

2018 Administrative Guide/ Care Provider Manual

Texas STAR Kids

Physician, Health Care Professional, Facility and Ancillary

**Serving the following Service Delivery Areas: Jefferson, Harris and Hidalgo,
as well as Medicaid Rural Service Area (MRSA) Central and MRSA Northeast.**

Provider Customer Service – 888-887-9003

March 15, 2018

UHCommunityPlan.com, UHCprovider.com and Link



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Welcome!

Welcome

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

Click the following links to access different manuals:

- [UnitedHealthcare Administrative Guide](#) for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- UHCCommunityPlan.com, click For Health Care Professionals at the top of the screen. Select the desired state.

Easily find information in the manual using the following steps:

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

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

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

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

Important Information about the use of this manual

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

This manual is amended as policies change.

Welcome!

It is with great pleasure that I welcome you to UnitedHealthcare Community Plan STAR Kids Health Plan. I applaud you for partnering with us to care for such a special population of children. We envision this partnership as a comprehensive engagement to guide these children through a healthier, balanced and fulfilled childhood and beyond. We are here to support you as you serve our STAR Kids. Not only are you providing care for children with special needs, but you are giving back to our community by allowing these children to reach their fullest potential as they enter adulthood.

We provide supplemental education and training toolkits to help you care for this special population. With Vanderbilt Kennedy Center through Vanderbilt University, we offer training for working with people with Intellectual and Developmental Disabilities (IDD), Down Syndrome and Autism.

This provider manual is a comprehensive document that explains our company and how to do business with us. We strongly encourage our network care providers to become familiar with all aspects of this manual. We look forward to strengthening our relationship with you as we pursue our mission to help our members live healthier lives.

Thank you again for partnering with UnitedHealthcare Community Plan!

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Medical Director, STAR Kids

Table of Contents

• Welcome	
• Chapter 1: Introduction	6
• Chapter 2: About STAR Kids	7
• Chapter 3: Care Provider and Network Considerations	8
• Chapter 4: After-Hour Access to Care	13
• Chapter 5: Keeping your Contact Information Current	14
• Chapter 6: Family Planning	15
• Chapter 7: Eligibility	16
• Chapter 8: Service Coordination	19
• Chapter 9: Authorizations	23
• Chapter 10: Texas Health Steps	25
• Chapter 11: Texas Health Steps Billing and Payments	36
• Chapter 12: Early Childhood Intervention Services	37
• Chapter 13: Successful Transition to Adulthood	39
• Chapter 14: Behavioral Health	41
• Chapter 15: Pharmacy	45
• Chapter 16: Long-term Services and Supports (LTSS)	49
• Chapter 17: Value-added Services	54
• Chapter 18: Quality	55
• Chapter 19: In Case of an Emergency	57
• Chapter 20: Fraud, Waste and Abuse	58
• Chapter 21: Billing and Payments	59
• Chapter 22: Claims Submissions	63
• Chapter 23: Payments	66
• Chapter 24: Complaints and Appeals	67
• Chapter 25: Definition of Terms	71

Appendices

- **A: Member Rights and Responsibilities** **74**
- **B: STAR Kids Covered Services** **77**
- **C: Fraud Information** **80**
- **D: Reporting Abuse, Neglect or Exploitation (ANE) Medicaid Managed Care** **81**
- **E: Community First Choice Provider Responsibilities** **82**
- **F: Electronic Visit Verification** **83**
- **G: Member Complaints and Appeals** **87**
- **H: State Fair Hearing Information** **89**
- **I: Care Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)** **90**
- **J: Claims Forms** **91**
- **K: Facility and Inpatient Services** **92**
- **L: Medical Record Documentation Standards** **93**
- **M: Sample Member ID Card** **96**
- **N: Adoption Assistance and Permanency Care Assistance** **97**

Chapter 1: Introduction

This provider manual is applicable for our STAR Kids. It is designed as a comprehensive reference source for the information you and your staff need to conduct interactions and transactions with us in the most efficient manner possible. This manual, along with other resources, are available at our website UHCCommunityPlan.com. The below are other sources of important information when serving our members:

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

The Texas Health and Human Services Commission Uniform Managed Care Manual at hpsc.state.tx.us/medicaid/managed-care/umcm/

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

The Texas Medicaid & Healthcare Partnership at tmhp.com

The Texas Department of State Health Services at dshs.texas.gov/thsteps/providers.shtm

Newsletters are a means of care provider notification:

- **Network Bulletin:** Monthly edition posted to uhcprovider.com/news
- **Practice Matters:** Quarterly edition posted to UHCCommunityPlan.com > For Healthcare Professionals > TX > Newsletters

The Texas Department of Rehabilitative Services at dars.state.tx.us/

The Texas Department of Aging and Disability Services at dads.state.tx.us/

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

UnitedHealthcare Dual Complete (HMO SNP)

For information regarding UnitedHealthcare Dual Complete, please see the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products at UHCprovider.com >Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Administrative Guide.

Chapter 2: About STAR Kids

Background

Senate Bill 7, 83rd Legislature, Regular Session, 2013, directs the Texas Health and Human Services Commission (HHSC) to establish a mandatory, capitated STAR Kids managed care program tailored to provide Medicaid benefits to children and young adults with disabilities. This legislature also calls for the inclusion of the Medically Dependent Children Program (MDCP) and requires HHSC to consult with the STAR Kids Medicaid Managed Care Advisory Committee and Children's Policy Council on the establishment and implementation of the program.

Quick Reference Phone List

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

Contact	Phone
Customer Service for Care Providers	888-887-9003
Long-term Services and Supports Care Provider Customer Service	888-787-4107
Service Coordination Hotline	877-352-7798
Prior Authorization Phone	866-604-3267
Prior Authorization Fax	877-940-1972
Prescription Prior Authorization	800-310-6826
Medicaid Transportation (Houston and Beaumont)	855-687-4786
Medicaid Transportation (All other service areas)	877-633-8747
Language Interpreters	888-887-9003
Texas Department of State Health Services Laboratory Services	888-963-7111, ext. 7318
Vaccines for Children	888-777-5320
ImmTrac Customer Support	800-348-9158

Contact	Phone
Texas Department of State Health Services Case Management for Children and Pregnant Women	800-252-8023 ext. 2168
Optum (Behavioral Health) Referral and Crisis	877-855-3405
NurseLine	844-222-7326
MAXIMUS	800-964-2777
Early Childhood Intervention (ECI)	800-628-5115
Children with Special Health Care Needs Program	800-252-8023
THSteps Outreach Team	800-784-6999
THSteps Provider Outreach Referral Service	877-847-8377
Texas Department of Family and Protective Services to Report Abuse, Neglect and Exploitation:	800-647-7418
Fraud, Waste and Abuse Office of Inspector General	800-436-6184
Credentialing	877-842-3210
UHCprovider.com Help Desk	866-842-3278
Physician Advocates	888-303-6162
Optum Care Provider Services	800-873-4575

Program Objectives

The objectives of Texas Medicaid managed care are to:

- Emphasize preventive care
- Improve access to care
- Help ensure appropriate utilization of services
- Improve client and care provider satisfaction
- Establish a medical home for Medicaid clients through a primary care provider (PCP)
- Improve health outcomes, quality of care, and cost effectiveness
- Promote care in least restrictive, most appropriate setting

Chapter 3: Care Provider and Network Considerations

Role of Primary Care

The primary care provider (PCP) led medical home is the base of care for STAR Kids. The PCP works closely with the member and their family throughout the years to observe wellness and to anticipate future health care needs. A person-centered approach addresses the varied needs of the patient and, in so doing, 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

This inclusive care for special needs children with complex health care needs includes the PCP being accessible to members and their family 24 hours a day/seven days a week. Members should be comfortable calling their PCP for support and/or direction. They need to know when they have worsening symptoms, when to come in for a next-day appointment, when to seek urgent care or when it is appropriate to go to the emergency room. For more information about PCP access and after-hour care, see the Care Provider Responsibility section of this manual.

For additional information visit the Texas Health and Human Services Commission at HHSC.state.tx.us > News & Information > Reports/Publications > [Texas Medicaid Patient-Centered Medical Home Report](#).

Care providers serving as a PCP may come from different professional practice areas including:

- General Practice
- Family Practice
- Internal Medicine
- Pediatrics

- Obstetrics/Gynecology (OB/GYN)
- Advanced Practice Registered Nurses (APRNs)
- Physician Assistants (PAs)
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs), and similar community clinics
- Specialist physicians who are willing to provide a Health Home to selected members with special needs and conditions

Members have the right to designate an OB/GYN as their primary care (excluding STAR Kids Dual Eligible members), provided that the care provider agrees to serve as their 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 (excludes STAR Kids Dual-Eligible members).

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 service coordination for the member. 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. Health homes are specially contracted care providers that deliver:

- 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)

Panel Roster

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

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

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

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

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

Assignment to PCP Panel Roster

Once a member has been assigned to a PCP, panel rosters can be viewed electronically on the UnitedHealthcare Provider Portal at UHCprovider.com. The portal requires a unique user name and password combination to gain access.

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

The Role of a Specialty Care Provider

Specialist consultations do not require authorization as long as the specialist is an in-network care provider. Medical specialists are responsible for providing covered health services within the scope of their UnitedHealthcare Community Plan agreement and within the scope of their specialty license. You agree to render covered health services to members in the same manner as offered to other patients, in compliance with State regulations and as described within this provider manual. Specialty care provider responsibilities include communicating to the member's PCP the specialist's findings, recommendations and treatments. The report should be after the initial assessment and quarterly thereafter.

Network Limitations

We recognize network limitations in that referrals should be to contracted in-network facilities, contractors and care providers, except under certain circumstances. We require justification to us regarding any out-of-network referrals, including partners not contracted with us. For a list of participating care providers, network facilities and contractors for referrals, visit UHCCommunityPlan.com > For Healthcare Professionals > Texas > [Find a Physician](#). The list includes all care provider types. Customer service is also a resource for identifying in-network referrals. Please call **888-887-9003**.

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

- Obtaining medication from any network pharmacy
- Selecting and having access to a network ophthalmologist or therapeutic 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 specialists appropriate to the member's condition and identified needs, such as a standing order for a specialty physician. Coordination of care for the referral and on-going communication with the specialist surrounding the member's care needs documented in the member's medical record.

Members may have access to a second opinion regarding the use of any medically necessary covered service. A member is allowed access to a second opinion from a network provider or out-of-network care provider, if a network care provider is not available or does not have the clinical experience in a condition or treatment, at no cost to the member.

Continuity of Care

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

- Pregnant women past the 24th week of pregnancy are allowed to remain under their current OB/BYN care through their post-partum checkup through the delivery of the child, immediate postpartum care and the follow-up checkup within the first six 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 preexisting condition that is not imposed
- Members moving out of a UnitedHealthcare Community Plan contracted service area

Out-of-Network Care Providers Delivering Care

Members receiving community-based services or other services prior to Nov. 1, 2016 may remain with their care provider until 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.

When a member changes managed care organizations (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 on a case-by-case basis when medically necessary, covered services are not available from an available in-network care provider.

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

Care Provider Responsibilities

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

Care Provider Responsibilities:

- Abide by member access criteria for care (in this chapter)
- Verify member eligibility and any necessary authorization(s) for services
- Notify us and TMHP of any changes to your contact information, such as address, telephone number or group affiliation
- Coordinate care with the member's PCP
- Maintain current Medicaid enrollment by reenrolling when due for reenrollment at TMHP.com > [providers](#).
- The following providers should see their additional responsibilities in this manual:
 - Long-term Services and Supports, see the LTSS chapter
 - Community First Choice, see Appendix E
 - Behavioral Health, see the Behavioral Health chapter

Responsibilities Unique to PCPs:

- Deliver primary care though a patient-centered medical home model for STAR Kids members who are not dual-eligible members.
- Observe Texas Health Steps for wellness and screening.
- Refer to specialists and health-related services and document coordination of referrals and services provided that occurs between yourself, as the PCP, and the referred care provider (not applicable to STAR Kids Dual-eligible members).
- Honor a member's right to refuse, withhold or withdraw medical treatment and mental health treatment through advance directives.
- Have 24-hour availability for members (see access below).

Provider Plan Termination

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

You must notify us, in writing, at the address stated in your Provider Agreement within 10 calendar days of your knowledge of any of the following occurrences:

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

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

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

Availability and Accessibility Standards

All providers need to adhere to the access standards as requirements for when scheduling appointments.

Appointments should be made as soon as possible, but no later than the following:

Service Type	Date of Presentation or Request	Calendar Days
THSteps medical checkup for members over 36 months of age	Member's birthday	364
Routine Medical Care	Request	14
Specialty Care Referrals	Referral	30
Initial Outpatient Behavioral Health	Request	14
Behavioral Health	Post-psychiatric inpatient stay discharge	7
Newborns	Birth or enrollment	14
Prenatal care for high-risk pregnancies or new members in the third trimester	Request	5
For a newborn through age 20, overdue or upcoming Texas Health Steps medical checkups, must be offered as soon as practicable, but in no case later than 90 days of enrollment.	Enrollment	90

Service Type	Date of Presentation or Request	Calendar Days
Urgent Care, including urgent specialty care	Request	1 (24 hours)
Emergency	Presentation	Immediately

Your office hours for STAR Kids need to be at least equal to those offered to your other patients.

Additional PCP Responsibilities

Though normally referred to as PCP 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 our network services at **866-574-6088** to contract as a PCP.

Chapter 4: After-Hour Access to Care

A PCP has the responsibility to help ensure necessary health care services are available to members at any time. This includes the responsibility to return member after-hour phone calls within 30 minutes of the call. When unable to provide this level of member care, you must arrange with another in-network PCP to cover this availability. The minimum requirements are outlined in our contract with the Texas Health and Human Services Commission and, ultimately, our contract with you.

Your office phone should be accessible 24 hours a day. After hours, you must answer the phone using the following methods:

- An answering service in a language the member can understand, or by someone who is familiar with engaging language translation services. The answering service needs to be able to contact you. You must return the call to the answering service within 30 minutes.
- A recording in a language the member can understand and directing the member to call another number to reach you or another designated care provider. Someone must be available to answer the telephone; another recording is not acceptable.
- Transfer to another location where someone will answer the phone and be able to contact you or another designated care provider. Return the call within 30 minutes.

The following business practices are not considered compliant after-hours arrangements. The office telephone is answered:

- Only during office hours
- After-hours by a recording that tells members to leave a message, text or page
- After-hours by a recording that directs members to go to an emergency room for services without providing an option to contact a care provider.

Member Accessibility Rights

Members have the following access rights without a PCP referral:

- Obtain medication from any network pharmacy
- Select and have access to a network ophthalmologist or therapy to provide eye health care services other than surgery

- Direct access for members with special health care needs to a specialist appropriate to the member's condition and identified needs, such as a standing order for a specialty physician
- The right for members with disabilities, special health care needs, and chronic or complex conditions to designate a specialist as their PCP, as long as the specialist agrees to designate an OB/GYN as their PCP as long as the specialist agrees
- Access to a second opinion
- Access to telemedicine, telemonitoring and telehealth
- Self-referral to any network care provider, including behavioral health

Potentially Preventable Episodes

Our STAR Kids live with chronic and complex medical conditions. We believe the person-centered medical home maintained by you as their primary care provider is a cornerstone to their medical management. We urge you to practice wellness by closing gaps in care per the Effectiveness Data and Information Set HEDIS® and best practice guidelines. Our adopted best practice guidelines are posted to UHCommunityPlan.com > For Health Care Providers > Texas > [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 emergency room

Chapter 5: Keep Your Contact Information Current

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

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

Submit a form with your changes by visiting UHCprovider.com > Tools & Resources > Forms > [Form: Provider Demographic Change Form](#).

- Physicians and facilities should fax the form to:
United Health Network
Fax: **866-571-1060**
- All other health care providers should fax the form to:
UnitedHealthcare Community Plan
Fax: **855-500-3356**

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

Visit TMPH.com > Providers, select TexMedConnect and log in to update your profile.

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

Mail the completed form to:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
P.O. Box 200795
Austin, TX 78720-0795

Texas [Medicaid providers](#) are required to revalidate their enrollment in Texas Medicaid every three or five 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 **800-925-9126**, Option 2.

Challenge Survey

It is a network care provider's responsibility to fully participate in the challenge survey located at UHCprovider.com. This survey is a random action to help ensure the accuracy of our information to improve member access to care.

Network Referrals

UnitedHealthcare Community Plan has no network limitation on referrals to any in-network care provider. Referrals should be made to care providers, facilities and contractors who are contracted as in the UnitedHealthcare Community Plan and thereby in-network. Justification needs to be provided to UnitedHealthcare Community Plan for any referrals that would be considered out-of-network, including partners not contracted with UnitedHealthcare Community Plan. If the member accesses care through a non-contracted 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.

We recognize network limitations in that referrals should be to contracted in-network care providers, except under certain circumstances. For a list of participating care providers, network facilities and contractors for referrals, visit UHCCommunityPlan.com > For Healthcare Professionals > Texas > [Find a Physician](#). The list includes all care provider types. Customer service is also a resource for identifying in-network referrals. Please call **888-887-9003**.

Chapter 6: Family Planning

We have a perinatal health care system that, at a minimum, provides the following 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 one 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

To see the prior authorization requirements for these services, go to Link at UHCprovider.com and access the Member Eligibility & Benefits tile. Or, visit UHCCommunityPlan.com > For Health Care Professionals > Texas > [Prior Authorizations](#).

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.

Chapter 7: Eligibility

You must verify a member's eligibility of Medicaid membership, health plan membership and benefits prior to delivering services.

Verifying Medicaid Eligibility and MCO Enrollment

Each person approved for Medicaid benefits gets a *Your Texas Benefits Medicaid* card. However, having a card does not always mean the patient has current Medicaid coverage. Verify the patient's eligibility for the date of service prior to services being rendered. There are several ways to do this:

- Swipe the patient's *Your Texas Benefits* Medicaid card through a standard magnetic card reader, if your office uses that technology.
- Use the automated inquiry service (AIS) or TexMedConnect on the TMHP website at tmhp.com.
- Call the Your Texas Benefits provider helpline at **855-827-3747**.
- View member eligibility online at UHCprovider.com > Link > [Patient Eligibility & Benefits](#).
- Call provider service at the patient's medical or dental plan at **888-887-9003**.

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 **855-827-3748**. Medicaid members can go online to order new cards or print temporary cards.

Important: Request and keep hard copies of any Medicaid Eligibility Verification (Frm H1027) submitted by clients or proof of client eligibility from the Your Texas Benefits Medicaid card website at YourTexasBenefitsCard.com. A copy is required during the appeal process if the client's eligibility becomes an issue.

Your Texas Benefits give you access to Medicaid health information

Medicaid care providers can log into the site to see a patient's Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). All of this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It's FREE and requires a one-time registration.

To access the portal, visit YourTexasBenefitsCard.com and follow the instructions in the 'Initial Registration Guide for Medicaid Providers'. For more information on how to get registered, download the 'Welcome Packet' on the home page. YourTexasBenefitsCard.com allows you to:

- View available health information such as:
 - Vaccinations
 - Prescription drugs
 - Past Medicaid visits
 - Health events, including diagnosis and treatment
 - Lab results
- Verify a Medicaid patient's eligibility and view patient program information.
- View Texas Health Steps Alerts.
- Use the Blue Button to request a Medicaid patient's available health information in a consolidated format.

Patients can also log in to YourTexasBenefits.com to see their benefit and case information, print or order a Medicaid ID card, set up Texas Health Steps Alerts and more.

If you have questions, call 855-827-3747 or email ytb-card-support@hpe.com.

If the member gets Medicare, Medicare is responsible for most primary, acute and behavioral health services, therefore, the PCP's name, address and telephone number are not listed on the member's ID card. The member receives Long-Term Services and Supports (LTSS) through UnitedHealthcare Community Plan.

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

Children and young adults formerly STAR+PLUS members are STAR Kids members effective Nov. 1, 2016. United Healthcare Community Plan members may change their assigned PCP, as needed, with UnitedHealthcare Community Plan.

When STAR Kids begins Nov. 1, 2016, we will 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 (HCS), 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.

Eligibility Determination

The Texas Health and Human Services Commission (HHSC) determines eligibility for Medicaid members and helps ensure members receive all the benefits of the Texas Medicaid programs. HHSC has selected an independent broker, MAXIMUS, to serve as the enrollment broker for STAR Kids.

MAXIMUS 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 provider network to MAXIMUS for this reason.

Mandatory MCO Participation

As recipients of Supplemental Security Income (SSI), STAR Kids members are mandated to select an MCO and a primary care provider (PCP). The MCO provides acute and long-term care services. If the member also has Medicare, the MCO provides long-term care services only and that member is not required to select a PCP.

Disenrollment

A member's disenrollment request from UnitedHealthcare Community Plan will require medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment. The Texas Health and Human Services Commission will make the final decision.

Notice to Providers

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



You are required to call us immediately at 888-887-9003 when a pregnant STAR Kids member is identified.

Automatic Re-Enrollment

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

Newborn Enrollment

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

Chapter 8: Service Coordination

Our service coordinators help ensure that every STAR Kid is fully assessed and served in a person-centered manner that is holistic, unique, culturally competent and conducive to coordination of care. We aspire to this well-rounded approach in conjunction with the member's PCP medical home model in which the PCP coordinates care across the span of member needs and lifetime. We believe that every STAR Kid is unique in their care needs, aspirations and abilities. It is our mission to put into place for each and every one of them what they need to live healthier lives.

Service coordination is a cornerstone of managed care. Service coordination services help to maximize a member's health, well-being, and independence. The service coordinator's role is to consider the member's situation as a whole, including his or her medical, behavioral, social, and educational needs. A member can contact his or her service coordinator directly or by calling the service coordination hotline at **877-352-7798**.

The service coordinator works with the member, the member's family or legally authorized representative (LAR) and those involved in his or her care – including PCP and specialists — 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 CommunityPlan service coordinators. The Health Home provides all assessment, planning and service delivery of the person-centered care.

Our service coordinators are experienced in meeting the needs of pediatric vulnerable populations who have chronic or complex conditions in a person-centered manner that is culturally considerate. They are certified nurses or social workers.

Assessment and Planning Care

The STAR Kids Screening Assessment Instrument (SK-SAI) is performed in the member's home by one of our service coordinators, a registered nurse, 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 to prioritize which members require the most immediate attention and what level of need meets the member's 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

Service Coordination Levels

Level 1 members have a personally assigned service coordinator who visits them a minimum of four face-to-face visits annually, in addition to monthly phone calls, unless otherwise requested by the member or member's LAR.

Members at this level of coordination:

- Are in the Medically Dependent Children Program (MDCP) qualify financially and would 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 members also have a personally assigned service coordinator who visits them a minimum of two times annually with six 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 any other findings
- Have a history of substance abuse, and multiple outpatient visits, hospitalization, or institutionalization within the past year
- Have a behavioral health condition that significantly impairs their normal functioning, but that is not a serious emotional disorder (SED) or a serious and persistent mental illness (SPMI)

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

Individualized Service Plan

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

- Member
- Member's family and/or legally authorized representative
- Member's PCP
- Other service providers for the member
 - Specialists such as behavioral health or medical
 - Therapists
 - Providers of long-term services and supports
 - Early childhood education providers
 - Adult transition specialist
 - Others as indicated for the member's personal and complex needs

The care plan is developed with a person-centered planning approach addressing short and long-term goals. It includes:

- Natural strengths of the member
- Member and family goals and service preferences
- Personal and community supports
- Detailed services for the member, both covered and non-covered services to address the member needs identified through the planning of the service coordination team and the STAR Kids Screening and Assessment process. These medically necessary services will have a prior authorization secured by the service coordinator within the planning process.
- A plan for coordination of member care

The care plan is shared through CommunityCare – our online care coordination tool to which the treatment team has secure access. Go to Link at UHCprovider.com and access the CommunityCare application.

The care plan is updated annually with enough lead time to 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 that is listed in CommunityCare accessible through Link at UHCprovider.com. You may also call the STAR Kids service coordination hotline at **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 service coordinator to request 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 is delivered to meet their complex needs, the member may continue to receive presently authorized services that were included in the member's 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 that we are able to complete a STAR Kids Screening and Assessment Process and issue a new treatment plan.

Discharge Planning

When a member is about to discharge from a hospital or other treatment facility, our service coordinator works to develop a discharge plan with:

- The hospitalized member
- His or her family and/or legally authorized representative(s)
- The member's PCP
- Facility attending physician
- Hospital or inpatient psychiatric facility discharge planner(s)

Any necessary prior authorizations for services included in the discharge plan are secured by the service coordinator. The service coordinator secures any long-term services and supports that are necessary 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.

Our individual service plans address services that are covered and non-covered by a member's benefits. For more information, please visit tmhp.com > providers > Medicaid Provider Manual > [Texas Medicaid Provider Procedures Manual](#):

- Texas Health Steps dental (including orthodontia)
- Texas Health Steps environmental lead investigation (ELI)
- Early Childhood Intervention (ECI) targeted case management/service coordination
- Early Childhood Intervention Specialized Skills Training
- Case Management for Children and Pregnant Women
- Texas School Health and Related Services (SHARS)
- Department of Assistive and Rehabilitative Services (DARS) Blind
- Children's Vocational Discovery and Development Program
- Tuberculosis services provided by Department of State Health Services (DSHS-approved care providers directly observed therapy and contact investigation)
- Health and Human Services Commission's Medical Transportation Program (MTP)
- Department of Aging and Disability Services (DADS) hospice services

- The Texas Department of Aging and Disability Services (DADS) and The Texas Department of State Health Services (DSHS) Home and Community-Based Services (HCBS) Waiver programs, including:
 - Community Living Assistance and Support Services (CLASS)
 - Deaf Blind with Multiple Disabilities (DBMD)
 - Home and Community-based Services (HCS)
 - Texas Home Living (TxHmL)
 - Youth Empowerment Services (YES) (to begin managed care at a date determined by the Texas Health and Human Services Commission)

Inpatient Concurrent Review: Clinical Information

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

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

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within four hours of receipt of our request if it is received before 1 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1 p.m. local time (but no later than 12 p.m. local time the next business day). UnitedHealthcare uses MCG (formally Milliman Care Guidelines), CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

Promoting Independence

Through our contract with the Texas Health and Human Services Commission, we participate in the Texas promoting independence initiative. This philosophy helps ensure that Texans aged and/or disabled can remain in the most integrated and least restrictive level-of-care setting, utilizing long-term services and supports to help make sure their most basic needs are met.

Promoting Independence is the Texas response to the U.S. Supreme Court ruling in *Olmstead v. L.L.C.*, which requires states to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services, when:

1. It is determined that such placement is appropriate.
2. The member does not oppose LTSS.
3. LTSS can be reasonably accommodated, taking into account the resources available and in consideration of disability services.

Our service coordinators complete a member assessment within 30 days of admission to a long-term care facility, such as a nursing home. At that time, a plan of care is developed, if appropriate, to transition the member back into the community. If at this initial assessment, a return to the community is possible, the service coordinator works with the member, family or representative and care team to return the member to the community using community-based long-term services and supports.

If the initial assessment does not support a return to the community, the service coordinator will conduct a second assessment 90 days after the initial assessment to determine any changes in the member's condition or circumstances that would 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 UnitedHealthcare Community Plan member to further assess for a possible return to the community. In the meantime, the member's benefits return to fee-for-service.

Nursing Facility Residential Assessment

The Preadmission Screening and Resident Review (PASRR) is a federally mandated program applied to all individuals seeking admission to a Medicaid-certified nursing facility. PASRR helps ensure that individuals are not inappropriately placed in nursing facilities for long-term care, and requires that all applicants to a Medicaid-certified nursing facility:

- Be evaluated for mental illness, intellectual disability, or both
- Be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings)
- Receive the services they need in those settings

Chapter 9: Authorizations

Prior Authorization Request

Some services require us to review a request prior to you providing them so we may consider whether the service is medically necessary for the member. You will not be paid for service claims delivered without an approved authorization. For a complete list of which services require prior authorization and the corresponding codes, visit UHCCommunityPlan.com > For Health Care Professionals > Texas > [Prior Authorizations](#).

Online

The best way to request a prior authorization is online. The steps are as follows:

1. Sign in to UHCprovider.com.
2. Click on Link.
3. Select “Eligibility & Benefits Center.”
4. Enter member information to determine service eligibility. A pop-link will appear for those services that require a prior authorization. Follow the link to request a prior authorization by utilizing the brief drop down selections.

If supporting documentation is necessary for the request, go to UHCprovider.com > Tools & Resources > UnitedHealthcare Community Plan Resources > Texas > [Attachment Submission Process for Texas Community Plan](#).

Fax

Fax prior authorization requests to **877-940-1972**.

The fax form is available on UHCCommunityPlan.com > Health Care Professionals > Texas > Provider Forms > Prior Authorization Forms > [Standard Prior Authorization Form: Texas Department of Insurance](#).

Phone

You may also call us for a prior authorization consideration at **866-604-3267**.

Decisions are made within three business days from the prior authorization request as long as information is available to complete the review. For members younger than 21, we allow up to seven days for any necessary additional information. Lack of supporting documentation may result in denied authorizations. For information about clinical documentation to support prior authorization requests, visit Link through UHCprovider.com > Tools & Resources > Policies, Protocols and Guides > Protocols > [Medical Records Requirement for Pre-Service](#).

PA Not Required

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

To check the status of a prior authorization request which you initiated:

1. Sign in to UHCprovider.com.
2. Click on Link.
3. Select “Notification/Prior Authorization Status” from the Notifications/Prior Authorizations drop-down menu on UHCprovider.com.

Unique Prior Authorization Requests

The following services involve unique avenues to request authorization.

- **Cardiology, Oncology and Radiology:** Information is posted to UHCprovider.com > [Notifications/Prior Authorization](#) (see separate listings for Cardiology, Oncology and Radiology). Prior authorization is required for injectable outpatient chemotherapy drugs when given for a cancer diagnosis.
- **Pharmacy:** Visit UHCCommunityPlan.com > For Health Care Professionals > Texas > [Pharmacy Program](#) for forms and information, or call the Pharmacy Help Desk at **800-310-6826** or fax at **866-940-7328**.
- **Home and Community-based Services:** The need for these services are determined within the person-centered planning process and based on medical necessity. Authorizations for these services are solely secured and authorized by the service coordinator as outlined in the member's plan of care. A change in member condition and services requires a new authorization.

Prior authorization requests for physical, occupational and speech therapy services must be sent to Optum before being delivered.

Optum Utilization Review/Clinical Submissions may be requested:

- Online: myoptumhealthphysicalhealth.com
- Mail: Optum, PO Box 212, Minneapolis, MN 55440-0212

Medical policies and coverage determination guidelines can be found at UHCCommunityPlan.com > For Health Care Professionals > Texas > Provider Information > UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines.

- Fax: **877-470-7613** (pediatric member submissions only)

- Our Clinical Practice Guidelines at UHCCommunityPlan.com > For Health Care Professionals > Texas > [Clinical Practice Guidelines](#)
- The Texas Medicaid Provider Procedures Manual at tmhp.com > Providers > Reference Material > [The Texas Medicaid Provider Procedures Manual](#)
- Covered CPT codes are located at UHCprovider.com > Tools & Resources > Policies, Protocols and Guides > [UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines](#)
- Reimbursement Policy considerations at UHCCommunityPlan.com > For Health Care Professionals > Texas > [Reimbursement Policies](#)

Continuity of Care Transition Plan

Members may receive services from their existing care provider, even if you are not contracted in our network. The authorization for Nov. 1, 2016 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.

Members New to our Health Plan

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 period.

Continuity of Care Exceptions:

Members who are pregnant and past the 24th week of pregnancy will be able to continue with their present care provider, even if the care provider is out-of-network, through the birth of the baby.

Members diagnosed with and receiving treatment for terminal illness may stay with their established care providers, even if they are out of network, for up to 12 months from the time the patient joins our health plan.

We will continue to cover medically necessity services for members who move outside of our service areas, even though the receiving care provider would be out of our network, through the end of that month of coverage.

For More Information

- MCG Care Guidelines® are followed for medical necessity criteria located at careguidelines.com

Chapter 10: Texas Health Steps

The Texas Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for 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 for STAR Kids is delivered in accordance with 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 dshs.texas.gov/thsteps > Provider Information (Medical).

The checkups and screenings listed on the periodicity schedule were developed according to the recommendations from the American Academy of Pediatrics (AAP) and in consultation with recognized authorities in pediatric preventive health. In Texas, the THSteps Periodicity Schedule may differ from the AAP periodicity schedule based on the scheduling of laboratory or other tests in federal EPSDT or state regulations. The THSteps periodicity schedule is the schedule to use for STAR Kids members.

Children of Migrant Farmworkers

Children of migrant farmworkers due for a Texas Health Steps medical checkup may 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 either an exception to periodicity or an accelerated service. It is considered a late checkup.

Texas Health Steps Medical Checkup Components

Every office visit is an opportunity for a comprehensive assessment. For more information, visit dshs.texas.gov/thsteps > Provider Information (Medical).

Documentation of Completed Texas Health Steps Components and Elements

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

Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. The medical record must contain documentation on all screening tools used for TB, growth and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation. THSteps checkups are made up of six primary components. Many of the primary components include individual elements. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. **Comprehensive health and developmental history** which includes nutrition screening, developmental and mental health screening and TB screening
 - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
2. **Comprehensive unclothed physical examination** which includes measurements; height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening
 - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (zero to two years), and blood pressure (three to 20 years). Vision and hearing screenings are also required components of the physical exam. It is important to 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 is responsible for administration of the immunization and are not to 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).
- 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

- Newborn Screening: 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 nine to 12 years of age and again 18 to 20 years of age
- HIV screening at 16 to 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 assist parents, caregivers and clients in understanding what to expect in terms of growth and development. Health education and counseling includes

healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.

6. **Dental referral** every six months until the parent or caregiver reports a dental home is established.

- Clients must be referred to establish a dental home beginning at six 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.

Use of the THSteps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Their use is optional, and recommended. 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.

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 three and four 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 UHCCCommunityPlan.com > For Health Care Professionals > Texas > Bulletins > [Provider Reference Guides](#) > Behavioral Health Toolkit for 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 1.75 AMA PRA Category 1 Credit(s)[™].

Newborn Blood Screenings

Newborn screens need to be sent to the DSHS Lab or a laboratory approved by the department under Section 33.016 of the Health and Safety Code. 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 THSteps medical checkup.

The initial newborn blood specimen is obtained 24 – 48 hours post birth.

When the newborn is between seven and 14 days old, obtain a second blood specimen and send to the DSHS Laboratory Services in Austin, TX

Newborn laboratory kits and information are available from the Texas Department of Health Services Laboratory visit dshs.texas.gov > Health Services > Family Health > Newborn Screening or call **512-776-7661** or fax 512-776-7672.

For more information, including specimen collection and submission procedures, visit Txhealthsteps.com > Find a Course > Newborn Screening. This course counts as 1.50 AMA PRA Category 1 Credit(s)[™].

Newborn Screening Out-of-range Results

Out-of-range results require prompt follow-up by you, parents, and DSHS.

ACT Sheets

You will receive an ACT Sheet specific to the disorder indicated by the screening which outlines your necessary actions. For example, when a screening indicates sickle cell anemia, the ACT Sheet instructions include educating the family and ordering a hemoglobin profile analysis.

For more information visit the National Center for Biotechnology > Learn > ncbi.nlm.nih.gov > Popular Resources > Read: Browse Titles > Enter in Search: Newborn Screening ACT Sheets and Confirmatory Algorithms.

Fact Sheets

Parents and caregivers need condition-specific FACT Sheets defining the condition, along with symptoms, treatment and other considerations. See the Screening, Technology and Research in Genetics (STAR-G) Project > newbornscreening.info > Take Me Directly to the Disorder Fact Sheets for Parents. See also newbornscreening.info > The Screening, Technology and Research in Genetics (STAR-G) Project > Spanish Website.

You may also download informational ACT and FACT Sheets from Resources for Healthcare Providers on the DSHS Newborn Screening website dshs.texas.gov/lab > Biochemistry and Genetics > Newborn Screening.

Hearing Screening

Hearing screenings are conducted for patients four, five, six, eight, 10, and 15 years old. It assesses potential hearing loss with a pure-tone audiometry threshold screening.

You may also administer a pure-tone audiometric threshold screening if you determine it medically necessary any time a parent or caregiver requests the screening.

Refer patients with high risk for hearing loss to a health care provider enrolled in Medicaid who specializes in pediatric audiology services.

School Testing

Texas school testing begins when a child is four years old by Sept. 1 and enrolled in a licensed child-care provider or a school, in kindergarten, 1st, 3rd, 5th and 7th grades.

You may satisfy the Texas Health Steps hearing screening with the documented audiometric results from a school hearing screening if the screen, included in the patient's medical record, was conducted within the prior 12 months.

Subjective Hearing Screen

You may offer a subjective hearing screening for a at any time it is indicated.

A subjective screening includes the following:

- Observation of the child

- A history obtained from a parent or guardian. See dshs.texas.gov > Health Services > Family Health > Texas Early Hearing Detection and Intervention > Parents > Hearing Checklist for Parents. Use of the checklist is optional.

Newborn Hearing Screening

The Texas Early Hearing Detection and Intervention (TEHDI) program is provided by the Texas Department of State Health Services (DSHS). The TEHDI program is designed to oversee newborn hearing screening, diagnostics and referral to early intervention services. The program is also responsible for reducing the rates of patient loss to follow-up and loss-to-documentation rate. The program identifies newborns with hearing loss so that they can gain the ability to achieve communication and social skills at the earliest possible stage, at least by six months of age.

For more information visit txhealthsteps.com > Find a Course > **Newborn Hearing Screening**. This course qualifies as 1.25 AMA PRA Category 1 Credit(s)[™].

Vision Screenings

Birth to Two Years

- Collect observations and a vision history from a caregiver
- Check for red reflex
- Check pupils reacting equally to light
- Screen for strabismus with the corneal light reflex test and cover test for children seven months and older

Three Years and Older: Subjective Screen:

A vision screen for patients at ages when an acuity screening is NOT applicable, this screening includes client history, physical assessment, and observation of the client for signs of vision difficulty.

Parents and caregivers are a valuable resource during a vision screening. Helpful questions to ask include:

- Does your child appear to see well?
- Do your child’s eyes cross or does one eye wander independently of the other?
- Does your child hold objects close to his or her eyes?
- Does your child squint?
- Do your child’s eyelids droop?

- Has your child had any injuries to the eyes?
- Do you have a family history of vision or eye problems?

Three Years and Older: Acuity Screen

- For children who don’t know their letters, use symbol tests such as LEA symbols with a match response card and enable a child to point to the displayed test optotype or symbol.
- School-age children who know their letters are best tested with a variant of traditional Sloan letter charts that use uniform logarithmic progression with equal numbers of block letters, known as Sloan letters, on each line.

Screeners

The Texas Department of State Health Services (DSHS) publishes a Vision Screening Manual that equips “each vision screener with the knowledge and skills necessary to make appropriate referrals for evaluation by a medical professional.”

Referrals

You must refer members with abnormal vision screening results to a network optometrist or ophthalmologist experienced with the pediatric population.

You must refer members who are at high-risk for eye abnormality to a network ophthalmologist experienced with the pediatric population.

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

Grade	Ages
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](#) training module is qualified as 1.50 AMA PRA Category 1 Credit(s)[™].

Blood Lead Levels

Blood Lead Levels blood screening tests are required for the ages noted in the Periodicity Schedule. Exceptions for testing outside the schedule may be:

- Medical necessity, for example if a member has a developmental delay, suspected abuse or other medical concerns or a member is in a high-risk environment, such as living with a sibling with elevated blood lead
- Required to meet state or federal exam requirements for Head Start, day care, foster care, or preadoption
- When needed before a dental procedure requiring general anesthesia

Perform initial testing using a venous or capillary specimen and either send to the DSHS lab or perform in your office by point-of-care testing. Point-of-care lead testing, when performed in your office, may be reimbursed separately. Perform confirmatory tests using a venous specimen. Send confirmatory specimens to the DSHS lab or send the client or specimen to the lab of your choice.

The Texas Childhood Lead Poisoning Prevention Program maintains a surveillance system of blood lead results on children younger than 15 years of age. Texas law requires reporting of blood lead tests, elevated and non-elevated, for children younger than 15 years of age. Report all blood lead tests to the Texas Child Lead Registry with the Texas State Health Services. Assessment and reporting forms are located at dshs.texas.gov/lead > [For Providers](#).

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

Early Childhood Intervention Referral for Developmental Delay

Early Childhood Intervention (ECI) is a state and federally funded program created with part C of the Individuals with Disabilities Education Act 2011. Its 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. Members may self-refer without a PCP referral to this program.

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 meeting eligibility criteria for ECI services within seven days of your suspicion. To refer, call the Client Inquiry Line at **800-628-5115** or send an email to dars.inquiries@dars.state.tx.us An easy-to-use physician referral form is located at the [Texas Pediatric Society](#) > ECI Referral Form.

For more information about federal laws on child find and referral procedures, visit 2001 US Code > Title 20 – Education > [Chapter 33 – Education of Individuals with Disabilities](#) > Subchapter III: Infants and Toddlers with Disabilities > Section 1435 - Requirements for statewide system (a)(5) and Chapter 34 Section 303.303 - Referral procedures.

For list of conditions, see ECI Qualifying Diagnosis Search at The Texas Department of Assistive and Rehabilitative Services at Help for Texans > Early Childhood Intervention > How to Make a Referral > [List of Medical Diagnoses](#).

Oral Health

1. Six to 35 Months

- a. Oral Evaluation (may be completed by a PCP when certified by the Texas Department of State Health Services [DSHS])
- b. Fluoride Varnish Application

As a THSteps Medical Home PCP, you need to be trained and certified by the Texas Department of State Health Services to provide and be reimbursed for this service.

The Oral Evaluation and Fluoride Varnish (OEFV) service takes place during a Texas Health Steps medical checkup and is billed as a separate service when provided by a trained and certified professional.

For information about becoming a certified OEFV provider, visit dshs.texas.gov/thsteps > Provider Information (Dental) > Link to information on Oral Evaluation and Fluoride Varnish in the Medical Home.

2. Refer to a Dental Home

- Six Months
To establish a dental home for dental checkups, refer to a Texas Health Steps dental provider at the six month medical checkup or earlier if trauma or early childhood caries are identified
- Five months and younger may be referred to a dental professional when there is a medical necessity for emergency dental services due to trauma or for early childhood caries.
- Seven months and older who do not yet have a Dental Home

Provide a referral at the child's next medical checkup visit. Confirm that a dental home has been established and is ongoing; if not, then continue to make referrals at subsequent medical checkup visits until the parent or guardian confirms a dental home has been established for the child.

How to Help a Member Find Dental Home

The dental plan member ID card lists the name and phone number of a member's Main Dental Home provider. The member can contact the dental plan to select a different Main Dental Home provider at any time. If the member selects a different Main Dental Home provider, the change is reflected immediately in the dental plan's system, and the member is mailed a new ID card within five business days.

If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can contact the Medicaid/CHIP Enrollment Broker's toll-free telephone number at **800-964-2777**.

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 six months or older must have a designated Main Dental Home.

Role of Main Dental Home

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

3. The Dental Component of Anticipatory Guidance

Dental anticipatory guidance to include the following topics, see also Anticipatory Guidance by age.

- The need for thorough daily oral hygiene practices
- Education in potential gingival manifestations for patients with diabetes and/or under long-term medication therapy
- THSteps eligibility qualifies the client for dental services
- Diet, nutrition, and food choices
- Fluoride needs
- Injury prevention
- Antimicrobials, medications, and oral health

Resource Patient Education Flip Charts

Texas Health Steps provides Take Time for Teeth flip charts in English (Order number: Dental 8-20) and Spanish (Order number: Dental 8-20S) about the dental health program. These flip charts can be ordered in small quantities or downloaded from the [Texas Health Steps Resource Catalog](https://dshs.texas.gov/thsteps). Go to dshs.texas.gov/thsteps > Texas Health Steps Resource Catalogue.

Non-emergency Dental Services

Medicaid Non-emergency Dental Services: UnitedHealthcare Community Plan is not responsible for paying for routine dental services provided to Medicaid members. These services are paid through Dental Managed Care Organizations.

UnitedHealthcare Community Plan is responsible for paying for treatment and devices for craniofacial anomalies and of OEFV provided as part of a Texas Health Steps medical checkup for members aged six through 35 months. Here are some billing guidelines:

- OEFV benefit includes (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance, and assistance with a Main Dental Home choice.
- OEFV is billed by Texas Health Steps care providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- UnitedHealthcare Community Plan is responsible for paying for treatment and devices for craniofacial anomalies.
- 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 on the Texas Health Steps dental component, including oral examinations, recognizing oral conditions and emergencies requiring a referral and healthy teeth, soft tissues and facial bones, visit thsteps.com > Find a Course > [Oral Health For Primary Care Providers](#). This course qualifies for 1.25 AMA PRA Category 1 Credit(s)TM.

For information about dental services (including Orthodontia), go to tmhp.com > providers > Medicaid Provider Manual > [The Texas Medicaid Provider Procedures Manual](#).

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. A prior authorization is not necessary and a PCP referral is not necessary. Members may self-refer. 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. You may find additional information at the Texas Administrative Code Title 25, Part 1, Chapter 97 Communicable Diseases.

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

Council members about their responsibility of risk reduction and partner notification if syphilis, chancroid, gonorrhea, chlamydia and/or HIV 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.

Tuberculosis

Administer the Tuberculosis (TB) Questionnaire annually 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. This is to be billed separate from the THSteps medical checkup.

Confirmed or suspected cases of 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 any investigation of member records. 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 effective treatment visit the World Wide Medical Association at wma.net > what we do > education > [Tuberculosis Refresher Course for Physicians](#).

Laboratory services

DSHS Laboratory Services in Austin, TX

The Texas Department of State Health Services (DSHS) Laboratory Services is required for specimens obtained as part of a THSteps medical checkup, including:

- Texas Health Steps newborn screens
- Blood lead testing
- Hemoglobin electrophoresis
- Total hemoglobin tests

State Laboratory Instructions

Requirements for submitting laboratory tests to DSHS Laboratory Services include:

- Specimen collection and handling criteria to encourage accurate results
- Standard Precautions and Personal Protective Barriers and prevention of puncture injuries
- Using the right instrument and technique for the right specimen
- Label the specimen clearly, complete the correct form, mark the right test on the form and mail or ship the same day as the specimen collection

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 > Reference Material > The Texas Medicaid Provider Procedures Manual, Children Services Handbook
- The Texas Department of State Health Services Laboratory at **888-963-7111**, ext. 6236 or go to for information regarding procedures and resources

Anticipatory Guidance

Texas Health Steps offers Anticipatory Guidance-A Guide for Providers at dshs.texas.gov/thsteps > Provider Information (Medical) > Anticipatory Guidance - A Guide for Providers, which includes guidance topics for every age group birth through 20 years. It mirrors anticipatory guidance topics included on the Texas Health Steps Child Health Record Forms at dshs.texas.gov/thsteps > Forms > Child Health Clinical Record Forms.

Immunizations

As the member's PCP medical home, your practice is the place for immunizations. Do not refer STAR Kids to the local health department for immunizations. Immunizations are to be given according to the Advisory Committee for Immunization Practices (ACIP) guidelines with a combo 4 in Texas.

The MCO must educate care providers on the Immunization Standard Requirements set forth in Chapter 161, Health and Safety Code standards in the ACIP Immunization Schedule for Medicaid Members.

Members must be immunized during the Texas Health Steps checkup according to the ACIP routine immunization schedule. For more information go to The Texas Constitution and Statutes at statutes.legi.state.tx.us > Health and Safety Code > Chapter 161 Public Health Provision > Section 161.004 Statewide Immunization of Children.

Flu

Neurologic and neurodevelopmental conditions, such as cerebral palsy, epilepsy, stroke, spinal cord conditions, and other brain conditions such as intellectual disability can put members at high-risk for influenza.

To learn more about the flu in children with neurologic or neurodevelopmental conditions and how to protect these children from illness, please visit cdc.gov > Diseases & Conditions > [Flu \(Influenza\)](#) > High Risk of Flu Complications.

Texas Vaccines for Children

Texas Vaccines for Children (TVFC) makes vaccines available to allow STAR Kids through age 18 to receive their immunizations in your office at no cost to you. For more information on becoming a care provider and to apply, visit dshs.texas.gov/immunize > Texas Vaccines for Children (TVFC) > Provider Manual, Forms, & Resources or call **800-252-9152**.

Young Adults

The Current Procedural Terminology (CPT) Code 90630, traditionally applicable for adults older than 21, can be used for STAR Kids 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.

Immunization Tool: ImmTrac

The ImmTrac registry provides online access to the Texas immunization registry. Enter or import client data using the electronic health record system. In addition to online ImmTrac access, an electronic data import process is available for entering data into a client encounter or Electronic Health Records (EHR) system. For more information, contact ImmTrac customer support at **800-348-9158**. Learn more about ImmTrac at dshs.texas.gov/immunize > ImmTrac – Texas Immunization Registry > ImmTrac Home.

Care providers without computers or internet access can report immunizations by using a Paper Reporting Form. The form is available by calling ImmTrac Customer Support at **800-348-9158**. For more information and 2.0 AMA PRA Category 1 Credit(s)[™], visit Txhealthsteps.com > Find a Course > Immunizations.

Teens

Several conditions allow teens to obtain medical treatment without parental consent. The DSHS Adolescent Health – A Guide for Professionals offers guidelines on health and health-related legal issues pertinent to the adolescent years. In addition, THSteps online care provider training offers adolescent health courses, which address screening, identifying

and treating high-risk behaviors, consent and confidentiality. Minors can consent to treatment by a care provider or dentist when the minor is:

- On active duty with armed services
- Age 16 and older and residing apart from parents or managing conservator or guardian and managing his or her own financial affairs
- Unmarried and pregnant and consenting to treatment related to pregnancy other than abortion
- Unmarried and the parent of a child, has actual custody of that child and consents for him or her
- Consenting to diagnosis or treatment of an infectious, contagious, or communicable disease reportable to DSHS
- Consenting to examination or treatment for chemical addiction, dependency, or any other condition directly related to chemical use
- Consenting for counseling for suicide prevention, chemical addiction or dependency, or for sexual, physical, or emotional abuse

A parent or guardian needs to accompany a STAR Kids member younger than 15 to a Texas Health Steps medical checkup.

Resources

Adolescent Health – A Guide for Professionals at dshs.texas.gov/thsteps > Provider Information (Medical) > Adolescent Health - A Guide for Providers

For Texas Health Steps Medicaid Policies and Procedures, go to tmhp.com > Providers > [Medicaid Provider Manual](#) > The Texas Medicaid Provider Procedures Manual.

Support Services

MEDICAL TRANSPORTATION PROGRAM (MTP) What is MTP?

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

What services are offered by MTP?

- Passes or tickets for transportation such as mass transit within and between cities or states, to include rail, bus, or commercial air
- Curb to curb service provided by taxi, wheelchair van, and other transportation vehicles
- Mileage reimbursement for a registered individual transportation participant (ITP) to a covered healthcare event. The ITP can be the responsible party, family member, friend, neighbor, or client.
- Meals and lodging allowance when treatment requires an overnight stay outside the county of residence
- Attendant services (a responsible adult who accompanies a minor or an attendant needed for mobility assistance or due to medical necessity, who accompanies the client to a healthcare service)
- Advanced funds to cover authorized transportation services prior to travel

Call MTP:

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

When a Patient Misses an Appointment

Please call the patient to reschedule and, if necessary, assist them in securing Medicaid transportation or refer them to their health plan, if they offer back up transportation. UnitedHealthcare Community Plan Customer Service is available at **888-887-9003**.

Complete online the Provider [Outreach Referral Service Form](#) at [SDHS.state.tx.gov/Texas Health Steps](http://SDHS.state.tx.gov/TexasHealthSteps) and fax to THSteps at **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

Comprehensive Care Program

Newborns covered by Medicaid have access to diagnosis and treatment services through Medicaid Children's Services, known as 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 patient's disability, physical or mental illness, or chronic condition, even if the service may not be available to other individuals enrolled in Medicaid in Texas. For more information go to TMHP > providers > [Medicaid Provider Manual](#).

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women serves children eligible for Medicaid from birth through 20 years with a health condition or health risk and high-risk pregnant women of all ages. Those patients receive assistance with accessing health-related resources and services, educational services, vocational services, psychosocial services, financial assistance, and transportation services from case managers. For more information go to TMHP > providers > [Medicaid Provider Manual](#).

Language Translation

Our members may need help communicating with you due to English speaking ability, an intellectual disability and/or hearing or visual aid needs. Consider reading grade level for members. For UnitedHealthcare Community Plan member translation services, please call Customer Service at **888-887-9003**.

Many of our members require special accommodations to access the services they need. See more at the American with Disabilities Act at ada.gov > Technical Assistance Materials > Title III: Materials Specifically for Business and non-profits > [Access to Medical Care for Individuals with Mobile Disabilities](#).

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 each and every member. You may request a copy to be sent to you of our UnitedHealthcare Community Plan Cultural Competency Plan by calling **888-887-9003**. For more information, including national standards and training, we encourage you to visit thinkculturalhealth.hhsc.gov.

Administrative and Billing

Timely Access to Care

As the PCP Medical Home, your Medicaid patients need to be able to access you 24-hours a day. For more information, visit TMHP.com > providers > [Provider Manual](#) > Texas Medicaid Provider Procedures Manual 2.4.4 Continuous Access and 2.4.4.1 24-hour Availability.

Texas Health Steps Medical Checkups

New Members

A member new to your care is due for a THSteps medical checkup as soon as practicable, but in no case later than:

- 14 days of enrollment for newborns
- 90 days of enrollment for all other eligible child members

Birth to 35 months: Members already in your care

A checkup is timely as indicated on the Periodicity Schedule.

36 months and older: Members already in your care

A checkup is due on the child's third birthday and is considered timely if it occurs within 364 calendar days after the child's birthday in a non-leap year or 365 days after the child's birthday in a leap year.

Checkups received before a child's birthday are not reportable as timely medical checkups, unless the child is a member of a migrant family leaving the area. THSteps fee-for-service policy creates this flexibility by allowing a total number of checkups at each age range.

For help with scheduling appointments for UnitedHealthcare Community Plan members, visit UHCommunityPlan.com > For Health Care Professionals > Texas > [Bulletins](#) > Provider Reference > Member Appointment Scheduling Assistance.

PCPs can also view care opportunity reporting through CommunityCare, our online care coordination tool. Go to UHCprovider.com and sign in to Link to access the application. Another option is through UHCprovider.com > sign into Link > Eligibility & Benefits > Gaps in Care Exist.

Chapter 11: Texas Health Steps Billing and Payments

Sick and Well Visit in the Same Day

We will reimburse a disease-related or problem-oriented service visit with a preventive medicine service visit. You must append it the claim with modifier 25 indicating you provided a significant, separately identifiable evaluation and management (E/M) service on the same day you provided the preventive medicine service.

This applies to services provided for the same member on the same day by a physician or other qualified health care professional in the same group or specialty with the same Federal Tax ID number.

For more information, visit tmhp.com > Providers > Provider Manual > [Texas Medicaid Provider Procedures Manual](#) > 5.4.1 Separate Identifiable Acute Care Evaluation and Management Visit.

Behavioral Health Screening

Texas Health Steps requires the use of a standardized developmental screening tool at ages nine, 18, and 24 months and at three and four years of age, or when a parent or care provider voices a concern. Medicaid reimburses the developmental screen separately from 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)

Use procedure code 99420 for mental health screenings when applying one of the validated, standardized mental health screening tools recognized by THSteps.

Submit procedure code 99420 on the same date of service by the same care provider as procedure code 99384, 99385, 99394, or 99395. Each member may have this service billed only once per lifetime.

You may be reimbursed separately for the Texas Health Steps medical checkup when you use one of the required screening tools.

The member medical record must include documentation identifying the tool used, the screening results, and any referrals.

You may use reimbursable screening tools more than once, but the adolescent mental health screening is separately reimbursable only once for each patient.

Oral Evaluation and Fluoride Varnish

OEFV in the Medical Home is a Texas Health Steps service for children six months through 35 months. Give OEFV during a Texas Health Steps medical checkup and bill as a separate service when provided by a trained and certified PCP. For Texas Health Steps, a PCP includes a primary care physician, physician assistant or an advanced practice nurse practitioner enrolled to serve THSteps.

Immunizations

You should bill the usual and customary fee, except for vaccines obtained from TVFC. You may not charge Medicaid or clients for the vaccine received from TVFC. You may charge a usual and customary fee not to exceed \$14.85 for vaccine administration when providing immunizations to a client eligible for TVFC. You are reimbursed the lesser of the billed amount or the maximum allowable fee.

Resources

- UHCprovider.com > For Health Care Professionals > Texas > Reference Guides
- Tmhp.com > Providers > THSteps for news, reference guides and the Texas Medicaid Provider Procedures Manual
- UHCCommunityPlan.com > For Health care Professionals > [Texas](#)
 - Manuals > STAR Kids Provider Administrative Manual (available in summer 2016)
 - Reimbursement Policies
 - Bulletins > Provider Alerts

Chapter 12: Early Childhood Intervention

Early Childhood Intervention (ECI) is a state and federally funded program created with part C of the Individuals with Disabilities Education Act 2011. The goal is to help ensure children with developmental delays are ready for preschool and kindergarten.

ECI is a comprehensive enrichment program for children younger than three years old who have a delay in the following developmental areas:

- Physical
- Cognitive
- Communication
- Social or emotional
- Adaptive

For more information, go to diagsearch.hhsc.state.tx.us.

Health conditions associated with developmental delays include:

- Conditions beginning in the perinatal period
- Congenital malformations, deformations and chromosomal abnormalities
- Mental, behavioral and neurodevelopmental disorders
- Injury, poisoning and other external causes

Referrals

ECI care providers are in the UnitedHealthcare Community Plan network that serve our members.

You do not need a diagnosis to refer a child. You do need parent or guardian's permission.

Refer a patient to ECI services within seven days of suspecting a developmental delay, or when the child meets eligibility criteria.

To refer a child to ECI services, call the Texas Department of Assistive and Rehabilitative Services at **800-628-5115** or send an email to dars.inquiries@dars.state.tx.us.

An easy-to-use physician referral form is located at the Texas Pediatric Society > [ECI](#) > Referral Form.

If a member was previously referred and found ineligible, a change in the child's development requires reconsideration and may result in another referral. Anyone, including a parent, can refer a child to ECI. A medical diagnosis or a confirmed developmental delay is not necessary to refer a child.

Eligibility Evaluation

ECI determines eligibility using the Battelle Developmental Inventory (BDI-2), an evaluation that may include medical and developmental history and interviews with parents and other primary caregivers and medical care providers.

A team of professionals, including a licensed professional of the healing arts, determines medical necessity for the inclusion of health and behavioral health covered services.

Services

Once a child is determined eligible for ECI services, the team creates an Individualized Family Services Plan (IFSP). The IFSP outlines ECI services and becomes part of the plan of care.

ECI services are outlined in the IFSP by amount, duration, scope and practice setting for delivery. The services outlined in the IFSP determine authorization for these medically needed services.

ECI services may include:

- Case management
- Audiology and vision
- Nursing and nutrition
- Physical, occupational, speech therapy
- Specialized skills training
- Family education and training
- Assistive technology

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

Case Management

ECI case management helps families access and receive the services, resources, and support they need for their child's development. Supports include helping developmentally delayed children and their families transition to special education services. For more information about ECI case management/ service coordination, visit [TMHP.com](#) > Provides > Reference Material > [Texas Medicaid Provider Procedures Manual](#) > Section 8 Carved Out Services.

When a child is eligible and receives ECI services, the ECI service provider, a UnitedHealthcare Community Plan network care provider qualified to handle ECI services, shares the IFSP with the member's coordinator and PCP through CommunityCare, our online coordination tool. You may access CommunityCare through Link at [UHCprovider.com](#).

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.

Children receiving ECI services are transferred to School Health and Related Services (SHARS) through the ECI program.

SHARS allows local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services. The student services are considered special education under Individuals with Disabilities Education Act (IDEA) and are documented in a student's Individualized Education Plan.

The following websites contain additional information about ECI:

- For more information about federal laws on child find and referral procedures, visit 2001 US Code > [Title 20 – Education](#) > Chapter 33 – Education of Individuals with Disabilities > Subchapter III: Infants and Toddlers with Disabilities > Section 1435 - Requirements for statewide system (a) (5) and Chapter 34 Section 303.303 - Referral procedures.
- For list of conditions, see [diagsearch.hhsc.state.tx.us](#).
- Our policies see [UHCCommunityPlan.com](#) > For Health Care Providers > TX > [Manuals](#) > STAR Kids Provider Manual

For more information about SHARS, visit [TMHP.com](#) > Provides > Reference Material > [Texas Medicaid Provider Procedures Manual](#) > Children's Services Handbook > Section 3 Texas School Health and Related Services (SHARS).

Chapter 13: Successful Transition to Adulthood

The STAR Kids program is for members ages 0-20. We support the unique transition needs of STAR Kids members younger than 10 years old. An example is a personal assistance coach to teach the member to perform activities of daily living such as self-dressing or feeding.

Beginning at age 15, a transition specialist joins the STAR Kids person-centered care coordination team. The role of the transition specialists is to counsel and educate members and others in their support network about considerations and resources for transitioning out of STAR Kids when they are age 21. Members have the opportunity for personal awareness as they and their families begin to think about the future.

Our multifaceted approach determines a member's personal development support:

- Personal attributes likes/dislikes
- Social, spiritual and cultural values
- Level of any intellectual ability
- Sensory accommodations
- Activities of daily living
- 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 when speaking. Use terms that help them understand their condition(s), medications, and what actions they should take for their care.
- **Building Skills and Supporting Community Living**
Our service coordinator will work with you for any necessary long-term services and supports (LTSS), such as habilitation, personal assistance to learn activities of daily living, or employment assistance to train for a job. See the LTSS section of this manual for more information about available LTSS services. See the Service Coordination section of this manual for more assessment information.

- **Transferring Care**

You may refer a STAR Kid to an adult PCP and any other appropriate specialists. We help find adult health care professionals that meet their needs. To assist in this transition, we will work with you to transfer records of care to the receiving PCP.

UnitedHealthcare may directly contact the receiving (adult) PCP on your behalf. We also encourage you to contact the receiving PCP. We reach out to the receiving PCP prior to the STAR Kid's first appointment. Overall, 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 service.

UnitedHealthcare Community Plan will help assure that 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 must be an employee of the MCO and wholly 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. 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 service.
2. Prior to the age of 10, the MCO must inform the member and the member's LAR regarding LTSS programs offered through the Department of Aging and Disability Services (DADS) and, if applicable, provide assistance in completing the information needed to apply. DADS LTSS programs include CLASS, DBMD, TxHmL, and HCS.
3. Beginning at age 15, the MCO must regularly update the ISP with transition goals.

4. Coordination with DARS to help identify future employment and employment training opportunities.
5. If desired by the member or the member's LAR, coordination with the member's school and Individual Education Plan (IEP) to help ensure consistency of goals.
6. Health and wellness education to assist the member with Self-Management.
7. Identification of other resources to assist the member, the member's LAR, and others in the member's support system to anticipate barriers and opportunities that will 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.

Chapter 14: Behavioral Health

Behavioral health, the assessment and treatment of mental health and substance use disorders, is integral in our holistic person-centered care for STAR Kids. Each STAR Kid member has unique behavioral health needs. One member may benefit from brief supportive counseling to address teen life experiences. Another member may be in a residential treatment facility for enduring mood disturbances with disruptive behaviors. Both members are monitored by their treating behavioral health specialist, family or caregiver, PCP, our service coordinator and any medical specialists for any change in condition that could affect their course of treatment. Every interaction a child has with the health care system is an opportunity to integrate behavioral health and wellness.

Comorbidity

STAR Kids and their families live with complex chronic conditions. These members often have multiple medical and behavioral comorbid conditions addressed in an integrated fashion. As unique individuals, STAR Kids may exhibit both medical and behavioral disorders. For example, a STAR Kid with:

- A developmental disorder may also have one or more of the following: anxiety, attention-deficit/hyperactivity disorder (ADHD) and mood disorder.
- Cerebral palsy may also have one or more of the following: mood disorder, adjustment disorder, and/or disruptive disorder.
- Fetal alcohol syndrome may have a comorbid anxiety disorder, mood disorder, ADHD, and/or intermittent explosive disorder.
- A seizure disorder may also have an anxiety, mood disorder and/or substance use disorder.

Screening

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 UHCCommunityPlan.com > For Health Care Providers > TX > Bulletins > [Provider Reference Guides](#) > Behavioral Health Toolkit for PCPs.

Referrals

To refer a member for further assessment and possible treatment for behavioral health and substance use disorders please call **877-855-3405** anytime. Members may access behavioral health services without a referral. Face-to-face assessment for acute and crisis situations are also available anytime.

Behavioral health care providers are expected to contact members who have missed appointments within 24 hours to reschedule the appointment.

From the time of the referral to the time of an appointment, waiting times will be no longer than:

- Initial outpatient behavioral health appointment -14 days
- Discharged from inpatient psychiatric facility – seven days
- Urgent care – within 24 hours
- Emergency - immediately upon presentation

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 abuse care providers, should refer members for physical assessment and treatment by calling Customer Service at **877-855-3405**. Members may also self-refer by calling Customer Service or by consulting our online provider directory at UHCCommunityPlan.com 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.

Specialized Service Coordination

The best member care includes care coordination. CommunityCare, our online care tool, 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, please visit Link at UHCprovider.com > CommunityCare.

The PCP and behavioral health specialist, including substance use disorder specialists, may choose other methods of communicating such a secure fax or encrypted email. We recommend a sharing of the initial finding and recommendation(s), as well as updated physical and behavioral health status reports. Medical record documentation is documented using the current classifications in the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. An informed release of information accompanies any exchange of member information.

We support integrated medical and behavioral health specialists practices in the same location, such as the same building, practice or general area. We believe it is the most efficient and clinically effective environment to care for a STAR Kid holistically.

Mental Health Condition Centers and Member Education

Please go to the Optum provider website at providerexpress.com. > USA > Clinical Resources > [Live and Work Well clinician center](#). This site provides information and assessment tools for several mental health and substance abuse diagnoses, symptoms, treatment options, prevention and other resources in one, easy-to-access area. They are available for PCP use as preliminary tools. Through this site, you can access some of the same clinical content, self-assessment tools and other resources Optum makes available to its members.

Service Focus on Resilience and Recovery

Our mental health and substance use services identify, address and treat underlying mental health illnesses including depression, bipolar disorder and post-traumatic stress disorder. These services promote the recovery of members experiencing mental illness and the resiliency for members with substance use disorders. For more information, visit providerexpress.com > Clinical Resources > Recovery & Resiliency Toolkit.

See also dshs.texas.gov > Mental Health and Substance Use > Texas Resilience and Recovery > Utilization Management (UM) Guidelines and Manual > [Texas Resilience and Recovery Utilization Management Guidelines- Child and Adolescent Services](#).

For a complete list of covered benefit services, see manual Appendix. Some Medicaid services are discussed in more detail here.

Rehabilitation and Case Management

The specialists providing these services are trained and certified to administer, the Adult Needs and Strengths Assessment (ANSA) for members between the ages of 0 and 18 and the Child and Adolescent Needs and Strengths (CANS) 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. See manual Appendix for more information about specialist qualifications.

RRUMG information located at: dshs.texas.gov > Mental Health and Substance Use > Texas Resilience and Recovery > Utilization Management (UM) 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 his or her 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.

This program is designed to support members experiencing chronic serious behavioral health conditions, in particular members who have:

Serious and persistent mental illness

Severe and persistent mental illness (SPMI) 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.

Serious emotional disturbances (SED)

Children who experience functional impairment and are diagnosed for more than a year with a serious disorder, such as autism spectrum disorder, schizophrenia, conduct disorder, affective disorder and disorders with serious medical implications, such as eating disorders, or persistent involvement with alcohol or drugs.

Mental Health Rehabilitative Services

These services offer training and provide support services that assist the member in maintaining independence in the home and community:

- Medication training and support
- Psychosocial rehabilitative services
- Skills training and development
- Crisis intervention for behavioral health emergencies
- Day program for acute needs
- Assessment and Support Team (CAST) provides crisis services for rapid, community-based screening.

- Child and Family Centered Services (CFCS) are for members who have not responded to treatment and who are at increased risk of inpatient admission or out-of-home placement. These services may include targeted case management along with in-home services.

Targeted Case Management (TCM)

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. Once a comprehensive care plan is created, the case manager works with the family and service coordinator to have those needs met.

Cognitive Rehabilitation Therapy

This service assists members with learning or relearning cognitive skills lost or altered as a result of damage to brain cells/chemistry. The need for cognitive rehabilitation is addressed in the member's person-centered care planning. This service can be delivered by psychologists, occupational therapists (OT) or speech and language pathologists (SLP).

Local Mental Health Authority

Community Mental Health Centers (CMHCs) also referred to as Local Mental Health Authorities (LMHAs) are individually owned and operated. Specific referral criteria differ, so for program and referral information visit texas.gov > Find Services > Mental Health Services Search. If a member becomes ineligible for Medicaid services, our service coordinator will make a referral to the LMHA for indigent mental health services.

Court-Ordered Hospitalization

Court-ordered inpatient admissions for members younger than 21 are not subject to admission and length 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.

We coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facility regarding admission and discharge planning, treatment objectives and projected length of stay for members committed by a court of law to the state psychiatric facility.

This type of court order is not covered if the member is given the choice of court-ordered admission vs. incarceration. Use Healthcare Common Procedure Coding System (HCPCS) modifier HZ, for procedure, supply and durable medical equipment (DME). It is funded by the Criminal Justice Agency, and is not a covered benefit. These services will continue to be covered under the criminal justice system. For more information, visit TMHP.com > Provides > Reference Material > [Texas Medicaid Provider Procedures Manual](#) > section 3.4.4 Freestanding and State Psychiatric Facilities and section 3.4.4.1 CCIP Services.

UnitedHealthcare Community Plan is responsible for authorized inpatient hospital services. This includes services provided in freestanding psychiatric facilities.

Members who receive inpatient psychiatric services will be scheduled for an outpatient follow-up appointment within seven days of discharge.

Administrative Notes

Optum clinical specialists provide the behavioral health and substance abuse services for UnitedHealthcare Community Plan STAR Kids members.

The Optum Network Manual for behavioral health specialists generally applies to all types of Optum contracted business. There are some sections where differences may apply based on state law. This addendum does not replace the Optum Network Manual for behavioral health specialists at providerexpress.com > United States > Clinical Resources > Manuals > [Optum Network Manual](#). Rather, it supplements the Optum Provider Network Manual by focusing on the core service array and procedures specific to the Texas STAR Kids membership.

Behavioral health specialists may reach a network manager by:

- Phone: **877-614-0484**
- Email: ohbs.centralregion@optum.com
- Fax: **866-388-1710**

Behavioral health benefits cover ADHD services, including reimbursement as necessary for ADHD medications and follow up medication monitoring for when ADHD medications are prescribed.

Resources

- See the Pharmacy section of this manual about the available 72-hour emergency medicine supply and other drug information.
- See the Behavioral Health Toolkit for PPCs available at UHCCommunityPlan.com > For Healthcare Professionals > Texas > Bulletins > [Provider Reference Guides](#) > PCP Behavioral Health Toolkit.
- For more information about Department of Aging and Disability Services (DADS) participating providers of case management or service coordination services for individuals who have intellectual or developmental disabilities, visit TMHP.com > Providers > Reference Material > [Texas Medicaid Provider Procedures Manual](#) > Behavioral Health, Rehabilitation and Case Management Services Handbook > Mental Health Rehabilitation, Mental Health Case Management, and Intellectual Disability Service Coordination > 5.2.1 Service Coordination and 5.2.2 Case Management.
- Behavioral health specialists are referred to providerexpress.com for guidelines, policies, and other helpful tools. See also providerexpress.com > United States > Clinical Resources > Manuals > [Optum Network Manual](#).

Chapter 15: Pharmacy

Children with special needs constitute a unique and vulnerable population that deserves special attention from their care providers who are pharmacists. You may be the best person to review the appropriateness of a medication regimen and to serve as the intermediary between other health care providers, the child and the caregiver. Be alert for polypharmacy; inappropriate drug selection, dosing, or treatment length; drug interactions; adverse drug reactions; poor adherence. Do not hesitate to act as an advocate for your patients. Counsel families and our young adult STAR Kids members and coordinate with their PCPs as you may offer a unique perspective.

Remember it is important to assess and treat each child and their family individually, because the response to drug therapy usually observed may not apply to children with special needs. See also the Culturally Considerate Care chapter and the Successful Transition to Adulthood chapter of this manual for special considerations in working with STAR Kids and their families. Please help us transition our young adult STAR Kids to a successful adulthood with special consideration and respect as they increasingly take responsibility for their own care.

Formulary and Preferred Drug List

The Texas Health and Human Services Commission Medicaid formulary for a list of covered drugs and preferred drug list is located at the Texas Vendor Drug txvendordrug.com > Formulary/PDL.

Epocrates Rx is a free service that provides instant access, via a hand-held or other online device, to information on the drugs covered by Texas Medicaid. Supported platforms include: Android, Palm, Blackberry, Windows Mobile, and iPhone. To register for the service, go to epocrates.com and sign up for free Epocrates Rx or search for and 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.

E-Prescribing

Electronic prescribing (e-prescribing or eRx) allows care providers who prescribe to electronically send an accurate, error-free and understandable prescription directly to a pharmacy. It is also the ability to verify eligibility and formulary data for a patient prior to and during the prescribing process. It also enables you to view medication history reports. This is enabled with the authorized exchange data from the pharmacy benefit manager, payer and the prescriber.

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.

Role of Pharmacy

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

Pharmacy providers have the following responsibilities:

- Adhere to the formulary
- Adhere to the preferred drug list (PDL)
- Coordinate with the prescribing physician
- Help ensure members receive all 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 tx.vendordrug.com > [Learn more about enrolling as a pharmacy provider](#).

DME Provider Enrollment

To participate as a Durable Medical Equipment (DME) provider, pharmacies complete the enrollment application available at tmhp.com. For assistance, call the Texas Medicaid and Healthcare Partnership (TMHP) Contact Center at **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 **866-574-6088** to amend your contract as a DME provider.

Comprehensive Care Program

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.

Pharmacies not enrolled with CCP should ask the member to call TMHP at **800-335-8957** to locate a CCP pharmacy.

Pharmacies that want to enroll should complete an application at tmhp.com. For assistance, call the TMHP Contact Center at **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 > [Learn more about enrolling in the Comprehensive Care Program or providing DME/supplies](#).

Prior Authorization

Some drugs on the formulary and preferred drug list may require prior authorization. Pharmacists receiving prescriptions for drugs which require a Prior Authorization (PA) should work with the prescribing physician to request the PA. You may also

call the Pharmacy Help Desk at **800-310-6826** with questions concerning the prior authorization process. The formulary identifies which drugs require a prior authorization. The formulary and preferred drug list is located at the Texas Vendor Drug Program at txvendordrug.com > Formulary/PDL.

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 Preferred Drug List or because they are subject to clinical edits.

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

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

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

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

Pharmacies may call our Pharmacy Help Desk at **877-305-8952** for questions or assistance with submission information for a 72-hour emergency prescription supply.

Care providers who prescribe may call the **800-310-6826** for more information about the 72-hour emergency prescription supply policy.

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 will 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 care provider who prescribes 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

STAR Kids members may receive up to a one-month supply (31 days) of a specific medication per prescription order or prescription refill. A medication may be reordered or refilled when the member uses 75% percent of the medication. If you submit a claim before the member uses 75% of the medication, based on the original day supply submitted on the claim, the claim will reject with a "refill too soon" message. Care providers who prescribe may call the Help Desk at **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 types of quantity limitation:

- Prescriptions for monthly quantities greater than the indicated limit require a prior authorization request
- Quantity limits based on efficient medication dosing
- The efficient medication-dosing program is designed to consolidate medication dosage to the most efficient daily quantity to increase adherence to therapy and promote the efficient use of health care dollars.
- The limits for the program are established based on Federal Drug Administration dosing approval and the availability of the total daily dose in the least amount of tablets or capsules daily. Quantity limits in the prescription claims processing system will limit the dispensing to consolidate dosing.
- The pharmacy claims processing system will prompt the pharmacist to request a new prescription order from the care provider who prescribes.

Additions to the quantity limitations program drug list will be made from time to time. You will be notified accordingly. As always, we recognize a number of patient-specific variables must be taken into consideration when drug therapy is prescribed and therefore overrides will be available through the medical exception (prior authorization) process. More information regarding drug specific quantity limits can be found at UHCCommunityPlan.com > For Healthcare Professionals > TX > [Pharmacy Program](#). Members not in the dual eligibility program can have unlimited prescriptions.

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

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

How This Affects You and Your Patients

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

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

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

Why We're Making the Change

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

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

Member Choice

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

Cancellation of Product Orders

If you offer service delivery for covered products, such as DME, home health supplies, or outpatient drugs or biological products, then 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 received directly from the prescribing care provider. 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 make sure you have a policy in place for allowing the member to do so.

Pharmacy Claims Processing

Please refer to the OptumRx Pharmacy Provider Manual and payer specification documents for complete claims submission requirements and guidelines, including NCPDP E1 Transaction to verify eligibility.

See also the Texas Uniform Managed Care Manual > Chapter 2.2 Pharmacy Claims Manual.

Pharmacy Payment

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

Log on to [OptumRx.com](https://www.optumrx.com) > [Health Care Professionals](#) > Pharmacy Electric Funds Transfer (EFT) to obtain detailed program information, a Pharmacy EFT Enrollment Form and an online EFT Trading Partner Information Request:

- Print, complete and return the enrollment form via fax or mail to:
Prescription Solutions
P.O. Box 6104
Cypress, CA 90630-6104
Fax: **800-732-7601**
- Click the online link to complete the EFT Trading Partner Information Request. Use this form to set up the 835 electronic remittance advice file transfer Refer to the OptumRx Pharmacy Manual for EFT Program requirements and enrollment information or call the Help Desk at **877-305-8952**.

STAR Kids may not be in foster care. However, PCPs treating a STAR Kid must contractually comply with the *Psychotropic Medication Utilization Parameters for Foster Children* found at [dshs.texas.gov](https://www.dshs.texas.gov) > mental health programs > Psychotropic Medication Utilization Parameters for Foster Children.

Additional Resources:

For more information about serving special needs children, please see the California Department of Developmental Services > Vendor/Provider > Publications & other Resources > [Care of Children & Adults with Developmental Disabilities](#).

Chapter 16: Long-Term Services and Supports (LTSS)

STAR Kids children and young adults have special needs which they and their families live with every day. Their needs are severe enough to qualify them for LTSS in their home or the community. LTSS means assistance with daily healthcare and living needs for individuals with a long-lasting illness or disability. Otherwise, they would need to reside in a residential facility, such as a nursing home, to receive the level of care necessary to meet their needs.

The services you provide are personal as they may involve you working directly with the member in his or her home. Help us make sure that our STAR Kids are treated with respect, courtesy and are always included in the decisions affecting them. Since you see them on a regular basis, this puts you in the unique position of knowing if they experience a change in their condition or circumstances, physical condition or eligibility. If you notice a change, please call the member's service coordinator directly or call the service coordination hotline at **877-352-7798**.

Role of LTSS Provider

Your role is to help enable a member to live in the community rather than a nursing home. Services are to be 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 tool which you can use to communicate member progress and any needs that you see to the service coordinator.

LTSS provider responsibilities include:

- Providing LTSS Services within seven days of the authorization
 - Communicating a member change in condition or circumstances to the service coordinator
 - Delivering person-centered care with respect and dignity
 - Observing Confidentiality
 - Contact us to verify member eligibility or authorization for services
 - Contact us to verify member eligibility or authorization of services
 - Electronic Visit Verification
- 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 E for additional care provider responsibilities.
 - Employment Assistance and Supported Employment providers have the responsibility to develop and update quarterly a plan for the delivery of employment assistance services.
 - Medicare/Medicaid Coordination: As when a member is dually eligible for Medicare services for health care and Medicaid services for support and community living. Be sure to work with the member's Medicare care providers.
 - Continuity of Care: As a member is transferring into or out of your care, communicate with a provider who may have been providing services before the member came into your services, such as an adult day health care or employment assistance provider or a care provider to whom you will refer care, such as a hospital.

As an LTSS provider program owner or administrator, you are required to train your staff regarding critical incident reporting, including abuse, neglect and exploitation. See the UnitedHealthcare Community Plan Reporting Critical Incident, Including Abuse, Neglect and Exploitation at UHCCommunityPlan.com > For Health Care Providers > Texas > [Provider Training](#).

Services

Medically Dependent Children Program (MDCP)

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:

- **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.
- **Minor Home Modification:** A structural change to a member's home, which is necessary due to his or her disability, to allow the member to continue living in the home

- **Adult Day Health Services:** Transition Assistance Services: This once-in-a-lifetime financial assistance help a member move back into the community after living in a nursing facility.

Consumer Directed Services (CDS) option

CDS is a service structure available to members or their families which allows them to directly employ and manage the attendants who provide their LTSS. They do not handle the financial aspects of being an employer. Members are required to use a financial management service for managing funds associated with the CDS option, such as managing timesheets and payroll. The following services can be received using CDS:

- **Respite services:** This is temporary relief for the primary caregiver from their caregiving role during times when the caregiver would normally provide care. Respite may occur in the member's home, assisted living facility or a nursing home.
- **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 so 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 activities of daily living (ADL), instrumental ADL or skilled tasks so he or she can attend child care, post high school education or to reside in independent living.

Flexible Family Support Services include personal care supports for basic ADL and instrumental ADL, skilled task and delegated skilled task supports. ADL are basic self-care tasks, including:

- bathing or showering
- dressing
- toileting
- transferring in or out of a bed or chair
- using the toilet (continence)
- feeding

Instrumental ADL are more complex self-care activities, including:

- preparing meals
- shopping for groceries or personal items
- housekeeping
- using the telephone

- taking medications
- managing money

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.

- **Employment Assistance:** A program that teaches workplace skills and helps members find paying jobs.
- **Supported employment:** A program that delivers assistance to sustain competitive employment for a person who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform work in a setting at which people without disabilities are employed.

STAR Kids who are not in the Medically Dependent Children Program (MDCP) may be eligible to receive the following LTSS:

- **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.
- **Day Activity and Health Services (DAHS)** Normally provided Monday through Friday, services include lunch and snacks; nursing and personal care; physical rehabilitation; social, educational and recreational activities; and transportation. This is available for waiver and non-waiver members.
- **Transition Assistance Services (TAS)** This is available for 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.

This includes but is not limited to payment of security deposits to lease an apartment, purchase of essential furnishings and moving expenses.

- **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

Care Planning and Service Authorization

A member's need for LTSS is determined by the service coordinator and the member's PCP. Through person-centered planning with the member and member's family a plan of care is created 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.

When a member experiences a change in condition or circumstances, their care plan may need to be adjusted to better meet their needs. Services may be added, changed or deleted from the care plan. A member or their family may initiate this change by calling their service coordinator directly or by calling the service coordinator hotline at **877-352-7798**.

Report any change in member condition or circumstances directly to their service coordinator or call the services coordination hotline at **877-352-7798**.

Before providing services, please make sure the service(s) you provide are authorized. Confirm that the authorization is for the correct member and includes the correct billing codes with modifiers and units. Visit UHCprovider.com > Notifications/Prior Authorizations > [Notification/Prior Authorization Status](#).

It is also your responsibility to be sure the child or young adult is a current member of UnitedHealthcare Community Plan by

going to log into Link at UHCprovider.com > UnitedHealthcare Eligibility & Benefits. See the eligibility section of this manual for more ways to determine eligibility or call customer service at **888-887-9003**.

For more information visit TMHP.com > Provides > Reference Material > [Texas Medicaid Provider Procedures Manual](#).

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 Code Title 40: Social Services and Assistance > Part 1: Department of Aging and Disability Services > Chapter 3: Responsibilities of States and Facilities > [Subchapter F: Restraints](#).

Abuse, Neglect and Exploitation

As a care provider, you are a mandated to report if you suspect a member 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 UHCCommunityPlan.com > For Health Care Providers > TX > [Provider Training](#).

Electronic Visit Verification (EVV)

LTSS providers are required to verify when they perform a service visit or accompany a member to an appointment. This involves being contracted with an EVV vendor. 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 **888-787-4107**. For more information visit UHCCommunityPlan.com > For Health Care Providers > TX > Bulletins > [Provider Reference Guides](#).

Attendant Compensation Rate Enhancement

Employees who work directly with members are eligible to receive added compensation for their services. The Texas Health and Human Services Commission (HHSC) announces the amount every year. Then the Texas Department of Aging and Disability Services (DADS) 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 hhsc.state.tx.us > Rate Analysis > Long-Term Services and Supports > [Long-term Services and Supports](#).

See also UHCCommunityPlan.com > For Healthcare Professionals > Texas > Provider Training > Additional Resource Materials > [Attendant Compensation Rate Enhancement](#) or contact your provide 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 your network contract during the enrollment period from October through November every year.

Complete and submit the Attendant Compensation Rate Enhancement Form located at UHCCommunityPlan.com > For Health Care Providers > Texas > [Provider Forms](#) > Attendant Compensation Rate Enhancement Request.

Submit your request and DADS contract number to your provider advocate directly or fax to **855-500-3356**. For questions you may call LTSS Provider Relations at **888-787-4107**.

Services in the Community Requirements

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 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.

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

It is the responsibility of the LTSS provider, the owner and employees who carry out the services, to help ensure a safe environment that:

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

See the Appendix: 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 that 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](https://www.Medicaid.gov) > Medicaid > [Home & Community-based Services](#).

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 **877-597-7799** or sending the complaint to:

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

See the Complaint and Appeals Section of this manual for more information.

Chapter 17: Value-added Services

We offer additional services at no cost to the member. These special services are selected to address member needs and experiences in an effort to help them live healthier lives.

Examples of Value-added Services include:

- Incentives for member annual wellness exams
- Extra help with non-emergency transportation
- Support for camp activities

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

Members are able to directly access most of these services by calling member Customer Service at **877-597-7799**. 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 year unless otherwise noted. These services may change in September and March of each year.

For the most current Value-added Services, please visit UHCCommunityPlan.com > For Healthcare Professionals > Texas > Bulletins > [Quick Reference Guides](#) > Value-added Services. You may also call Customer Service at **888-887-9003**.

Chapter 18: Quality

Clinical Practice Guidelines

We review and update the appropriateness of our adopted clinical practice guidelines in consideration of the needs of our members. We select the guidelines that most align with our expectations of care for our members.

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

Health Effectiveness Data and Information Set (HEDIS®)

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

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 [Centers for Medicare and Medicaid Services \(CMS\) External Quality Review protocols](#) which includes focus studies of these measures, such as behavioral health.

For more information visit HHSC.state.tx.us > HHSC Projects > Medicaid and CHIP Quality and Efficiency Improvement > [Health Plan Performance Improvement Projects](#).

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. We report the following dynamics on a regular basis, including for behavioral health services. Detailed information is located on the Uniform Managed Care Manual located at HHSC.state.tx.us > Medicaid > Managed Care > [Uniform Managed Care Manual](#).

Maintaining Medical Record Documentation Standards

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

Clinical data needs to be provided to UnitedHealthcare Community Plan consistent with state and federal law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the American Recovery and Reinvestment Act of 2009 (ARRA) and the Clinical Laboratory Improvement Act (CLIA). Evidence of data provenance will be provided upon request by us to satisfy National Committee for Quality Assurance (NCQA) audits or other compliance requirements. You need to help ensure that the data submitted is accurate and complete, meaning all clinical data will represent the information received from the ordering physician and all results from the rendering provider.

We verify that security measures, protocols, and practices are compliant with HIPAA regulation and our e-data usage, governance, and security policies, and will be used for the lawful receipt of clinical data from care providers. Any clinical data received will be used only as allowed under applicable state and federal law. We use this data to perform treatment, payment or health care operations – as defined in HIPAA – for members. Our operations may include the following:

- Compliance with state and federal data collection and reporting requirements, including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS), NCQA accreditation, Centers for Medicare & Medicaid Services' (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 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 authorized personnel. The companion guides are available at UHCprovider.com, numbers 11 and 12.

Protect Confidential Member Data

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

We require our associates and business associates to protect privacy and abide by privacy laws. If a member requests specific medical record information, we refer the member to you as the primary holder of the medical records. Applicable regulatory requirements need to be observed, including but not limited to those related to confidentiality of Medical information. Our care providers agree to comply in all relevant respects with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and associated regulations, including applicable state laws and regulations.

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 requests from DFPS, including providing medical records and recognition and appropriate referral to DFPS of abuse and neglect.

Chapter 19: In Case of Emergency

We provide for all medically necessary emergency services for inpatient, outpatient and ambulance transportation at network hospitals for our members 24 hours a day and seven days per week without prior authorization. Medically necessary emergency services do not require prior authorization. Medical records for emergency and inpatient services will be reviewed retrospectively for medical necessity by us prior to claims payment.

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

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

For behavioral health (mental health or substance use) emergencies, call the following numbers 24 hours a day/seven days a week call **877-855-3405**.

Potentially Preventable Episodes

A majority of our members live with chronic and complex medical conditions. We believe that the person-centered medical home maintained by their primary care provider is cornerstone to their medical management. We urge you to practice wellness by closing gaps in care per Effectiveness Data and Information Set HEDIS® and best practice guidelines. Our adopted best practice guidelines are posted to UHCCommunityPlan.com > For Health Care Providers > Texas > [Clinical Practice Guidelines](#).

Please help teach our members to:

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

Medicaid Emergency Dental Services

UnitedHealthcare Community Plan is responsible for emergency dental services provided to Medicaid Members in a hospital, free standing emergency room, or an ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) including but not limited to:

- treatment of a dislocated jaw, traumatic damage to teeth and supporting structures, removal of cysts
- treatment of oral abscess of tooth or gum origin
- treatment and devices for correction of craniofacial anomalies and drugs

Urgent Care

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

Please have a plan in place for those members for whom you can reasonably anticipate may require urgent care at some point due to their medical condition or make arrangements for a same or next day appointment availability with you.

Emergency service claims should be directed to [Link at UHCprovider.com](#).

Become a registered user at [UHCprovider.com](#) and OptumRx to allow for a protected exchange of information when billing. Claims may be submitted per member. Payer ID is 87726. Go to Claims and Payments > Claim Submission > Sign In.

Chapter 20: Fraud, Waste and Abuse

Everyone bears the responsibility to help ensure public monies are used with public trust. The STAR Kids Program is a Medicaid program. Anyone knowing of suspicious activities that have the potential for fraud, waste and abuse must respond by reporting such suspicions.

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

Abuse is defined as practices inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program; the reimbursement for services not medically necessary or fail to meet professionally recognized standards for health care; or a practice by a recipient that results in an unnecessary cost to the Medicaid program.

Waste is 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.

Laws to protect you for reporting include:

- The Federal False Claims Act prohibits any person from knowingly presenting or causing a false claim or fraudulent claim for a federal government payment. The Act permits any person who knows of fraud against the United States Government to file a lawsuit on behalf of the government against the person or business that committed the fraud.
- The Texas False Claims Act states that a person may also be liable if s/he knowingly presents a claim for payment under the Medicaid program for a product or service rendered by an unlicensed care provider or has not been approved by a healthcare practitioner. The civil penalty under the Act is greater than the Federal False Claims Act for unlawful acts that result in injury to an elderly person, a disabled person, or someone under the age of eighteen. The Act includes provisions to prevent employers from retaliating against employees who report their employer's false claims.

- The Whistleblower Act provides protection to an employee who is retaliated against by an employer because of the employee's participation. The protection is available to any employee who is fired, demoted, threatened, harassed or otherwise discriminated against by an employer because the employee investigates, files, or participates in a qui tam action. The protections includes reinstatement and damages for lost wages if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against.

You may use any of the following avenues to report the suspected fraud, waste, and/or abuse:

You can report online to the Texas Health and Human Services Commission Office of Inspector at oig.hhsc.state.tx.us > Report Fraud. You may also call the Texas HHSC OIG Hotline at **800-436-6184**.

You can also report to us by calling **888-887-9003** or mail to the following address:

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

Resource

See the Fraud Appendix of this manual for a message from the Texas Health and Human Services Commission (HSCC) for reporting fraud, waste or abuse by a provider or member.

Chapter 21: Billing and Payments

National Drug Code

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

Present on Admission (POA)

All hospitals and inpatient rehabilitation facilities must report 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](#).

New Patients

A new patient is a patient who has not received any professional services from you as a physician, or another physician of the same specialty who belongs to the same group practice, within the past three years. For more information, including a list of new patient Current Procedural Terminology (CPT®) codes, go to UHCCommunityPlan.com > For Health Care Professionals > Texas > Reimbursement Policy > [New Patient Visit Policy](#).

Sick and Well Visit in the Same Day

The following codes for annual physical and well child examinations are usually separate from disease-related diagnoses: Preventive Medicine Services CPT codes 99381-99387 or 99391-99397 with Healthcare Common Procedure

Coding System (HCPCS) code G0402. You may bill for an abnormality or a pre-existing problem that is addressed during the preventive visit, and significant elements of related Evaluation and Management (E/M) services are provided during the same visit. Bill with the preventive medicine service code and include the problem-oriented E/M service code(s). Add a “25” in cell 24d when using Centers for Medicare and Medicaid Services (CMS) form 1500. For specific codes and modifiers for Texas Health Steps medical checkups for STAR Kids members though age 20, go to dshs.texas.gov/thsteps.

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

Children of Migrant Farmworkers due for a THSteps medical checkup and planning to leave the area soon for work can receive their periodic checkup and screenings ahead of the schedule outlined on the THSteps periodicity schedule. 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 THSteps medical checkup which was previously missed per the outlined periodicity schedule is not considered an exception or an accelerated service. It is considered a late checkup.

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

Value-added Services

For Value-added Services special billing codes see the reference guide located at UHCCommunityPlan.com > For Health Care Professionals > TX > Bulletins > Quick Reference Guides > [Value-added Services](#).

Compound Medications

- **Reimbursement for Buy-and-Bill for Compounded 17P**

If you administer compounded, preservative-free 17P in your office through the buy-and-bill process, then for billing instructions see UHCCCommunityPlan.com > For Health Care Providers > TX > [Pharmacy](#).

- **Network Specialty Pharmacies May Bill UnitedHealthcare Community Plan for Makena**

You may obtain Makena from one of UnitedHealthcare Community Plan's network specialty pharmacies. For billing instructions see UHCCCommunityPlan.com > For Health Care Providers > TX > [Pharmacy](#).

Dental Sedation Services

Network facilities, anesthesiologists, and PCPs supporting a dentist who is providing dental services to a member under general anesthesia or intravenous (IV) sedation needs to submit a prior authorization for any services requiring an authorization that may be delivered in the course of this care. Reimbursement is per your provider contract.

You will be alerted to any services requiring prior authorization when your office checks member eligibility and benefits at UHCprovider.com. Log in to Link to access the application. Also, a complete list of services that require a prior authorization is posted to UHCCCommunityPlan.com > For Health Care Providers > Texas > [Prior Authorization](#). You may also call customer service at **888-887-9003**.

Long-Acting Reversible Contraception (LARC) Devices

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

limitations. If you participate in the 340B Drug Pricing Program, use Modifier U8 When Submitting Claims for 340B clinician-administered Drugs.

Long-Term Services and Supports (LTSS)

Facilities and agencies that provide Personal Care Services (PCS) and Medically Dependent Children Program (MDCP) STAR Kids attendant services must pay attendants at or above \$7.86 per hour.

Long-Term Care Daily Rates

Daily rate claims for services rendered in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ for IDD) or other related conditions should be submitted to the Texas Medicaid & Health Care Partnership at TMHP.com > Providers > [Go to TexMedConnect](#). See more at HHSC.tx.us. > Medicaid/CHIP > Managed Care > [Uniform Managed Care Manual](#) Attachment B-1, 8.1.2.

Durable Medical Equipment

Claims for custom Durable Medical Equipment (DME) or augmentative devices when the member changes Managed Care Organizations (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 Kid 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. See more at HHSC.tx.us.

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 (LTSS) Claims

UnitedHealthcare Community Plan is responsible for paying 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](https://www.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 [DADS.state.tx.us.com](https://dads.state.tx.us.com) > Forms & Handbooks > Handbooks.

Billing Members

Balance Billing

STAR Kids 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 healthcare benefit. STAR Kids members have no copayments for services.

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

You may bill the member only if:

- A specific service or item is provided at the member's request
- 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 miembro solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

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

- Any service that is not a benefit of Texas Medicaid (for example, cellular therapy)
- All services incurred on non-covered days because of eligibility or spell-of-illness limitation. Total member liability is determined by reviewing the itemized statement and identifying specific charges incurred on the non-covered days. Spell of illness limitations do not apply to medically necessary stays for Medicaid members who are 20 years of age and younger.
- The \$200,000 annual limit on inpatient services does not apply.
- 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.
- Services may be provided as a private pay patient. If the care provider accepts the member as a private pay patient, the care provider must advise members that 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 the care provider 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, the care provider 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. The care provider is allowed to bill the member as a private pay patient if retroactive eligibility is not granted. If the member becomes eligible retroactively, the member notifies the provider of the change in status. Ultimately, the care provider is responsible for filing timely Texas Medicaid claims. If the member becomes eligible, the care provider 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 above conditions may be subject to exclusion from Texas Medicaid.

Chapter 22: Claims Submissions

There are three methods to submit electronic outpatient claims and encounter data to UnitedHealthcare Community Plan: UHCprovider.com through a clearinghouse of your choice, and the Texas Medicaid & Healthcare Partnership online. Postmarked claims are also accepted. Claims and encounters must be submitted electronically or in a Centers for Medicare and Medicaid Services (CMS) form 1500 or claim form UB-04 using HHSC-approved Current Procedural Terminology (CPT®) codes. Claims for non-capitated services which are not a covered benefit of UnitedHealthcare Community Plan, but payable directly from HHSC, are to be submitted to tmhp.com. Claims and encounter data are to be submitted within 95 days from date of service. See the appendix of this manual for more information about claims forms.

Electronic Claims:

UHCprovider.com

Become a registered user at UHCprovider.com to allow for a protected exchange of information when billing. Claims may be submitted by member. Payer ID is 87726. Go to UHCprovider.com > Claims and Payments > Claim Submission.

Education and guidance for submitting claims to UnitedHealthcareOnline.com:

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

Claims Attachments

Texas UnitedHealthcare Community Plan care providers submitting claims electronically through Link at UHCprovider.com. You may also submit attachments. For instructions visit UHCprovider.com > Tools & Resources > UnitedHealthcare Community Plan Resources > Texas > Notification/Prior Authorization Submission & Status.

Claims Batching

Connectivity Director is our free direct connection allows you to batch claims submissions to UnitedHealthcare Community Plan. For more information visit UHCprovider.com. Ingenix EDI Solutions – All-Payer Gateway is a seamless, low-cost connection from UHCprovider.com to Ingenix, where you can upload and submit batch claim files, verify eligibility, check claim status, track claims, and make referrals and authorizations. For more information visit UHCprovider.com.

Claims Management

This feature allows you to search by claims detail, such as check number, edits, codes, line level and payment. You can also use additional reporting features to assist in account reconciliation, and status indicator for pre and post adjudication claims. Registered users can use Claims Management Application through Link at UHCprovider.com. For more information, go to UHCprovider.com > Tools & Resources > Training & Education.

A Clearinghouse

You may select an office software vendor or a clearinghouse through which to submit your claims to UHCprovider.com. The information is transferred from your terminal to a secure clearinghouse, where it is checked for errors and data omissions. If there is a problem with the submission, the information is immediately sent back to the office software vendor or clearinghouse and you for correction. This significantly reduces your wait time for claims that are denied due to errors or missing information. The office software vendor or clearinghouse then submits the corrected data to us, and you receive a report of the electronic activity, including confirmation of information. Office Ally is one clearing house that offers Medicaid billing free of

charge. For information about submitting claims through clearing houses, please visit Link at UHCprovider.com > Tools & Resources > EDI Education for Electronic Transactions.

Texas Medicaid & Healthcare Partnership

You may submit claims regardless of a member's managed care organization (MCO) membership to the Texas Medicaid & Healthcare Partnership (TMHP) and the claims will be forward to the appropriate MCO. TMHP will not forward the following claims, which need to be submitted directly to UnitedHealthcare Community Plan:

- Paper claim forms
- Electronic submissions for Pharmacy, LTSS

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 or the dental plan.

Mailed Claims

Claims need to be submitted on approved claim forms: In-patient claims need to be on a Center for Medicare and Medicaid Services (CMS) Institutional paper claim form CMS-1450 (UB-O4) form. All others should be on a CMS 1500 form. See the Claims Forms Appendix of this manual for additional information about completing these forms.

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

STAR Kids
PO Box 5290
Kingston, NY 12402-5290

Sub-contracted care provider networks such as dental and vision should submit claims directly to their contractor. Optum Behavioral Health should send their claims to:

P.O. Box 30660
Salt Lake City, Utah 84130-0760.

Deadlines

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

Clean Claims

We abide by the following the Texas Department of Aging and Disability Services (DADS) claims adjudication requirements for clean claims:

- You must be in good standing for the dates of service billed (i.e., not on vendor payment hold for any reason).
- The member must be:
 - Medicaid eligible for the dates of service billed
 - Medical necessity determination (prior authorization as applicable) must be in place for the dates of service billed

The 110-Day Rule

Medicaid is the payer of last resort. When a Medicaid member has other health insurance, including Medicare, you must bill the other insurance before submitting a STAR Kids 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 you sign and date that no disposition has been received from the TPR within 110 days of the date the claim was billed

Fee Schedules

Fee schedules are located at the Texas Medicaid & Healthcare Partnership at TMHP.com > Providers > [Fee Schedules](#).

The Attendant Compensation Rate Enhancement for qualifying care providers of LTSS 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.

Capitation Rates

Services that are included in a monthly capitation are included in the care provider network agreement for those providers for whom this is applicable. For additional information, speak with your physician advocate or call customer service at **888-887-9003** for contact information to assist you to reach your physician advocate.

Corrected Claims

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

Chapter 23: Payments

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 13 day will include accrual of interest payments according to the Texas Health and Human Services Commission.

Electronic Payments & Statements

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

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

For registration and additional information visit Link at UHCprovider.com > [Electronic Payments and Statements](#). Speak with your physician or provider advocate if you are unable to participate in EPS or call customer service at **888-887-9003** to obtain the contact information or your advocate.

Overpayments

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

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

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

In the event of our identification of an overpayment in the process of claims adjustments, we may recoup payments, but will always let you know.

Adjustments

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

Reconsiderations

You can electronically re-submit a claim reconsideration online saving time and money by providing seamless visibility for each reconsideration with receipt and real-time tracking capability. Visit Link at UHCprovider.com, click on Link, then select Claim Reconsideration from the Claims & Payments drop down menu on UHCprovider.com.

To mail a claim reconsideration, a form is available at UHCCommunityPlan.com > For Healthcare Professionals > Texas > [Provider Forms](#) > Claim Reconsideration Form.

Chapter 24: Complaints and Appeals

Care Provider Complaints to UnitedHealthcare Community Plan

As a care provider, you have the opportunity to complain to UnitedHealthcare Community Plan regarding any aspect of the health plan. Submit the complaint by completing the Provider Complaint/Grievance Form located at UHCCommunityPlan.com > For Health Care Professionals > TX > [Provider Forms](#) > Provider Complaint/Grievance Form. Customer service is available to provide assistance by calling **888-887-9003**.

You may mail written complaints to:

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

You may also submit an appeal online. Go to UHCprovider.com > Tools & Resources > UnitedHealthcare Community Plan Resources > [Texas](#) > Complaints.

You may also fax a completed fax form to **801-994-1082**.

UnitedHealthcare will give receipt notification within five business days. A written decision is rendered within 30 calendar days.

Please be sure to keep a copy of any faxed cover pages that you send or receive, in addition to any email in addition to a log of any telephone communications(s) related to/from UnitedHealthcare Community Plan that may be related to a complaint or appeal.

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.

You may mail written complaints to:

Texas Health and Human Services Commission
Provider Complaints
Health Plan Operations, H320
P. O. Box 85200
Austin, TX 78708

You may also email complaints to: HPM_complaints@hhsc.state.tx.

Care Provider Appeal Process to HHSC (related to claim recoupment due to member disenrollment)

You may appeal claim recoupment by submitting the following information to 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, DOS, and recoupment amount. The information should match the payment EOB.
- Completed clean claim. All paper claims must include both the valid NPI and TPI number. 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.

Mail appeal requests to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

Care Provider Appeals

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

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

- **Electronic**
You may electronically submit an appeal by visiting UHCCCommunityPlan.com > For Health Care Providers > Texas > Provider Forms > [Appeal Request Form](#).
- **Paper**
Mail a completed Appeal Request Form to the address shown on the form. Forms are located at UHCCCommunityPlan.com > For Health Care Professionals > Texas > Provider Forms > [Appeal Request Form: Editable](#).

UnitedHealthcare Community Plan processes claims/administrative appeals within 30 calendar days from receipt of the appeal. 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.

Specialty Review

For services you believe are medically necessary that we continue to deny, you have the option to request a specialty review. You must request a specialty review within 30 calendar days of the appeal decision date. We will send receipt notification within five days. We perform the review by an independent physician of the same or similar specialty. We complete the process within 15 calendar days after we receive the request.

Member Complaints

All members have the right to file a complaint regarding any aspect of the health plan. There is no time limitation for filing a complaint. 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 a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.

Members may file complaints verbally or through a letter. For verbal complaints, members may call Customer Service toll-free at **888-887-9003** to speak with a member advocate.

Members may mail a written complaint letter to:

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

The member should state the date of service, issue or concern. Members may have a representative file their complaint for them. To become a member representative, the member must send a letter designating another individual to act on his or her behalf. Members will receive a letter acknowledging their complaint within five business days of receipt of the complaint. Members will receive a letter detailing the results of the investigation into their complaint within 30 calendar days of receipt.

STAR Kids members may also file a complaint with the Texas Health and Human Services Commission (HHSC). Members may mail written complaints to:

Texas Health and Human Services Commission
Attn: Resolution Services
Health Plan Operations, H320
P. O. Box 85200
Austin, TX 78708-5200

STAR Kids members may also email complaints to:

HPM_complaints@hhsc.state.tx

Member Appeals

If we deny or limit a member's request for a covered service, the member will receive written notice of the action informing him/her of the denial and the reason the service was denied. Members may request an appeal for the denial of payment for services in whole or in part. To help ensure continuity of current authorized services, the member must file the appeal within 10 days following the mailing notice of action, or the intended effective date of the proposed action.

The member or the member's representative may file an appeal requesting another review of the case. Members may file appeals by contacting Customer Service at **888-887-9003** or through a written letter.

Members should mail the letter to the following address:

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

Member advocates are available to help a member file an appeal by calling **888-887-9003** and requesting to speak to a member advocate.

Oral appeals must be confirmed by a written, signed appeal by the member, or his or her representative, unless the member or representative requests an expedited resolution.

Members must file appeals within 60 calendar days of the denial notice date.

Members may continue to receive current authorized services, if his/her appeal is filed on or before the later of ten days following the MCO's mailing of the action notice, or the intended proposed action effective date and:

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- An authorized care provider ordered the services
- The original period covered by the original authorization has not expired
- The member requests an extension of benefits

If, at the member's request, we continue or reinstate the service while the appeal is pending, we will continue benefits until one of the following occurs:

- The member withdraws the appeal
- Ten calendar days pass after we mail the notice resolving the appeal. This is unless the member, within ten days, has requested a Fair Hearing with continuation of benefits until a Fair Hearing decision can be reached.
- A state Fair Hearing officer issues a hearing decision denying benefits
- The previously authorized service dates expired

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

Standard appeals

Once received, UnitedHealthcare will forward the member an acknowledgement letter within five business days of receipt. A physician of the same or a similar specialty will perform the review of member's appeal. Once completed, we send the member written correspondence containing the appeal decision.

Expedited Appeals

Expedited appeals may be requested when we determine (due to a member request or the care provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health.

As with standard appeals, an independent physician of the same or similar specialty will perform the review. A decision will be rendered within 72 hours for expedited appeals and one business day for expedited appeals related to ongoing emergencies and hospitalizations.

To request an expedited appeal and/or to get help to file an expedited appeal, call Customer Service at **888-887-9003**. Otherwise, you may request an expedited appeal in writing to:
UnitedHealthcare Community Plan
14141 Southwest Freeway, Ste. 800
Sugar Land, TX 77478

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

Upon review of the circumstances surrounding the expedited appeal, we will determine if the request meets the expedited appeal criteria. Should the request not meet the criteria, the appeal will be downgraded to a standard appeal. The member or the member's representative will receive written correspondence stating the appeal has been downgraded and will follow the standard appeal guidelines.

Extensions

Members or their representative may request up to an additional 14 calendar days for the appeal decision. Additionally, we can request up to 14 calendar days for an extension if able to show there is a need for additional information and the delay is in the member's best interest. Extensions do not apply to provider claims appeals.

State Fair Hearing Information

If a member of the health plan disagrees with the health plan's appeal decision, the member has the right to ask for a State Fair Hearing. 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. The member or the member's representative must ask for the State Fair Hearing of the challenged decision within 120 days on the health plan's appeal decision letter. 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 request a State Fair Hearing, the member or the member's representative should call **800-288-2160** or send a letter to the health plan at:

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

If the member requests a State Fair Hearing within 10 calendar days of the appeal decision letter from the health plan, they have the right to keep getting any service the health plan denied, 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.

If the member asks for a State Fair Hearing, the member will receive a packet of information with the date, time, and location of the hearing, as well as additional information. Most State Fair Hearings are 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 calendar days from the date the member asked for the hearing.

Chapter 25: Definition of Terms

1915(i) Home and Community Based Services- Adult Mental Health (HCBS-AMH)

HCBS-AMH 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.

Community Living Assistance and Support Services (CLASS) Waiver Program

The CLASS 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.

Deaf Blind with Multiple Disabilities (DBMD) Waiver Program

The DBMD 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.

Dual-Eligible

Medicaid recipients who are also eligible for Medicare.

Home and Community-based Services (HCBS) Waiver Program

The HCBS 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 four people live. The local authority provides service coordination.

Medical Dependent Children Program (MDCP) Waiver Program

The 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.

Texas Home Living (TxHmL) Waiver Program

The TxHmL 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.

Youth Empowerment Services (YES) Waiver Program

The YES waiver provides comprehensive home and community-based mental health services to youth between the ages of three 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.

Routine Care

Health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.

Urgent

Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

Emergency Care

A medical condition manifesting itself by acute symptoms of severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual in serious jeopardy
- serious impairment of bodily functions
- serious dysfunction of any bodily organ or part

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. Be prepared to give the member's Medicaid number and Social Security number; the medical care provider's name, address and phone; the date and time of the health care appointment; and the health care service being provided. For more information see the Medical Transportation Program Handbook of the Texas Medicaid Provider Procedures Manual at TMHP.com > Providers > [Texas Medicaid Provider Procedures Manual](#).

Appendices

- **A: Member Rights and Responsibilities**
- **B: STAR Kids Covered Services**
- **C: Fraud Information**
- **D: Reporting Abuse, Neglect or Exploitation (ANE) Medicaid Managed Care**
- **E: Community First Choice Provider Responsibilities**
- **F: Electronic Visit Verification**
- **G: Member Complaints and Appeals**
- **H: State Fair Hearing Information**
- **I: Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)**
- **J: Outpatient Services**
- **K: Facility and Inpatient Services**
- **L: Span of Coverage (Hospital) – Responsibility during a Continuous Inpatient Stay**
- **M: Medical Record Documentation Standards**
- **N: Sample Member ID Card**

Appendix A: Member 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 care 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 care 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 care provider in deciding what health care is best for you.
 - b. Say yes or no to the care recommended by your care provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:
 - a. Make a complaint to your health plan or to the state Medicaid program about your health care, your care provider, or your health plan.
 - b. Get a timely answer to your complaint.
 - c. Use the plan's appeal process and be told how to use it.
 - d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
 - a. Have telephone access to a medical professional 24 hours a day, seven days a week to get any emergency or urgent care you need.
 - b. Get medical care in a timely manner.
 - c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
 - d. Have interpreters, if needed, during appointments with your care 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.

Member Responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
 - a. Learn and understand your rights under the Medicaid program.
 - b. Ask questions if you do not understand your rights.
 - c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
 - a. Learn and follow your health plan's rules and Medicaid rules.
 - b. Choose your health plan and a primary care provider quickly.
 - c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
 - d. Keep your scheduled appointments.
 - e. Cancel appointments in advance when you cannot keep them.
 - f. Always contact your primary care provider first for your non-emergency medical needs.
 - g. Be sure you have approval from your primary care provider before going to a specialist.
 - h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
 - a. Tell your primary care provider about your health.
 - b. Talk to your care providers about your health care needs and ask questions about the different ways your health care problems can be treated.
 - c. Help your care 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 as a team 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 care providers and staff with respect.
 - e. Talk to your care provider about all of your medications.

Member's Right to Designate OB/GYN

UnitedHealthcare Community Plan DOES NOT LIMIT To Network.

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

ATTENTION FEMALE MEMBERS

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the member:

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

Appendix B: 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](#).

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.
 - Outpatient mental health services
 - Psychiatry 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 chemical dependency treatment facility in lieu of an acute care inpatient hospital setting, including
 - Detoxification services
 - Substance use disorder treatment (including room and board)
- 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 six 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
- 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).

- Personal Care Services - CFC - All qualified members may receive medically and functionally necessary Personal Assistance Services 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 Services - 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.

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 C: Fraud Information

Reporting Waste, Abuse, or Fraud by a Care Provider or a Client Medicaid Managed Care

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 ID.
- Using someone else's Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse or fraud, choose one of the following:

Call the OIG Hotline at **800-436-6184**.

Waste, Abuse, and Fraud" to complete the online form; or

- You can report directly to your health plan:
UnitedHealthcare Community Plan
Attn: Compliance
14141 Southwest Freeway, Ste. 800,
Sugar Land, TX 77478
Or call **888-887-9003**

To report waste, abuse or fraud, gather as much information as possible.

When reporting about a care provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the care provider and facility, if you have it
- Type of care 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 D: Reporting Abuse, Neglect or Exploitation (ANE) Medicaid Managed Care

Report suspected Abuse, Neglect, and Exploitation:

MCOs and care providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and care provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and care provider requirements continue to apply.

Report to the Department of Aging and Disability Services (DADS) 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 DADS;
- Adult day care centers; or
- Licensed adult foster care providers Contact DADS at **800-647-7418**.

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

- An adult with a disability or child residing in or receiving services from one of the following care providers or their contractors:
 - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
 - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
 - a managed care organization;
 - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at **800-252-5400** or, in non-emergency situations, online at txabusehotline.org

Report to Local Law Enforcement:

- If a care provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, 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, DADS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Appendix E: Community First Choice Care Provider Responsibilities

- The CFC services must be delivered in accordance with the member's service plan.
- The program provider must maintain 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).
- The program provider must help ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies, and any other needs specific to the member that are required to help ensure the member's health, safety, and welfare. The program provider must maintain documentation of this training in the member's record.
- The program provider must help ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect, and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation). The program provider must also provide the member/LAR with information on how to report acts or suspected acts of abuse, neglect, and exploitation and the DFPS hotline **(800-647-7418)**.
- The program provider must address any complaints received from a member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation.
- The program provider must help ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED or competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must help ensure that the provider of ERS has the appropriate licensure.
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must 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 F: Electronic Visit Verification

What is EVV?

- Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies service visits and documents the precise time service provision begins and ends.
- EVV is a method by which a person, including but not limited to a personal care attendant, who enters a STAR Kids member's home to provide a service will document their arrival time, tasks and departure time using a telephonic or computer-based application system. This visit information will be recorded and used as an electronic version of a paper time sheet for an attendant and used to support claims to the MCO for targeted EVV services.

Do care providers have a choice of EVV vendors?

- Care provider selection of EVV vendor
Care providers have a choice of EVV vendors. During the contracting and credentialing process with an MCO, a copy of the Provider Electronic Visit Verification Vendor System Selection form should be provided in the application packet. Forms are located at UHCCommunityPlan.com > Texas > For Health Care Professionals > Texas > [Provider Forms](#).
- Care provider EVV default process for non-selection
- Mandated care providers that do not make an EVV vendor selection or who do not implement use of their selected vendor, are subject to contract actions and are defaulted to a selected vendor by HHSC. The care provider will receive a default letter detailing out the vendor that they have been defaulted to and when they are required to be implemented with the vendor.
- When can a care provider change EVV vendors?
 - A care provider may change EVV vendors 120 calendar days after the submission request by completing the Medicaid EVV.
 - A care provider may change EVV vendors twice in the life of their contract with the MCO.

Can a care provider elect not to use EVV?

EVV will be required to document delivery of the following STAR Kids services delivered through the agency model:

- Personal care services (PCS)
- Community First Choice attendant care and habilitation (PAS/HAB)
- MDCP in-home respite
- MDCP flexible family support services

Is EVV required for CDS employers?

If you are a CDS Employer, there are three EVV options:

- Phone and Computer (Full Participation): The telephone portion of EVV will be used by your Consumer Directed Services (CDS) Employee(s) and you will use the computer portion of the system to perform visit maintenance.
- Phone Only (Partial Participation): This option is available to CDS Employers who can participate in EVV, but may need some assistance from the FMSA with visit maintenance. You will use a paper time sheet to document service delivery. Your CDS Employee will call-in when they start work and call-out when they end work. Your FMSA will perform visit maintenance to make the EVV system match your paper time sheet.
- No EVV Participation: If you do not have access to a computer, assistive devices, or other supports, or you do not feel you can fully participate in EVV, or do not wish to participate in EVV, you may choose to use a paper time sheet to document service delivery.

How do care providers with assistive technology (ADA) needs use EVV?

If you use assistive technology and need to discuss accommodations related to the EVV system or materials, please contact the HHSC-approved EVV vendors.

DataLogic (Vesta) Software, Inc.

Contact Information:

Email: Sales & Training info@vestaevv.com

Phone: **888-880-2400**

Website: vestaevv.com

MEDsys Software Solutions, LLC

Contact Information:

Email: info@medsyshcs.com

Phone: Support: **877-698-9392**; Option 1

Sales: **877-698-9392**; Option 2

Website: medsyshcs.com

EVV use of small alternative device (SAD) process and required SAD forms

- The SAD process is found at: dads.state.tx.us/evv/docs/ProviderAlternativeDeviceNotification_3-2015.pdf
- SAD forms can be found at UHCCommunityPlan.com > For Health Care Professionals > Texas > [Bulletins](#) > EVV.
- Where do I submit the SAD agreement/order form?
 - The form is submitted to the provider-selected EVV vendor.
 - a) DataLogic - email for to: tokens@vestaevv.com or send secure eFax to **956-290-8728**
 - b) MEDsys - email form to: tokens@medsyshcs.com or send secure fax to **888-521-0692**
- Equipment provided by an EVV contractor to a provider, if applicable, must be returned in good condition.

EVV Compliance

All care providers providing the mandated services must use the EVV system and must maintain compliance with the following requirements:

- The provider must enter member information, provider information, and service schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual system.
- The provider must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.
- 90% adherence to Provider Compliance Plan
 - **HHSC EVV Initiative Provider Compliance Plan** – A set of requirements that establish a standard for EVV usage that must be adhered to by provider agencies under the HHSC EVV initiative.
 - Provider agencies must achieve and maintain an HHSC EVV Initiative Provider Compliance Plan Score of at least 90% per Review Period. Reason codes must be used each time a change is made to an EVV visit record in the EVV System.

Care provider agencies must complete any and all required visit maintenance in the EVV system within 60 days of the visit (date of service). Visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. Care provider agencies must submit claims in accordance with their contracted entity claim submission policy. No visit maintenance will be allowed more than 60 days after the date of service and before claims submission, unless an exception is granted.

- The HHSC Compliance Plan is located at: dads.state.tx.us/evv/docs/hhsc-provider-compliance-plan.pdf
- The MCO Compliance Plan UHCCommunityPlan.com > For Health Care Professionals > Texas > [Bulletins](#) > EVV.

- The care provider agency must help ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
- The care provider agency must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
- Care providers should notify the appropriate MCO, or HHSC, within 48 hours of any ongoing issues with EVV vendors or issues with EVV Systems.
- The network care provider must submit any corrective action plan the MCO requires within 10 calendar days of receipt of request.
- MCO care provider agencies may be subject to termination from the MCO network for failure to submit a requested corrective action plan in a timely manner.

All care providers, with the exception of Consumer-Directed Services (CDS) employers, providing the mandated services must use the EVV system and must maintain compliance.

The HHSC Compliance Plan, including compliance standards and EVV guidelines as they relate to claims, training, reports, equipment and corrective action plans, are located at: dads.state.tx.us/evv/docs/hhsc-provider-compliance-plan.pdf (excludes Consumer-Directed Services (SDS).

- The MCO Compliance Plan is located at UHCCommunityPlan.com > For Health Care Professionals > Texas > [Bulletins](#) > EVV.

Will there be a cost to the care provider for the access and use of the selected EVV vendor system?

There is no cost to the care provider associated with the use of EVV.

Do Home Health Services care providers have EVV responsibilities?

- [Provider Compliance Plan](#) (excluding Consumer-Directed Services [CDS])
- Non-CDS EVV providers must adhere to the Provider Compliance plan found at UHCCommunityPlan.com > For Health Care Professionals > Texas > [Bulletins](#) > EVV or by contacting UnitedHealthcare Community Plan **888-787-4107** for the most current version.
- Use of reason codes
Any change to the prior authorized services and the actual service delivery (for example, a missed visit) need to be justified with a reason code. To review the list of reason codes, visit UHCCommunityPlan.com > For Health Care Providers > Texas > [Bulletins](#) > [Electronic Visit Verification](#).

Will training be offered to care providers?

Training (including for CDS employers) is available online at UHCCommunityPlan.com > For Health Care Professionals > Texas > Provider Training. You may also consult your provider advocate directly for personal training. Community First Choice providers are including in these training opportunities.

Will claim payment be affected by the use of EVV?

Care providers must adhere to EVV guidelines in the provider compliance plan when submitting a claim. Claims must be submitted within 95 calendar days of the EVV Visit.

What if I need Assistance?

You should contact your provider advocate directly for assistance with EVV issues or call LTSS Customer Service to help you reach your provider advocate **888-787-4107**.

What if I have a complaint related to the EVV Process?

To submit a complaint to UnitedHealthcare Community Plan, [How to File a Complaint](#).

To file a complaint, go to UHCCommunityPlan.com > For Health Care Professionals > Texas > [Forms](#), complete and send the Provider Complaint/Grievance Form to:

UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131-0364

You may also submit a complaint to the Texas Health and Human Services Commission (HHSC) Provider Resolution Services.

Written complaints may be mailed to:

Texas Health and Human Services Commission
Provider Complaints
Health Plan Operations, H320
P.O. Box 85200
Austin, Texas 78708

Or, Email to: HPM_complaints@hhsc.state.txs

Appendix G: 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 **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 toll-free **866-566-8989**. If you would like to make your complaint in writing, please send it to the following address:

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

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

Who Do I Call?

Call UnitedHealthcare Member Services for help **888-887-9003**.

Where Can I Mail a Complaint?

For written complaints please send your letter to UnitedHealthcare Community Plan. You must state your name, your member ID, your telephone number and address, and the reason for your complaint. Please send your letter to:

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

Can Someone Help Me File a Complaint?

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

What Are the Requirements and Timeframes for Filing a Complaint?

There is no time limit on filing a complaint with UnitedHealthcare Community Plan. UnitedHealthcare Community Plan will send you a letter telling you what we did about your complaint.

How Long Will It Take to Process My Complaint?

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

Can Someone From UnitedHealthcare Community Plan Help Me File a Complaint?

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

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. Then we will send you a letter and ask you or someone acting on your behalf to sign a form so we can have it in writing.

How Will I Find Out if Services Are Denied?

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

What Are the Timeframes for the Appeal Process?

UnitedHealthcare Community Plan has up to 30 calendar days to decide if your request for care is medically needed and covered. We will send you a letter of our decision within 30 days. In some cases you have the right to a decision within one business day. 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 one working day from the time we get the information and request.

What Happens if UnitedHealthcare Community Plan Denies the Request for an Expedited Appeal?

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

Who Can Help Me File an Expedited Appeal?

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

Appendix H: State Fair Hearing Information

Can a Member Ask for a State Fair Hearing?

If a member of the health plan disagrees with the health plan's appeal decision, the member has the right to ask for a 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 provider may be the member's representative. The member or the member's representative must ask for the fair hearing within 120 days of the date on the health plan's letter that tells of the appeal decision being challenged. If the member does not ask for the fair hearing within 120 days, the member may lose their right to a fair hearing. To ask for a fair hearing, the member or the member's representative should either send a letter to the health plan at:

14141 Southwest Freeway, Suite 800
Sugar Land, TX 77478
Or call **888-887-9003**.

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

If the member asks for a fair hearing, the member will get a packet of information letting the member know the date, time, and location of the hearing. Most fair hearings are held by telephone. At that time, the member or the member's representative can tell why the member needs the service the health plan denied.

HHSC will give the member a final decision within 90 days from the date the member asked for the hearing.

Appendix I: Care Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

You may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that you are requesting an exception.
- **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.** All paper claims must include both the valid NPI and TPI number. Note: 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.

Mail appeal requests to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

Appendix J: Claims Forms

Outpatient services use an approved Center for Medicare and Medicaid (CMS) form 1500. Download this form by visiting [CMS.gov](https://www.cms.gov) > Medicare > CMS Forms > CMS Forms List > [Filter On: CMS 1500](#). Any missing or invalid data will result in a claim not being paid. Claim information must match referral information.

For help filling out the CMS 1500 form, go to [CMS.gov](https://www.cms.gov) > Outreach & Education > Medicare > Medicare Learning Network (MLN Homepage) > Publications > Filter On: 1500 > [Medicare Billing: 837P and Form CMS-1500](#).

Institutional providers, such as hospitals, skilled nursing facilities, (SNFs), home health agencies (HHAs) and federally qualified health centers (FQHCs) use an approved CMS 1450 form. This is called the UB-04. Download this form by visiting [CMS.gov](https://www.cms.gov) > Medicare > CMS Forms > CMS Forms List > [Filter On: CMS 1450](#).

For help filling out the CMS 1450 form, go to [CMS.gov](https://www.cms.gov) > Outreach & Education > Medicare > Medicare Learning Network (MLN Homepage) > Publications > Filter On: 1450 > [Medicare Billing: 837I and Form CMS-1450](#).

Appendix K: Facility and Inpatient Services

Facility and Inpatient Services utilize an approved Center for Medicare and Medicaid Services (CMS) UB-04 Form available at CMS (Home > Medicare > CMS Forms > CMS Forms Items > Details for title: CMS 1450). The below list contains the minimum amount of information required to process a claim on a CMS UB-04 Form. Any missing/invalid data will result in the claim not being paid. Claim information must match referral information. Please see the [Uniform Billing \(UB-04\) Implementation guidelines](#).

Appendix L: Medical Record Documentation Standards

All participating primary care UnitedHealthcare Community and State practitioners are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care. Participating practitioners are subject to UnitedHealthcare Community and State's periodic quality review of medical records to determine compliance to the following medical record keeping requirements.

Medical Record Documentation Standards

All participating primary care providers are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care. Participating practitioners are subject to UnitedHealthcare Community and State's periodic quality review of medical records to determine compliance to the following medical record keeping requirements.

Confidentiality of Records

Office policies and procedures exist for the following:

- Confidentiality of the patient medical record
- Initial and periodic training of office staff concerning medical record confidentiality
- Release of information
- Record retention
- Availability of medical record when housed in a different office location (as applicable)

Record Organization

An office policy exists that addresses a process to respond to and provide medical records upon request of patients to include a provision to provide copies within 48 hours in urgent situations.

Medical records are maintained in a current, detailed, organized and comprehensive manner. Organization should include evidence of:

- Identifiable order to the chart assembly
- Papers are fastened in the chart
- Each patient has a separate medical record

Medical records are:

- Filed in a manner for easy retrieval
- Readily available to the treating practitioner where the member generally receives care
- Promptly sent to specialty providers upon patient request and within 48 hours in urgent situations. Medical records are:
 - Stored in a manner that helps ensure protection of confidentiality
 - Released only to entities as designated consistent with federal requirements.
 - Kept in a secure area accessible only to authorized personnel

Procedural Elements

- **Medical records are legible***
- All entries are signed and dated
- Patient name/identification number is located on each page of the record.
- Linguistic or cultural needs are documented as appropriate
- Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the patient's first language is something other than English
- Mechanism for monitoring and handling missed appointments is evident
- An executed advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information regarding advance directives.
- **A problem list includes a list of all significant illnesses and active medical conditions***
- **A medication list includes prescribed and over the counter medications and is reviewed annually***
- **Documentation of the presence or absence of allergies or adverse reactions is clearly documented ***
- **History**
- An initial history (for patients seen three or more times) and physical is present to include:
 - **Medical and surgical history***
 - A family history that minimally includes pertinent medical history of parents and/or siblings
 - A social history that minimally includes pertinent information such as occupation, living situations, education, smoking, ETOH, and/or substance abuse use/history beginning at age 11
 - Current and history of immunizations of children, adolescents and adults
- Screenings of/for:
 - Recommended preventive health screenings/tests
 - Depression
 - High risk behaviors such as drug, alcohol and tobacco use; and if present, advise to quit
 - Medicare patients for functional status assessment and pain
 - Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Problem Evaluation and Management

Documentation for each visit includes:

- Appropriate vital signs (Measurement of height, weight, and BMI annually)
 - Chief complaint*
 - Physical assessment*
 - Diagnosis*
 - Treatment plan*
- Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines
- Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)
- Clinical decisions and safety support tools are in place to help ensure evidence based care, such as flow sheets
- Treatment plans are consistent with evidence-based care and with findings/diagnosis
 - Timeframe for follow-up visit as appropriate
 - Appropriate use of referrals/consults, studies, tests
 - X-rays, labs consultation reports are included in the medical record with evidence of practitioner review
 - There is evidence of practitioner follow-up of abnormal results
 - Unresolved issues from a previous visit are followed up on the subsequent visit
- There is evidence of coordination with behavioral health care provider
- Education, including lifestyle counseling is documented
- Patient input and/or understanding of treatment plan and options is documented
- Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies, as ordered by the practitioner are documented.

* Critical element

Appendix M: Sample Member ID Card

To see a sample STAR Kids UnitedHealthcare Community Plan Member ID card, go to UHCCommunityPlan.com > For Health Care Professionals > Texas > Reference Guides.

Appendix N: Adoption Assistance and Permanency Care Assistance

The Adoption Assistance Program is for members who have been adopted. The Permanency Care Assistance Program is for members that live with a foster family that has committed to be a permanent placement. Members in both these programs are considered Members with Special Health Care Needs (MSHCN) and are in our STAR Kids program. Other MSHCN STAR members include farmworker children, who have one or more patents and who travel for seasonal harvesting work. Children in the Early Childhood Intervention (ECI) program are also MSHCN.

We provide Service Management to MSHCN, including the development of a service plan and ensuring access to treatment by a multidisciplinary team when necessary. We include primary care and specialty care providers who are experienced in patients with MSHCN. Sometimes, it makes sense to have a standing referral to a specialty care provider so that the member has ready access when he or she needs it.

We explore the availability to community resources to help support a holistic approach to meeting member needs and encouraging the attainment of their aspirations. Samples include:

1. Local school districts (Special Education)
2. Health and Human Services Medical Transportation Program (MTP)
3. Civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy

Service Coordination

Service management is an included benefit for members in the Adoption Assistance and Permanency Care Assistance programs. Our service coordinators work with a care planning team to develop a person-centered service plan that centers around the member and their family or legally authorize representative (LAS). The team includes a primary care provider, specialty providers, including behavioral health clinicians as well as provider of long-term services and supports (LTSS). We use our online care coordination tool, CommunityCare, to plan and coordinate ongoing care.

Unique to each member, the service plan includes, but is not limited to, the following:

- Member history
- Member's service preferences
- Short and long-term member needs and goals
- Member natural strengths and supports, such as the Member's abilities or family members
- Member current medical and social needs and concerns including:
 - Behavioral Health: mental health and/or substance use disorders
 - Physical, occupational, speech, or other specialized therapy services
 - Durable Medical equipment and medical supplies
 - Nursing services including Home Health Skilled Nursing, Private Duty Nursing
 - Nursing Services offered through a Prescribed Pediatric Extended Care Center
 - Prescription drugs including psychotropic medications
- Non-covered services, community supports, and other resources that the member already receives or that would be beneficial to the member, such as assistance with housing.
- Component of other existing service plans such as the school Individual Family Service Plan (IFSP) or the ECI

To help ensure members care is coordinated and meeting their ongoing needs. We continue to work with them throughout the year based on their level of need.

Members with High-Risk Needs

Members with this level of need include those members in the home and community-based waiver programs, nursing facility (except for nursing facility members listed under Level 3), individuals with serious and persistent mental illness (SMI) or other members with complex medical needs.

These members have an assigned service manager. Members in a nursing facility receive quarterly face-to-face visits, including nursing facility care planning meetings or other interdisciplinary team meetings. All other Level 1 members receive a minimum of two face-to-face visits with their service manager every year. Members with SPMI also receive one telephone call from their service manager every year in addition to the minimum of two annual face-to-face service coordination contacts.

Members with Lower Risk Needs

Members receive annually at least one in-person visit and one phone call from their service manager when:

- They are receiving LTSS, such as Personal Assistance Services, Day Activity and Health Services, Community First Choice Services
- They are experiencing behavioral health issues that do not qualify as SMI
- They are in the Breast Cancer and Cervical Cancer Program

Members who are eligible for both Medicare and Medicaid and who do not meet eligibility as a level one high risk member, is considered a Level 2 member and so will receive at least two phone calls from a service manager during the year to help ensure their needs are met.

Members Not of High-Risk or Lower Risk Needs

Members who do not have needs that place them at high-risk or low-risk, can still receive service management. These members may request service management or may automatically receive it if they are living in a nursing facility to receive hospice or are living in a nursing facility that is outside of our service area.

To see more about how we coordinate member care, please see the service coordination section of this manual.

To help us make sure our members continue receive the services they need even as they experiences changes, let us know if you see a change in circumstances or member condition. Please call our service coordination hotline at **877-352-7798**.