.

Medication-assisted treatment

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat opioid use disorders (OUD). The FDA-approved medications for OUD include buprenorphine, methadone and naltrexone. To prescribe buprenorphine, you must have a current registration with the United States Drug Enforcement Agency (DEA) and be authorized to prescribe buprenorphine in the state.

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services. If you need help finding a behavioral health care provider, call the number on the back of the member's health plan ID card or search for a behavioral health professional on **liveandworkwell.com**.

To find a medical MAT provider in Texas:

1. Go to **UHCprovider.com/findprovider.**
2. Select the care provider information.
3. Click on "Medical Directory."
4. Click on "Medicaid Plans."
5. Click on applicable state.
6. Select applicable plan.
7. Refine the search by selecting "Medication Assisted Treatment."

If you have questions about MAT, please call **Provider Services** at **1-888-887-9003**, enter your Tax Identification Number (TIN) then say 'Representative', and 'Representative' a second time, then 'Something Else' to speak to a representative.

Service coordination (All)

Service coordinator role

Our UnitedHealthcare Community Plan and UnitedHealthcare Connected service coordination is arranged by the MCO to:

- Develop a service plan or Individualized Service Plan as appropriate
- Coordinate services among a member's PCP, specialty providers and non-medical care providers

This ensures appropriate access to covered services, non-capitated services and community services.

Each member has a Service Coordination Team led by an assigned service coordinator who develops and implements a person-centered plan for care. The team consists of the member and/or their legally authorized representative (LAR). The member is assured the choice of the providers who will participate, as appropriate, including the PCP, behavioral health providers, and Long-Term Services and Supports (LTSS) care providers.

The service coordinator works with the member, the member's family or legally authorized representative (LAR) and those involved in the member's care to coordinate all covered services, non-capitated services, and non-covered services available through other sources.

Some service coordination is accomplished through a care provider group contracted as a Health Home rather than from our UnitedHealthcare Community Plan service coordinators. The Health Home provides all assessment, planning and service delivery of the person-centered care.

Service coordinators contact members by telephone, audio-visual telecommunications or in-person visits based on the member's needs and preferences. HHSC may, on a case-by-case basis, require us to discontinue service coordination or assessments using telecommunications if discontinuation is in the best interest of the recipient. An initial health risk assessment is performed within 30 days of health plan enrollment.

Members who have intellectual or developmental disabilities (IDD), who live in a community-based intermediate care facility for individuals with an intellectual disability or related conditions (ICF-IID) or who are receiving LTSS through an IDD waiver must have a named service coordinator, regardless of service coordination level. The number of required service coordination contacts and level of service coordination shall vary based on the member's acuity and individual needs/preferences of the member or their authorized representative (AR). Service coordinators must document, in the member record, the recommended number and types of contact needed to support the member, along with the member's preferences for service coordination.

Assessment and planning care (STAR Kids)

Our registered nurse service coordinators perform the STAR Kids Screening Assessment Instrument (SK-SAI) in the member's home, when a member is new to our health plan and annually thereafter, unless the member experiences a change in condition or circumstances. The SK-SAI helps prioritize which members require the most immediate attention and their level of needs.

The SK-SAI addresses:

- Member preferences, cultural considerations and abilities
- Possible need to add the Personal Care Assessment Module (PCAM) and/or the Nursing Care Assessment Module (NCAM)
- Possible need for the Medically Dependent Children's Program Module (MDCP)
- Follow-up assessment needs, such as behavioral health, physical/occupational/speech therapy or community-based long-term service and supports
- Determination of service coordination levels based on each member's complexity of care
- Considerations for inclusion to the member's individual service plan

Texas Health and Human Services Commission

Texas Health and Human Services Commission (HHSC) 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 > Medicaid Provider Manual > Behavioral Health, and Case Management Services Handbook > Section 5.2 Services, Benefits, Limitations, and Prior Authorization > 5.2.1 Service Coordination.

Service coordination levels (STAR+PLUS)

Level 1: Higher-risk members are considered level I service coordination category. These members have complex medical needs, are in a STAR+PLUS waiver program or have a severe and persistent mental illness (SPMI). Their service coordinator visits them at least twice per year and speaks with members with SPMI by phone at least once per year.

Level 2: Lower risk members are in the level 2 service coordination category. They may have a history of certain behavioral health issues, may be dual eligible but do not meet level 1 requirements, or be in the Medicaid Breast and Cervical Cancer (MBCC) program. Members in this category also include those receiving LTSS for personal assistance, community first choice or day activity health care. Members who are dual eligible (D-SNP) in this level will receive at least two telephone calls per year. Other members in this category must have their service coordinator visit them at a minimum once per year. A service coordinator may determine it is appropriate to offer telehealth service coordination in place of an in-person visit if no assessment or reassessment is being conducted. MBCC may receive in-person assistance with the 6 month recertification process as part of the required in-person visit.

Level 3: STAR+PLUS members who do not qualify for service coordination levels 1 or 2 are considered level 3. This includes members in nursing facilities for hospice care or in nursing facilities outside of UnitedHealthcare Community Plan's contracted service areas. These members receive at least 2 phone calls from a service coordinator per year, and are not required to have a named service coordinator unless:

- They request service coordination services
- They are nursing facility residents receiving hospice services
- They are residents in a nursing facility outside the MCO's service area

Service coordination levels Medicare-Medicaid plans

Level 1: Higher-risk members are considered level I service coordination category. These members have complex medical needs, are in a waiver program or have an SPMI. Their service coordinator has two face-to-face visits with them per year and speaks with SPMI members by phone at least once per year.

Level 2: Lower-risk members are in the level 2 service coordination category. They may have a

history of certain behavioral health issues and are dual eligible but do not meet level 1 requirements. Members in this category also include those receiving LTSS for personal assistance, community first choice or day activity health care. Members who are in this level will receive at least one face-to-face visit and one telephone call per year.

Service coordination levels (STAR Kids)

Level 1: These members have a personally assigned service coordinator who visits them a minimum of 4 face-to-face visits annually, in addition to monthly phone calls, unless otherwise requested by the member or member's LAR. A face-to-face service coordination contact may be counted as a monthly contact as long as there are no additional needs identified during the contact that require coordination of the member's needs. Members at this level of coordination:

- Are in the Medically Dependent Children Program (MDCP) qualify financially and require nursing facility level-of-care for their complex needs without community Long-Term Services and Supports
- Have complex needs or a history of developmental or behavioral health issues, such as multiple outpatient visits, hospitalization, or institutionalization within the past year
- Have serious emotional disorders or serious persistent mental illness that is long-lasting and has disrupted their daily lives

Level 2: These members have a personally assigned service coordinator who visits them a minimum of two times annually with 6 phone calls, unless otherwise requested by the member or the member's LAR. Members at this level of coordination:

- Receive Personal Care Services (PCS), Community First Choice (CFC), or Nursing as supports to allow them to live in the community
- Would benefit from this higher level of service coordination based on results from the STAR Kids Screening and Assessment Process and other findings
- Have a history of substance use disorder, and multiple outpatient visits, hospitalization, or institutionalization within the past year
- Have a behavioral health condition that significantly impairs their normal functioning, but is not a serious emotional disorder (SED) or a serious and persistent mental illness (SPMI)

Level 3: These members have a personally assigned service coordination to visit at least once annually with at least 3 phone calls. This service coordination is received at the member's request.

Individualized service plan (STAR Kids)

A comprehensive person-centered individual service plan is uniquely developed for every STAR Kids member, to articulate assessment findings, short and long-term goals, service needs, and member preferences. The care team is facilitated by the member's assigned service coordinator and consists of the:

- Member
- Member's family and/or legally authorized representative (LAR)
- Member's PCP
- Other service providers for the member
- Specialists such as medical or behavioral health
- Therapists
- LTSS providers
- Early childhood education providers
- Adult transition specialist
- Others as indicated for the member's personal and complex needs

The care plan has a person-centered planning approach and addresses short and long-term goals. We share the care plan through CommunityCare, our online care coordination capability the treatment team can securely access.

Access the CommunityCare application on **UHCprovider.com.**

We update the care plan annually and allow for continuity of care for member service needs. It may also be updated when the member requests it or when the member experiences a change in condition or circumstances. If you notice a change in member condition or circumstances, send an email directly to the member's service coordinator using the service coordinator's contact information listed in CommunityCare.

You may also call the STAR Kids service coordination hotline at **1-877-352-7798.**

To help ensure a seamless transition of service coordination, when a member transitions to our care from another managed care organization (MCO), our service coordinator assigned to the member will contact the member's previous MCO service coordinator requesting information regarding the member's needs, current medical necessity determinations, authorized care, and treatment plans.

To help ensure the member's condition remains stable and treatment meets their complex needs, the member may continue to receive presently authorized services that were included in the member's previous care plan. These services may continue with the care provider delivering those services, even if the care provider is out-of-network. These services may continue until the time we are able to complete a STAR Kids Screening and Assessment Process and issue a new treatment plan.

Promoting independence

We participate in the Promoting Independence initiative, which helps aged and disabled individuals remain in their home and community with LTSS assistance.

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, depending on available resources and considering the needs of others who are receiving state-supported disability services

Our service coordinators complete a member assessment within 30 days of admission to a long-term care facility. We develop a plan of care and if appropriate, include plans to transition the member back into the community.

- If a return to the community is possible at the initial review, the service coordinator works with the member and family to return the member to the community using community- based Long-Term Services and Supports
- 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 changes in the member's condition or circumstances that may allow a return to the community. The service coordinator will develop and implement the transition plan.
- If the second assessment does not support a return to the community, we will continue to follow our member to further assess for a possible return to the community. In the meantime, the member's benefits return to fee-for-service.

Discharge planning (STAR+PLUS and Medicare-Medicaid plan)

Discharge planning involves the member, the member's family or LAR, attending physician, member's PCP, the hospital, or nursing facility or other care settings discharge planner(s). Discharge means a member's formal release from an inpatient stay when the need for continued care has ended. A transfer from one hospital or facility to another for continued treatment within 24 hours is not a discharge under this contract. Planning considers the next least restrictive level of care, necessary community resources and follow up. When a member is ready to return to community living, our service coordinator develops and implements a member-centered transition plan which includes coordinating:

- Member and member's family (or other social supports)
- The facility social worker
- The HHSC relocation specialist
- The long-term care ombudsman
- Member's PCP and other health care professionals
- Community resources

The service coordinator secures any necessary service prior authorizations in the discharge plan. The service coordinator also secures necessary Long-Term Services and Supports to allow the member to have their complex needs met while living in the community. The treatment team will be able to preview potential, medically necessary community-based service supports.

The plan includes appropriate and available resources, and address covered and non-covered services from a member's benefits, including those from the Texas Health and Human Services or Department of State Health Services Home and Community-based Waiver Programs:

- Community Living Assistance and Support Services (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD)

- Home and Community-based Services (HCBS)
- Texas Home Living (TxHmL)
- Youth Empowerment Services (YES)

UnitedHealthcare Connected (MMP) will assist participating care providers and hospitals in the inpatient discharge planning process implemented in accordance with requirements under the Medicare Advantage Program.

At the time of admission and during the hospitalization, the UnitedHealthcare Connected medical management staff may discuss discharge planning with the participating care provider, member and family.

Outpatient services review

Outpatient review involves the retrospective evaluation of outpatient procedures and therapies to determine medical necessity and appropriateness.

For more information, visit TMHP.com > Medicaid Provider Manual.

Preadmission Screening and Resident Review

The STAR+PLUS (including MMP) Preadmission Screening and Resident Review (PASRR) requires 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 they need in those settings.

For more information, visit TMHP.com > Medicaid Provider Manual > Behavioral Health and Case Management Services Handbook.

Transition plan (STAR+PLUS and Medicare-Medicaid 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 additional managed care programs

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 , MMP or STAR Kids program in a service area, we must honor existing LTSS authorizations for up to 6 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. An exception is reimbursement for service continuation 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 6 weeks of delivery.

Contact the service coordinator at **1-800-349-0550** for STAR+PLUS or MMP, **1-877-352-7798** for STAR Kids or **1-888-887-9003** for CHIP and STAR to report any change in a member's condition or circumstances. You may also send an electronic message through CommunityCare, our online service coordination platform, to plan and coordinate ongoing care.

Adoption assistance and permanency care assistance (STAR)

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 of 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, or children in the Early Childhood Intervention (ECI) program.

We provide service management to MSHCN, including developing a service plan and ensuring treatment

access by a multidisciplinary team when necessary. We include primary care and specialty care providers who are experienced in patients with MSHCN.

We explore community resource availability to help support a holistic approach to meeting member needs, such as:

1. Local school districts (Special Education).
2. Texas HHSC Medical Transportation Program (MTP).
3. Civic and religious organizations and consumer and advocacy groups (United Cerebral Palsy).

Members with Special Health Care Needs

Members with Special Health Care Needs (MSHCN) means a member who both:

- Has a serious ongoing illness, a chronic or complex condition or a disability that has lasted or is anticipated to last for a significant period of time; and
- Requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel

Members may need access to IDD services. These include case management and LTSS delivered by care providers contracted with the Texas Health and Human Services (formerly the Department of Aging and Disability Services). See more at TMHP.com > Resources > Provider Manuals > Texas Medicaid Provider Procedures Manual.

MSHCN also includes Early Childhood Intervention (ECI) program participants, pregnant women who have a high-risk pregnancy, members that have a mental illness with substance use disorder, members with behavioral health issues that may affect physical health or treatment compliance and Adoption Assistance and Permanency Care Assistance program members. (This is not an all-inclusive list.)

We have an established system for identifying and contacting members who may have special health care needs. Members may also request an assessment to determine if they meet the criteria for MSHCN. For members identified as MSHCN, we provide case management. This includes the development of a service and care plan to ensure the provision of medically necessary covered services and services with non-managed care programs, such as FFS waivers to meet preventive, primary acute care and specialty health care needs appropriate for treatment of the member's condition, and access to treatment by a multidisciplinary team when needed.

To refer a patient who may qualify as having special health care needs, contact **1-888-887-9003** or email **uhctxstaraapca@uhc.com.**

Sexually transmitted diseases and human immunodeficiency virus/ acquired immunodeficiency syndrome (All)

Inform members about their responsibility of risk reduction and partner notification if sexually transmitted diseases (STDs) syphilis, cancroid, gonorrhea, chlamydia and/or human immunodeficiency virus (HIV)/ acquired immunodeficiency syndrome (AIDS) are confirmed.

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

- The manner in which medical records are safeguarded
- How employees are to protect medical information
- Under what conditions information can be shared

For STD and/or HIV/AIDS prevention, screening, counseling, diagnosis, and treatment, see the American Academy of Pediatrics Policy Statement. Screening for Nonviral Sexually Transmitted Infections in Adolescents and Young Adults by the Committee on Adolescence and Society for Adolescent Health and Medicine. July 2014, VOLUME 134. ISSUE 1.

You may find information about Texas laws pertaining to STD and/or HIV/ AIDS at the Texas Department of State Health Services at dshs.texas.gov/hivstd > HIV/STD Topics A-Z > Laws, Rules and Authorization.

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high quality, cost effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has one or more of the following characteristics:

- It is used by a small number of people
- Treats rare, chronic, and/or potentially life-threatening diseases
- Has special storage or handling requirements such as needing to be refrigerated
- May need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- May not be available at retail pharmacies
- May be oral, injectable, or inhaled

Specialty pharmacy medications are available through our specialty pharmacy network. For more information about specialty pharmacy medications, go to **UHCprovider.com/priorauth.**

Specialty pharmacy medications requirements

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/pharmacy** > For Community Plans > 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.

Successful transition to adulthood (STAR Kids)

The STAR Kids program is for members ages birth – 20 years. We support the unique transition needs of STAR Kids members younger than 10 years old.

We will help ensure teens and young adult members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. Each MCO is responsible for conducting ongoing transition planning starting when the member turns 15 years old. The MCO must provide transition planning services as a team approach through the named service coordinator, if applicable, and with a transition specialist within the

Member Services Division. Transition specialists are dedicated to counseling and educating members and others in their support network about considerations and resources for transitioning out of STAR Kids. Transition specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the member in the transition process.

We determine the member's personal development and provide the following needed supports:

- Personal attributes likes/dislikes
- Social, spiritual and cultural values
- Intellectual ability
- Sensory accommodations
- Daily living activities
- School and vocational training
- Employment aspirations
- Ultimate residential type
- Physical and behavioral health care

How you can help:

- **Member Involvement in Health Care:** Address STAR Kid members directly. Use terms that help them understand their condition(s), medications, and actions they should take for their care.
- **Building Skills and Supporting Community Living:** Our service coordinator will work with you for necessary Long-Term Services and Supports (LTSS). See the LTSS section of this manual for available LTSS services information. See the Service Coordination section of this manual for assessment information.
- **Transferring Care:** You may refer a STAR Kid to an adult PCP and other appropriate specialists. We help find adult health care professionals that meet members' needs, and work with you to assist transferring care records to the receiving PCP.

UnitedHealthcare Community Plan may directly contact the receiving (adult) PCP on your behalf, and we encourage you to contact them also. We contact the receiving PCP before the STAR Kid member's first appointment. We help ensure continuity of care for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in member service(s).

Transition planning must include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in member service(s).
2. Before the member is 10 years old, the MCO must inform the member and the member's LAR about Texas Health and Human Services' (HHS) LTSS programs and, if applicable, assist in completing the needed application information.
   - LTSS programs include CLASS, DBMD, TxHmL, and HCS.
3. We must regularly update the ISP with transition goals starting when the member is 15 years old.
4. Coordination with DARS to help identify future employment and employment training opportunities.
5. Coordination with the member's school and Individual Education Plan (IEP) to help ensure consistency of goals, if requested by the member or the member's LAR.
6. Health and wellness education to assist the member with self-management.
7. Resource identification to assist the member, the member's LAR, and others in the member's support system to anticipate barriers and opportunities that may impact the member's transition to adulthood.
8. Assistance applying for community services and other supports under the STAR+PLUS program after the member's 21st birthday.
9. Assistance identifying adult health care providers.

Tuberculosis screening and treatment; direct observation therapy

Tuberculosis (TB) services are provided by DSHS-approved care providers (direct observation therapy (DOT) and contact investigation). For more information, visit Texas Medicaid Provider Procedures Manual TMHP > Clinics and Other Outpatient Facility Services Handbook

Guidelines for TB screening and treatment should follow the recommendations of the American Thoracic Society (ATS) and the CDC.

Responsibilities

Identification – The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment.

You will coordinate and collaborate with Local Health Departments (LHDs) for TB screening, diagnosis, treatment, compliance, and follow-up of members. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the Local Health Department (LHD). The PCP must report known or suspected cases of TB to the LHD TB Control Program within one day of identification.

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.

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.

Waiver programs

Human immunodeficiency virus / acquired immune deficiency syndrome Home and Community-Based Services waiver program

The HIV/AIDS in-home waiver services program is available to members who would otherwise require long-term institutional services.

Identification – Members with symptomatic HIV or AIDS who require nursing home level of care services may be eligible for the waiver. The care coordinator or the PCP may identify members potentially eligible for the waiver program. They may also inform the member of the waiver program services.

Referral – If the member agrees to participation, provide the waiver agency with supportive documentation including history and physical, any relevant labs or other diagnostic study results and current treatment plan.

Continuity of Care – The HIV/AIDS waiver program will coordinate in-home HCBS services in collaboration with the PCP and care coordinator. If the member does not meet criteria for the waiver program, or declines participation, the health plan will continue care coordination as needed to support the member.

Other federal waiver programs

Other waiver services, including the Nursing Facility Acute Hospital Waiver, may be appropriate for members who may benefit from HCBS services. These members are referred to the Long Term Care Division / HCBS Branch to determine eligibility and availability. If deemed eligible, the health plan will continue to cover all medically necessary covered services for the member unless/until member is disenrolled from the Medicaid Program.

Medical management guidelines

Admission authorization and prior authorization guidelines

All prior authorizations must have the following to create the request, but additional information is needed to review the request for medical necessity. Review the applicable UnitedHealthcare medical policy or the Texas Medicaid Provider Procedures Manual for additional details.

- Member name
- Member number or Medicaid number
- Member date of birth
- Requesting provider name
- Requesting provider's National Provider Identifier (NPI)

- Service requested - Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) or Current Dental Terminology (CDT)
- Service requested start and end date(s)
- Quantity of service units requested based on the CPT, HCPCS or CDT requested

For behavioral health and substance use disorder authorizations, please contact **1-888-887-9003.**

Locate the Prior Authorization Request Form at **UHCprovider.com/priorauth**. If you have questions, please connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal.**

The following table lists medical management notification requests and the amount of time required for a decision, approval or denial.

Type of request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Non-urgent pre-service	Within 3 working days of receipt of medical record information required but no longer 14 calendar days of receipt.	Within 24 hours of the decision.	Within 2 business days of the decision.
Urgent/expedited pre-service	Within 72 hours of request receipt.	Within 3 days of the request.	Within 3 days of the request.
Concurrent review	Within 24 hours or next business day following.	Notified within 24 hours of determination.	Notified within 24 hours of determination and member notification within 2 business days.
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information.	Within 24 hours of determination.	Within 24 hours of determination and member notification within 2 business days.

*This chart represents timelines for complete requests. For incomplete requests, we follow the guidelines in the Uniform Managed Care Manual 3.22.

Unique prior authorization requests

The below services involve unique avenues to request authorization.

- Cardiology, Oncology and Radiology: Information is posted to **UHCprovider.com/TXcommunityplan** > Prior Authorization and Notification > Specialty Programs Prior Authorizations
  - Prior authorization is required for outpatient injectable chemotherapy drugs when given for a cancer diagnosis
- **Pharmacy:** See the Pharmacy section in **Chapter 5** of this manual
- **Long-Term Services and Supports/Home and Community-Based Services:** The PCP and/or service coordinator determine the member's care need(s), and solely secures and authorizes them as outlined in the member's plan of care. A change in member condition and services requires a new authorization.
- Request prior authorization for physical, occupational and speech therapy services before delivering these services
  - Request Optum utilization review/clinical submissions by:
    - Online:
      1. To access the Prior Authorization and Notification app, go to **UHCprovider.com**, then click Sign In.
      2. Select Prior Authorization and Notification.

The form is available at **UHCprovider.com/TXcommunityplan** > Prior Authorization and Notification > Prior Authorization Forms and Documentation Supporting Medical Necessity > Texas Standard Prior Authorization Request Form for Health Care Services.

MMP: Complete the Optum Patient Summary Form (PSF-750) to request prior authorization. You can find the form at **myoptumhealthphysicalhealth.com** > Resource Library > Clinical Submission Forms > Patient Summary Form PSF-750.

If necessary, your patient must also complete their section of the form. You can include clinical documentation for children younger than 16. All submissions should be completed online at **myoptumhealthphysicalhealth.com** unless otherwise instructed.

Concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. We perform a record or phone review for each day's stay using InterQual, CMS or other nationally recognized guidelines to help clinicians make informed decisions in many health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

UnitedHealthcare Community Plan denies payment for days that do not have a documented need for acute care services. Failure to document results in payment denial to the facility and you.

Medicare-Medicaid plans

UnitedHealthcare Connected will review all member hospitalizations within 48 business hours of admission to confirm that the hospitalization and/or procedures were medically necessary. Reviewers will assess the usage of ancillary resources, service and level of care according to professionally recognized standards of care. Concurrent hospital reviews will validate the medical necessity for continued stay.

Concurrent review details

Concurrent review for all other programs is notification within 24 hours or one business day of admission. It finds medical necessity clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or record review.

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning including: primary and secondary diagnosis, clinical information, care plan, admission order, member 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 Community Plan requests from our 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.

UnitedHealthcare Community Plan uses InterQual, 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.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

- Prevent, diagnose, alleviate or cure a physical or mental illness or condition
- Maintain health
- Prevent the onset of an illness, condition or disability
- Prevent or treat a condition that endangers life, causes suffering or pain or results in illness or infirmity
- Prevent the deterioration of a condition
- Promote daily activities; remember the member's functional capacity and capabilities appropriate for individuals of the same age
- Prevent or treat a condition that threatens to cause or worsen a handicap, physical deformity, or malfunction; there is no other equally effective, more conservative or substantially less costly treatment available to the member
- Not experimental treatments

Determination process

Benefit coverage for health services is determined by the member specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws. You may freely communicate with members about their treatment, regardless of benefit coverage limitations.

Evidence-based clinical guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to **UHCprovider.com**.

Medical and drug policies and coverage determination guidelines

Find medical and drug policies and guidelines at **UHCprovider.com/policies** > **For Community Plans.**

Referral guidelines

You must coordinate member referrals for medically necessary services beyond the scope of your practice. UnitedHealthcare Community Plan and UnitedHealthcare Connected has no network limitation on referrals to any network care provider. For a list of participating care providers, network facilities and contractors for referrals, visit **UHCprovider.com/TXCommunityPlan** > Provider Directories.

Provider Services can assist you in identifying in-network referrals. Please call **1-888-887-9003.**

Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

We require prior authorization and justification of all out of-network referrals. Members accessing care through a non-contracted care 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.

The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the medical director for review and determination. Out-of-network referrals are approved for, but not limited to, the following:

- Continuity of care issues
- Necessary services are not available within network

UnitedHealthcare Community Plan monitors out-of-network referrals on an individual basis. Care provider or geographical location trends are reported to Network Management to assess root causes for action planning.

Primary care provider referral responsibilities Medicare-Medicaid plans

If a member self-refers or the PCP is making a referral to a specialist, the PCP should check the UnitedHealthcare Connected provider directory to

help ensure the specialist is in the UnitedHealthcare Connected network.

The PCP should provide the specialist with the following clinical information:

- Member's name
- Referring PCP
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialist

Member accessibility rights

UnitedHealthcare Community Plan members have the below access rights without a PCP referral:

- Obtain medication from any network pharmacy
- Select and have access to a network ophthalmologist or therapeutic optometrist to provide eye health care services other than surgery
- Members with special health care needs (excluding STAR Kids dual-eligible members) have direct access 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 This includes coordination of referrals and service documentation between PCP and specialist.
- Designate an OB/GYN as their PCP as long as the specialist agrees
- Get a second opinion
- Access to telemedicine, telemonitoring and telehealth
- Self-refer to any network care provider

Reimbursement

UnitedHealthcare Community Plan authorization helps ensure reimbursement for all covered services. You should:

- Determine if the member is eligible on the date of service by using the eligibility capability on **UHCprovider.com**, contacting UnitedHealthcare Community Plan **Provider Services** at **1-888-887-9003** department, or the Texas Medicaid Eligibility System
- Submit documentation needed to support the medical necessity of the requested procedure
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized
- Determine if the member has other insurance that should be billed first

UnitedHealthcare Community Plan will not reimburse:

- Services UnitedHealthcare Community Plan decides are not medically necessary
- Non-covered services
- Services provided to members not enrolled on the date(s) of service

For more information on our reimbursement policies, go to **UHCprovider.com/policies** > For Community Plans > Reimbursement Policies for Community Plan.

Second medical or surgical opinion

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. A member may request a second opinion if:

- The member disputes reasonableness decision
- The member disputes necessity of procedure decision
- The member does not respond to medical treatment after a reasonable amount of time

Scheduling the appointment for the second opinion should follow the access standards established by the Texas HHSC. These access standards are defined in Chapter 2. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network care provider is not available, UnitedHealthcare Community Plan will

arrange for a consultation with a non-participating care provider. The participating provider should contact UnitedHealthcare Community Plan at **1-888-887-9003**.

- Once the second opinion has been given, the member and the PCP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PCP before receiving treatment

Services not covered by UnitedHealthcare Community Plan

The following services are not included in the UnitedHealthcare Community Plan program:

- Any health care not given by a doctor from our list (except emergency treatment)
- Any care covered by Medicaid but not through managed care:
  - Prescription drugs
  - Long-term care services in a nursing home
  - Nursing facility services
  - Intermediate care facilities for members with mental handicap
  - Home- and community-based waiver services
  - Dental services, except for those performed in an outpatient setting. UnitedHealthcare Community Plan covers the facility and anesthesia services when deemed medical necessary. Prior authorization is required.
  - Residential inpatient hospice services
- Mental health and substance use disorder care. This service is covered by Optum Behavioral Health.
- Phones and TVs used when in the hospital
- Personal comfort items used in the hospital such as a barber
- Contact lenses, unless used to treat eye disease
- Sunglasses and photo-gray lenses
- Ambulances, unless medically necessary
- Infertility services

Services not covered by UnitedHealthcare Connected

The plan will not cover the excluded medical benefits listed in this section and neither will Medicaid. In addition to any exclusions or limitations described in the benefits chart [link to chart], the following items and services are not covered by our plan:

- Services considered not "reasonable and necessary" according to the standards of Medicare and Medicaid, unless our plan lists them as covered
- Experimental medical and surgical treatments, items and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Experimental treatment and items are those not generally accepted by the medical community.
- Inpatient treatment to stop using drugs and/or alcohol (Inpatient detoxification services in a general hospital are covered)
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare covers it
- A private room in a hospital, except when it is medically needed
- Personal items in a member's room at a hospital or a nursing facility, such as a telephone or a television
- Inpatient hospital custodial care
- Full-time nursing care in the member's home
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. (The plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.)
- Chiropractic care, other than diagnostic X-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines
- Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines
- Abortions, except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Acupuncture and biofeedback services
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Infertility services for males or females

- Voluntary sterilization if younger than 21 years or legally incapable of consenting to the procedure
- Reversal of sterilization procedures, sex change operations and non-prescription contraceptive supplies
- Paternity testing
- Sexual or marriage counseling
- Naturopath services (the use of natural or alternative treatments)
- Services provided to veterans in Veterans Affairs (VA) facilities
- Services to find cause of death (autopsy)

Services requiring prior authorization

For a list of services that require prior authorization, go to **UHCprovider.com/TXcommunityplan.**

Direct access services – Native Americans

Native Americans seeking tribal clinic or Indian Health hospital services do not require prior authorization.

Seek prior authorization within the following time frames

- **Emergency or Urgent Facility Admission:** one business day
- **Inpatient Admissions; After Ambulatory Surgery:** one business day
- **Non-Emergency Admissions and/or Outpatient Services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

We make decisions within 3 business days after the prior authorization request, as long as information is available to complete the review. For members younger than 21 years of age, we allow up to 7 days for any necessary additional information.

Prior authorization not required

After requesting a prior authorization, you may receive the message "PA Not Required". When you receive this message, it does not mean the service is approved. Re-check member benefits through **UHCprovider.com/eligibility** or call **Provider Services** at **1-888-887-9003.**

Utilization management guidelines

Call **1-888-887-9003** to discuss the guidelines and utilization management.

Utilization management (UM) is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its in-network PCPs and specialists on a fee-for-service basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on a fee-for-service basis. The plan's UM staff works with care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

Utilization management appeals

These appeals contest UnitedHealthcare Community Plan's UM decisions. They are appeals of UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. The appeal states it is not medically necessary or is considered experimental or investigational. It may also contest any admission, extension of stay, or other health care service due to late notification, or lack of complete or accurate information. Any member, their designee, or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal. Adverse determination decisions may include UnitedHealthcare Community Plan's decision to deny a service authorization request or to authorize a service in an amount, duration, or scope less than requested. See Appeals in **Chapter 13** for more details.

Utilization management reporting

We contract with the Texas Health and Human Services Commission HHSC to which we are held accountable for the oversight of member care in a manner that improves quality and controls costs.

Detailed information is located on the Uniform Managed Care Manual at hhs.texas.gov > Services > Health > Medicaid and CHIP > Provider Information > Contracts and Manuals > Uniform Managed Care Manual.

Key contacts

Topic	Link	Phone number
Long-Term Services and Supports provider advocates	**UHCprovider.com/TXcommunityplan**	**1-888-787-4107**

Long-Term Services and Supports (STAR Kids, STAR+PLUS, Medicare-Medicaid plan)

Long-Term Services and Supports (LTSS) provides care in the least restrictive setting and provide accountability and control on costs. LTSS provides assistance with daily healthcare and living needs for elderly members and those with a long-lasting illness, disability or need assistance in maintaining their independence. 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.

Services are delivered as outlined in your Agreement, this manual and any other referenced guidelines. There is a focus on person-centered care, which means being part of the member's care coordination team. LTSS care providers offer covered health services to members within the scope of their UnitedHealthcare Community Plan agreement and their specialty license.

Report to the member's service coordinator any significant change in condition to a member's health, informal support, or functional status that will not normally resolve itself without further intervention and requires review of and revision to the current Individual Service Plan (ISP) and/or overall Plan of Care (POC). Report any change that may affect a member's eligibility, to your knowledge.

Please call the service coordinator directly or call the Service Coordination Hotline at **1-800-349-0550** for STAR+PLUS and MMP or **1-877-352-7798** for STAR Kids.

Long-Term Services and Supports care provider roles and responsibilities

The role of a LTSS care provider is to help members live in their home and in their community, when possible, rather than a nursing home. Services are delivered in a manner outlined in your contract, this manual and any other referenced guidelines, with special focus on person-centered care. This includes participating as part of the member's care coordination team. CommunityCare is our online care coordination capability which you can use to communicate member progress and any needs that you see to the service coordinator.

LTSS care provider responsibilities include:

- Providing LTSS Services within 7 days of authorization being secured by the member's service coordinator
- Being enrolled in TMHP
- Communicating a member change in condition or circumstances to the service coordinator
- Delivering person-centered care with respect and dignity
- Observing confidentiality
- Verifying member eligibility and help ensure the service coordinator secured authorization for services before you deliver services
- Help ensure continuity of care, as members may be involved in several LTSS services at one time
- Use of electronic visit verification (EVV) for qualifying services, such as personal care attending
- Participating in the random mandatory challenge survey located at **UHCprovider.com** designed to help ensure correct contact information for you
- Community First Choice Providers please see Appendix D for additional care provider responsibilities
- Employment Assistance and Supported Employment care providers have the responsibility to develop

and update quarterly a plan for the delivery of employment assistance services

- Work with PCPs to coordinate the delivery of Medicare and Medicaid services and coordination of benefits for dual eligible members (if applicable.
- Train staff regarding the use and alternatives of restraint in accordance with Texas Administrative Code Title 26, Part 1, Chapter 554, Subchapter G, Freedom from Abuse, Neglect, and Exploitation. For reference see: https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=26&pt=1&ch=554&rl=601.
- Do not use physical restraint except in situations where the member's behavior poses imminent danger of serious physical harm to self or others. Restraint and seclusion should be avoided to the greatest extent possible without endangering the safety of the member and 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 in the member's plan of care.
- As an LTSS provider program owner or administrator, you are required to train your staff and volunteers regarding critical incident reporting, including abuse, neglect and exploitation. See the UnitedHealthcare Community Plan Reporting Critical Incident, Including Abuse, Neglect and Exploitation at **UHCprovider.com/training** > State Specific Training > **Texas** > Reporting Critical Incidents: Including 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' health, safety and welfare. The program provider must maintain documentation of this training in the member's record.
- Help ensure member rights are protected, including privacy during visitation, the ability to send/receive sealed and uncensored mail, and make/receive telephone calls
- For the Consumer Directed Services (CDS) 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 **1-888-887-9003** or sending the complaint to:

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

Project Independence

Project Independence is the Texas initiative to use LTSS to help a member remain in their home instead of a nursing facility.

Our service coordinators complete an assessment of the member within 30 days of admission. If we determine that:

- A return to the community is possible, we work with the member and family to return the member to the community using LTSS
- The member cannot return home, we reassess the member in 90 days

A PCP can work with our service coordinators to order LTSS, including personal assistance with basic needs, which can help a member to continue living at home.

If you notice a change in member condition or circumstances, call **1-877-285-9093**. 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. It requires a review and revision to the current person-centered care plan.

Long-Term Services and Supports definitions

- **Adaptive Aid**: An item or service that enables members to retain or increase the ability to perform activities of daily living or to control their environment
- **Adult Foster Care:** Adult foster care (AFC) is a full-time living arrangement in an 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. This may include meal preparation, housekeeping, minimal help with personal care, help with activities of daily living and provision of or arrangement for transportation.
- **Assisted Living and Residential Care Facilities**: These facilities provide services in 3 types of living arrangements: assisted living apartments, residential care apartments and residential care non- apartment settings

An assisted living facility (ALF):

- Furnishes, in one or more facilities, food and shelter to 4 or more persons who are unrelated to the establishment proprietor;
- Provides:
  1. Personal care services.
  2. Medication administration by a person licensed or otherwise authorized in the state to administer the medication; or
  3. Services described in clauses (1) and (2); and
     - May provide assistance with or supervision of the medication administration.

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

- Coordinate resident care with an outside home and community support services agency or health care professional;
- Provide or delegate personal care services and medication administration, as described in this chapter;
- Assess residents to determine the care required; and
- 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:

- Common ownership;
- Physical proximity;
- Shared services, personnel or equipment in any part of the facilities' operations; and
- Any public appearance of joint operations or of a relationship between the facilities.

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

For more information about licensing and contracting for ALFs, go to hhs.texas.gov > Providers > Long-term Care Providers > Assisted Living Facilities.

- **Community First Choice (CFC)**: Individuals on a 1915(c) waiver interest list who meet eligibility and coverage requirements may be eligible to get Community First Choice services. This waiver program is for individuals with an intellectual disability or behavioral health diagnoses. It includes:
  - Personal Assistance: Help 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: Hands-on assistance, supervision and/or cueing to help the member toward acquiring, maintaining and enhancing skills necessary to accomplish activities of daily living (ADLs), instrumental activities of daily living (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: Voluntary member training on how to select, manage and dismiss attendants (Consumer-Directed Service Option only)
- **Day Activity and Health Services (DAHS)**: Normally provided Monday-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 when the member is 18 years old and over.
- **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 eEmployment helps members with onsite work accommodations that may be necessary to maintain employment.

- **Flexible Family Support Services**: A personal care attendant visits the home at a time when the primary caregiver needs to be at work, job training, or attending school and is unable to assist the child or young adult member to get ready for the day. The attendant helps the child or young adult member with ADL, instrumental ADL or skilled tasks so they can attend child care, post high school education or to reside in independent living.
  Flexible Family Support Services may be delivered by a Home and Community Support Service Agency (HCSSA) and also may be delivered by attendants or nurses employed through the Consumer Directed Services (CDS) option.
- **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 to help. A value-added service allows for home-delivered meals for non-waiver members.
- **Minor Home Modification**: A structural change to a member's home, which is necessary due to the member's disability, to allow the member to continue living in the home
- **Personal Attendant Services (PAS)**
  - 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
- **Private Duty Nursing (PDN)**: Extended nurse visits provide observation, assessment, intervention, evaluation, rehabilitation, care and counsel and/or health teachings
- **Personal Care Services (PCS)**: An attendant comes to the home to help member with ADLs and IADLs
- **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 in-home care to non-waiver members.
- **Transition Assistance Services**: A transition 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.
- **Vehicle Modifications**: Mechanical or structural changes to a motor vehicle allow members with a disability to safely drive or ride as a passenger

STAR Kids services

STAR Kids who are not in the Medically Dependent Children Program may be eligible to receive the following Long-Term Services and Supports:

- Private Duty Nursing (PDN)
- Personal Care Services (PCS)
- Day Activity and Health Services (DAHS)
- Community First Choice (CFC)
  - Personal assistance
  - Habilitation
  - Emergency response services
  - Support consultation

Medically Dependent Children Program

The Medically Dependent Children Program (MDCP) provides services to support families caring for children who are medically dependent and encourages the transition of children in nursing homes back to the community. It is a home and community-based service waiver authorized under §1915(c) of the Social Security Act.

Services may include those previously listed for members not in the waiver program and:

- Adaptive aids
- Employment assistance
- Flexible family support services
- Minor home modification
- Supported employment
- Transition assistance services

STAR+PLUS and Medicare-Medicaid plan services

The following Medicaid services are available for STAR+PLUS Community Plan and UnitedHealthcare Connected (MMP) members. All STAR+PLUS and MMP 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
  - Primary home care
  - Protective services
  - Personal attendant services
- Respite services
- Assisted living and residential care
- Adult foster care
- DAHS
- Home delivered meals

Additional Long-Term Services and Supports for STAR+PLUS waiver and Medicare-Medicaid plan waiver members

Services may include those previously listed for STAR+PLUS waiver and MMP waiver members and:

- Adaptive aids and medical supplies
- Specialized nursing
- In-home physical, speech and occupational therapies
- Minor home modifications
- Vehicle modifications
- Transition assistance services
- Employment assistance and supported employment
- CFC, includes:
  - Personal assistance
  - Habilitation
  - Emergency response services
  - Support consultation

Care planning and service authorization (STAR+PLUS, Medicare-Medicaid plan, STAR Kids)

A member's need for LTSS begins when the service coordinator assesses the member's needs and works with the member, their family and their PCP 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.

Report any change in member condition or circumstances directly to their service coordinator or call the service coordination hotline at **1-800-349-0550** for STAR+PLUS and MMP and **1-877-352-7798** for STAR Kids. Service coordinators can adjust a member's care plan, as needed, for a change in condition or circumstances.

Before providing services, please make sure the service(s) you provide are authorized. Confirm the authorization is for the correct member and includes the correct billing codes with modifiers and units.

Visit **UHCprovider.com/priorauth** > Notification/Prior Authorization Status Please also verify the member's eligibility at **UHCprovider.com/eligibility** or by calling **1-888-887-9003**.

For more information visit TMHP.com > Medicaid Provider Manual.

Consumer Directed Services option (STAR Kids, STAR+PLUS, Medicare-Medicaid plan)

Consumer Directed Services (CDS) is a service structure available to members or their legally appointed representatives (LARs) that allows them to directly employ and manage their service care providers. The member or the member's LAR is responsible for ensuring the contracted service provider meets the qualifications and requirements. They do not handle the financial aspects of being an employer. Members or the member's LARs are required to use a financial management service agency (FMSA) for managing funds associated with the CDS option, such as managing timesheets, payroll, withholding taxes and filing tax-related reports to the Internal Revenue

Service and the Texas Workforce Commission for services delivered through the CDS option. The FMSA is also responsible for providing training to the member or member's LAR on being an employer, verifying provider qualifications (including criminal history and registry checks) and approving the CDS budget.

FMSAs are required to complete the mandatory FMSA enrollment training provided by HHSC.

The CDS option is available for the following STAR Kids and MDCP-covered services:

- CFC personal care services and habilitation
- PCS
- Respite
- Flexible family support services
- Employment assistance

The CDS option is available for the following STAR+PLUS, MMP and STAR+PLUS HCBS covered-services:

- CFC personal assistance services
- CFC habilitation
- Personal assistance services
- Respite
- Nursing
- Physical, occupational, cognitive rehabilitation and speech therapies
- Supported employment
- Employment assistance
- Support consultation

Some of the CDS options, in more detail, follow:

- Respite services
- Flexible family support services
- Employment assistance
- Supported employment

The CDS employer in the CDS option is the individual receiving services or, when applicable, the individual's legally authorized representative (LAR).

Employer responsibilities

To participate in the CDS option, the member must be able to perform all CDS employer tasks, or the member may appoint a willing adult as their designated representative (DR) to assist them or to perform employer tasks for the member. As a CDS employer, the member's responsibilities include:

- Recruiting, hiring, training, managing, and terminating the member's employees and other service providers (service providers include employees, contractors, and vendors)
- Submitting required information for potential employees to the Financial Management Services Agency (FMSA) to verify their eligibility before the member hires them
- Setting wages and benefits for the member's employee(s) within funds allocated for services elected for delivery through the CDS option
- Evaluating each service provider's job performance
- Approving, signing, and submitting time sheets, invoices and receipts to the FMSA for payment to the member's employee(s) and service providers
- Resolving employee and service provider concerns and complaints
- Maintaining a personnel file on each service provider
- Developing and implementing backup service plans for services when requested by the service planning team; and
- Ensuring protection of the individual receiving services and preserving evidence in the event of a Texas Health and Human
- Services Commission (HHSC) Provider Investigation program investigation of an allegation of abuse, neglect, or exploitation (ANE) against a CDS employee, DR, FMSA representative, or case manager or service coordinator

Note: This information is from Form 1582 by HHSC.

Note: The CDS option is funded by public funds, state and/or federal money. Discriminating against applicants and employees based on race, creed, color, national origin, sex, age, or disability is prohibited and against the law. The employer is accountable for the funds spent through the CDS option. HHSC will report a CDS employer or DR who submits false or fraudulent service delivery documents to the appropriate authorities for investigation and possible prosecution as Medicaid fraud.

Coordinator responsibilities

The member's case manager or service coordinator is responsible for informing the member about the CDS option and reviewing the self-assessment tool with the member to help the member determine if the CDS option is right for them. In addition, the responsibilities of the member's case manager or service coordinator include:

- Assessing the member's service level needs

- Coordinating the development of the service plan or plan of care
- Presenting a list of available FMSA providers from which to select
- Educating the members on their rights, responsibilities, and resources
- Revising the member's service plan when the member's needs change
- Being a resource if the member has health, safety, or exploitation concerns; and
- Monitoring and reviewing the member's satisfaction with the services provided by the FMSA in accordance with the requirements of the member's program

Responsibilities of the financial management services agency

The employer must select an FMSA before services are delivered through the CDS option. The responsibilities of the FMSA include:

- Providing orientation and training for the member and/or the member's DR about CDS employer responsibilities, including the legal requirements of various governmental agencies
- Assisting with the development of the member's budget for each service to be delivered through CDS and approving the budget
- Conducting criminal history checks of employee applicants when requested by the employer or DR
- Verifying each applicant's eligibility with program requirements, including Medicaid fraud exclusions, before an applicant is employed or retained by the employer
- Providing assistance in completing forms to obtain an employer identification number (EIN) from federal and state agencies
- Registering as the member's employer-agent with the Internal Revenue Service (IRS) and assuming liability for filing reports and paying employer taxes on the CDS employer's behalf to the IRS
- Processing employee time sheets, computing and paying all federal and state employment-related taxes and withholdings, and distributing payroll at least twice a month
- Processing invoices and receipts for payment
- Maintaining records of all expenses and reimbursements, and monitoring the CDS employer's budget
- Providing written summaries and budget balances of payroll and other expenses at least quarterly
- Preparing and filing employer-related tax and withholding forms and reports (this does not include filing personal income tax returns for the member or the member's employees); and
- Providing ongoing training and assistance, as needed, or requested.

CDS option advantage vs. potential risks

Advantages of the CDS option

- Members select and manage the people who provide your services
- Members schedule the times when their services are delivered
- Members train their service providers and supervise them (service providers include employees, contractors, and vendors)
- Members control the rate of pay for their service providers), within the spending limits of the unit rate for the service
- Members can offer benefits to their service providers, including bonuses, vacation pay, sick pay and insurance
- Members select an FMSA that will pay their service providers, make deposits and file reports with governmental agencies on their behalf
- Members may be able to recruit eligible service providers, including family members, friends and other persons they know to work for them. The person selected must meet all eligibility requirements of their program to be hired or retained.
- Members may appoint someone to assist with CDS employer tasks or to perform employer tasks for them.
- Members may be able to get additional training and assistance from a CDS support advisor to help them be a successful employer in the CDS option depending upon the program they are enrolled in.

Potential risks in the CDS option

- Members are responsible for creating a backup plan for services to be delivered if their service provider does not show up for work
- Member's service providers are not the employees of the FMSA, HHSC, any other state or federal agency or any other contracted provider agency
- As the CDS employer, members are solely responsible and liable for any negligent acts or omissions made by them, their service providers, and their DR
- Members are responsible for handling all conflicts with service providers. The FMSA and the individual's

other program provider agencies are not involved in these situations
- Members are required to keep and store paperwork for up to 5 years or possibly longer
- The CDS employer is ultimately responsible for payroll taxes owed to the Texas Workforce Commission (TWC) and is liable if the FMSA fails to pay. The FMSA assumes full responsibility for payment of payroll taxes owed to the IRS.
- The CDS employer is responsible for meeting all requirements as any employer in any business and can be held liable for failure to meet those requirements

Referral information (STAR+PLUS, Medicare-Medicaid plan)

PCPs may contact a service coordinator to obtain LTSS for the patient who is our member. This may be accomplished through Community Care, our online service coordination and health care management capability at **UHCprovider.com**. You may also call the Service Coordination hotline at **1-800-349-0550.**

Restraints

Restraints should only be used as a last alternative, in the least amount restraint necessary to prevent harm and for the shortest period possible. Any restraining needs to be documented and be in the member's care plan with proper prior review and approvals. Train staff regarding the use and alternatives of restraint in accordance with §9.179 of the Texas Administrative CodeTitle 26, Part 1, Chapter 554, Subchapter G, Rule §554.601 Freedom from Abuse, Neglect, and Exploitation. See HHSC's Evidence-Based Best Practices: Physical Restraints**.**

Abuse, neglect and exploitation

As a care provider, you are mandated to report if you suspect a member is being abused, neglected or the victim of exploitation. Program owners and supervisors must train staff to report. Find out more at the required LTSS training at **UHCprovider.com/Training** > State Specific Training > **Texas** > Reporting Critical Incidents: Including Abuse, Neglect and Exploitation.

Electronic Visit Verification

LTSS care providers are required to verify when they perform a service visit or accompany a member to an appointment. This involves being contracted with an Electronic Visit Verification (EVV) vendor or using an approved EVV proprietary system. We measure compliance quarterly. Consequences of non-compliance could involve training, a correction action plan or fines. See the appendix section of this manual for important information about EVV. For assistance call your provider advocate directly or LTSS Provider Relations at **1-888-787-4107**. For more information visit **UHCprovider.com/EVV**.

Attendant compensation rate enhancement (STAR+PLUS only)

Employees who work directly with members are eligible to receive added compensation for their services. The Texas Health and Human Services (HHS) announces the amount every year. Then the Texas Health and Human Services (HHS) determines each of their participating care provider's amount and communicates that to us so we can make the payments.

Attendants who qualify for this rate are unlicensed and work directly with member, providing services such as personal assistance with activities of daily living and instrumental activities of daily living. For example:

- Medication Aides
- Drivers
- Direct care workers
  - Adult day health care
  - Assisted living
  - Personal attendant services

Acceptable ways to pass this payment onto your staff include:

- Salaries and wages
- Payroll taxes
- Workers' compensation
- Employer-paid health insurance
- Employer-paid life insurance
- Uniforms
- Hepatitis B vaccinations and Tuberculosis 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 hhs.texas.gov > Long-term Services & Supports. See also **UHCprovider.com/TXCommunityPlan** > Provider Forms > Attendant Compensation Enhancement Program (ACEP)

or contact your provider advocate. This rate can be received as an increased amount with the LTSS agency claims payments by contacting your provider advocate to have this included in your network contract during the enrollment period from August 1 to 5 p.m. October 1. Complete and submit the Attendant **Compensation Enhancement Program online form** located at **UHCprovider.com/ TXCommunityPlan** > Provider Forms > Attendant Compensation Enhancement Program (ACEP).

For questions, contact your provider advocate or you may call LTSS Provider Relations at **1-888-787-4107**.

The Attendant Compensation Rate Enhancement for qualifying LTSS care providers is included in the regular claims payment process. Include the amount of your rate enhancement when you submit your bill to us. For example, if you submit a bill for a service that is reimbursable at $12, add your reimbursement rate (for example, $1) so the billed amount is $13. The enhancement rate will then be paid as part of the service payment.

Enhancement rates are located on Texas Health and Human Services' page at hhs.texas.gov > Long-term Services and Supports > Home and Community Based Services > Rate Enhancement - Attendant Compensation. You may request a paper copy of your fee schedule by calling **Provider Services** at **1-888-887-9003**

Services in the community requirements (STAR Kids and Medicare-Medicaid plan)

Members living in the community and receiving Medicaid Home and Community-Based Services need to have full access to the benefits of community living. This includes but is not limited to:

- Encouraging member choices
- Person-centered care
- Member rights
- Access to community living
- Personal freedom in residential living

These guidelines apply to Adult Day Health Cares, Foster Care Homes, Employment Assistant Services and Assisted Living and Residential Care

Choice

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

Members are able to choose the setting in which they receive LTSS services. This choice is 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 plays a part in the member's life choices, such as daily activities, physical environment, and personal interaction.

Person-centered care

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

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

Community

Members need to have full access to the benefits of community living. This includes:

- Earning a competitive salary and to work with people who do not necessarily have special needs
- Engage in community life, such as go to a show, recreation center or the park
- Control his or her 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 Services

Personal freedom in residential living

In a provider-owned or controlled setting, in addition to the qualities above listed, the following additional conditions must be met. Give members:

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

Please note these setting guidelines do not apply to inpatient settings such as:

- A nursing facility
- An institution for mental diseases
- An intermediate care facility for members with intellectual disabilities
- A hospital
- Other locations that have qualities of an institutional setting

For more information, please visit Medicaid.gov > Medicaid > Home & Community-Based Service.

Federal Home and Community-Based Services rules (STAR+PLUS and Medicare-Medicaid plan)

The following guidelines address requirements in the Code of Federal Regulations 42 CFR 441.301.

Visit EFCR.gov > Libraries > enter "CFR 441.301" in the search tool.

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 assurances

The LTSS care 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

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

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

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

Member complaints

You must 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 **1-888-887-9003** or sending the complaint to:

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

See **Chapter 13** of this manual for more information

Long-Term Services and Supports resources

- For more information about STAR+PLUS community-based LTSS, visit TMHP.com > Medicaid Provider Manual
- For information about the HHSC-contracted care providers of long-term services and supports for individual who have intellectual or developmental disabilities, visit TMHP.com > Medicaid Provider Manual > Behavioral Health and Case Management Services Handbook
- For information about the HHSC-contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities, visit TMHP.com > Medicaid Provider Manual > Behavioral Health and Case Management Services Handbook
- LTSS care providers please refer to the Abuse, Neglect and Exploitation section earlier in this chapter for additional information

Key contacts

Topic	Link	Phone number
EPSDT	Texas Health Steps	1-512-776-7745
Vaccines for Children	Texas Vaccines for Children	1-800-252-9152

Lead screening/treatment

Call **Provider Services** if you find a child has a lead blood level over 10ug/dL. Children with elevated blood lead levels will be offered enrollment in a care coordination program.

Texas Health Steps

The Texas Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for STAR, STAR+PLUS, and STAR Kids through age 20 is Texas Health Steps (THSteps). These services are provided by a THSteps-enrolled Medicaid PCP who is a member of the UnitedHealthcare Community Plan Network.

Preventive and wellness care is delivered based on THSteps benefits and policies including the Periodicity Schedule and required components of checkups.

For more information, visit The Texas State Department of Health Services at Texas Health Steps | Texas Health and Human Services > Provider Information (Medical). 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 from 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. Phillips, et al. Consent Decree.

For a full list, visit Texas HHSC at hhs.texas.gov > Search Services > Health > Medicaid and CHIP > Managed Care Contract Management > Managed Care Organization Sanctions.

Documentation of completed Texas Health Steps components and elements

Each of the 6 components and their individual elements established by the Texas Health Steps periodicity schedule for children 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. You must document the results of these screenings and any necessary referrals in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

Below is a summary of the federal and state mandated components of a Texas Health Steps medical checkup that must be documented in the medical record as a condition for provider reimbursement by Medicaid. For details regarding specific checkup and reimbursement requirements, please review the Texas Medicaid Provider Procedures Manual, Children's Services Handbook.

THSteps checkups are made up of 6 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. For Centers for Disease Control Prevention Guidelines, go to https://www.cdc.gov/lead-prevention/php/guidelines/index.html.
   - 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 6 months until the parent or caregiver reports a dental home is established.
   - Clients must be referred to establish a dental home beginning at 6 months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

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.

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 within 364 days of the member's birthday.

To help ensure a member receives their wellness per schedule, these can be performed on the same day as when a member may come into the office for a sick visit or a sport/camp physical. Use procedure code modifier 25 when billing for both a well visit with a sick or sport/physical visit.

For more information, visit **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.

A parent must be present for members 14 years of age or younger to bill for THSteps Medical Checkup.

To report any STAR members that you identify as children of migrant farmworkers, please call **1-800-784-6999** or email: **texashealthsteps@uhc.com**.

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

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, including when they can seek treatment without parental consent, is the Texas Health Steps Continuing Education page located at https://www.txhealthsteps.com/physician > Teen Consent and Confidentiality.

Please see **Chapter 4** for information about medical transportation. This program provides non- emergency medical transportation to members who need help getting to and from their covered health care appointments and the pharmacy.

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.

For more information, visit the Texas Department of State Health Services at txhealthsteps.com > Provider Information (Medical) > Texas Health Steps Provider Outreach Referral Service.

Visit The Texas Department of State Health Services for more information at txhealthsteps.com > Texas Health Steps Provider Outreach Referral Service.

Our Texas Healthsteps 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 families. To refer a STAR member for assistance email **texashealthsteps@uhc.com**, or call **1-800-784-6999**.

Laboratory services

All laboratory tests (with the exception of screening for dyslipidemia, type 2 diabetes, syphilis, HIV and point-of-care testing for blood lead level in the care provider's office) must be performed by the Texas Department of State and Health Services (DSHS) laboratory at no cost to you.

The Texas Childhood Lead Poisoning Prevention Program at DSHS monitors blood lead results on children younger than 15, which is required by Texas law. Please report all blood lead tests to the Texas Child Lead Registry. Lead screening, follow-up testing, and environmental lead investigations are all covered.

Find specimen submission and specific tests requirements at dshs.texas.gov > Disease Prevention > DSHS Laboratory > Laboratory Testing Services Manual.

The DSHS laboratory in Austin has web-based services that allow medical care providers to submit orders and receive test results electronically. dshs.texas.gov > Disease Prevention > DSHS Laboratory > About the Laboratory > Remote Data.

For specific information, visit:

- txhealthsteps.com > Find a Course > Laboratory Services: Specimen Collection
- tmhp.com > Providers > Medicaid Provider Manual > Children Services Handbook
- The Texas Department of State Health Services Laboratory at **1-888-963-7111**, ext. 6236
- For Centers for Disease Control Prevention Guidelines, go to https://www.cdc.gov/lead-prevention/php/guidelines/index.html

Lead testing

The mission of the Environmental Lead Program is to protect the public, especially young children, from exposure to lead in their environment through assuring that persons conducting lead inspections, lead risk assessments, and lead abatements in target housing (built before 1978), and child-occupied facilities (built before 1978), are properly trained certified, and following minimum standards that protect the health of workers and building occupants.

For information about the Texas Health Steps environmental lead investigation (ELI) visit TMHP.com > Medicaid Provider Manual > Children's Services Handbook > Appendix C Lead Screening or go to dshs.texas.gov/elp/.

- The Texas Medicaid & Healthcare Partnership THSteps Page tmhp.com
- The Texas Department of State Health Services (DSHS) DSHS.texas.gov
- The Texas DSHS Texas Health Steps Online Provider Education txhealthsteps.com
- The Texas Medicaid Provider Procedure Manual at tmhp.com

Vaccines for children

The Texas Vaccines for Children (VFC) program provides vaccinations. Vaccinations offered in the state VFC program must be ordered by your office. We do not reimburse for the vaccine ordered by the VFC Program, but we reimburse for administering the vaccine.

Vaccine administration fees are reimbursable when submitted with an appropriate CPT and modifier code.

Young adults

The Current Procedural Terminology (CPT) Code 90630, traditionally applicable for adults older than 21, can be used for Medicaid recipients ages 19 and 20 for the influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use. Bill this code with a vaccine administration procedure code to identify the vaccine administered. ICD-10 code Z23 Encounter for Immunization separately.

Contact VFC with questions.
Phone: 1-800-219-3224
Fax: 1-573-526-5220

Any member through 18 years of age who meets at least one of the following criteria is eligible for the VFC Program:

- Eligible for Medicaid
- American Indian or Alaska Native, as defined by the Indian Health Services Act
- Uninsured
- Underinsured (these children have health insurance but the benefit plan does not cover immunizations

As the member's PCP medical home, your practice is the place for vaccinations. Do not refer our patients who are Medicaid members to the local health department for vaccinations.

Give vaccinations according to the Advisory Committee for Immunization Practices (ACIP) guidelines with a combo 4 in Texas.

ImmTrac

The ImmTrac registry offers you and other authorized entities secure, online access to the Texas Immunization Registry.

Online access to ImmTrac, as well as an electronic data import process is available to you through electronic health records (EHR) system. For more information, contact ImmTrac customer support at **1-800-348-9158**.

You don't need a computer to submit to Immtrac, you can report immunizations by using a Paper Reporting Form. The form is available by calling ImmTrac Customer Support at **1-800-348-9158**.

For more information and 2.0 AMA PRA Category 1 Credit(s), visit TXhealthsteps.com > Find a Course > Immunizations.

Vision screenings

School screenings

Children around these ages may have had a school vision screening within the past 12 months of their visit with you. The school vision screening counts for the required THSteps vision checkup component when documentation of the school screening is placed into Primary Care Provider (PCP) Medical Home member record.

Approximate ages for children at the beginning of the school year of Texas public school vision screening grades:

Grade	Ages
Kindergarten	5-6
1st grade	6-7
3rd grade	8-9
5th grade	10-11
7th grade	12-13

For more information about Hearing and Vision Screenings, visit txhealthsteps.com > Find a Course > Hearing and Vision Screening.

The training module is qualified as 1.50 AMA PRA Category 1 Credit(s).

Additional information

For Texas Health Steps and CCP services, including private duty nursing, prescribed pediatric extended care centers, personal care services and therapies, go to tmhp.com > Medicaid Provider Manual > Children's Services Handbook.

Additional training on Texas Health Steps, visit **UHCprovider.com/training** > State Specific Training > Texas > Texas Health Steps Medical Checkups: For STAR. STAR Kids and STAR+PLUS Members.

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com**	**1-888-887-9003**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**
Value added services	**uhccommunityplan.com/tx** > View plan details	**1-888-887-9003**

We offer the following services to our UnitedHealthcare Community Plan members. Value-added Services are free of cost for members, and available once per year unless otherwise noted. You cannot bill members as a whole or in part for these services.

Examples of value-added services include:

- 24-hour access to NurseLine;
- Extra dental services; and
- Extra behavioral health support

Members are informed of these services through their UnitedHealthcare Community Plan welcome packet. Value-added services are 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 a list of the most current Value-added Services and special billing codes, please visit **UHCprovider.com/TXCommunityPlan** > Reference Guides and Value-added services.

If you have questions or need to refer a member, call our **Provider Services** at **1-888-887-9003**, 8 a.m. - 6 p.m., CT, Monday-Friday, except major holidays.

UnitedHealthcare Connected Medicare-Medicaid plan

We offer additional services at no cost to the member for UnitedHealthcare Connected Medicare-Medicaid plan (MMP) members. These special services are selected to address member needs and experiences in an effort to help them live healthier lives.

Examples of flexible benefits and rewards and incentives include:

- Extra dental care
- Extra vision care
- **liveandworkwell.com**

This site gives access to mental health and substance use and self-help programs, interactive tools, educational resources and in-network care provider searches. This site is also available in Spanish.

Members are informed of these services through their UnitedHealthcare Community Plan welcome packet. Flexible benefits and rewards and incentives are listed in the member handbook and at **UHCcommunityplan.com**.

Information about services that are diagnosis-specific, such as asthma 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. Benefits, rewards, and incentives are available once per calendar year unless otherwise noted. These services may change in January of each year.

For the most current Flexible Benefits and Rewards and Incentives, please visit **UHCprovider.com** > Reference Guides and Value-Added Services > UnitedHealthcare Connected Flexible Benefits and Rewards and Incentives.

You may also call **Provider Services** at **1-888-887-9003**.

Chapter 8: Mental health and substance use

Key contacts

Topic	Link	Phone number
Behavioral Health/Provider Express	**providerexpress.com**	**1-877-614-0484**
Provider Services	**UHCprovider.com**	**1-888-887-9003**

United Behavioral Health, operating under Optum, provides UnitedHealthcare Community Plan members with mental health and substance use disorder (SUD) benefits. The national Optum network manual generally applies to all types of business. Some sections may apply differently based on state law.

The National Optum Behavioral Health manual is located on **providerexpress.com**.

This chapter does not replace the national Optum network manual. Rather, it supplements the national manual by focusing on Medicaid's specific services and procedures.

You must have a National Provider Identification (NPI) number and have an active Texas Medicaid enrollment to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

To enroll in Texas Medicaid, go to the Texas Medicaid & Healthcare Partnership (TMHP) website at tmhp.com > Provider Enrollment.

Credentialing

Credentialing information is available at **providerexpress.com** > Clinical Resources > Guidelines/ Policies & Manuals > Credentialing Plans > Optum.

Covered services

UnitedHealthcare Community Plan offers covered behavioral health services for mental, emotional and substance use disorders. We offer care management to help members, clinicians, and PCPs using and offering behavioral health services. We provide information and tools for mental health and substance use disorder diagnoses, symptoms, treatments, prevention and other resources in one place.

liveandworkwell.com, accessed through a link on **myuhc.com**, includes mental health and well-being information, articles on health conditions, addictions and coping, and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.

For member resources, go to **providerexpress.com** click on the Live and Work Well (LAWW) link at the bottom of the page. LAWW includes tools to help members address mental health and substance use issues. Access the site using the guest access code "Clinician."

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention)
- Inpatient psychiatric hospital (acute and sub-acute)
- Psychiatric residential treatment facility
- Outpatient assessment and treatment:
  - Social detoxification
  - Day treatment
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)
  - Child-parent psychotherapy

  - Multi-systemic therapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telehealth
- Rehabilitation services
- Day treatment/intensive outpatient
- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential
- Community support
- Psychiatric residential rehabilitation
- Secure residential rehabilitation
- Laboratory and radiology services for diagnosis and medication regulation
- Medication for injectables covered under the medical benefit at the Medicaid rate
  - Medication administration (96372) under the behavioral health benefit

The following HHSC-approved services may be provided in lieu of inpatient hospitalization services:

- Partial Hospitalization Services
- Intensive Outpatient Program (IOP) Services

When medically appropriate, members in MMP, STAR, STAR Kids and STAR+PLUS can choose in-lieu-of services instead of a covered Medicaid state plan service, such as inpatient hospitalization services. An exception would be if the member is at immediate risk of harming themselves or others. The member must receive the most appropriate service during an episode of care.

Medicaid services for STAR+PLUS and Medicare-Medicaid plan members

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

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

For information about the Texas Department of State Health Services (DSHS) Mental Health Rehabilitation, see TMHP.com > Medicaid Provider Manual > Behavioral Health and Case Management Services.

Mental Health Rehabilitative Services Qualified Providers Qualified Mental Health Professionals for Community Services

The Qualified Mental Health Professionals for Community Services (QMHP-CS) requirements are as follows:

- Demonstrated competency in the work to be performed
- Bachelor's degree from an accredited college or university with a minimum number of hours 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
  - Licensed practitioner of the healing arts (LPHA)
  - Physician
  - Licensed professional counselor
  - Licensed clinical social worker
  - Licensed psychologist
  - Advanced practice nurse
  - 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.

Eligibility

Verify the UnitedHealthcare Community Plan member's Medicaid eligibility on day of service before treating them. View eligibility online on **UHCprovider.com/eligibility.**

Assessment instruments

Assessment 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.

Screening (STAR Kids)

PCPs are responsible for screening for mental health and substance use disorders routinely, according to the Texas Health Steps Periodicity Schedule and as clinically indicated (excludes STAR Kids Dual eligible members). For more information:

- Sign into the Texas Health Steps free online continuing education courses > Find a Course > Behavioral Health: Screening and Intervention
- For screening tools and assessment instruments for behavioral health see also the **UHCprovider.com/TXCommunityPlan** > Reference Guides and Value-Added Services > Behavioral Health Toolkit for Primary Care Providers (PCPs)

Screenings: Behavioral health (mental health and substance use)

Texas Health Steps requires the use of a standardized developmental screening tool at ages nine, 18, and 24 months and at 3 and 4 years old, or when a parent or care provider voices a concern. Medicaid can reimburse the developmental screen separately, in addition to the annual wellness check-up.

- Ages and Stages, Third Edition (ASQ-3)
- Ages and Stages: Social Emotional (ASQ:SE)
- Parents' Evaluation of Developmental Status (PEDS)
- Modified Checklist for Autism in Toddlers (M-CHAT)

The member's medical record must include documentation identifying the tool used, the screening results and any referrals made.

You may use reimbursable screening tools more than once, but the adolescent mental health screening is separately reimbursable only once for each patient.

See more tools and at **UHCprovider.com/TXCommunityPlan** > Reference Guides and Value-Added Services > Behavioral Health Toolkit for Primary Care Providers (PCPs) (Applicable also to STAR members for THSteps behavioral health screenings).

See also Txhealthsteps.com > Find a Course > Behavioral Health: Screening and Intervention. This course counts for 1.5 AMA PRA Category 1 Credit(s).

Preventive health screening and exam (ALL)

Behavioral health screening is included in a member's annual wellness exam.

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.

Screening tools

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.

Referrals

Call **1-888-887-9003** anytime to refer a member for further assessment and possible treatment for behavioral health and substance use disorders. Members may access behavioral health services without a referral. Face-to-face assessment for acute and crisis situations are also available anytime.

PCPs may provide behavioral-health related services within the appropriate scope of their practice and may refer members for specialized treatment through our care provider network.

Behavioral health specialists, including substance use disorder care providers, should refer members for physical assessment and treatment by calling **Provider Services** at **1-888-887-9003**. Members may also self-refer by calling **Provider Services** or by consulting our online provider directory at **UHCprovider.com/TXcommunityplan** and selecting their coverage plan and residence location. Directories are listed by plan.

Members who may need access to Intellectual and Developmental Disability (IDD) services and Home and Community Based Services (HCBS) Waiver services will receive an appropriate evaluation and psychometric testing done by a qualified care provider. See more details in the Rehabilitation and Case Management section of this chapter.

Behavioral health care providers will contact members who have missed an appointment within 24 hours to reschedule the appointment.

An urgent condition is a health condition, including an urgent behavioral health situation, that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that their condition requires medical treatment evaluation or treatment within 24 hours by a care provider to prevent serious deterioration of the member's condition or health.

Member access to services

Members can self-refer or be referred for behavioral health care appointments; a referral is not required for members to use services.

If there is an appropriate disclosure agreement, the behavioral health care provider can communicate with the appropriate care provider or individual regarding diagnosis and treatment planning to help ensure the continuity and coordination of behavioral health care. The behavioral health care provider will coordinate care with the PCP and send initial and quarterly summary reports of a members' behavioral health status, provided the member or member's legal parent, guardian or other authorized adult on file has provided a release of information. Medical record documentation and referral information is documented using the current Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications.

The member or the care provider must call **1-888-887-9003** to verify eligibility, benefits and request authorizations.

Services available 24 hours per day, 7 days per week include:

- Emergency services, service coordination and crisis services
- Face-to-face assessment for acute and crisis situations
- Telephonic assessment for acute and crisis situations

All members who receive inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must happen within 7 days from the date of discharge. Behavioral health care providers will contact members who have missed an appointment within 24 hours to reschedule the appointment.

Authorizations

Members may access all behavioral health outpatient services (mental health and substance use) without referral. Prior authorization may be required for more intensive services, such as intensive outpatient program; day treatment; or partial, inpatient or residential care.

Help ensure prior authorizations are in place before rendering non-emergent services. Get prior authorization by going to **UHCprovider.com/priorauth**, calling **1-888-887-9003**.

Collaboration with other care providers

Coordination of care

When a member is receiving services from more than one professional, you must coordinate to deliver comprehensive, safe and effective care. This is especially true when the member:

- Is prescribed medication,
- Has coexisting medical/psychiatric symptoms, or
- Has been hospitalized for a medical or psychiatric condition.

Please talk to your patients about the benefits of sharing essential clinical information. Medical record documentation should be done using the current DSM classifications. A consent for disclosure of information should accompany any exchange of member information.

Court-ordered hospitalization (STAR, STAR+PLUS and Medicare-Medicaid plan)

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. For more information visit TMHP.com > Medicaid Provider Manual > Inpatient and Outpatient Hospital Services Handbook > Section 3.4 Services, Benefits, Limitations, and Prior Authorization - Inpatient Psychiatric Services.

UnitedHealthcare Community Plan is responsible for authorized inpatient hospital services, this includes services provided in freestanding psychiatric facilities for children in STAR and STAR+PLUS, and for adults in STAR+PLUS and MMP.

To notify UnitedHealthcare Community Plan of Texas about a member's court-ordered psychiatric services or SUD treatment, please access the **Secure Transactions on Provider Express**. You also may call the number on the back of the member's ID card or behavioral health care providers at **1-877-614-0484**.

Members who receive inpatient psychiatric services will be scheduled for an outpatient follow-up appointment within 7 days of discharge.

Cognitive rehabilitation therapy (CHIP, STAR, Medicare-Medicaid plan and STAR+PLUS)

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 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

Comorbidity (STAR Kids)

Our members may exhibit both medical and behavioral disorders. These members often have multiple medical and behavioral comorbid conditions addressed in an integrated fashion.

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.

Health Behavioral Assessment and Intervention (STAR, STAR+PLUS and Medicare-Medicaid plan)

Health Behavioral Assessment and Intervention (HBAI) services are for STAR, STAR+PLUS and MMP 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

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 > Medicaid Provider Manual > Children's Services Handbook > 2.9 Health and Behavior Assessment and Intervention.

Local behavioral health authority

We coordinate with the local behavioral health authority (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. For specific program and referral criteria visit hhs.texas.gov.

UnitedHealthcare Connected (Medicare-Medicaid plan only)

Optum, operating under UnitedHealthcare Connected, is the administrator of mental health and substance use disorder benefits for UnitedHealthcare Community Plan members. Behavioral health covered services are for the treatment of mental, emotional and substance use disorders. Optum maintains a clinician center with patient resources that is accessible from the provider website, **providerexpress.com** > Live and Work Well (LAWW) clinician center.

These resources provide information and assessment instruments 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 to both behavioral clinicians and medical physicians to share with patients. The **Provider Express Recovery and Resiliency page** also includes tools for use by practitioners working with individuals who are addressing mental health and substance use issues.

The following benefits are available for our members who seek services for mental health or substance use disorders:

- Emergency hospitalization and treatment for acute psychiatric episodes or medically necessary detoxification
- Treatment at community mental health centers,

federally qualified health centers and chemical dependency treatment centers
- Inpatient treatment under the direction of a psychiatrist in an inpatient hospital or a freestanding psychiatric facility
- Individual, group and/or family therapy with a behavioral health professional
- Immediate crisis intervention services available 24 hours/day to provide support in situations where the member's decision-making and coping patterns are temporarily impaired
- Evaluation and diagnostic services by a behavioral health professional to find out if a behavioral health disorder exists
- Evaluation and monitoring of psychotropic medication
- Laboratory and radiology services for diagnosis and medication regulation
- Medication for injectables covered under the medical benefit at the Medicaid rate
- Medication administration (96372)

Coordination of Non-covered Services

Mental Health Rehabilitative Services and Mental Health Targeted Case Management are behavioral health services that can help members with severe mental illness live in their community. See these care provider qualifications in **Appendix T**.

For information about the Texas Department of State Health Services (DSHS) Mental Health Rehabilitation, see TMHP.com > Resources > Provider Manuals > Texas Medicaid Provider Procedures Manual > Behavioral Health and Case Management Services.

The member's PCP has the responsibility to check for mental health or substance use disorders. The PCP may treat the member's behavioral health if it is within their scope of practice. A referral for a behavioral health specialist may be necessary. To get a referral, call **1-888- 887-9003**. Members may also self-refer to any network care provider.

Specialists and PCPs must coordinate care. A member-signed consent for disclosure of information should be on file.

Rehabilitation and case management

The specialists providing these services are trained and certified to administer the Child and Adolescent Needs and Strengths (CANS) assessment for members between the ages of 0 and 18 and the Adult Needs and Strengths Assessment (ANSA) assessment for members 19 and 20.

Specialists will need to recommend the appropriate level of care for eligible members when requesting prior authorization through the Texas Department of State Health Services Clinical Management for Behavioral Health Services (CMBHS) web based system.

Use the Texas Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG) when requesting services. An attestation signed by the specialist confirms their ability to provide a full array of mental health rehabilitation and targeted case management as outlined in the RRUMG. Specialists observe HHSC established qualification and supervisory protocols.

RRUMG information located at: hhs.texas.gov > Behavioral Health Services Providers > Behavioral Health Provider Resources > Utilization Management Guidelines and Manual > Texas Resilience and Recovery Utilization Management Guidelines- Child and Adolescent Services.

To refer a STAR Kid for consideration of these services, contact their service coordinator who will work with the specialist to help ensure the integration of behavioral health and physical needs of the member to access mental health rehabilitation services and targeted case management.

Specialized service coordination

The best member care includes care coordination. CommunityCare, our online care service, is accessible by the entire coordination team: PCPs, Behavioral Health specialists, other specialists, the member and family, and our service coordinator. This resource facilitates confidential communication between care providers and is similar to an electronic medical record (be sure to have a member representative consent for disclosure).

For more information about CommunityCare, visit **UHCprovider.com** and sign in.

The PCP and behavioral health specialist, including substance use disorder specialists, may choose other methods of communicating.

Targeted case management

A case manager works with the member and family. They can make face to face or phone outreach to assess member's holistic needs, such as social, educational, developmental, physical and behavioral health - target case management (TCM). Once a comprehensive care plan is created, the case manager works with the family and service coordinator to have those needs met.

Portal access

You can use the **UnitedHealthcare Provider Portal** for all of your online services, including claims, eligibility, prior authorization, referrals and much more. The portal allows you to take action and quickly access claims-related information using our digital features and tools. It's a one-stop shop for working with us more efficiently.

Claims

Submit claims using the 1500 Claim Form (v 02/12) or UB-04 form, whichever is appropriate. Use applicable coding, including ICD diagnosis code(s), CPT, Revenue and HCPCS coding. Include all necessary data to process a complete claim. Find out more about filing claims in **Chapter 12**.

Training resources and materials

We provide the following resources to assist you in your practice and to help your patients.

- **Behavioral health toolkits**
- **Provider training materials**
- **Network provider manuals**

Monitoring audits

We conduct routine care provider on-site audits. These audits focus on the physical environment, policies and procedures, and quality record documentation.

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction.

Brief summary of framework

- **Prevention**
  Prevent OUD before they occur through pharmacy management, care provider practices and education
- **Treatment**
  Access and reduce barriers to evidence-based and integrated treatment
- **Recovery**
  Support case management and referral to person-centered recovery resources
- **Harm reduction**
  Access to naloxone and facilitating safe use, storage and disposal of opioids
- **Strategic community relationships and approaches**
  Tailor solutions to local needs
- **Enhanced solutions for pregnant members and their children** Prevent neonatal abstinence syndrome and supporting birth parents in recovery
- **Enhanced data infrastructure and analytics**
  Identify needs early and measure progress

Increasing education & awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, "The Role of the Health Care Team in Solving the Opioid Epidemic," and "The Fight Against the Prescription Opioid Abuse Epidemic." While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at **UHCprovider.com/pharmacy.** Click "Opioid Programs and Resources-Community Plan" to find a list of tools and education.

Prescribing opioids

Go to our **Drug Lists and Pharmacy** page to learn more about which opioids require prior authorization and if they have prescription limits.

Pharmacy lock-in

Pharmacy lock-ins minimize drug abuse. Pharmacy lock-ins identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse, (e.g. narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances). When lock-in is determined appropriate, a member will be locked into one pharmacy for periods of 36 months, 60 months or a lifetime depending upon certain circumstances.

Expanding medication assisted treatment access & capacity

Evidence-based MAT treatment is central to OUD treatment. MAT takes a chronic condition approach and incorporates medication use in addition to other services, such as counseling, cognitive behavioral therapies, and recovery support, to provide a comprehensive approach to OUD. We expand MAT access and help ensure we have an adequate member MAT network.

To find a behavioral health MAT provider in Texas:

1. Go to **UHCprovider.com/findprovider**.
2. Select under "Specialty Directory and Tools" the option of Optum Behavioral Health, EAP, Worklife & Mental Health Services.
3. Click on "Search for a Behavioral Health Provider."
4. Enter "(city)" and "(state)" for options.
5. If needed, refine the search by selecting "Medication Assisted Treatment."

We contract with OUD Centers of Excellence (where available), which are designated as premier facilities to help ensure people with OUD stay in treatment and receive appropriate follow-up care and supports within their communities.

To find medical MAT providers, see the Mat section in **Chapter 4.**

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.

Optum routinely monitors claims, encounters, referrals and other data looking for potential over- and under-utilization of all mental health services. Based on this data, Optum will target areas with opportunities for improvement to promote efficient and effective use of services.

How are appeals or complaints related to behavioral health services filed and processed?

Member and care provider appeals and complaints related to behavioral health services follow the same steps outlined in this manual but should be submitted to United Behavioral Health operating under the UnitedHealthcare Connected at the following address:

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

Information outlined here provides an overview to assist behavioral health care providers when working specifically with UnitedHealthcare Community Plan STAR+PLUS members.

The general Network manual located at **providerexpress.com** also includes information that is relevant to you when working in coordination with Optum

Resources

See the CHIP, STAR, STAR+PLUS and MMP Benefits **Appendices** section of this manual: for a complete list of covered behavioral health services.

See the Pharmacy section in **Chapter 5** 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).

Optum network provider manual: **providerexpress.com** for behavioral health guidelines, policies, billing, appeals.

Chapter 9: Member rights and responsibilities

Key contacts

Topic	Link	Phone number
Member Services	**UHCCommunityplan.com/TX**	CHIP, STAR, STAR+PLUS: **1-866-314-0025** STAR Kids **1-866-919-4381**
Member handbook	**UHCcommunityplan.com/TX** > Community Plan > Member benefits	CHIP, STAR, STAR+PLUS: **1-866-314-0025** STAR Kids **1-866-919-4381**

Our Member handbook has a section on member rights and responsibilities. In it, we ask that members treat you with respect and courtesy.

Privacy regulations

HIPAA privacy regulations offer full federal protection to protect member health care information. These regulations control the internal and external uses and disclosures of such data. They also assert member rights.

Access to protected health information

Members may access their medical records or billing information either held at your office or through us. If their information is electronic, they may ask you or us send a copy in an electronic format. They may also ask that a copy of their information be provided to a third party.

Amendment of protected health information

Our members have the right to ask that information be changed if they believe it is inaccurate or incomplete. Any request must be in writing and explain why they want the change. This request must be acted on within 60 days. The timing may be extended 30 days with written notice to the member. If the request is denied, members may have a disagreement statement added to their health information.

Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their PHI, made by you or us, during 6 years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:

- For treatment, payment and health care operations purposes
- To members or pursuant to member's authorization
- To correctional institutions or law enforcement officials
- For which federal law does not need us to give an accounting

Right to request restrictions

Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or by other means. Accommodate reasonable requests, especially if the member states disclosure could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member rights and responsibilities

The following information is in the Member handbook at the following link under the Member Information tab: **UHCcommunityplan.com/TX**.

Native American access to care

Native American members can access care at tribal clinics and Indian hospitals without approval.

Member rights

Members may:

- Give and be treated with respect, dignity and privacy
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered
- Know the qualifications of their health care provider
- Receive information about in-network care providers and practitioners, and choose a care provider from our network
- Register grievances or complaints concerning the health plan or the care provided
- Appeal any payment or benefit decision we make
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care
- Get a second opinion with a care provider
- Expect health care professionals are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage
- Make suggestions about our member rights and responsibilities policies
- Have confidence their medical records and discussions with their care providers will be kept private and confidential
- Ask questions and get answers about anything that is not understood
- Agree to/refuse treatment and actively participate in treatment decisions
- Receive timely access to care that does not involve communication or physical access barriers
- Exercise rights regardless of member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care

Member responsibilities

Our member rights and responsibilities help uphold the quality of care and services they receive from you. The 3 primary member responsibilities as required by the National Committee of Quality Assurance (NCQA) are to:

- Supply information (to the extent possible) to UnitedHealthcare Community Plan and to you that is needed for you to provide care
- Follow care to which they have agreed
- Understand their condition and take part in developing mutually agreed-upon treatment goals, to the degree possible

Please refer to the full list of member rights and responsibilities in the **Appendix** section of this manual.

Chapter 10: Medical records

You are required to keep complete and orderly medical records in paper or electronic format, which fosters efficient and quality member care. You are subject to our periodic quality medical record review. The review could include any of the following items to determine compliance:

Topic	Contact
Confidentiality of record	Office policies and procedures exist for: • Privacy of the member medical record • Initial and periodic training of office staff about medical record privacy • Release of information • Record retention • Availability of medical record if housed in a different office location • Process for notifying United Healthcare Community Plan upon becoming aware of a patient safety issue or concern • Coordination of care between medical and behavioral care providers
Record organization and documentation	• Have a policy that provides medical records upon request. Urgent situations require you to provide records within 48 hours • Maintain medical records in a current, detailed, organized and comprehensive manner. You must help ensure privacy when storing Medical records. • Release only to entities as designated consistent with federal requirements. • Keep in a secure area accessible only to authorized personnel

Topic	Contact
Procedural elements	**Medical records are readable*** • Sign and date all entries • Member name/identification number is on each page of the record • Document language or cultural needs • 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 member's first language is something other than English • Procedure for monitoring and handling missed appointments is in place • An 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 about advance directives. • Include a list of significant illnesses and active medical conditions • Include a list of prescribed and over-the-counter medications. Review it annually.* • Document the presence or absence of allergies or adverse reactions*
History	An initial history (for members seen 3 or more times) and physical is performed. It should include: • **Medical and surgical history*** • A family history that includes relevant medical history of parents and/or siblings • A social history that includes information about occupation, living situations, education, smoking, alcohol use, 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; if present, advise to quit – Medicare members for functional status assessment and pain – Adolescents on depression, substance use, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Topic	Contact

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:
	  – Time frame 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 care provider review
	• There is evidence of care provider 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 care provider*
	• Education, including lifestyle counseling, is documented
	• Member input and/or understanding of treatment plan and options is documented
	• Copies of hospital discharge summaries, home health care reports, emergency room care, practitioner are documented

***Critical element**

Member copies

A member or their representative is entitled to one free copy of their medical record. Additional copies may be available at the member's cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandate a longer time frame.(i.e., immunization and tuberculosis records required for lifetime).

Data compliance

Provide clinical data 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 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 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 For further information about EDI online, go to **UHCprovider.com/resourcelibrary** to find **Electronic Data Interchange** menu.

Chapter 11: Quality management program/compliance information

Key contacts

Topic	Link	Phone number
Credentialing	Medical: Network management support team Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat** Chiropractic: **myoptumhealthphysicalhealth.com**	**1-877-614-0484**
Fraud, waste and abuse (payment integrity)	**uhc.com/fraud**	**1-844-359-7736**

What is the quality improvement program?

The UnitedHealthcare Community Plan comprehensive quality improvement (QI) program falls under the leadership of the CEO and the chief medical officer. A copy of our Quality Improvement program is available upon request.

The program consists of:

- Identifying the scope of care and services given
- Developing clinical guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services given to our members based on the guidelines
- Promoting wellness and preventive health, as well as chronic condition self-management
- Maintaining a network of care providers that meets adequacy standards
- Striving for improvement of member health care and services
- Monitoring and enhance patient safety
- Tracking member and care provider satisfaction and take actions as appropriate

As a participating care provider, you may offer input through representation on our Quality Improvement Committees and your provider services representative/provider advocate.

Cooperation with quality-improvement activities

You must comply with all quality-improvement activities. These include:

- Providing requested timely medical records
- Cooperation with quality-of-care investigations. For example, responding to questions and/or completing quality-improvement action plans.
- Participation in quality audits, such as site visits and medical record standards reviews, and taking part in the annual Healthcare Effectiveness Data and Information Set (HEDIS) record review
- Requested medical records at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email, secure email or secure fax.
- Practitioner appointment access and availability surveys

We require your cooperation and compliance to:

- Allow the plan to use your performance data
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members)

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 External Quality Review protocols which includes focus studies of these measures.

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

Care provider satisfaction

Every year, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through:

- Annual care provider satisfaction surveys
- Regular visits
- Town hall meetings

Our main concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

Survey results are reported to our Quality Management Committee. It compares the results year over year as well as to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you according to applicable Texas statutes and the National Committee of Quality Assurance (NCQA). The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current DEA certificate
- Current professional liability insurance

We verify information from primary sources regarding licensure, education and training. We also verify board certification and malpractice claims history.

Credentialing and recredentialing process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan care provider network. You must go through the credentialing and recredentialing process before you may treat our members.

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting,
- Hospitalists employed only by the facility; and/or
- Nurse practitioners and physician assistants who practice under a credentialed UnitedHealthcare Community Plan care provider.

Health facilities

Facility providers such as hospitals, home health agencies, skilled nursing facilities and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements.

Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and NPI number
- Have a current unrestricted license to operate
- Have been reviewed and approved by an accrediting body
- Have malpractice coverage/liability insurance that meets contract minimums
- Agree to a site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency
- Have no Medicare/Medicaid sanctions

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based on race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

The National Credentialing Center (NCC) completes these reviews. Find applications on the Council for Affordable Quality Healthcare (CAQH) website at caqh.org.First-time applicants must call the National Credentialing Center (VETTS line) at 1-877-842-3210 to get a CAQH number and complete the application online.

Go to **UHCprovider.com/join** to submit a participation request. For chiropractic credentialing, call **1-800-873-4575** or go to **myoptumhealthphysicalhealth.com**.

Submit the following supporting documents to CAQH after completing the application:

- Curriculum vitae
- Medical license
- DEA certificate
- Malpractice insurance coverage
- IRS W-9 form

Optum quality management and improvement

The Quality Management and Improvement (QMI) department monitors the performance in the following areas:

- Access to care
- Member satisfaction
- Utilization management
- Coordination of care between member's PCP and behavioral health care provider specialists

In addition, QMI provides summary reports related to established performance metrics.

Optum's QMI department monitors the quality of care and the outcomes of treatment through several clinical focus studies. Examples of focus studies completed are:

- Major depression
- Anxiety disorder
- Medication management
- Substance use disorder treatment

Another method of monitoring the quality of care delivered to members is through direct review of medical records. Optum reviews a sample of medical records at least annually. Care providers are notified of audit results with identified strengths and weaknesses.

Corrective action plans are required of care providers when performance falls below expected thresholds. Issues resulting from care providers' availability, noncompliance or diminished quality of care are forwarded to Optum's Regional Peer Review Committee. The committee reviews such cases, decides the action and notifies the care provider and the health plan of all such actions. The peer review process is strictly confidential.

Peer review

Credentialing process

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

Performance review

As part of the recredentialing process, UnitedHealthcare Community Plan looks in its Quality Management database for information about your performance. This includes member complaints and quality of care issues.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the NCC finds erroneous information, a representative will contact you by phone or in writing. You must submit corrections within 30 days of notification by phone, or in writing to the number or address the NCC representative provided.

You also have the right to receive the status of your credentialing application; please connect with a live advocate via chat. It is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.

Confidentiality

All credentialing information collected during the review process is kept confidential. It is only shared with your approval or as required by law with those involved in the credentialing process.

Resolving disputes

Contract concerns

If you have a concern about your Agreement with us, send a letter to:

UnitedHealthcare Community Plan Central Escalation Unit
P.O. Box 5032
Kingston, NY, 12402-5032

A representative will work to resolve the issue with you. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your Provider Agreement.

If your concern is about a UnitedHealthcare Community Plan procedure, such as the credentialing or Care Coordination process, we will resolve it by following the procedures in that plan. If you are still dissatisfied, please follow the dispute resolution provisions in your Provider Agreement.

If we have a concern about our Agreement with you, we will send you a letter. If the issue can't be resolved this way, please follow the dispute resolution provisions in your Provider Agreement.

If a member has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the Member handbook and **Chapter 13** of this manual.

Health Insurance Portability and Accountability Act compliance – your responsibilities

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all health care providers who conduct business electronically.

Transactions and code sets

If you conduct business electronically, submit claims using the standard formats adopted under HIPAA. Otherwise, submit claims using a Clearinghouse.

Unique identifier

HIPAA also requires unique identifiers for employers, health care providers, health plans and individuals for use in standard transactions.

National Provider Identifier

The National Provider Identifier (NPI) is your standard unique identifier. It is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While HIPAA only requires you to use the NPI in electronic transactions, many state agencies require it on fee-for-service claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan.

Privacy of individually identifiable health information

The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members' medical information. The regulations protect medical records and other identifiable health information. This includes electronic, paper or spoken data.

They enhance consumers' rights by giving them

access to their health information and controlling its inappropriate use. They also improve health care delivery by extending the privacy efforts of states and health systems to a national level.

Security

Covered entities must meet basic security measures:

- Help ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates,
- Protect against any reasonably anticipated threats, uses or disclosures of information not permitted or required under the Privacy Regulations, and
- Help ensure compliance with the security regulations by the covered entity's staff

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations.

Find additional information on HIPAA regulations at cms.hhs.gov.

Ethics and integrity

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, suppliers and government officials and agencies. Making sound decisions as we interact with you, other health care providers, regulators and others is necessary for our continued success and that of our business associates. It's also the right thing to do.

Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required 7 elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the Ethics and Integrity program
- Development and implementation of ethical standards and business conduct policies
- Creating awareness of the standards and policies by educating employees
- Assessing compliance by monitoring and auditing
- Responding to allegations of violations
- Enforcing policies and disciplining confirmed misconduct or serious neglect of duty
- Reporting mechanisms for workers to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health plan has a compliance committee consisting of senior managers from key organizational areas. The committee provides program direction and oversight.

Reporting and auditing

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.

UnitedHealthcare Community Plan's Special Investigations Unit (SIU) is an important part of the Compliance program. The SIU focuses on prevention, detection and investigation of potentially fraudulent and abusive acts committed by care providers and members. This department oversees coordination of anti-fraud activities.

To facilitate the reporting process of questionable incidents involving members or care providers, call our Fraud and, waste and abuse hotline.

Please refer to the Fraud, Waste and Abuse section of this manual for additional details about the UnitedHealthcare Community Plan Fraud, waste and abuse program.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

If you become the subject of a government inquiry or investigation, or a government agency requests documents relating to your operations (other than a routine request for documentation), you must provide UnitedHealthcare Community Plan with the details. You must also reveal what triggered the inquiry.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the state of Texas to perform "individual and corporate extrapolation audits." This may affect all programs supported by dual funds (state and federal funding) as well as state-funded programs, as requested by the Texas Health and Human Services Commission.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the Texas program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until one year after the resolution of all issues that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

To help ensure members receive quality services, you must also comply with requests for on-site reviews conducted by the state. During these reviews, the state will address your capability to meet Texas program standards.

You must cooperate with the state or any of its authorized representatives, the Texas Health and Human Services Commission, the CMS, Office of Inspector General (OIG) or any other agency prior-approved by the state, at any time during your Provider Agreement.

These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

We will perform reviews and audits without delaying your work. If you refuse to allow access, this will constitute a breach of your Provider Agreement.

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable Provider Agreement and this manual.

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care and service (QOC) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PCP office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance
- Available handicapped parking
- Handicapped accessible facility
- Available adequate waiting room space
- Adequate exam room(s) for providing member care
- Privacy in exam room(s)
- Clearly marked exits
- Accessible fire extinguishers
- Post file inspection record in the last year

Criteria for site visits

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit according to UnitedHealthcare Community Plan policy.

QOC issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determine to pose a risk to patient safety	1 complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Office facilities are dirty; smelly or otherwise in need of cleaning Office exams rooms do not provide adequate privacy	2 complaints in 6 months
Other	All other complaints concerning the office facilities	3 complaints in 6 months

UnitedHealthcare Connected Medicare-Medicaid plan

UnitedHealthcare Connected members are eligible for both Medicaid and Medicare services. Medical records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to HIPAA requirements and other federal and state laws. Claims for members will be paid according to the Medicare Cost Sharing Policy. UnitedHealthcare Connected is not responsible for cost sharing should the payment from the primary payer be equal to or greater than what the care provider would have received under Medicaid.

As part of our quality management program, we submit quarterly reporting to the Texas Health and Human Services Commission. We share the number of:

- Critical incident and abuse reports for members we have received from care providers.
- Our service coordinators who have received consumer-driven services (CDS) training.

The referral and prior authorization procedure are

UnitedHealthcare Connected seeks to accomplish the following objectives through its Quality Improvement and Medical Management Programs. UnitedHealthcare Connected seeks to improve the quality of care provided to its members. Thus, UnitedHealthcare Connected encourages care provider participation in health promotion and disease prevention programs. You are encouraged to work with UnitedHealthcare Connected in its efforts to promote healthy lifestyles through member education and information sharing.

Referrals and prior authorization

You are required to coordinate member care within the UnitedHealthcare Connected care provider network. If possible, all UnitedHealthcare Connected member referrals should be directed to UnitedHealthcare Connected participating care providers. Referrals outside of the network are permitted, but only with authorization approval from UnitedHealthcare Connected.

The referral and prior authorization procedure are important to the UnitedHealthcare Connected managed care program. Prior authorization is one of the tools we use to monitor the medical necessity and cost-effectiveness of the health care members receive. You are required to comply with UnitedHealthcare Connected prior authorization policies and procedures important to the UnitedHealthcare Connected managed care program. Prior authorization is one of the tools we use to monitor the medical necessity and cost-effectiveness of the health care members receive. You are required to comply with UnitedHealthcare Connected prior authorization policies and procedures. Non-compliance may result in delay or denial of reimbursement. Because the PCP coordinates most services provided to a member, the PCP usually initiates requests for prior authorization. However, specialists and ancillary care providers may also request prior authorization for services within their specialty areas.

The prior authorization department, under the direction of licensed nurses and medical directors, documents and evaluates requests for authorization. This includes:

- Verification that the member is enrolled with UnitedHealthcare Connected at the time of the request for authorization and on each date of service
- Verification that the requested service is a covered benefit for the member
- Assessment of the requested service's medical necessity and appropriateness
- UnitedHealthcare Connected medical review criteria based on CMS/Medicaid program requirements, applicable policies and procedures, contracts, and law
- Verification that the service is being provided by a participating care provider and in the appropriate setting
- Verification of other insurance for coordination of benefits

Requests for elective services generally need review and approval by a medical director and frequently require additional documentation.

Referrals should be made largely to network care providers. For a list of participating providers, visit **UHCprovider.com/TXCommunityPlan** > Provider Directories. The list includes all provider types. You may also call **Provider Services** at **1-888-887-9003**.

Denial of requests for prior authorization

Denials of authorization requests occur only after a UnitedHealthcare Connected medical director has reviewed the request. A UnitedHealthcare Connected medical director is always available to speak to you and review a request.

Prior authorization request are often denied because of a lack of medical documentation. You are encouraged to call or submit additional information for reconsideration. If more information is requested and not received within 5 business days, the request is denied.

Pre-admission authorization

For coordination of care, PCPs or the admitting hospital facilities should notify UnitedHealthcare Connected if they are admitting a UnitedHealthcare Connected member to a hospital or other inpatient facility.

Provide the following information:

- Notifying PCP or hospital
- Name of admitting PCP
- Member's name, sex, and UnitedHealthcare Connected ID number
- Admitting facility
- Primary diagnosis
- Reason for admission
- Date of admission

Concurrent hospital review

Medicare-Medicaid plan

UnitedHealthcare Connected will review all member hospitalizations within 48 business hours of admission to confirm that the hospitalization and/or procedures were medically necessary. Reviewers will assess the usage of ancillary resources, service and level of care according to professionally recognized standards of care. Concurrent hospital reviews will validate the medical necessity for continued stay.

Your cooperation is required with all requests for information, documents or discussions related to concurrent review and discharge planning. This includes 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

Community Plan 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 4 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 Community Plan uses InterQual (we previously used MCG 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.

Medical criteria

Qualified professionals who are members of the UnitedHealthcare Connected Quality Improvement Committees and the board of directors will approve the medical criteria used to review medical practices and determine medical necessity. UnitedHealthcare Connected currently uses nationally recognized criteria, such as Diagnostic Related Groups Criteria and InterQual, to guide the prior authorization, concurrent review and retrospective review processes. These criteria are used and accepted nationally as clinical decision support criteria.

UnitedHealthcare Connected may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the utilization of specific drugs.

UnitedHealthcare Connected has established the Quality and Utilization Management Peer Review Committee to allow physicians to provide guidance on medical policy, quality assurance and improvement programs and medical management procedures. You may recommend specific clinical guidelines to be used for a specific diagnosis. These requests should be supported with current medical research and or data and submitted to the UnitedHealthcare Connected Quality and Utilization Management Peer Review Committee.

A goal of the Quality and Utilization Management Peer Review Committee is to help ensure that practice guidelines and utilization management guidelines:

- Are based on reasonable medical evidence or a consensus of health care professionals in the particular field
- Consider the needs of the enrolled population
- Are developed in consultation with participating physicians
- Are reviewed and updated periodically

Find medical policies and coverage determination guidelines at **UHCprovider.com/TXCommunityPlan** > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan Medical & Drug Policies and Coverage Determination Guidelines.

Clinical practice guidelines

We regularly update our clinical practice guidelines in consideration of our members' needs. These guidelines describe a range of acceptable approaches to the diagnosis, management and prevention of specific diseases or conditions, helping you make clinical decisions. However, the ultimate judgment about member care rests with you. The guidelines are found on **UHCprovider.com/TXCommunityPlan** > Current Policies and Clinical Guidelines > Clinical Guidelines.

Health Effectiveness Data and Information Set

Health Effectiveness Data and Information Set (HEDIS) is a tool designed to help people reliably compare health plan performance. It measures important dimensions of care and service. In our accountability to these standards, we look to you to address gaps in care. 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. These measures may change from year to year. For more information, visit NCQA.org > HEDIS Quality Measurement.

Compliance Plan

For information about the Provider Compliance Plan (excluding CDS), go to texas.gov.

Utilization Management Reporting

We regularly report the following dynamics, including for behavioral health services specified by individual mental health service type. 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 include:

- Financial
  (i.e., third-party recovery, out-of-network utilization)
- Care provider network
  (i.e., credentialing, capacity, termination)
- Complaints and appeals
- Hotlines (i.e., call centers)
- Historically underutilized business
- Long-Term Services and Supports utilization
- Claims
- Pharmacy
- Geo mapping for access to care

Chapter 12: Billing and submission

Key contacts

Topic	Link	Phone number
Claims	**UHCprovider.com/claims**	**1-888-887-9003** Electronic billing (code: 87726) **1-866-842-3278**
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	**UHCprovider.com/edi**	**1-866-633-4449**

Our claims process

For claims, billing and payment questions, go to **UHCprovider.com/claims**.

We follow the same claims process as UnitedHealthcare. See the Claims Process chapter of the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) on **UHCprovider.com/guides**.

For mailed claims, use the following addresses:

STAR and CHIP

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5270

STAR Kids

UnitedHealthcare Community Plan
P.O. Box 5290
Kingston, NY 12402-5290

STAR+PLUS

UnitedHealthcare Community Plan
P.O. Box 31352
Salt Lake City, UT 84131-0352

Medicare-Medicaid plan

UnitedHealthcare Connected
P.O. Box 31352
Salt Lake City, UT 84131-0352

NOTE: UnitedHealthcare and its subcontractors cannot directly or indirectly charge or hold a member or care provider responsible for claims adjudication or transaction fees.

1. Claims process from submission to payment.
2. You submit EDI claims to a clearinghouse or paper claims to us. We scan paper claims.
3. All claims are checked for compliance and validated.
4. Claims are routed to the correct claims system and loaded.
5. Claims with errors are manually reviewed.
6. Claims are processed based on edits, pricing and member benefits.
7. Claims are checked, finalized and validated before sending to the state.
8. Adjustments are grouped and processed.
9. Claims information is copied into data warehouse for analytics and reporting.
10. We make payments as appropriate.

If you think we processed your claim incorrectly, please see the Claims reconsiderations, appeals and grievances chapter in this care provider manual for next steps.

Care providers (All)

Submit claims to UnitedHealthcare Connected as soon as possible after service is rendered using the standard paper CMS claim form or electronic submission process.

To expedite claims payment, identify the following items on your claims:

- Member's name, date of birth, address and ID number
- Name, signature, address and phone number of physician performing the service, as in your contract document
- NPI number
- Physician's tax ID number
- CPT-4 and HCPCS procedure codes with modifiers where appropriate
- ICD-10 diagnostic codes
- Revenue codes (UB-04 only)
- Date of service(s), place of service(s) and number of services (units) rendered
- Referring physician's name (if applicable)
- Information about other insurance coverage, including job-related, auto or accident information, if available
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers
- Attach a description of the procedure/service provided for claims submitted with unlisted medical or surgical CPT codes or experimental or reconstructive services (if applicable)

Outpatient services uses an approved CMS form 1500. You may download it from CMS.gov > Home > Medicare > CMS Forms > CMS Forms List > CMS 1500.

Facility and Inpatient Services uses an approved CMS UB-04 Form available at CMS.gov > Medicare > CMS Forms > CMS Forms List > CMS 1450. Claim information must match referral data. Any missing or invalid data will result in a claim being denied.

Original claims submissions and adjustments processed after the thirtieth day will include interest payments, according to Texas HHS.

For more information, go to CMS.gov > Regulations & Guidance > Manuals > Internet Only Manuals (IOMs) > 100-04 Medicare Claims Processing Manual > Manuals > Internet Only Manuals (IOMs) > 100-04 Medicare Claims Processing Manual.

Any electronic claims submitted to UnitedHealthcare Connected should comply with HIPAA requirements.

To learn more about claim submissions, see **https://chameleoncloud4.io/welcome** > Sign In.

Hospitals

Hospitals should submit claims to the UnitedHealthcare Connected claims address as soon as possible after service is rendered, using the standard UB-92 form or electronically using payer ID 87726.

To expedite claims payment, identify the following items on your claims:

- Member's name
- Member's date of birth and sex
- Member's UnitedHealthcare Connected ID number
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- Appropriate diagnosis, procedure and service codes
- Date of services (including admission and discharge date)
- Charge for each service
- Care provider's ID number and locator code, if applicable
- Care provider's TIN
- Name/address of participating care provider

Any electronic claims submitted to UnitedHealthcare Connected should comply with HIPAA requirements

National Provider Identifier

HIPAA requires you have a unique NPI. The NPI identifies you in all standard transactions. If you have not applied for a NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan. Call **Provider Services** at **1-888-887-9003.**

Your clean claims must include your NPI and federal TIN.

General billing guidelines

We only consider reimbursing claims if you met billing and coverage requirements. Submitting a referral does not guarantee we will pay you. Payment depends on the member's coverage on the date(s) of service, medical necessity, plan rules about limitations and exclusions, and UnitedHealthcare Community Plan policies. Claims must be received by UnitedHealthcare Community Plan within 95 days of the service date to be considered for payment. We don't reimburse excessive, inappropriate or non-covered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for overpayments or offset future payments as allowed by law.

Fee schedule

Fee schedules are located at the Texas Medicaid

& Healthcare Partnership at TMHP.com > Providers > Fee Schedules.

You may request a paper copy of your fee schedule by calling **Provider Services** at **1-888-887-9003.**

Modifier codes

Use the appropriate modifier codes on your claim form. Find our modifier reference policies in our **Community Plan Reimbursement Policies** by searching for "modifier." The modifier must be used based on the date of service.

To find the code(s) for a particular service, go to Texas Medicaid Provider Procedures Manual | TMHP.

Member ID card for billing

The member ID card has both the UnitedHealthcare Community Plan member ID and the state Document Control Number (DCN). UnitedHealthcare Community Plan prefers you bill with the member ID.

Acceptable claim forms

UnitedHealthcare Community Plan only processes claims submitted on 1500 and UB-04 claim forms.

Use the 02/12 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other care providers.

Clean claims and submission requirements

A clean claim is defined in Texas Revised Statutes as one that can be processed without obtaining additional information from the care provider of service or from a third party. It does not include a claim from a care provider under investigation for fraud or abuse or a claim selected for medical review.

Complete a CMS 1500 or UB-04 form whether you submit an electronic or a paper claim. Clean claims have:

- A health service provided by an eligible health care provider to a covered UnitedHealthcare Community Plan member
- All the required documentation, including correct diagnosis and procedure codes
- The correct amount claimed

We abide by the following the 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) and have an active Texas Medicaid enrollment
- You must include correct taxonomy code and National Provider Identifier (NPI) for billing and rendering care providers
- 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

We may require additional information for some services, situations or state requirements.

Submit any services completed by nurse practitioners or physician assistants who are part of a collaborative agreement.

For more information see the Texas Uniform Managed Care Manual Chapter 2.0, "Claims Manual" at hhs.texas.gov > Services > Health > Medicaid and CHIP > Managed Care Contract Management > Texas Medicaid & CHIP - Uniform Managed Care Manual > Chapter 2: Claims Manual.

Professional and institutional claims, whether electronic or paper, for both rendering and billing care providers, 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. For example, if attested as your business address at 100 Main Street, submitting claims with 100 Main St. will result in denials. Professional claims also need to add qualifiers to the taxonomy code.

We have a 30-day clean claim payment for professional and institutional claims submissions. Non-electronic 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 30th day will include interest payments according to Texas HHSC.

A clean claim is defined in Texas Revised Statutes as one that can be processed without obtaining additional information from the care provider of service or from a third party. It does not include a claim from a care

provider under investigation for fraud or abuse or a claim selected for medical review by UnitedHealthcare Connected. Please mail paper claims to:

Mail UnitedHealthcare Connected claims to:

UnitedHealthcare Connected
P.O. Box 31352
Salt Lake City, UT 84131-0352

Sub-contracted care provider networks such as dental and vision should submit claims directly to their contractor.

Care provider coding

UnitedHealthcare Community Plan complies with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) state standards based on claims data and chart review. Use the UnitedHealthcare ICD-10-CM Code Lookup Tool to find an ICD-10 code.

Electronic claims submission and billing

You may submit claims by electronic data interchange (EDI). EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

- All claims are set up as "commercial" through the clearinghouse
- Our payer ID is 87726
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms

For more information, contact **EDI Claims**.

Electronic data interchange companion documents

UnitedHealthcare Community Plan's companion documents are intended to share information within Implementation Guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

- Clarify data content that meets the needs of the health plan's business purposes when the IG allows multiple choices
- Provide values the health plan will return in outbound transactions
- Outline which situational elements the health plan requires

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements. The companion documents are located on **UHCprovider.com.edi** > **EDI transaction and code sets**.

Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties. For clearinghouse options, go to **UHCprovider.com/edi** > **EDI Clearinghouse Options**.

e-Business support

Call UnitedHealthcare Community Plan at **1-888-887-9003** for help with online billing, claims, Electronic Remittance Advices (ERAs), Electronic Funds Transfers (EFTs).

For all of our claims and payment options, such as business support and EDI claims, go to **Chapter 1** under Online Services.

For further information about EDI online, go to **UHCprovider.com/resourcelibrary** to find **Electronic Data Interchange** menu.

Important electronic data interchange payer information

- Claim Payer ID: 87726
- ERA Payer ID: UFNEP

Electronic payment solutions: Optum Pay

UnitedHealthcare has launched the replacement of paper checks with electronic payments Optum Pay™ and will no longer be sending paper checks for payment. You will have the option of signing up for Automated Clearing House (ACH)/direct deposit, our preferred method of payment, or to receive a Virtual Card payment (Virtual Card). The only alternative to a Virtual Card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose ACH/direct deposit?

- Direct deposit puts payment directly into your bank account
- Easy and fast way to get paid
- Improved financial control; no paper checks or remittance information to lose or misplace
- Ability to track information on online portal

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/healthcare organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay™ or receiving Virtual Cards there is no action you need to take
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment.**

All regulated entities have a Management Agreement with United HealthCare Services, Inc. (UHS), under which UHS provides a whole host of administrative services (many of which are provided to UHS by an Optum entity and then passed through to the regulated entities), including those of a financial nature. Those agreements are filed with the DOI in the regulated entity's state of domicile for approval.

Texas Medicaid & Healthcare Partnership

You may submit claims regardless of a member's managed care organization (MCO) membership to TMHP. The claims will be forwarded 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 services that do not use EVV

To submit claims go to TMHP.com > Providers > Go To TexMedConnect.

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.

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com/EDI**.

Visit the National Uniform Claim Committee website to learn how to complete the CMS 1500 form.

Completing the UB-04 form

Bill all hospital inpatient, outpatient and ER services using revenue codes and the UB-04 claim form:

- Include ICD CM diagnosis codes
- Identify other services by the CPT/HCPCS and modifiers

Direct Connect

Direct Connect is a free online portal that lets you securely communicate with payers to address errant claims. This portal has the ability to replace previous methods of letters, faxes, phone calls and spreadsheets. It also helps:

- Manage overpayments in a controlled process
- Create a transparent view between care provider

and payer
- Avoid duplicate recoupment and returned checks
- Decrease resolution timeframes
- Real-time reporting to track statuses of inventories in resolution process
- Provide control over financial resolution methods

All users will access Direct Connect using the **UnitedHealthcare Provider Portal**. On-site and online training is available. Email **directconnectsupport@optum.com** to get started with Direct Connect.

Capitated services

Capitation is a payment arrangement for health care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to you per period of time. We pay you whether or not that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary provider or hospital.

We use the term 'medical group/IPA' interchangeably with the term 'capitated care providers'. Capitation payment arrangements apply to participating physicians, health care providers, facilities and ancillary providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for members:

- Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member, and
- Who are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare Community Plan.

Additionally, capitated care providers may be subject to any or all delegated activities. Capitated care providers should refer to their Delegation Grids within their participation agreements to determine which delegated activities the capitated providers are performing on behalf of UnitedHealthcare Community Plan.

For capitated services, include all services related to an inpatient stay on the UB-04 when a member is admitted to the hospital, they received ER treatment, observation or other outpatient hospital services.

We deny claims submitted with service dates that don't match the itemization and medical records. This is a billing error denial.

Capitation rates

Services part of a monthly capitation are included in the provider network agreement for applicable care providers. For more information, contact your physician advocate or call **Provider Services** at **1-888-887-9003**.

Form reminders

- Note the attending provider name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims
- Send the referring provider NPI and name on outpatient claims when this care provider is not the attending care provider.
- Include the attending care provider's NPI in the Attending Provider Name and Identifiers Fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefit

Our benefits contracts are subject to subrogation and coordination of benefits (COB) rules:

- **Subrogation:** We may recover benefits paid for a member's treatment when a third party causes the injury or illness
- **COB:** We coordinate benefits based on the member's benefit contract and applicable regulations. UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

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 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.

Hospital and clinic method of billing professional services

Hospital and clinics must bill for professional services bill on a CMS 1500. The servicing provider's name is placed in box 31, and the servicing provider's group NPI number is placed in box 33a.

Global days

Global days include the billable period involving pre-operative visits, the procedure itself, and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same care provider or another care provider reporting the same TIN in either an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), or physician's office.

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on **UHCprovider.com**/policies > For Community Plans > **Reimbursement Policies for Community Plan** > Global Days Policy, Professional-Reimbursement Policy-UnitedHealthcare Community Plan.

Correct Coding Initiative

UnitedHealthcare Community Plan performs coding edit procedures based on the Correct Coding Initiative (CCI) and other nationally recognized sources.

Comprehensive and component codes

Comprehensive and component code combination edits apply when a code pair(s) appears to be related. These edits can be further broken down to explain the bundling rationale. Some of the most common causes for denials in this category are:

- **Separate procedures:** Only report these codes when performed independently
- **Most extensive procedures:** You can perform some procedures with different complexities. Only report the most extensive service.
- **With/without services:** Don't report combinations where one code includes and the other excludes certain services
- **Medical practice standards:** Services part of a larger procedure are bundled
- **Laboratory panels:** Don't report individual components of panels or multichannel tests separately

Clinical Laboratory Improvements Amendments

Submit your laboratory claims with the Clinical Laboratory Improvements Amendments (CLIA) number. In box 23 of the CMS 1500 claim form, enter the 10-digit CLIA certification number for laboratory services billed by an entity performing CLIA-covered procedures.

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at 1-410-786-3531 or go to the CMS.gov

Billing multiple units

When billing multiple units:

- If the same procedure is repeated on the same date of service, enter the procedure code once with the appropriate number of units
- The total line charge is the unit charge multiplied by the number of units

Billing guidelines for obstetrical services

Follow this reporting procedure when submitting obstetrical delivery claims. Otherwise, we will deny the claim:

- If billing for both delivery and prenatal care, use the date of delivery
- Use one unit with the appropriate charge in the charge column

Newborn billing

Claims submitted for services provided to a newborn can include a proxy ID number, the mother's name or Medicaid ID, or state-issued Medicaid ID number for newborns until they receive their own Medicaid ID number. Claims submitted without a Medicaid ID for a newborn won't be denied. However, it is best to obtain a Medicaid ID for an eligible newborn as soon as possible and begin submitting claims for the newborn using his or her Medicaid ID.

Billing guidelines for transplants

The Department of Health and Human Services covers medically necessary, non-experimental transplants. UnitedHealthcare Community Plan covers the transplant evaluation and work-ups. Get prior authorization for the transplant evaluation. Gather all required referrals and evaluations to complete the pre-transplant evaluation process once the member is a possible candidate.

Ambulance claims

Ambulance claims must include the point of origin, destination address, mileage, city, state and ZIP.

Direct ambulance service claims to **UHCprovider.com**. Become a registered user at **UHCprovider.com** to allow for a protected exchange of information when billing. Members may submit claims as well. Go to **UHCprovider.com/claims** > Sign In.

Non-emergency medical transportation services

Care providers contracted with Modivcare to provider Non-emergency medical transportation (NEMT) services will submit claims directly to Modivcare. For more information, go to modivcare.com > Login > Transportation Providers. For inquiry follow-ups that surpass 3 days or escalation requests, send an email to Tx.Transportation@modivcare.com.

National drug code

Claims must include:

- National Drug Code (NDC) and unit of measurement for the drug billed
- HCPCS/CPT code and units of service for the drug billed
- Actual metric decimal quantity administered

Submit the NDC on all claims with procedure codes for care provider-administered drugs in outpatient clinical settings. The claims must show the NDC that appears on the product. Enter the identifier N4, the 11-digit NDC code, unit/basis of measurement qualified, and metric decimal quantity administered. Include HCPCS/CPT codes. Covered CPT codes are located at **UHCprovider.com/policies** > For Community Plans > Medicaid & Drug Policies and Coverage Determination Guidelines for Community Plan.

For more information about clinician administered drugs go to txvendordrug.com > Formulary > Clinician-Administered Drugs.

Long-acting reversible contraception devices

Hospitals may receive reimbursement for the following procedure codes in addition to the hospital diagnosis related group (DRG) payment when a Long-acting reversible contraception (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.

Long-term care daily rates

Daily rate claims for services rendered in a nursing facility or Intermediate Care Facility (ICF) for Individuals with Intellectual Disabilities (IDDs) or other related conditions should be submitted to the Texas Medicaid & Health Care Partnership at TMHP.com > Providers > TexMedConnect.

See more at hhs.texas.gov > Services > Health > Medicaid and CHIP > Provider Information > Contracts and Manuals > Uniform Managed Care Manual.

Skilled nursing facility long-term care billing

One special payment policy applies when a member in a skilled nursing facility (SNF) for long-term care (LTC) transitions into UnitedHealthcare Connected.

Bill for services performed during the transition period, which can be up to 6 months. Submit the bill through a clearinghouse to the **UnitedHealthcare Provider Portal**.

Other special billing

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 denial or be subject to recoupment. Billing instructions are detailed in a training available at txvendordrug.com > Formulary > Clinician-Administered Drugs > Education > TMHP: NDC Requirements for the Submission of Clinician-Administered Drug Claims (log in required).

Durable medical equipment

Claims for custom DME or augmentative devices when the member changes MCOs and the authorizing MCO is not the member's MCO on the date of delivery (UMCC, Att A, Section 5.03, (g)):

- If the member is a STAR Kid and moves to a STAR Kids program with another MCO, then the former MCO pays the claim
- If the member moves from fee-for-service to a STAR Kids program with an MCO, then the new MCO pays the claim
- If the member leaves our health plan for another MMP, we will pay for the DME

See more at hhs.texas.gov.

Minor home modification

Claims for minor home modifications should be submitted to the MCO in which the member was previously enrolled before switching membership to UnitedHealthcare Community Plan. This applies to a Medically Dependent Children Program STAR Kids Waiver member when the original MCO authorized the service, even though the member is with UnitedHealthcare Community Plan by the date of completion of the minor home modification.

Long-Term Services and Supports claims (STAR Kids)

UnitedHealthcare Community Plan is responsible for paying Long-Term Services and Supports (LTSS) services for members in the Medically Dependent Children Program Waiver. Other waiver LTSS services are payable by the Texas Health and Human Services Commission. Submit claims through TMHP.com. Community First Choice care provider billing is held accountable to the Home and Community-Based Services (HCBS) Program Billing Guidelines. These standards address billable activities, what not to bill, units of service, care provider qualifications and any necessary documentation. Visit hhs.texas.gov > Laws & Regulations > Handbooks > Home and Community-Based Services (HCBS) Program Billing Guidelines.

Medical necessity

UnitedHealthcare Community Plan only pays for medically necessary services. Hospital admissions denied by the Texas Medical Review Program (TMRP) also apply under this policy. See **Chapter 5** for more information about medical necessity.

Present on admission

Hospitals and inpatient rehabilitation facilities must report present on admission (POA) 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® (MLN) General Education Products > MLN Catalogue > Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision.

For more information, visit CMS.gov > Medicare > Hospital-Acquired Conditions | CMS.

Place of service codes

Go to CMS.gov for Place of Service codes.

Spell-of-illness

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 and STAR Kids members. There is no spell-of-illness limitation for CHIP and CHIP Perinate Newborn members.

Asking about a claim

You can ask about claims through **Provider Services** at **1-888-887-9003** and through the **UnitedHealthcare Provider Portal**. Follow the instructions to get a user ID. You will receive your user ID and password within 48 hours.

Provider Services

Provider Services helps resolve claims issues. Have the following information ready before you call:

- Member's ID number
- Date of service
- Procedure code
- Amount billed
- Your ID number
- Claim number

Allow Provider Services 45 days to solve your concern.

UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information — all at no cost without calling.

See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

- If you already have a One Healthcare ID, simply go to the **UnitedHealthcare Provider Portal** to access
- If you need to set up an account on the portal, follow **these steps** to register

Here are the most frequently used tools on the **UnitedHealthcare Provider Portal**:

- **Eligibility and benefits**
  View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims**
  Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **Prior authorization and notification**
  Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/priorauth**.
- **Specialty pharmacy transactions**
  Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile**
  View and update the provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **Document Library**
  Access reports and claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, which can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.

  See **UnitedHealthcare Provider Portal** to learn more about the available self-paced user guides for various tools/tasks.

Resolving claim issues

To resolve claim issues, contact Provider Services through the **UnitedHealthcare Provider Portal**, or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

Allow up to 30 days for UnitedHealthcare Community Plan to receive payment for initial claims and adjustment requests.

For paper claims

Submit a screen shot from your accounting software that shows when you submitted the claim. The screen

shot must show the correct:

- Member name
- Date of service
- Claim date submission (within the timely filing period)

Timely filing

Timely filing issues may occur if members give the wrong insurance information when you treat them. This results in receiving:

- A denial/rejection letter from another carrier
- Another carrier's explanation of benefits
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service

All of the above must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.

The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

If a claim is rejected, and corrections are not received within 90 days from date of service or close of business from the primary carrier, the claim is considered late billed. It will be denied timely filing.

Timely filing limits can vary based on state requirements and contracts. If you don't know your timely filing limit, refer to your Provider Agreement

Balance billing

The balance billing amount is the difference between Medicare's and Medicaid's allowed charge and the care provider's actual charge to the patient. You are prohibited from billing, charging or otherwise seeking payment from enrollees for covered services.

Do not balance bill members if:

- The charge amount and the UnitedHealthcare Community Plan fee schedule differ
- Your claim is denied for late submission, unauthorized service or as not medically necessary
- UnitedHealthcare Community Plan is reviewing a claim

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, STAR Kids, 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.

You are able to balance bill the member for non-covered services only if:

- A specific service or item is provided at the member's request
- 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 (care 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 solicité (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 membere solicite o reciba. También comprendo que tengo la responsibilidad 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 $200,000 annual limit on inpatient services does not apply. (STAR Kids)
- 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.

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

If you don't know who your provider advocate is, connect with a live advocate via chat on **UHCprovider.com/chat**, available 7 a.m.-7 p.m. CT or via email: **ProviderServiceSTX@uhc.com** for Houston, Corpus Christi, Victoria, Beaumont and the Rio Grande Valley **ProviderServiceCTX@uhc.com** for Austin, Waco and San Antonio **ProviderServiceNTX@uhc.com** for Amarillo, Dallas, El Paso, the areas of North Central Texas, West Texas, West Central Texas and East Texas.

Medicare-Medicaid program

Services to members cannot be denied for failure to pay copayments. If a member requests a service not covered by UnitedHealthcare Connected, you should have the member sign a release form indicating they understand the service is not covered by UnitedHealthcare Connected and they are financially responsible for all applicable charges.

This release must include the date of the service and the specific service being rendered. You may bill the member when UnitedHealthcare Connected has denied prior authorization or referral for the services and the following conditions are met:

- The member was notified by the care provider of the financial liability in advance of service delivery
- The notification by the provider was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose. To see an acceptable sample, go to TMHP.com > Resources > Forms > Private Pay Agreement.
- The notification is dated and signed by the member. For laboratory services, you are only reimbursed for the services you are certified for through the Federal Clinical Laboratory Improvement Amendments (CLIA) to perform; you must not bill the member for any laboratory services for which you lack the applicable CLIA certification. However, this requirement does not apply to laboratory services rendered by physicians, practitioners or medical groups in office settings that have been granted waived status under CLIA. We require that all participating laboratory testing sites maintain certification under CLIA or have a waiver of CLIA certification.

Childrens health insurance program CHIP cost-sharing

If UnitedHealthcare Community Plan negotiates a lesser benefit amount than the identified copayment per a care provider's network agreement, 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 **1-877-305-8952**.

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)

Members must pay copayments for medical services or prescription drugs at the time of service. Copayment requirements are found at hhs.texas.gov.

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. The CHIP member will be responsible for all costs in such cases.

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.

Cost-sharing for UnitedHealthcare Connected Medicare-Medicaid members

You will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any UnitedHealthcare Connected member who is eligible for both Medicare and Medicaid (MMR), their representative or the UnitedHealthcare Connected organization for Medicare Part A and B cost-sharing (e.g., copays, deductibles, coinsurance) when the state is responsible for paying such amounts. You will either:

- Accept payment made by or on behalf of the UnitedHealthcare Connected organization as payment in full; or
- Bill the appropriate state source for such cost-sharing amount

Third-party resources

UnitedHealthcare Community Plan is, by law, the payer of last resort for eligible members. Therefore, you must bill and obtain an explanation of benefits (EOB) from any other insurance or health care coverage resource before billing UnitedHealthcare Community Plan, as required by contract. Refer to your Agreement for third-party claim submission deadlines. Once you bill the other carrier and receive an EOB, the claim may then be submitted to UnitedHealthcare Community Plan. Please attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or denial reason.

CHIP cost-sharing	
Effective January 1, 2014	
Enrollment fees (for 12-month enrollment period):	
	Charge
At or below 151% of FPL*	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-pays (per visit):	
At or below 151% FPL	**Charge**
Office visit (non-preventative)	$5
Non-emergency ER	$5
Generic drug	$0
Brand drug	$5
Facility co-pay, inpatient (per admission)	$35
Cost-sharing cap	5% (of family's income)**
Above 151% up to and including 186% FPL	**Charge**
Office visit (non-preventative)	$20
Non-emergency ER	$75
Generic drug	$10
Brand drug	$35
Facility co-pay, inpatient (per admission)	$75
Cost-sharing cap	5% (of family's income)**
Above 186% up to and including 201% FPL	**Charge**
Office visit (non-preventative)	$25
Non-emergency ER	$75
Generic drug	$10
Brand drug	$35
Facility co-pay, inpatient (per admission)	$125
Cost-sharing cap	5% (of family's income)**

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.

**Per 12-month term of coverage.

Chapter 13: Claim reconsiderations, appeals and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCprovider.com/claims**. We no longer use fax numbers. Please use our online options or phone number.

The following grid lists the types of disputes and processes that apply:

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing timeframe	UnitedHealthcare Community Plan response timeframe
Care provider claim correction	If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5270	UHCprovider.com/claims	**1-800-600-9007**	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com,** then click Claims.	Claim reconsiderations need to be submitted within 120 days from the disposition date.	30 business days.
Care provider claim reconsideration (step 1 of claim dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care provider	Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide**. For those care providers exempted from this requirement, requests may be submitted at the following address: **UnitedHealthcare Community Plan** P.O. Box 5270 Kingston, NY 12402-5270		**1-800-600-9007**	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com,** then click Claims.	Claim reconsiderations need to be submitted within 120 days from the disposition date.	30 business days.
Care provider claim formal appeal (step 2 of claim dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care provider	Most care providers in your state must submit reconsideration requests electronically. For further information on appeals, see the **Reconsiderations and Appeals interactive guide**. For those care providers exempted from this requirement, requests may be submitted at the following address: **UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-600-9007**	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com,** then click Claims.	A reconsideration should be submitted prior to appealing a claim. An appeal needs to be submitted no later than 12 months from the date of service.	30 calendar days for claims disputes resulting from a denial, limitation, reduction, suspension or termination of a covered service for lack of medical necessity and 15 calendar days for all other disputes.
Care provider grievance	A complaint expressing dissatisfaction with operations, activities, or behavior of a health plan or member.	Care provider	**UnitedHealthcare Community Plan / Connected** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-600-9007**	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com,** then click Claims.	N/A	5 business days - we must give receipt notification 30 calendar days - we will render a written decision.

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing timeframe	UnitedHealthcare Community Plan response timeframe
Member appeal	A request to change an adverse benefit determination that we made.	*Member. *Member's authorized representative (such as friend or family member) with written member consent. *Care provider on behalf of a member with member's written consent.	**Part C appeals: UnitedHealthcare Community Plan / Connected** P.O. Box 31364 Salt Lake City, UT 84131-0364 **Part D appeals UnitedHealthcare Community Plan** Attn: Part D Standard Appeals P.O. Box 6103 Cypress, CA 90630-9998	**providerforms.uhc.com** AOR Provider Consent Form on this site for member appeals.	**1-800-895-2017,** TTY **711**	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com,** then click Claims.	Urgent appeals - must receive within 60 calendar days. Standard appeals - 60 calendar days.	Urgent appeals - 72 hours. Standard appeals - 30 calendar days.
Member complaint/ grievance	A member's written or oral expression of dissatisfaction regarding the plan and/or care provider, including quality of care concerns. Part C & D grievances.	*Member. *Member's authorized representative (such as friend or family member) with written member consent. *Care provider on behalf of a member with member's written consent.	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-895-2017,** TTY **711**	Use the claims and payments tab on the UnitedHealthcare Provider Portal. To access the portal, go to **UHCprovider.com,** then click Claims.	**MMP:** Complaints for which remedial action is requested must be filed within 90 days after the event or incident triggering the grievance.	30 business days.

These definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements.

UnitedHealthcare Community Plan and its in-network care providers may agree to more stringent requirements within care provider agreements than described in the standard process.

UnitedHealthcare Community Plan Medicare-Medicaid plan appeals

Other than Medicare Part D appeals, the following process applies for members:

- **Appeal time frames** – Members and/or their authorized representatives, including care providers, have 60 calendar days from the date of the notice of action to file an appeal with UnitedHealthcare Community Plan related to denial of any covered services. Members may receive a continuation of benefits when the member files an appeal of a reduction or denial of previously authorized services on or before the later of 1) 10 days after the notice of action, or 2) the intended effective date of UnitedHealthcare Community Plan's proposed action.
- The member may also appeal to the HHSC Appeals Division for a state fair hearing within 120 days from the date of the appeal decision letter

Denial

Your claim may be denied for administrative or medical necessity reasons.

An **Administrative denial** is when we didn't get notification before the service, or the notification came in too late.

Denial for **medical necessity** means the level of care billed wasn't approved as medically necessary.

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file an appeal.

Other top reasons for denial include:

Duplicate claim – This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.

Claim lacks information. Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.

Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

Claim not covered by UnitedHealthcare Community Plan. Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.

Time limit expired. This is when you don't send the claim in time.

Adjustments

If you believe a claim should not have been denied, call **Provider Services** at **1-888-887-9003**. 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.

Claim correction

What is it?

You may need to update information on a claim you've already submitted. A corrected claim replaces a previously processed or denied claim submitted in error.

When to use:

Submit a corrected claim to fix or void one that has already processed.

How to use:

Use the claims reconsideration application on the UnitedHealthcare Provider Portal.

To access the **UnitedHealthcare Provider Portal,** sign in to using your One Healthcare ID.

Most care providers in your state must submit reconsideration requests electronically.

For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.**

For those care providers exempted from this requirement, you may submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Mailing address:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

Additional information

- When correcting or submitting late charges on 837 institutional claims, use bill type xx7: Replacement of Prior Claim
- Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim
- To void a claim, use bill type xx8
- 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.

Resubmitting a claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected. A rejected claim is one that has not been processed due to problems detected before claim processing. Since rejected claims have not been processed yet, there is no appeal - the claim needs to be corrected through resubmission.

Common Reasons for Rejected Claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address
- Errors in care provider data
- Wrong member insurance ID
- No referring care provider ID or NPI number
- Inactive Texas Medicaid enrollment

How to use:

To resubmit the claim, follow the same submission instructions as a new claim.

To mail your resubmission, provide all claim information to:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

Claim reconsideration (step 1 of dispute)

What is it?

Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with. A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly.

When to use:

Submit a claim reconsideration when you think a claim has not been properly processed.

For administrative denials:

- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records

For medical necessity denials:

- In your request, please include any additional clinical information that may not have been reviewed with your original claim
- Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation

How to use:

If you disagree with a claim determination, submit a claim reconsideration request electronically, by phone or mail.

- **Electronically –** Use the Claim Reconsideration application on the UnitedHealthcare Provider Portal. Include electronic attachments. You may also check your status using the **UnitedHealthcare Provider Portal**.
- **Phone –** Call **Provider Services** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.

Most care providers in your state must submit claim reconsideration requests electronically.

For further information on claim reconsiderations, see the **Reconsiderations and Appeals interactive guide.**

For those care providers exempted from this requirement, you may submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

- **Mail –** Submit the Claim Reconsideration Request Form to:

  UnitedHealthcare Community Plan
  P.O. Box 5240
  Kingston, NY 12402-5240

Available at **UHCprovider.com/claims.**

Valid proof of timely filing documentation (reconsideration)

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service. It includes:

- A denial or rejection letter from another insurance carrier
- Another insurance carrier's explanation of benefits
- Letter from another insurance carrier or employer group indicating
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request electronically or by mail with the following information:

- **Electronic claims –** Include the EDI acceptance report stating we received your claim

Most care providers in your state must submit reconsideration requests electronically.

For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.**

For those care providers exempted from this requirement, requests may be submitted at the following address:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

- Submit a screenshot from your accounting software that shows the date you submitted the claim. The screenshot must show:
  - Correct member name
  - Correct date of service
  - Claim submission date

Timely filing limits can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Provider Agreement.

Overpayment

What is it?

An overpayment happens when we overpay a claim.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call **Provider Services** at **1-888-887-9003**.

If you prefer to mail a refund, send an Overpayment Return Check or the Overpayment Refund/Notification form.

Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions
- Member identification number
- Date of service
- Original claim number (if known)
- Date of payment
- Amount paid
- Amount of overpayment
- Overpayment reason
- Check number

Where to send:

Mail refunds with an Overpayment Return Check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
Attn: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

Instructions and forms are on **UHCprovider.com/claims**.

If you do not agree with the overpayment findings, submit a dispute within the required timeframe as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See Dispute section in this chapter.

We make claim adjustments without requesting additional information from you. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional information is needed, we will ask you to provide it.

Sample overpayment report

***The information provided is sample data only for illustrative purposes.**
Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
11111	01/01/24	14A000000001	01/31/24	$115.03	$115.03	Double payment of claim.
2222222	02/02/24	14A000000002	03/15/24	$77.29	$27.19	Contract states $50.00, claim paid $77.29.
3333333	03/03/24	14A000000003	04/01/24	$131.41	$98.56	You paid 4 units, we billed only 1.
44444444	04/04/24	14A000000004	05/02/24	$412.26	$412.26	Member has other insurance.
55555555	05/05/24	14A000000005	06/15/24	$332.63	$332.63	Member terminated.

Appeals (step 2 of dispute)

What is it?

An appeal is a second review of a reconsideration claim.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step one, use the claim appeal process.

We adhere to the TMHP claims payment and appeals deadlines. You must file claims/administrative appeals 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. You must complete claims appeals or post mark no later than 120 calendar days from the date on the provider remittance advice (PRA).

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Send your information electronically or by mail. In your appeal, please include any supporting information not included with your reconsideration request.

- **Electronic claims:** Use Claims Management or Claims on the UnitedHealthcare Provider Portal. Click Sign In on the top right corner of **UHCprovider.com**, then click Claims.
- You may upload attachments

Most care providers in your state must submit reconsideration requests electronically.

For further information on appeals, see the **Reconsiderations and Appeals interactive guide.**

For those care providers exempted from this requirement, requests may be submitted at the following address:

- **Mail:** Send the appeal to:

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

Questions about your appeal or need a status update?

Claims/administrative appeals are processed within 30 calendar days from appeal receipt.

- If we reverse the original denial, we reprocess the claim and a PRA is re-issued with the claim detail*
- If, after review, we still do not approve the claim, in whole or in part, we send a written explanation to you

See **Appendix J for Care Provider Appeals to HHSC** (about claim recovery).

Care provider appeal process to Heath and Human Services Commission (related to claim recoupment due to member disenrollment)

1. **Member eligibility changed to Fee-for-Service on the date of service.**

   You may appeal claim recoupment by submitting the following information to Heath and Human Services Commission HHSC:

   A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the care provider is requesting an Exception Request.

   The Explanation of Benefits (EOB) showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid & Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.

   The EOB showing the recoupment and/or the plan's "demand" letter for recoupment. If sending the demand letter, it must identify the client name, identification number, date of service, and recoupment amount. The information should match the payment EOB.

   Claims must be submitted with a provider's NPI and appropriate Taxonomy that are actively enrolled with Texas Medicaid, benefit code (if applicable), and complete address with city, state, and ZIP+4 code. To avoid any claims processing errors, providers should complete their claims with the same information that was included on the prior authorization request.

   In cases where issuance of a prior authorization (PA) is needed, you will be contacted with the authorization number. You will need to submit a corrected claim that contains the valid authorization number.

   Note: Label the request "Expedited Review Request" at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

   Mail 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 claim that was recovered, and insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing that the claims payment was recovered. Submission of the new claims is not required before sending the administrative appeal letter. However, if a provider appeals prior to submitting the new claims, the provider must subsequently include the new claims with the administrative appeal.

   HHSC Claims Administrator Contract Management only reviews appeals that are received within 18 months from the date-of-service. Providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management, and all claims must be finalized within 24 months from the date of service.

2. **Member eligibility changed from one Managed Care Organization to another on the Date-of-Service (STAR Kids ONLY).**

   Providers may appeal claims payment recoveries and denials of services by submitting the following information to the appropriate Managed Care Organization (MCO) to which the member eligibility was changed on the date of service:

   - A letter indicating that the appeal is related to a managed care disenrollment/recovery and the care provider is requesting an exception request
   - The explanation of benefits (EOB) showing the original payment. The EOB showing the recovery and/or the MCO's "demand" letter for recovery must identify the client name, identification number, DOS and recovery amount. The information should match the payment EOB.
   - Documentation must identify the client name, identification number, DOS and recovery amount, as well as other claims information

   Note: Label the request "Expedited Review Request" at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

   Submit appeals online at:

   UHCprovider.com > Sign In.

   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

Specialty review

For claims/adverse benefit determinations 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 5 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 we receive the request.

FOR CHIP care providers: you 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.

For MMP care providers: you must request within 30 days. The process will take 15 days to complete after request received.

Call **Provider Services** at **1-888-887-9003** with any questions regarding claims or appeals.

Questions about your appeal or need a status update? Call **Provider Services**. If you filed your appeal online, you should receive a confirmation email.

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved
- Call **Provider Services** at **1-888-887-9003** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- File adjustment requests and claims disputes within contractual time requirements
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- Keep a copy of faxed cover pages and emails you send or receive, as well as a log of telephone communications(s) related to/from UnitedHealthcare Community Plan about a complaint or appeal
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Care provider grievance

What is it?

Grievances are complaints related to your UnitedHealthcare Community Plan policy, procedures or payments.

When to file:

You may file a grievance about:

- Benefits and limitations
- Eligibility and enrollment of a member or care provider
- Member issues or UnitedHealthcare Community Plan issues
- Availability of health services from UnitedHealthcare Community Plan to a member
- The delivery of health services
- The quality of service

How to file:

Complete the Provider Complaint/Grievance Form located at **UHCprovider.com/TXCommunityPlan** > Claims and Payments > Claim Administrative Dispute/ Appeals > Provider Complaint/Grievance Form.

File verbally or in writing.

- **Phone:** Call **Provider Services** at **1-888-887-9003**
- **Mail:** Send care provider name, contact information and your grievance to:

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

For STAR, STAR Kids, STAR+PLUS and Medicare-Medicaid plan care providers: Care provider complaints to the Texas Health and Human Services Commission

You also have the right to submit a complaint to the Texas Health and Human Services Commission (HHSC) Provider Resolution Services after completing the complaint process through UnitedHealthcare Community Plan.

You may mail written complaints to:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, Texas 78711-3247

If you have access to the internet, you can submit your complaint at hhs.texas.gov/managed-care-help.

FOR CHIP care providers: Care provider complaints to the Texas Department of Insurance

CHIP care providers have the right to submit complaints to the Texas Department of Insurance (TDI).

You may submit complaints by:

- Mail to:

  Texas Department of Insurance Consumer Protection (111-1A)
  P.O. Box 149091
  Austin, TX 78714 -9091
- Fax: 1-512-490-1007
- Email: ConsumerProtection@tdi.texas.gov
- Online: tdi.state.tx
- In person at:

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

You may only file an appeal or grievance on a member's behalf with the written consent of the member. See Member Appeals and Grievances Definitions and Procedures.

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

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. 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, a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.

For Medicare-Medicaid plan care providers: Care provider redeterminations and reconsiderations (Medicare) redetermination

You have 120 days from the initial date of determination to request a redetermination of the original claim payment decision. A decision will be rendered within 30 days of receipt.

Upon receipt of an adverse benefit determination for a redetermination request, you may then file for reconsideration. You have 120 days to file the reconsideration request. If the original decision to deny the claim was 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 you within 30 days from receipt of the request for reconsideration. Should the request be adverse to you, UnitedHealthcare Community Plan will follow the processes and procedures put in place for Medicare Advantage care providers.

Care provider complaints

You may file complaints online by submitting the form located at **UHCprovider.com/TXCommunityPlan** > Provider Forms > Care Provider Complaint Form**. Provider Services** is available to provide direction at **1-888-887-9003**. Notification of receipt of request will be given within 5 days of receipt. A decision is rendered within 30 days.

Medicaid managed care providers must exhaust the grievance process with their managed care health plan before filing a complaint with HHSC.

If, after completing this process, you believe you did not receive full due process from the respective managed care health plan, you may file a complaint by:

- Email: HPM_complaints@hhsc.state.tx.us
- Mail to:

  Texas Health and Human Services Commission Attn: Ombudsman Managed Care Assistance Team
  P.O. Box 13247
  Austin, TX 78711-3247
- Online: With Internet access, you can submit your complaint at: hhs.texas.gov/managed-care-help

Member appeals and grievances definitions and procedures

UnitedHealthcare Community Plan uses the CMS definitions for appeals and grievances.

Member benefit appeals

What is it?

An appeal is a formal way to share dissatisfaction with a benefit determination.

You (with a member's written consent) or a member may appeal when the plan:

- Lowers, suspends or ends a previously authorized service
- Refuses, in whole or part, payment for services
- Fails to provide services in a timely manner, as defined by the state or CMS
- Doesn't act within the time frame CMS or the state requires

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:

You or the member may call or mail the information within 60 calendar days from the date of the adverse benefit determination.

UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 8413-0364

- Phone: **1-800-587-5187** TTY **711**

How to use:

Whenever we deny a service, we must provide the member with UnitedHealthcare Community Plan appeal rights. The member has the right to:

- Receive a copy of the rule used to make the decision
- Ask someone (a family member, friend, lawyer, health care provider, etc.) to help. The member may present evidence, and allegations of fact or law, in person and in writing.
- The member or representative may review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal
- Ask for an expedited appeal if waiting for this health service could harm the member's health. You have 2 business days to provide certification of the appeal and evidence and allegations in person or in writing. Provider certification is a written confirmation from you that the expedited request is urgent.
  - To request an expedited appeal, and/or to get help to file an expedited appeal, contact **Provider Services** at **1-888-887-9003**. The request may also be sent to:

    UnitedHealthcare Community Plan
    2950 North Loop W, Suite 200
    Houston, TX 77092-8843
- Ask for continuation of services during the appeal. STAR, STAR+PLUS, MMP and STAR Kids 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. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the care provider, you cannot ask for a continuation. Only the member may do so.
- We resolve a standard appeal 30 calendar days from the day we receive it
- We resolve an expedited appeal 72 hours from when we receive it
- We may extend the response up to 14 calendar days if the following conditions apply:
  1. Member requests we take longer.
  2. We request additional information and explain how the delay is in the member's interest.

- The member may request an external medical review and State Fair Hearing or a State Fair Hearing ONLY at any time during or after the MCO's appeals process, but no later than 120 days after the MCO mails the appeal decision notice.

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-Claim Appeal.

A copy of the form is online at **providerforms.uhc.com**.

Other than Medicare Part D appeals, the following process applies for UnitedHealthcare Connected (MMP) members:

- **Appeal time frames** – Members and/or their authorized representatives, including care providers, have 60 calendar days from the date of the notice of action to file an appeal with UnitedHealthcare Community Plan related to denial of any covered services. Members may receive a continuation of benefits when the member files an appeal of a reduction or denial of previously authorized services on or before the later of:
  - 10 days after the notice of action, or
  - the intended effective date of UnitedHealthcare Community Plan's proposed action

The member may also appeal to the HHSC Appeals Division for a state fair hearing within 120 days from the date of the appeal decision letter.

Member grievance

What is it?

Grievances are complaints related to UnitedHealthcare Community Plan policies and/or procedures. It includes a member's right to dispute the time UnitedHealthcare takes to make an authorization decision or dissatisfaction about anything other than a benefit determination (see Member Appeals).

When to use:

You may act on the member's behalf with their written consent.

Where to send:

You or the member may call or mail the information anytime to:

Mailing address:

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

Member Services: **1-888-887-9003**

Phone: **1-800-587-5187** TTY **711**

We will send an answer no longer than 30 calendar days from when you filed the complaint/grievance or as quickly as the member's health condition requires.

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 **Provider Services** at **1-888-887-9003** 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.

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 5 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, STAR+PLUS and STAR Kids 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
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247

If you can get on the Internet, you can submit your complaint at hhs.texas.gov/managed-care-help.

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: 1-512-490-1007
- 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

Members may also file a grievance with HHSC or by calling 1-800-MEDICARE.

Ombudsman

Long-term care ombudsmen promote quality care by serving as advocates for residents of nursing facilities and assisted living facilities. Services include complaint resolution by an ombudsman who represents the residents' interests to the management of the facility. Advocacy activities also include development of resident and family councils, in addition to education for long-term care facility staff and community organizations. Long-term care ombudsmen also protect resident rights by advocating for change in policy, rule and law.

If they have concerns, UnitedHealthcare Community Plan and UnitedHealthcare Connected members may call the Office of the Independent Ombudsman for State Supported Living Centers at 1-877-323-6466 or go to apps.hhs.texas.gov/sslcombudsman.

Part D appeals

Standard

Members may appeal Part D drug denial within 60 days of the initial denial.

The health plan will provide a response to the member's appeal within 7 calendar days of receipt. Should the health plan not provide a decision within 7 calendar days, the members' request will be automatically be forwarded to the Independent Review Entity.

If the request for coverage is approved, coverage will be provided as quickly as the member's health requires, but no later than 7 calendar days after we get your appeal.

If the request for coverage is denied, a letter will be provided that explains why the request was denied as well as how the member can appeal our decision.

Expedited (fast) appeal

Members who use the fast appeal process for Part D denials will be provided an answer within 72 hours of receipt of the appeal. If an answer is not provided within 72 hours, the member's request will be automatically forwarded to the Independent Review Entity.

If the request for coverage is approved, coverage will be provided as quickly as the member's health requires, but no later than 72 hours after the request for appeal is received. If the request for coverage is denied, a letter will be provided that explains why the request was denied as well as how the member can appeal our decision.

Retention of communications

Keep a copy of any forms or attachments you email, mail, or receive (including cover pages). Also, keep a log of any phone communications related to a complaint or appeal.

External medical review information

Can a member ask for an external medical review?

If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the member has the right to ask for an external medical review. An external medical review is an optional, extra step the member can take to get the case reviewed for free before the State Fair Hearing. The member may name someone to represent him/her by writing a letter to the health plan telling the MCO the name of the person the member wants to represent them. A provider may be the member's representative. The member or the member's representative must ask for the external medical review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the member does not ask for the external medical review within 120 days, the member may lose their right to an external medical review. To ask for an external medical review, the member or the member's representative should either:

- Fill out the 'state fair hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to UnitedHealthcare by using the address at the top of the form;

- Call the MCO at **1-888-887-9003**;
- Email the MCO at **uhctx_fairhearings_appeals@uhc.com**.

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

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

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

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

Can a member ask for an emergency external medical review?

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

State fair hearings

What is it?

A stare fair hearing lets members share why they think Texas Medicaid services should not have been denied, reduced or terminated.

When to use:

Members have 120 days from the date on UnitedHealthcare Community Plan's adverse appeal determination letter. Members must exhaust appeal process before filing for a State Fair Hearing. The member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the member wants to represent him or her. A care provider may be the member's representative.

How to use:

The UnitedHealthcare Community Plan member may ask for a State Fair Hearing by writing a letter to:

UnitedHealthcare Community Plan
Attn: Fair Hearings/IRO
2950 North Loop W, Suite 200
Houston, TX 77092-8843
or call **1-800-288-2160**
MMP: 1-888-887-9003

- The member may ask UnitedHealthcare Community Plan **Provider Services** for help writing the letter
- If the member requests a State Fair Hearing within 10 calendar days of the health plan's appeal decision letter, they have the right to keep getting the denied health plan service, at least until the final hearing decision. If the member does not request a State Fair Hearing within 10 calendar days of appeal decision letter, the denied health plan service will be stopped.
- The member may have someone attend with them
- This may be a family member, friend, care provider or lawyer. Written consent is required
- We will notify you of the decision within the time frames specified by HHSC

CHIP - Request for an Independent Review Organization review CHIP

CHIP members can request an independent review organization (IRO), which is completely independent of UnitedHealthcare Community Plan. Members must have first appealed the original denial through UnitedHealthcare Community Plan unless the member has a life-threatening condition and services have not been received.

Form LHL009 is provided with each denial letter, and 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 Maximus to review the member's case.

The assigned IRO renders a decision and notifies the member and UnitedHealthcare Community Plan. We will notify you of the decision within the time frames specified by HHSC.

The IRO has 45 days for non-life-threatening cases and 72 hours for expedited life-threatening cases to make its decision. There is no cost to the member. We are responsible for any administrative fees related to the IRO review.

Processes related to reversal of our initial decision

If the state fair hearing outcome is to not deny, limit, or delay services while the member is waiting on an appeal, then we provide the services:

1. As quickly as the member's health condition requires or
2. No later than 72 hours from the date UnitedHealthcare Community Plan receives the determination reversal.

If the State Fair Hearing decides UnitedHealthcare Community Plan must approve appealed services, we pay for the services as specified in the policy and/or regulation.

Fraud, waste and abuse

Call the **Fraud, waste, and abuse hotline** to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud** to learn more or to report and track a concern.

UnitedHealthcare Community Plan's anti-fraud, waste and abuse efforts focus on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse. Please refer to the Glossary at the end of this manual for definitions of fraud, waste or abuse.

An important aspect of the Compliance Program is reviewing our operation's high-risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts. You are contractually obligated to cooperate with the company and government authorities.

Find the UnitedHealth Group policy on Fraud, waste, and abuse at **UHC.com/fraud**, or call **1-844-359-7736** or **1-888-887-9003**

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

Find out how we follow federal and state regulations around false claims at **UHCprovider.com/TXcommunityplan** > Integrity of Claims, Reports, and Representations to the Government.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

Participating care providers may request termination of a member due to fraud, disruption of medical services or repeated failure to make the required reimbursements for services.

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- Health and Human Services – OIG List of Excluded Individuals and Entities (LEIE)
- General Services Administration (GSA) System for Award Management

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Reporting Fraud, waste and abuse

Report online to the HHSC Office of Inspector General at https://oig.hhs.texas.gov/report-fraud-waste-or-abuse, or call **1-800-436-6184**.

Visit **UHC.com/fraud**, call us at **1-844-359-7736** or **1-888-887-9003**, or mail to the following address:

UnitedHealthcare Community Plan
Attn: Compliance
2950 North Loop W, Suite 200
Houston, TX 77092-8843

See the **Fraud Appendix** of this manual for a message from the Texas Health and Human Services Commission (HHSC) for reporting fraud, waste or abuse by a care provider or member.

Health programs and state law

You must help ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other Federal Health Care Programs are employed or subcontracted by you.

You must disclose to UnitedHealthcare Connected whether you or any staff member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of Texas; the federal government or any public insurer. You must notify UnitedHealthcare Connected immediately if any such sanction is imposed on you, a staff member, subcontractor or yourself.

Chapter 14: Care provider communications & outreach

Key contacts

Topic	Link	Phone number
Care provider education	**UHCprovider.com/resourcelibrary**	**1-888-887-9003**
News and bulletins	**UHCprovider.com/news**	**1-888-887-9003**
Care provider manuals	**UHCprovider.com/guides**	**1-888-887-9003**

Communication with care providers

UnitedHealthcare is on a **multi-year effort** to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes, news and other important updates.

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- **Chat support available**
  Have a question? Skip the phone and chat with a live service advocate when you sign in to the **UnitedHealthcare Provider Portal**.
  Available 7 a.m.–7 p.m. CT, Monday–Friday, chat support can help with claims, prior authorizations, credentialing and member benefits.
- **UHCprovider.com**
  This public website is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.
- **UHCprovider.com/TXcommunityplan**
  The UnitedHealthcare Community Plan of Texas page has state-specific resources, guidance and rules.
- **Policies and protocols**
  UHCprovider.com/policies > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **Social media**
  Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (formerly Twitter)
- **Texas health plans**
  UHCprovider.com/TX is the fastest way to review all of the health plans UnitedHealthcare offers in Texas. To review information for another state, use the drop-down menu at **UHCprovider.com/plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Community & State newsletter**
  Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **UnitedHealthcare Provider Portal**
  This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards.
  - You can learn more about the portal in Chapter 1 of this care provider manual or by visiting **UHCprovider.com/portal.**
  - You can also access **self-paced user guides** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com/networknews**.
  It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.

- You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients.
- Get news related to your role, specialty, health plan and state. When you **subscribe** to Network News, you can update your preferences to select what news you receive.
- You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the UnitedHealthcare Provider Portal, plan and product overviews, clinical tools and state-specific training.

View the training resources at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the **UnitedHealthcare Provider Portal.**
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.
3. Already have a One Healthcare ID? To review or update your email, simply sign in to the **UnitedHealthcare Provider Portal**. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a provider group to deliver face-to-face support. We do this to create program awareness and promote compliance and problem resolution.

If you are not sure who your provider advocate is, you can view a map to determine which provider advocate to contact based on your location at **UHCprovider.com/TXcommunityplan** > Contact Us.

Care provider manual

UnitedHealthcare Community Plan publishes this care provider manual online. It includes an overview of the program, a toll-free number for Provider Services and a list of additional care provider resources. You can request a hard copy of this care provider manual by contacting **Provider Services** at **1-888-887-9003**.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

Provider advocates are available by phone at **1-888-303-6162**, or by email at **providerservicesTX@uhc.com**.

They conduct town halls, host webinars and are available for office visits. LTSS providers should call **1-888-787-4107** or email **uhc_cp_prov_relations@uhc.com**.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a number for **Provider Services** at **1-888-887-9003** and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting **Provider Services** at **1-888-887-9003**.

Glossary

1915(i) Home and Community Based Services- Adult Mental Health

HCBS-AMH- Home and Community Based Services-Adult Mental Health is a state-wide program that provides Home and Community-Based Services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each individual's needs, to enable him or her to live and experience successful tenure in their chosen community. Services are designed to support long-term recovery from mental illness.

Assistance to the aged, blind and disabled

AABD -Assistance to the aged, blind and disabled

Abuse (by care provider)

Care provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost, or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost, as defined by 42 CFR 455.2.

Abuse (of member)

Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S 46-451.

Acute inpatient care

Care provided to members sufficiently ill or disabled requiring:

- Constant availability of medical supervision by attending care provider or other medical staff
- Constant availability of licensed nursing personnel
- Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to help ensure proper medical management by the care provider

Adult foster care

Personal care services; homemaker, chore, and companion services; and medication oversight provided in a licensed (where applicable) private home by an Adult Foster Care (AFC) provider who lives in the home. AFC services are furnished to adults who receive these services in conjunction with residing in the home.

Advance directive

Legal papers that list a member's wishes about their end-of-life health care.

Adverse benefit Determination

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner, as defined by the state.
5. The failure of someone or a company to act within the time frames provided in the contract and within the standard resolution of grievances and appeals.
6. For a resident of a rural area, the denial of a member's request to exercise his or her right, to obtain services outside the network.
7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Ambulatory care

Health care services that do not involve spending the night in the hospital. Also called "outpatient care". Examples include chemotherapy and physical therapy.

Ambulatory surgical facility

A state facility that is licensed, equipped and operated to provide surgeries and obstetrical deliveries. Members can leave the facility the same day surgery or delivery occurs.

Ancillary care provider services

Extra health services, like laboratory work and physical therapy, which a member gets in the hospital.

Appeal

A member request that their health insurer or plan review an adverse benefit determination.

Audio only

Interactive, two-way audio communication that only uses sound that meets the requirements of HIPAA. Audio only includes the use of telephonic communication. Audio only does not include audiovisual, in-person or face-to-face communication.

Audiovisual

Interactive, two-way audio and video communication that conforms to privacy requirements under HIPAA allowing persons in different locations to communicate. Audiovisual does not include Audio-only communication.

Authorization

Approval obtained by care providers from UnitedHealthcare Community Plan for a service before the service is rendered. Used interchangeably with "preauthorization" or "prior authorization."

Basic benefits

All health and medical services covered under Medicare Part A and Part B and Medicaid, except hospice services and additional benefits. All members of UnitedHealthcare Connected receive all basic benefits.

Behavioral health

Behavioral health is the assessment and treatment of mental, emotional or substance use disorders, or a combination thereof.

Billed charges

Charges you bill for rendering services to a UnitedHealthcare Community Plan member.

Capitation

A prepaid, periodic payment to providers, based upon the number of assigned members made to a care provider for providing covered services for a specific period.

Case manager

The individual responsible for coordinating the overall service plan for a member in conjunction with the member, the member's representative and the member's primary care provider (PCP).

Centers for Medicare & Medicaid Services

CMS - A federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs.

Children's Health Insurance Program

CHIP Children's Health Insurance Program.

Clean claim

A claim with no defect (including lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payment.

Collaborative care model

CoCM - A systematic approach to the treatment of behavioral health conditions (mental health and/or substance use) for persons of all ages in primary care settings. The model integrates the services of a behavioral health care manager and a consulting psychiatrist with PCP oversight to proactively manage behavioral health conditions as chronic diseases rather than treating acute symptoms. CoCM services include outreach and engagement, completion of an initial assessment, development of an individualized and person-centered plan of care, monitoring and tracking a person's progress using a registry, providing brief interventions and other focused treatments and conducting weekly caseload reviews with the psychiatric consultant.

Community Living Assistance and Support Services Waiver Program

CLASS - The Community Living Assistance and Support Services program provides Home and Community-Based Services to people with related conditions as a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). A related condition is a disability, other than an intellectual disability, that originated before age 22 that affects the ability to function in daily life.

Contracted health professionals

PCPs, care provider specialists, medical facilities, allied health professionals and ancillary service providers under contract with UnitedHealthcare Community Plan. These care providers deliver specific covered services to members. They represent those individuals and entities used through the UnitedHealthcare Community Plan prior authorization and referral policies and procedures.

Coordination of benefits

COB - A process of figuring out which of 2 or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Covered services (general)

The portion of a medical, dental or vision expense that a health insurance or plan has agreed to pay for or reimburse.

Covered services (MMP only)

The portion of a medical, dental or vision expense that a health insurance or plan has agreed to pay for or reimburse. Those benefits, services or supplies which are:

- Provided or furnished by participating care providers or authorized by UnitedHealthcare Connected or its participating care providers
- Wellness, acute and specialty services other than LTSS are primary Medicare
- Emergency services and urgently needed services that may be provided by non-participating care providers
- Renal dialysis services provided while you are temporarily outside the service area
- Basic and supplemental benefits

Credentialing

The verification of applicable licenses, certifications and experience. This process assures care provider status is extended only to professional, competent care providers who continually meet UnitedHealthcare Community Plan qualifications, standards and requirements.

Current procedural terminology codes

CPT - A code assigned to a task or service a health care provider does for a member. Every medical task or service has its own CPT code. These codes are used by the insurer to know how much they need to pay the physician. CPT codes are created and published by the American Medical Association.

Deaf Blind with Multiple Disabilities Waiver Program

DBMD - The Deaf Blind with Multiple Disabilities program provides Home and Community-Based Services to people who are deaf blind and have another disability. This is a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). The DBMD program focuses on increasing opportunities for consumers to communicate and interact with their environment.

Delivery system

The mechanism by which health care is delivered to a member. Examples include hospitals, provider offices and home health care.

Disallow amount

Amt - Medical charges for which the network provider may not receive payment from UnitedHealthcare Community Plan and cannot bill the member. Examples are:

- The difference between billed charges and in-network rates
- Charges for bundled or unbundled services as detected by Correct Coding Initiative edits

Discharge planning

Screening eligible candidates for continuing care following treatment in an acute care facility, long-term care facility or inpatient psychiatric facility. It involves care planning, scheduling, arranging and steps that move a member from one level of care to another.

Disenrollment

The discontinuance of a member's eligibility to receive covered services from a contractor.

Dispute

Provider claim reconsideration: Step 1 when a provider disagrees with the payment of a service, supply, or procedure.

Provider appeal: Step 2 when a provider disagrees with the payment of a service, supply, or procedure.

Dual-eligible

Medicaid recipients who are also eligible for Medicare.

Durable medical equipment

DME - Equipment and supplies ordered by a health care provider for everyday and extended use, for medical reasons other than convenience or comfort. DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Periodic Screening Diagnosis and Treatment Program

EPSDT - A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA Section 1905 (R). Covered services include a complete health history and developmental assessment; an unclothed physical exam; immunizations; laboratory tests; health education; and screenings for vision, dental, substance use disorder, mental health and hearing. They also include any medically necessary services found during the preventive exam.

Electronic data interchange

EDI -The electronic exchange of information between 2 or more organizations.

Electronic funds transfer

EFT - The electronic exchange of funds between 2 or more organizations.

Electronic medical record

EMR - An electronic version of a member's health record and the care they have received.

Electronic visit verification

EVV - A computer-based system that electronically documents and verifies service delivery information, such as the date, time, service type and location for certain Medicaid service visits. The electronic documentation includes:

- The date and time the provider begins and ends the delivery of services
- The attendant, the recipient and the location of services provided

Eligibility determination

Deciding whether an applicant meets the requirements for federal or state eligibility.

Emergency care

The provision of medically necessary services required for immediate attention to review or stabilize a medical emergency.

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

Emergency medical condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency transportation

Transportation for an emergency medical condition as defined within this manual.

Encounter

A record of health care-related services by care providers registered with Medicaid to an patient enrolled with UnitedHealthcare Community Plan on the date of service. You are required to report all service encounters to UnitedHealthcare Community Plan, including prepaid services. UnitedHealthcare Community Plan electronically reports these encounters to state Medicaid. The state audits encounter submission accuracy and timeliness on a regular basis.

Enrollee

Enrollee is interchangeable with the term member. Any person enrolled with an UnitedHealthcare Community Plan product as a subscriber or dependent.

Enrollment

The process where a person is determined eligible to receive Medicaid or Medicare benefits becomes an enrollee or member of a health plan.

Evidence-based care

An approach that helps care providers use the most current, scientifically accurate research to make decisions about members' care.

Expedited appeal

An expedited review process for appeals determines that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Experimental procedures and items

Items and procedures determined by UnitedHealthcare Connected and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, UnitedHealthcare Connected will follow CMS guidance (through the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare.

External medical review

EMR - An independent review of the relevant information the MCO used related to an Adverse Benefit Determination based on functional or medical necessity. EMRs are conducted by third-party organizations, known as Independent Review Organizations (IROs), contracted by HHSC.

Face-to-face

Means in-person or audiovisual communication that meets the requirements of HIPAA. Face-to-face does not include audio-only communication.

Fee for service

A method of payment to care providers on an amount-per-service basis, up to a maximum allowed by the UnitedHealthcare Community Plan fee schedule.

Fee-for-service Medicare

A payment system by which doctors, hospitals and other care providers are paid for each service performed (also known as traditional and/or original Medicare).

Family Health Center

FHC - Family Health Center

Fraud

A crime that involves misrepresenting or concealing information to receive benefits or to make a financial profit.

Grievance

Unhappiness about the plan and/or care provider regarding any matter including quality of care or service concerns. Does not include adverse benefit determination (see appeals/dispute). Grievances may include, but are not limited to, the quality of care or services provided, and relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed to make an authorization decision.

Habilitation

This service allows an individual to reside successfully in a community setting by assisting the individual to acquire, retain, and improve self-help, socialization, and daily living skills or assisting with and training the individual on daily living activities and instrumental activities of daily living.

Healthcare Effectiveness Data and Information Set

HEDIS - A rating system developed by NCQA that helps health insurance companies, employers, and consumers learn about the value of their health plan(s) and how it compares to other plans.

Health home

A health home is a specially contracted care provider that coordinates a comprehensive set of services, including service coordination services; patient self-management education; care provider education; behavioral health services; patient-centered and family-centered care; evidence-based models and minimum standards of care; patient and family support (including authorized representatives).

Health Insurance Portability and Accountability Act

HIPAA - Health Insurance Portability and Accountability Act. A federal law that provides data privacy protection and security provisions for safeguarding health information.

Home and Community-Based Services waiver program

HCBS - The Home and Community-Based Services waiver program provides individualized services and supports to people with intellectual disabilities who are living with their families, in their own homes or in other community settings, such as small group homes where no more than 4 people live. The local authority provides service coordination.

Home health care (home health services)

Health care services and supplies provided in the home, under physician's orders. Services may be provided by nurses, therapists, social workers or other licensed health care providers. Home health care usually does not include help with non-medical tasks, such as cooking, cleaning or driving.

Hospice

An organization or agency certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital

A Medicare-certified institution licensed in Texas, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "hospital" does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Hospitalist

A hospitalist is a member of a growing medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this new medical specialty, hospitalists must complete education and training in internal medicine.

As a key member of the health care team and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the patient's PCP.

Independent physicians association

IPA - A group of physicians who function as a participating medical care provider/group yet work out of their own independent medical offices.

Independent review organization

A third-party organization contracted by HHSC that conducts an External Medical Review (EMR) during member appeal processes related to Adverse Benefit Determinations based on functional or medical necessity.

In-network care provider

A care provider who has a written Agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their Agreement.

In-person or In person

Means within the physical presence of another person. In-person or In Person does not include audiovisual or audio-only communication.

Inpatient Services in an Institution of Mental Disease

IMD - Services include hospitalization at an IMD in lieu of an acute care inpatient hospital setting. Inpatient services in an IMD are to treat acute psychiatric conditions and are allowed for up to 15 calendar days per month for members aged 21-64 only. Legally authorized representative

Intensive Outpatient Services

IOP - Intensive outpatient services, also referred to as IOP services are used to treat behavioral health issues that do not require detoxification or 24-hour supervision. IOPs are generally less intensive than PHPs. They may be delivered for mental health, SUD, or both. Intensive outpatient services are organized non-residential services providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per Day.

Legally authorized representative

LAR - Parent, guardian or other authorized adult.

Long Term Services and Supports

LTSS - Long Term Services and Supports is assistance with daily healthcare and living needs for individuals with a long-lasting illness or disability.

Medicaid

A federal health insurance program for low-income families and children, eligible pregnant women, people with disabilities, and other adults. The federal government pays for part of Medicaid and sets guidelines for the program. States pay for part of Medicaid and have choices in how they design their program. Medicaid varies by state and may have a different name in your state.

Medical dependent children program

MDCP - The Medical Dependent Children Program provides services to support families caring for children who are medically dependent and encourages the transition of children in nursing homes back to the community.

Medical emergency

An illness, injury, symptom or condition that is severe enough (including severe pain), that if a member did not get immediate medical attention you could reasonably expect one of the following to result:

- Their health would be put in serious danger; or
- They would have serious problems with their bodily functions; or
- They would have serious damage to any part or organ of their body

Medical supplies

Medicaid benefits of the Home Health Services Program. A physician who is familiar with the client must sign and date a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form. To see more, go to TMHP.com > Resources > Provider Manuals > Texas Medicaid Provider Procedures Manual > Individual Chapters > Volume 2: Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook.

Medically Necessary

Medically necessary health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medicare

The federal government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A

Hospital insurance benefits including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.

Medicare Part A premium

Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement systems, or worked long enough in federal, island or local government employment to be insured, members do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, members may buy the coverage from Social Security if members are at least 65 years old and meet certain other requirements.

Medicare Part B

Supplemental medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood not covered under Part A.

Medicare Part B premium

A monthly premium paid to Medicare (usually deducted from a Member's Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive covered services whether members are covered by an Medicare Advantage Plan or by original Medicare.

Medicare Advantage plan

MA - A policy or benefit package offered by a Medicare Advantage Organization (MAO) under which a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by UnitedHealthcare Connected. An MAO may offer more than one benefit plan in the same service area. UnitedHealthcare Connected is an MA plan.

Member

An individual who is eligible and enrolled with UnitedHealthcare Community Plan and can receive services pursuant to the Agreement.
For MMP: The Medicare beneficiary entitled to receive covered services who has voluntarily elected to enroll in the UnitedHealthcare Connected plan.

Member advocates

People who strive to enhance patient care through one-to-one interaction with a goal of helping the member live a healthier life.

Member advocates work with members to ensure appropriate information sharing and appointment coordination to drive better outcomes.

Member advocates support member experience in the following ways:

- Educate patients to understand their covered healthcare benefits and resolve concerns or issues as quickly as possible
- Maintain or renew membership
- Choose and/or change a PCP that meets cultural and linguistic needs
- Assist in finding providers and locating referral sources
- Obtain transportation to the doctor
- File a complaint
- Provide resources to address non-medical drivers of health
- Educate patients on value-added services

Our member advocates can speak English, Spanish or other languages through a translator.

Non-participating medical care provider or facility

Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by Texas or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by or under contract to deliver covered services to UnitedHealthcare Connected members.

STAR+PLUS Nursing facility long-term care

A Medicaid benefit available to qualified members that includes room and board, medical supplies, personal needs items, social services and over-the-counter drugs. Includes add-on services such as ventilator care, tracheostomy care, emergency dental services, physician-ordered rehabilitation services, customized power wheelchairs and augmentative communication devices. Acute care services are included, such as preventive care, primary and other medical care provided under the direction of a physician and other medical care provided under the direction of a physician for a condition having a relatively short duration.

National Provider Identifier

NPI - National Provider Identifier is required by CMS for all care providers who bill, prescribe or refer for health care services and is used on all electronic transactions. It is a single unique provider identifier assigned to a care provider for life that replaces all other health care provider identifiers. It does NOT replace your DEA number.

Out-of-area care

Care received by a UnitedHealthcare Community Plan member when they are outside of their geographic territory.

Partial Hospitalization Services

Partial hospitalization services provide a structured day program of outpatient behavioral health services. Partial Hospitalization Programs (PHPs) may provide services for mental health, SUD, or both. These services resemble highly structured, short-term hospital inpatient programs. The treatment level is more intense than outpatient day treatment or psychosocial rehabilitation.

Participating care provider

Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the Texas Department of Medicaid, Texas Health and Human Services or Medicare to deliver or furnish health care services. This individual or institution has a written agreement to provide services directly or indirectly to UnitedHealthcare Connected members pursuant to the terms of the Agreement.

Participating hospital

A hospital that has a contract to provide services and/or supplies to UnitedHealthcare Connected members.

Participating medical group

Physicians organized as a legal entity for the purpose of providing medical care. The group has an agreement to provide medical services to UnitedHealthcare Connected members.

Participating pharmacy

A pharmacy that has an agreement to provide UnitedHealthcare Connected members with medication(s) prescribed by the members' PCPs in accordance with UnitedHealthcare Connected.

Peer-to-peer

Discussion held between the physician requesting, ordering or intending to provide a prior authorized service and our Medical Director or their physician designee regarding the medical necessity, appropriateness or the experimental or investigational nature of a healthcare service.

Preventive health care

Health care emphasizing priorities for prevention, early detection and early treatment of conditions. It generally includes routine/physical examination and immunization.

Primary care provider

PCP - A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law and the terms of the plan who provides, coordinates or helps members access a range of health care services.

Prior authorization (notification)

The process where health care providers seek approval prior to rendering health care services, drugs or DME as required by UnitedHealthcare Community Plan policy.

Provider group

A partnership, association, corporation, or other group of care providers.

Routine care

Health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.

Quality management

QM - A methodology that professional health personnel use to achieve desired medical standards and practices. The formal program includes activities to help improve and maintain quality service and care and involve multiple organizational components and committees.

Qualified mental health professionals

Texas HHSC established the following qualifications and supervisory protocols for providers of mental health rehabilitative services. A qualified provider must:

- Demonstrate competency in the work to be performed; and
- Have 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;
  - A licensed practitioner of the healing arts (LPHA) 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.

Texas HHSC established the following qualifications and supervisory protocols for providers of targeted case management services. A qualified provider 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;
- 3 continuous years of documented full-time experience in the provision of mental health case management services as of August 30, 2004;
- Demonstrated competency in the provision and documentation of case management services; and
- Are a case manager being clinically supervised by another qualified case manager who meets the criteria.

Routine medical care

This care should occur with a PCP, preferably within a medical home model. It includes at least an annual well preventive doctor visit consisting of a physical exam, blood work, immunizations and biometric screenings. Dental care is also a type of routine medical care.

Rural health clinic

A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics may receive enhanced payments for services provided to enrolled members.

Serious emotional disturbances

SED - Applies 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.

Serious and persistent mental illness

SPMI - Severe and persistent mental illness involves complex symptoms that require ongoing treatment and management, including medication. People with SPMI may function independently for periods of time. They can be susceptible to stress and may need intensive support with housing, school, work, social functioning and other everyday life concerns when they experience a stressful event.

Service area

The geographic area served by UnitedHealthcare Community Plan, designated and approved by Texas HHSC.

Severe and persistent mental illness

SPMI - Mental illnesses with complex symptoms that require ongoing treatment and management, most often varying types and dosages of medication and therapy.

Specialist

A care provider licensed in the state of Texas and has completed a residency or fellowship focusing on a specific area of medicine or group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a care provider who has special training in a specific area of health care.

State Fair Hearing

An administrative hearing requested if the member does not agree with a Notice of Appeal Resolution from the UnitedHealthcare Community Plan Appeals and Claim Dispute Department.

Substance Use disorder

SUD - The use of one or more drugs or substances, including alcohol, which significantly and negatively impacts one or more major areas of life functioning and which meets the criteria described in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for SUDs.

Temporary Assistance to Needy Families

TANF - A state program that gives cash assistance to low-income families with children.

Texas certified community behavioral health clinic

T-CCBHC - An entity certified in accordance with 26 Texas Administrative Code §306.105.

Texas home living waiver program

TxHmL - The Texas Home Living program provides selected essential services and supports to people with an intellectual disability or a related condition who live in their own home or their family's home.

Third-party liability

TPL - A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan pays claims for covered benefits and pursues refunds from the third party when liability is determined.

Timely filing

When UnitedHealthcare Community Plan puts a time limit on submitting claims.

Title XIX

Section of Social Security Act describing the Medicaid program coverage for eligible persons.

Transportation full-risk brokers

Full risk brokers manage the services. Medical Transportation Management serves the Houston and Jefferson service delivery areas. LogistiCare serves the Dallas/Fort Worth service delivery area.

UnitedHealthcare Community Plan

An affiliate of UnitedHealth Group with corporate headquarters located in Minnetonka, Minnesota. UnitedHealthcare Community Plan operates nationwide, serving aging, vulnerable and chronically ill people through Medicare, Medicaid and private-pay programs for long-term care products and programs.

Urgent care

Services required to prevent serious deterioration of health after the onset of an unforeseen condition or injury.

Urgent medical care

This option is for immediate care for when a person cannot wait for or cannot get a next-day appointment. It is designed to care for conditions such as the following:

- Severe cough, sore throat or flu-like symptoms
- Vomiting
- Painful urination
- Sprained ankle
- Persistent diarrhea
- Minor burn or laceration
- Ear infection
- Fever without rash
- Broken bone allergic reaction

Utilization management

UM - Involves coordinating how much care members get. It also determines each member's level or length of care. The goal is to help ensure members get the care they need without wasting resources.

Waste

The practice a reasonably prudent person would deem careless or would allow inefficient use of resources, items, or services. It is your obligation to report knowledge or suspicion of fraud, waste or abuse.

Wraparound services

Medicaid provides services to help cover treatment if Medicare does not cover it completely. These are called "wraparound services." Examples include some Medicaid durable medical equipment (DME) and certain medications. Also included are Long-Term Services and Supports when necessary to help members to have their basic needs met in their home and community when they would otherwise need to go into a nursing facility for that level of care.

Youth empowerment services waiver program

YES - The Youth Empowerment Services waiver provides comprehensive home and community-based mental health services to youth between the ages of 3 and 18, up to a youth's 19th birthday, who have a serious emotional disturbance. The YES Waiver not only provides flexible supports and specialized services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbance, but also strives to provide hope to families by offering services aimed at keeping children and youth in their homes and communities.

Appendices: Table of Contents

Appendix A: CHIP member rights and responsibilities

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 3 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.
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, as well as members 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 Obstetrician/Gynecologist

UnitedHealthcare Community Plan DOES NOT LIMIT TO NETWORK.

UnitedHealthcare Community Plan allows the member to pick any Obstetrician/Gynecologist (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 B: CHIP perinate member rights and responsibilities

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 that is 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, as well as members 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 Obstetrician/Gynecologist

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 C: STAR, STAR Kids, STAR+PLUS, Medicare-Medicaid plan rights and responsibilities

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, External Medical Reviews, and State Fair Hearings. That includes the right to:
   - **a.** Make a complaint to your health plan or to the state Medicaid program about your health care, your 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 an external medical review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   - **e.** Ask for a State Fair Hearing without an external medical review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   - **a.** Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   - **b.** Get medical care in a timely manner.
   - **c.** Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   - **d.** Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   - **e.** Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
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 ER.
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.
   - **f.** You have a responsibility to follow plans and instructions for care that you have agreed to with your practitioners.
5. When using non-emergent medical transportation (NEMT) services, you have the responsibilities to:
   - **a.** Provide the information requested by the person arranging or verifying your transportation.
   - **b.** Follow all rules and regulations affecting your NEMT services.
   - **c.** Return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
   - **d.** Do not verbally, sexually or physically abuse or harass anyone while requesting or receiving NEMT services.
   - **e.** You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
   - **f.** Only use NEMT Services to travel to and from your medical appointments.
   - **g.** Contact the person who helped you arrange your transportation as soon as possible if something changes and you no longer need the service.

Note: For inquiry follow-ups that surpass 3 days or escalation requests, send an email to TX.Transportation@modivcare.com.

Member's right to designate an Obstetrician/Gynecologist

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 D: Community first choice care 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 help 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, etc.).
- The program provider must 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 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 (ex., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). 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 Texas Abuse/Neglect Hotline **1-800-252-5400**.
- 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 3 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 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 E: Breast pump coverage

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.

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage and billing
STAR	STAR	STAR	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.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	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.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	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.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	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.
STAR+PLUS	STAR+ PLUS	Medicaid FFS or STAR**	
STAR Health	STAR Health	STAR Health	
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when medically necessary for the newborn when the mother does not have coverage. Bill breast pumps and supplies under the newborn's Medicaid ID.

*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.

Private Pay Form
SAMPLE FORM

Date:_____ Member's Name:_____

Medicaid #:_____ Care 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
(Care provider's name)

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 G: CHIP member complaints and appeals

The following information is intended for UnitedHealthcare Community Plan 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 at **1-888-887-9003** 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 1-800-252-3439. 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 **1-888-887-9003**. 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 **1-888-887-9003**.

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 **1-888-887-9003** 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 **1-888-887-9003**.

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, any person 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 **1-888-887-9003**. 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 **1-888-887-9003**.

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 **1-888-887-9003** and ask someone to help you start an appeal or ask your/your child's doctor to do it for you.

What is an independent review organization?

If you are not satisfied with the outcomes of the appeal with UnitedHealthcare Community Plan, you can file a request for an independent review organization (IRO) to review your appeal. This is an outside organization that reviews 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 an Adverse Determination.

How do I request an independent review organization?

If you choose an IRO, you may contact UnitedHealthcare Community Plan Member Services at **1-888-887-9003**.

What are the timeframes for this process?

Member may request an external review within 4 months of getting the appeal decision. When UnitedHealthcare Community Plan gets your request, we send it to the IRO, Maximus, within 5 calendar days.

We work with Maximus 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. For a standard review, the IRO will respond within 45 days. For an expedited review, the IRO will respond as quickly as medical circumstances require but no later than within 72 hours of receiving the request.

Specialty review

For claims/adverse benefit determinations that 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 5 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 we receive the request.

FOR CHIP Care Providers: You 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 **Provider Services** at **1-888-887-9003** with any questions regarding claims or appeals. **Questions about your appeal or need a status update?** Call **Provider Services**. If you filed your appeal online, you should receive a confirmation email.

Appendix H: STAR, STAR+PLUS and MMP member complaints and appeals

Note: The following information is intended for UnitedHealthcare Community Plan 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 at **1-888-887-9003** to tell us about your problem. A UnitedHealthcare Community Plan member services advocate can help you file a complaint. Just call **1-888-887-9003**. 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 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, Texas 78711-3247

If you have access to the internet, you can submit your complaint at hhs.texas.gov/managed-care-help.

Who do I call?

Call UnitedHealthcare Member Services for help **1-888-887-9003**.

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 **1-888-887-9003**. Most of the time, we can help you right away or at the most within a few days.

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.

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 or 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 **1-888-887-9003** 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 I: STAR Kids member complaints and appeals

What should i do if i have a complaint?

We want to help. If you have a complaint, please call us at **1-888-887-9003** to tell us about your problem. A UnitedHealthcare Community Plan Member Services Advocate can help you file a complaint. 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, members can complain to the Health and Human Services Commission (HHSC) by calling **1-866-566-8989**. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, Texas 78711-3247

If you have access to the internet, you can submit your complaint at hhs.texas.gov/managed-care-help.

Who do I call?

Call UnitedHealthcare Member Services for help **1-888-887-9003**.

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 **1-888-887-9003**. Most of the time, we can help you right away or at the most within a few days.

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 that 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 30 days from when you get our letter. You must appeal within 10 days of the date on the letter to make sure your services are not stopped.

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.

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. You can get an expedited 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 or 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, or call in your request for this type of appeal. You may also call UnitedHealthcare Community Plan Member Services at **1-888-887-9003** 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: Care provider appeal process to Health and Human Services Commission (claim recoupment)

Upon notification of claims payment recoupment, the first step is for the provider to re-check member eligibility to determine if a member was disenrolled or eligibility change was made to Fee-for-Service or a different managed care organization on the date of service.

1. Member disenrolled or eligibility changed to Fee-for-Service on the date of service:

Provider may 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.** Note: this is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- **The EOB showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- **Completed clean claim.** Claims must be submitted with a provider's NPI and appropriate Taxonomy that are actively enrolled with Texas Medicaid, benefit code (if applicable), and complete address with city, state, and ZIP+4 code. To avoid any claims processing errors, providers should complete their claims with the same information that was included on the prior authorization request. In cases when a prior authorization (PA) is needed, 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. In accordance with 1 TAC § 354.1003, you must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHSC Claims Administrator Contract Management, and all claims must be finalized within 24 months from the service date.

2. Member eligibility changed from one managed care organization (MCO) to another on the date of service (STAR Kids only):

Providers may appeal claims payment recoupments and denials of services by submitting the following information to the appropriate MCO to which the member eligibility was changed on the date of service:

- 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, and 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

Appendix K: State fair hearing

Can a member ask for a State Fair Hearing?

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

UnitedHealthcare Community Plan
Attn: Fair Hearing
2950 North Loop W, Suite 200
Houston, TX 77092-8843
Phone: **1-888-887-9003**

If the member asks for a State Fair Hearing within 10 days from the time the member gets the hearing notice from the health plan, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final hearing decision is made. If the member does not request a State Fair Hearing within 10 days from the time the member gets the 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 State Fair Hearings are held by telephone. At that time, the member or the member's representative can tell why the member needs the service the health plan denied.

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

Appendix L: Reporting abuse, neglect or exploitation

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.

Texas law says anyone who thinks a child, or person 65 years or older, or an adult with disabilities is being abused, neglected, or exploited must report it to DFPS.

Find out more at dfps.state.tx.us > Everyone's Business. Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at txabusehotline.org.

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 1-800-458-9858.

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 3 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.

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 complete the Critical Incident Report Form and return to us by email at **critical_incidents@uhc.com**. The form is located at **UHCprovider.com/TXcommunityplan** > Provider Forms > Critical Incident Reporting Form.
- 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.

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 1-800-647-7418.

You must provide us with a copy of the abuse, neglect, and exploitation report findings from the DFPS within one business day of receipt.

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 1-800-436-6184;
- Visit oig.hhsc.texas.gov and click Report Fraud in the red box, or
- You can report directly to your health plan:
  - **UnitedHealthcare Community Plan and UnitedHealthcare Connected/MMP**
    2950 North Loop W, Suite 200
    Houston, TX 77092-8843
  - **1-888-887-9003**

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 N: Electronic visit verification

General information about electronic visit verification

1. What is electronic visit verification?

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

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

2. Is there a law that requires the use of electronic visit verification?

Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. § 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Section 531.024172, requires HHSC to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To comply with these statutes, HHSC required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. HHSC plans to require the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2023.

3. Which services must a service provider or Consumer Directed Services employee document and verify using electronic visit verification?

The required services that must be documented and verified through EVV are listed on the HHSC EVV website.

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

4. Who must use electronic visit verification?

The following must use EVV:

- Provider: An entity that contracts with an MCO to provide an EVV service
- Service Provider: A person who provides an EVV-required service and who is employed or contracted by a Provider or a CDS Employer
- CDS Employee: A person who provides an EVV-required service and who is employed by a CDS Employer
- Financial Management Services Agency (FMSA): An entity that contracts with an MCO to provide financial management services to a CDS Employer as described in Title 26, Part 1, Chapter 264, Consumer Directed Services Option see https://www.sos.state.tx.us/texreg/archive/July122024/Transferred-Rules/Transferred-Rules.html § 41.103(25), Consumer Directed Services Option
- CDS Employer: A Member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a service provider who delivers a service

Electronic visit verification systems

5. Do providers and Financial Management Services Agencies have a choice of electronic visit verification systems?

Yes. A Provider or Financial Management Services Agencies (FMSA) must select one of the following two EVV Systems:

- EVV vendor system. An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHSC Claims Administrator, on behalf of HHSC, that a Provider or FMSA may opt to use instead of an EVV proprietary system.
- EVV proprietary system. An EVV proprietary system is an HHSC-approved EVV System that a Provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
  - Is purchased or developed by a Provider or an FMSA
  - Is used to exchange EVV information with HHSC or an MCO

  - Complies with the requirements of Texas Government Code Section 531.024172 or its successors

6. Does a Consumer Directed Services employer have a choice of electronic visit verification systems?

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

7. What is the process for a provider or Financial Management Services Agencies to select an electronic visit verification systems?

- To select an EVV vendor from the state vendor pool, a Provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign and date the EVV Provider Onboarding Form located on the EVV vendor's website.
- To use an EVV proprietary system, a Provider or FMSA, signature authority and the agency's appointed EVV System administrator must visit the TMHP Proprietary System webpage to review the EVV PSO Onboarding process and HHSC EVV Proprietary System approval process.

8. What requirements must a Provider or Financial Management Services Agencies meet before using the selected electronic visit verification system?

- Before using a selected EVV System
- The Provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process, which includes:
  - An EVV Proprietary System Request Form
  - EVV PSO Detailed Questionnaire (DQ)
  - TMHP Interface Access Request
- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHSC to use an EVV proprietary system to comply with HHSC EVV requirements
- If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:
  - Complete all required EVV training as described in the answer to Question #18;
  - Complete the EVV System onboarding activities.
    - Manually enter or electronically import identification data
    - Enter or verify Member service authorizations
    - Setup member schedules (if required)
    - Create the CDS Employer profile for CDS Employer credentials to the EVV System

9. Does a Provider or Financial Management Services Agencies pay to use the selected electronic visit verification system?

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

10. Can a Provider or Financial Management Services Agencies change electronic visit verification systems?

Yes. A Provider or FMSA may:

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

11. What is the process to change from one electronic visit verification system to another electronic visit verification system?

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

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

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

12. Are the electronic visit verification systems accessible for people with disabilities?

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

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

Electronic visit verification service authorizations

13. What responsibilities do Providers and Financial Management Services Agencies have regarding service authorizations issued by an managed care organization for an electronic visit verification required service?

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

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:
  - Name of the MCO
  - Name of the Provider or FMSA
  - Provider or FMSA Tax Identification Number;
  - National Provider Identifier (NPI) or Atypical Provider Identifier (API)
  - Member Medicaid ID
  - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s)
  - Authorization start date
  - Authorization end date
- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System
- Manually enter service authorization changes and updates into the EVV System as necessary

Electronic visit verification clock in and clock out methods

14. What are the approved methods a service provider or Consumer Directed Services employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?

A Service Provider or CDS Employee must use one of the following 3 approved electronic verification methods described to clock in to begin service delivery and to clock out to end service delivery when providing services to a member in the home or in the community. A Service Provider or CDS Employee may use one method to clock in and a different method to clock out.

1. Mobile method
   - **A Service Provider must use one of the following mobile devices to clock in and clock out:**
     - Service Provider's personal smart phone or tablet
     - A smart phone or tablet issued by the Provider
   - **A CDS Employee must use one of the following mobile devices to clock in and clock out:**
     - CDS Employee's personal smart phone or tablet
     - A smart phone or tablet issued by the FMSA
     - CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet

To use a mobile method, a Service Provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the Service Provider or CDS Employee has downloaded to the smart phone or tablet.

The mobile method is the only method that a Service

Provider or CDS Employee may use to clock in and clock out when providing services in the community.

NOTE: A Service Provider must not use a Member's smart phone or tablet to clock in and clock out

2. Home phone landline
   - A Service Provider or CDS Employee may use the Member's home phone landline, if the Member agrees, to clock in and clock out of the EVV System
   - To use a home phone landline, a Service Provider or CDS Employee must call the number provided by the EVV vendor or the PSO to clock in and clock out
   - If a Member does not agree to a Service Provider's or CDS Employee's use of their home phone landline, or if the Member's home phone landline is frequently not available for the Service Provider or CDS Employee to use, the Service Provider or CDS Employee must use another approved clock-in and clock-out method
   - The Provider or FMSA must enter the Member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type
3. Alternative device
   - A Service Provider or CDS Employee may use an HHSC-approved alternative device to clock in and clock out when providing services in the Member's home
   - An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or EVV PSO
   - An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends
   - The alternative device codes are active for only 7 days after the date of service and must be entered into the EVV system before the code expires
   - The Service Provider or CDS Employee must follow the instructions provided by the Provider or CDS Employer to use the alternative device to record a visit
   - An alternative device must always remain in the Member's home even during an evacuation

15. What actions must the Provider or Financial Management Services Agencies take if a service provider or Consumer Directed Services employee does not clock in or clock out or enters inaccurate information in the electronic visit verification system while clocking in or clocking out?

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

Electronic visit verification visit maintenance

16. Is there a timeframe in which providers, Financial Management Services Agencies and Consumer Directed Services employers must perform visit maintenance?

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

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

17. Are providers, Financial Management Services Agencies and Consumer Directed Services employers required to include information in the electronic visit t system explain why they are performing visit maintenance?

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

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

Reason Codes.

Electronic visit verification training

18. What are the electronic visit verification training requirements for each electronic visit verification system user?

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

Training Resources.

Compliance reviews

19. What are electronic visit verification compliance reviews?

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

Compliance Reviews.

Electronic visit verification claims

20. Are providers and Financial Management Services Agencies required to use an electronic visit verification system to receive payment for electronic visit verification-required services?

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

21. Where does a Provider or Financial Management Services Agencies submit an electronic visit verification claim?

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

22. What happens if a Provider or Financial Management Services Agencies submits an electronic visit verification claim to the managed care organization instead of the Health and Human Service Commission claims administrator?

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

23. What happens after the Health and Human Service Commission claims administrator receives an electronic visit verification claim from a Provider or Financial Management Services Agencies?

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

24. How does the automated electronic visit verification claims matching process work?

The claims matching process includes:

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

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

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

Note: No unit match is performed on CDS EVV claims or on visit transactions against the billed units on the claim line item for specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the units matching process.

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

EVV claim match codes viewable in the EVV Portal:

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

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

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

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

25. How can a provider and Financial Management Services Agencies see the results of the electronic visit verification claims matching process?

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

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

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

Appendix O: 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).

Covered benefits	CHIP members and CHIP perinate newborn members	CHIP perinate members (unborn child)
Inpatient general acute and inpatient rehabilitation hospital services	Services include, but are not limited to, the following: • Hospital-provided physician or care provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free-of-charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and care provider services for a mother and her newborn(s) for a m minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section	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. 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. Services include: • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component 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). 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: • Dilation and curettage (D&C) procedures; • Appropriate provider-administered medications; • Ultrasounds, and • Histological examination of tissue samples.

Covered benefits	CHIP members and CHIP perinate newborn members	CHIP perinate members (unborn child)
	• 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.	
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.

Covered benefits	CHIP members and CHIP perinate newborn members	CHIP perinate members (unborn child)
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. • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. • Surgical implants • Other artificial aids including surgical implants • Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, 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. • 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.	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. **1.** Laboratory and radiological services are limited to services that directly relate to antepartum care and/or the delivery of the covered CHIP Perinate until birth. **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. **3.** Amniocentesis, cordocentesis, fetal intrauterine transfusion (FIUT) and ultrasonic guidance for cordocentesis, FIUT are covered benefits with an appropriate diagnosis. **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. **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.

Covered benefits	CHIP members and CHIP perinate newborn members	CHIP perinate members (unborn child)
Physician/ physician extender professional services	Services include, but are not limited to, the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) • Physician office visits, inpatient and outpatient services • 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. • 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 • 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: – Dilation and curettage (D&C) procedures; – Appropriate provider-administered medications; – Ultrasounds, and – Histological examination of tissue samples. • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation • 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.	Services include, but are not limited to the following: • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth • Physician office visits, inpatient and outpatient services • Laboratory, X-rays, imaging and pathology services including technical component and /or professional interpretation • 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	CHIP members and CHIP perinate newborn members	CHIP perinate members (unborn child)
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 4 weeks for the first 28 weeks or pregnancy; **2.** One visit every 2 to 3 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).
Birthing center services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery). Limitation: Applies only to CHIP members.	Covers birthing services provided by a licensed birthing center. Limited to facility services related to labor with delivery. Applies only to CHIP Perinate members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).

Covered benefits	CHIP members and CHIP perinate newborn members	CHIP perinate members (unborn child)
Services rendered by a certified nurse midwife or physician in a licensed birthing center	CHIP members: Covers prenatal services and birthing services rendered in a licensed birthing center. CHIP Perinate newborn members: Covers services rendered to a newborn immediately following delivery.	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: 1. One visit every 4 weeks for the first 28 weeks or pregnancy; 2. One visit every 2 to 3 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 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).
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.

Covered benefits	CHIP members and CHIP perinate newborn members	CHIP perinate members (unborn child)
Home and community health services	Services provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies • Services are not intended to replace the child's caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services	Not a covered benefit.
Inpatient mental health services	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: • Neuropsychological and psychological testing. • 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. • 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 imitation for services provided in a free standing psychiatric hospital to members younger than age 21 or age 65 and older. – 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 – 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 • Does not require PCP referral	Not a covered benefit.

Covered benefits	CHIP members and CHIP perinate newborn members	CHIP perinate members (unborn child)
Outpatient mental health services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) • 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 • 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 • Does not require a PCP referral	Not a covered benefit.
Inpatient substance use disorder treatment services	Services include, but are not limited to: • Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • Does not require a PCP referral	Not a covered benefit.
Outpatient substance use disorder treatment services	Services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for substance use disorders • Intensive outpatient services • Partial hospitalization • 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 4 to 12 weeks, but less than 24 hours per day • 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 • Does not require PCP referral	Not a covered benefit.
Rehabilitation services	Services include, but are not limited to, the following: • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment): • Rehabilitation services, which include, but are not limited to, physical, occupational, and speech therapy and developmental assessment	Not a covered benefit.

Covered benefits	CHIP members and CHIP perinate newborn members	CHIP perinate members (unborn child)
Hospice care services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have 6 months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness • Up to a maximum of 120 days with a 6-month life expectancy • Patients electing hospice services may cancel this election at any time • Services apply to the hospice diagnosis	Not a covered benefit.
Emergency services, including emergency hospitals, physicians, and ambulance services	MCO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network care providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • 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	MCO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. • Emergency services based on prudent layperson definition of emergency health condition • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor with delivery of the covered unborn child. • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit • 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. 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.
Transplants	Services include, but are not limited to, the following: • 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	Not a covered benefit.
Vision benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	Not a covered benefit.
Chiropractic services	Services do not require physician prescription and are limited to spinal subluxation.	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12-month period limit for a plan-approved program • Health plan defines plan-approved program. • May be subject to formulary requirements.	Not a covered benefit.

Covered benefits	CHIP members and CHIP perinate newborn members	CHIP perinate members (unborn child)
Case management and care coordination services	These services include outreach informing, case management, care coordination and community referral.	Covered benefit.
Teleservices	• Telemedicine, telehealth, telepharmacy and telemonitoring are covered services and are benefits of Texas Medicaid. CHIP-covered services may be delivered by telemedicine, telehealth and telepharmacy. • School-based telemedicine medical services are a covered service for members. We will reimburse the distant site physician providing treatment even if the physician is not the member's PCP or is an out-of-network physician.	• Telemedicine, telehealth, telepharmacy and telemonitoring are covered services and are benefits of Texas Medicaid. CHIP-covered services may be delivered by telemedicine, telehealth and telepharmacy. • School-based telemedicine medical services are not a covered benefit.
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.	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
- 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 P: 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 3 exceptions. Adult STAR Members are provided with 3 enhanced benefits compared to the traditional, fee-for-service Medicaid coverage:

- 1 waiver of the 3 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)
  - Collaborative Care Model services
  - 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
- 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 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 6 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
- Telepharmacy

Appendix Q: 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 3 exceptions. Adult STAR+PLUS members are provided with 3 enhanced benefits compared to the traditional, fee-for-service Medicaid coverage:

1. Waiver of the 3 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
  - Collaborative Care Model 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 substance use disorder treatment facility in lieu of an acute care inpatient hospital setting, including
  - Detoxification services
  - Substance use disorder treatment
- 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
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age
- 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
- Telepharmacy

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 3 service delivery options: Consumer Directed Services (CDS), 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
  - 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 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 (CDS only)
  - 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 task.
  - 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

Appendix R: STAR Kids covered services

STAR Kids benefits are governed by the MCO's contract with the Health and Human Services Commission (HHSC), and include: medical, vision, behavioral health, pharmacy and Long-Term Services and Supports (LTSS). MDCP services are covered for individuals who qualify for and are approved to receive MDCP.

UnitedHealthcare Community Plan provides a benefit package to members that includes fee-for-service (FFS) acute care and LTSS services previously covered under the Texas Medicaid program. For a current listing of limitations and exclusions, go to TMHP.com > providers > Medicaid Provider Manual > Texas Medicaid Provider Procedures Manual | TMHP. The following is a non-exhaustive, high-level listing of Covered Services included under the STAR Kids Medicaid managed care program. The services listed here are subject to modification based on federal and state laws and regulations and HHSC policy updates.

Services included under the MCO capitation payment:

- Emergency and non-emergency ambulance services
- Audiology services, including hearing aids
- Behavioral Health Services including:
  - Inpatient mental health services. We may provide these services in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.
  - ADHD and follow-up care for children prescribed ADHD medications
  - Outpatient mental health services
  - Psychiatry services
  - Collaborative Care Model services
- Substance use disorder treatment services, including
  - Outpatient services, such as:
    - Assessment
    - Detoxification services
    - Counseling treatment
    - Medication assisted therapy
  - Residential services, which may be provided in a substance use disorder treatment facility in lieu of an acute care inpatient hospital setting, including
    - Detoxification services
    - Substance use disorder treatment
- 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 service
- Chiropractic services
- Dialysis
- Drugs and biologicals provided in an inpatient setting
- Durable medical equipment and supplies
- Early Childhood Intervention (ECI) services
- Emergency Services
- Family planning services
- Home health care services
- Hospital services, inpatient and outpatient
- 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 through the Texas Health Steps Program (EPSDT)
- Mental health rehabilitation services
- Mental health targeted case management
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age;
- Optometry, glasses, and contact lenses, if medically necessary
- Outpatient drugs and biologicals; including pharmacy-dispensed and care provider-administered outpatient drugs and biologicals
- Personal Care Services (PCS)
- Podiatry
- Prescribed pediatric extended care center (PPECC) services
- Primary care services
- Private Duty Nursing (PDN) services
- Radiology, imaging, and X-rays
- Specialty physician services
- Telemonitoring
- Telehealth
- Telemedicine
- Telepharmacy
- Therapies – physical, occupational, and speech
- Transplantation of organs and tissues
- Vision services
- Community First Choice (CFC) 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).

The CFC 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 who accompany members to medical appointments when they cannot go alone.
- Supervision or assistance to help the member acquire skills necessary to accomplish ADLs, instrumental activities of daily living (IADLs) and health-related tasks
- Electronic monitoring systems 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 involving training members how to select, manage and dismiss attendants

Services included under UnitedHealthcare Community Plan capitation payment for MDCP STAR Kids.

We will provide medically and functionally necessary services to members who meet the functional and financial eligibility for MDCP STAR Kids.

- Respite Care
- Supported Employment
- Financial Management Services
- Adaptive Aids such as, a travel chair or a low air pressure mattress
- Employment Assistance
- Flexible Family Support Services
- Minor home modifications
- Transition Assistance Services

For a more inclusive list of limitations and exclusions that apply to each Medicaid benefit category. This document can be accessed online at TMHP.com > providers > Medicaid Manual > The Texas Medicaid Provider Procedures Manual.

Appendix S: UnitedHealthcare connected benefits Medicare-Medicaid plan

The referral and prior authorization procedure are important to the UnitedHealthcare Connected managed care program. Prior authorization is one of the tools we use to monitor the medical necessity and cost effectiveness of the care members receive. You are required to comply with UnitedHealthcare Connected prior authorization policies and procedures. Non-compliance may result in delay or denial of reimbursement. Because the PCP coordinates most services provided to a member, the PCP usually initiates requests for prior authorization. However, specialists and ancillary care providers may also request prior authorization for services within their specialty areas.

The prior authorization department, under the direction of licensed nurses and medical directors, documents and evaluates requests for authorization. This includes:

- Verification the member is enrolled with UnitedHealthcare Connected at the time of the request for authorization and on each date of service
- Verification the requested service is a covered benefit for the member
- Assessment of the requested service's medical necessity and appropriateness
- UnitedHealthcare Connected medical review criteria based on CMS/Medicaid program requirements, applicable policies and procedures, contracts and law
- Verification the service is being provided by a participating care provider and in the appropriate setting
- Verification of other insurance for coordination of benefits

About the benefits chart

The following benefits chart is a general list of services the plan covers. It lists preventive services first and then categories of other services in alphabetical order. It also explains the covered services, how to access the services and if there are any limits or restrictions on the services.

We cover the services listed in the benefits chart only when the following rules are met:

- Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Texas Medicaid. The services (including medical care, services, supplies, equipment and drugs) must be a plan benefit and must be medically necessary. Medically necessary means the services are necessary to prevent, diagnose or treat a medical condition.
- Medicare is responsible for most primary, acute and behavioral health services. Therefore, the PCP's name, address and telephone number are listed on the member's ID card. The member receives LTSS through UnitedHealthcare Connected.
- Members must get their care from a network care provider. In most cases, the plan will not pay for care received from an out-of-network care provider.
- Members have a PCP and a care team providing and managing care. LTSS providers may help coordinate benefits.

Some of the services listed in the benefits chart are covered only if the care provider or other network care provider gets prior authorization from us. Also, some of the services listed in the benefits chart are covered only if the care provider or other network care provider writes an order or a prescription for the service.

Members do not pay anything for the services listed in the benefits chart as long as they meet the coverage requirements. The only exception is if a member has a patient liability for nursing facility services or waiver services as determined by HHSC.

The benefits chart

Preventive visits

Services covered by MMP	Limitations and exceptions
Annual checkup This is a visit to make or update a prevention plan based on current risk factors.	Members cannot have their first annual checkup within 12 months of their "Welcome to Medicare" preventive visit. They are covered for annual checkups after they have had Part B for 12 months. Members do not need to have had a "Welcome to Medicare" preventative visit."
"Welcome to Medicare" visit If a member has been in Medicare Part B for 12 months or less, they can get a one-time "Welcome to Medicare" preventive visit. When a member makes the appointment, they tell the care provider they want to schedule their "Welcome to Medicare" preventive visit. This visit includes: • A review of a member's health • Education and counseling about the preventive services a member needs (including screenings and shots) and referrals for other care, if needed	

Hospice

When a member qualifies for end-of-life hospice care, a HCSSA can provide home health, hospice, or PAS in the member's home or independent living environment as prescribed by a physician or ISP. The HCSSA develops an integrated plan of care, including specific services the agency agrees to perform and that the member agrees to receive. HCSSAs are licensed and monitored by the Texas Health and Human Services.

HCBS MMP waiver

- 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 3 service delivery options: Consumer Directed Services (CDS), 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
  - 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 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 (CDS only)
  - 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

Appendix T: Medically dependent children/ deaf-blind with multiple disabilities help line

What is the Medically Dependent Children Program / Deaf-Blind with Multiple Disabilities escalation help line?

The MDCP/DBMD escalation help line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf-Blind with Multiple Disabilities (DBMD) program.

The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about External Medical Reviews, State Fair Hearings and continuing services during the appeal process.

When should members call the escalation help line?

Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call 1-844-999-9543 and they will work to connect you with the right people.

Is the escalation help line the same as the Health and Human Services office of the Ombudsman?

No. The MDCP/DBMD Escalation Help Line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at 1-866-566-8989 or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

Who can call the help line?

You, your authorized representatives or your legal representative can call.

Can members call any time?

The escalation help line is available Monday-Friday from 8 a.m.–8 p.m. After these hours, please leave a message and one of our trained on-call staff will call you back.