STAR and STAR+PLUS 2015 (beginning Sept. 1, 2014)

Physician, Health Care Professional, Facility and Ancillary

Administrative Guide
Provider Manual

Texas State Fiscal Year 2015 (beginning September 1, 2014)

Effective for the following Areas:
Harris, Hidalgo, Jefferson, Nueces and Travis Service Delivery Areas
and Central and Northeast Medicaid Rural Service Areas

Customer Service: 888-887-9003

UnitedHealthcare
Community Plan
Welcome to UnitedHealthcare Community Plan! We are excited to have you as a partner of our growing network of high quality health care professionals. You play a key role as we pursue our commitment to improve the health and well-being of the members we serve.

As Vice President of Market Development, I have the opportunity to travel to all our service delivery areas and connect with providers and members. I am truly inspired by the innovation of your practices. Many providers are now offering extended hours, including evenings and weekends which demonstrates your commitment to serve your patients. During our provider visits over the last year we heard your concerns and have reorganized our provider manuals based on feedback we received. Many of these tools are found throughout the manual. See examples below.

- Provider Quick Reference Phone and Contact List
- Frequently Asked Questions
- Value-added Services Chart
- Prior Authorization List

Our Provider Manual is a comprehensive document that explains our company and how to do business with us. We strongly encourage our network providers to become familiar with all aspects of this manual. As we continue to build our relationships with our network providers, we hope to strengthen our partnership to help member live healthier lives. We strongly encourage dialogue and are open to your ideas. Thank you for participating.

Marian Cabanillas, Vice President. Market and Network Development
UnitedHealthcare Community Plan
Purpose of Provider Manual

UnitedHealthcare Community Plan welcomes you as a contracted health care provider. You play a key role as we pursue our commitment to improve the health and well-being of our members.

The purpose of this provider manual is to serve as a resource and reference guide to the UnitedHealthcare Community Plan STAR and STAR+PLUS Programs as it relates to our network providers. The manual contains information regarding Enrollment, Benefits, Contracting/Provider Relations, Quality Improvement, Medical Management, Best Practice Guidelines, Billing, Claims Payments and references to often used forms. Please share it with others in your office or organization.

This manual does not replace your Provider/Facility Agreement. Your Provider/Facility Agreement incorporates the Administrative Guide (this manual) as well as the Texas Medicaid Provider Procedures Manual located at Texas Medicaid & Healthcare Partnership at www.TMHP.com. The provider manual is designed to assist with day to day operations of your practice in working with UnitedHealthcare Community Plan. To the extent that the provisions of this manual differ from our Provider/Facility Agreement, the terms and conditions of the Provider/Facility Agreement govern.

The information contained in this manual applies as of the date it was published, and may be modified by UnitedHealthcare Community Plan at any time. The manual and updates are available at UHCCommunityPlan.com. Contact your provider advocate directly or contact Customer Service 888-887-9003 for a CD or paper copy of this manual. Visit UHCCommunityPlan.com for important provider alerts and updates.
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Introduction

Background Information
The UnitedHealthcare Community Plan division focuses on the complex and dynamic public sector health care market. UnitedHealthcare leverages assets and capabilities with engaged employees to help to provide members, providers and state partners with high value and quality services, in a manner that delivers the right service, at the lowest cost available in the market place. In the state of Texas, we are licensed as UnitedHealthcare Community Plan of Texas, L.L.C, known as UnitedHealthcare Community Plan. We are contracted to serve Medicaid managed care programs, specifically for people on Supplemental Security Income (SSI), aged, disabled and those who qualify financially. In Texas these programs are the State of Texas Access Reform (STAR) and the State of Texas Access Reform Long Term Care (STAR+PLUS).

This provider manual 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. Throughout the year, we offer several educational opportunities on a variety of topics for providers. Our goal is to ensure our members have convenient access to high quality care that is provided according to the most current protocols available. We build community by developing relationships with internal and external partners while focusing on our priorities and delivering results.

The Texas Health and Human Services Commission (HHSC) selected UnitedHealthcare Community Plan as a participating health plan with the STAR and STAR+PLUS Programs. Our contracts are for the Service Delivery Areas listed below along with our respective area offices:

<table>
<thead>
<tr>
<th>Harris</th>
<th>Travis</th>
<th>Hidalgo</th>
<th>MRSA Central</th>
<th>MRSA Northeast</th>
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</thead>
<tbody>
<tr>
<td>STAR</td>
<td>STAR+PLUS</td>
<td>STAR</td>
<td>STAR+PLUS</td>
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<tr>
<td>STAR+PLUS</td>
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<tr>
<td>14141 Southwest Freeway Ste. 800, Sugar Land, TX 77478</td>
<td>1250 S. Capital of Texas Hwy. Ste. 360 Austin, TX 78759</td>
<td>2010 S.10th Street Ste. 1610 McAllen, Texas 78501</td>
<td>1000 W. Hwy 6 Ste. 390 Waco, TX 76712</td>
<td>522 South Broadway Ave. Tyler, TX 75702</td>
</tr>
</tbody>
</table>
Objectives of STAR and STAR+PLUS

- Improve member access to care
- Increase member quality and continuity of care
- Increase efficient use of the health care continuum (i.e. member utilization of PCP office hours and emergency services only for qualifying emergency needs)
- Cost effectiveness and efficiency
- Increase provider and member satisfaction
- Integration of acute, long-term care and behavioral services
- Coordination of services for members that are dual eligible for Medicare and Medicaid services

Role of the Primary Care Physician

The success of UnitedHealthcare Community Plan depends on strong relationships with contracted providers. Members should contact their Primary Care Physician (PCP), also known as the Medical Home, to coordinate their care and help them access their benefits. PCPs are required to assess the medical and behavioral health needs of members and when appropriate refer to other health care providers, including specialists. PCPs coordinate member care and follow-up with other providers and member. Referrals do not require an authorization so long as the provider is in network with UnitedHealthcare Community Plan. If the member accesses care through a non-contracted provider without prior authorization, note that the services may not be reimbursed unless the service is an emergency, urgently needed, post-stabilization or out-of-area renal dialysis.

The UnitedHealthcare Community Plan goal is to support the provider/member relationship, so that PCPs are able spend their time practicing medicine and delivering high quality care to each member knowing that they have available supports such as contracted hospitals and specialists. PCPs are responsible for coordinating member health services, maintaining a central medical record for each member and ensuring continuity of care. Members with Special Health Care Needs will have direct access to a specialist as appropriate for the member’s condition and identified needs, such as a standing referral to a specialty physician.

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

Role of Specialty Care Provider

Specialist consultations do not require authorization as long as the specialist is an in network provider. Medical specialists are responsible for providing covered health services within the scope of their UnitedHealthcare Community Plan agreement and within the scope of their specialty license. Providers agree to render covered health services to members in the same time availability as offered to their other patients, in compliance with State regulations and as described within this provider manual. It is the responsibility of the specialist to report back to the PCP the specialist’s findings, recommendations and treatments. The report should be after the initial assessment and quarterly thereafter. Any necessary authorizations may be requested after the member’s visit to the specialist office for consultation or if the specialist was consulted during a member’s hospitalization. Forms are available at UHCCommunityPlan.com.
Role of Long Term Services and Supports (LTSS) Provider

Long Term Services and Supports (LTSS) providers deliver a continuum of care and assistance. These services range from in-home to community-based services for the elderly and people with disabilities who need assistance in maintaining their independence. LTSS includes adult day care, adult foster care, home delivered meals, home health services, minor home modifications, home therapy, Personal Attendant Services, Temporary Assistance Program, Emergency Response System, assisted living and respite care services. All of these services require an authorization from UnitedHealthcare Community Plan STAR+PLUS Health Services. LTSS providers are responsible to provide covered health services to members, within the scope of their UnitedHealthcare Community Plan Agreement and within the scope of their specialty license.

Role of Pharmacy

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

Role of Main Dental Home

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

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 specialist when appropriate. Federally Qualified Health Centers and individuals who are general dentist and pediatric dentists can service as Main Dental Homes.

Network Limitations

UnitedHealthcare Community Plan has no network limitation on referrals to any in network provider. If a provider is contracted with UnitedHealthcare Community Plan through an Independent Practice Association (IPA) or Medical Group, the provider is not limited to referring within that IPA for specialist services. Female members have the right to access an OB/GYN in network provider in addition to their PCP.
## Provider Quick Reference Phone and Contact List

<table>
<thead>
<tr>
<th>Contacts</th>
<th>Information</th>
<th>Phone/Fax Number/Email/Website Address</th>
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<tbody>
<tr>
<td>MAXIMUS</td>
<td>Medicaid enrollment broker; member eligibility issues and member enrollment.</td>
<td>800-964-2777</td>
</tr>
<tr>
<td>Texas Medicaid &amp; Healthcare Partnership (TMHP)</td>
<td>(Automated eligibility)</td>
<td>800-925-9126</td>
</tr>
<tr>
<td>Your Texas Benefits Medicaid Card</td>
<td>Automated Inquiry System (AIS) is available if member has misplaced or has questions regarding their Medicaid ID card.</td>
<td>800-252-8263 (Questions) 855-827-3748 (Replacement Card)</td>
</tr>
<tr>
<td>Customer Service Department</td>
<td>Monday through Friday 8 a.m. to 5 p.m. Central Standard Time (except on state approved holidays)</td>
<td>888-887-9003 Hearing Impaired: 800-735-2988 TTY (711)</td>
</tr>
<tr>
<td>Network Management</td>
<td>For questions regarding your Agreement, fee schedule and to report a change in demographics including address.</td>
<td>866-574-6088</td>
</tr>
<tr>
<td>Health Services</td>
<td>Authorization form for STAR and STAR+PLUS that need to be faxed to Health Services may be found at <a href="http://UHCCommunityPlan.com">UHCCommunityPlan.com</a>.</td>
<td><a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a></td>
</tr>
<tr>
<td>UnitedHealthcare® Online</td>
<td>UnitedHealthcare provider portal. Resources for verifying eligibility, authorizations, claims submission and claim status.</td>
<td><a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a></td>
</tr>
<tr>
<td>Electronic Claims Submission</td>
<td>Provides must register at UnitedHealthcare Online to view eligibility, authorizations and claims. Other resources are also available.</td>
<td>Electronic Claims may be submitted at: <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> Payer ID: 87726 Help Desk: 866-842-3278 Clearinghouse Help Desk: 800-842-1109</td>
</tr>
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| UHCCommunityPlan.com                    | Provider website unique to Medicaid and Medicare includes manuals, trainings, alerts and forms. 

*Note: some processes are only available at [UHCCommunityPlan.com](http://UHCCommunityPlan.com), go to Healthcare Professionals for Texas. Visit often for updates.* | [UHCCommunityPlan.com](http://UHCCommunityPlan.com) |
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<th>Contacts</th>
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<tbody>
<tr>
<td>OptumRx™</td>
<td>UnitedHealthcare Community Plan members may access covered drugs through OptumRx. Any questions regarding prescription services, including prior authorizations, formulary inquiries should be directed to OptumRx. For a listing of covered and/or preferred drugs visit <a href="http://UHCCommunityPlan.com">UHCCommunityPlan.com</a>.</td>
<td>For physician prescribers or pharmacy prior authorization Phone: 800-310-6826 Fax: 866-940-7328 For pharmacies: 877-305-8952</td>
</tr>
<tr>
<td>Provider and Member Complaints and Appeals</td>
<td>If you are dissatisfied after completing a requested reconsideration you may file an appeal.</td>
<td>UnitedHealthcare Community Plan P.O. Box 31364 Salt Lake City, UT 84131-0364</td>
</tr>
<tr>
<td>State Medical Transportation Program</td>
<td>Monday through Friday 8 a.m. to 5 p.m. Members should call to arrange transportation services immediately after scheduling a provider’s visit and at least two workdays before the appointment Members requesting an authorization will need to call 888 887-9003 and request to speak to a member advocate.</td>
<td>877-633-8747 (Hidalgo, Nueces and Travis Service Delivery Areas and MRSAs Central and Northeast) 855-687-4786 (Harris and Jefferson Service Delivery Areas)</td>
</tr>
<tr>
<td>Logisticare (Value-added Transportation Provider)</td>
<td>UnitedHealthcare Community Plan’s contracted transportation provider offering non-emergent transportation services (including wheelchair transportation) within UnitedHealthcare Community Plan’s Service Delivery Areas. Member will need to have member ID, provider address and phone available when making an appointment.</td>
<td>888-887-9003</td>
</tr>
<tr>
<td>Denta Quest USA Insurance Company, Inc. (Dental Contractor)</td>
<td>Customer Service Department (under 21 years of age)</td>
<td>855-776-6262</td>
</tr>
<tr>
<td>MCNA (Managed Care of North America)</td>
<td>(under 21 years of age)</td>
<td>855-691-6262</td>
</tr>
<tr>
<td>UnitedHealthcare® Dental</td>
<td>UnitedHealthcare Community Plan (ages 21 and above)</td>
<td>877-378-5294 <a href="http://www.myuhcdental.com">www.myuhcdental.com</a></td>
</tr>
<tr>
<td>OptiCare®</td>
<td>UnitedHealthcare Community Plan contracted vendor for medical eye services.</td>
<td>800-368-5315 <a href="http://www.opticare.com">www.opticare.com</a></td>
</tr>
</tbody>
</table>
### Contacts

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<tr>
<th>Contacts</th>
<th>Information</th>
<th>Phone/Fax Number/Email/Website Address</th>
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<tbody>
<tr>
<td>Block Vision</td>
<td>UnitedHealthcare Community Plan contracted vendor for routine eye services including exams, frames and lenses.</td>
<td>800-879-6901, Option 4 <a href="http://www.blockvisiononline.com">www.blockvisiononline.com</a></td>
</tr>
</tbody>
</table>
| Optum®                                        | UnitedHealthcare Community Plan contracted vendor for behavioral health services. They offer services for Mental Health & Substance Abuse. Visit [LiveandWorkWell.com](http://LiveandWorkWell.com) for additional resources. | STAR: 888-872-4205
STAR+PLUS: 866-302-3996 [www.providerexpress.com](http://www.providerexpress.com)                                                                 |
| Optum®NurseLine™ (Contracted 24/7 Nurses)      | UnitedHealthcare Community Plan contracted provider for nurse line services.                                                                                                                                  | STAR: 800-535-6714
STAR+PLUS: 877-839-5409
TTY/TDD: 800-855-2880                                                                                                                                     |
Frequently Asked Questions

Eligibility

How Do I Check Member Eligibility?
Visit UnitedHealthcare Online, use an automated card reader to scan the member’s Your Texas Benefit Medicaid card, call the Texas Medicaid & Healthcare Partnership (TMHP) automated phone line or contact Customer Service at 888-887-9003.

When Will a Member Become Eligible For Coverage?
The Medicaid application process is handled by the Texas Health and Human Services Commission (HHSC). Once approved for Medicaid the Medicaid member is referred to the enrollment broker (MAXIMUS) who then sends an enrollment packet. The packet includes information about available Managed Care Organizations. The Medicaid member then has up to thirty (30) days to choose a managed care plan or they will be defaulted into a plan.

How Often Can a Member Change Plans?
A member may change plans as often as once a month. The plan changes cannot occur if the member is in the hospital. Newborns are required to stay with the mother’s plan for at least ninety (90) days after birth, unless there is a medical reason for changing plans.

What is an Enrollment Broker?
The HHSC has selected MAXIMUS, to serve as the enrollment broker for the STAR and STAR+PLUS programs. As an enrollment broker, MAXIMUS assists members transferring from one Managed Care Organization to another. MAXIMUS performs outreach, education, and enrollment functions to assist members in transferring from the traditional Medicaid system into the STAR and STAR+PLUS programs.

Can UnitedHealthcare Community Plan Sell Directly to Members?
No. The Managed Care Organizations are not allowed to market directly to potential members, unless the potential member specifically requests information and additional data from the plan.

Services

Which Services are Covered Under a Member’s Benefit Plan?
A limited description of covered benefits can be found in the Member Handbook available at UHCCommunityPlan.com and in this manual. Call Customer Service at 888-887-9003 for member-specific inquiries.

What are Value-added Services?
All Managed Care Organizations provide standard Medicaid benefits. Value-added services are additional to the core benefits that UnitedHealthcare Community Plan offers and are free of charge to members. A complete list of these current plans can be found in the Member Handbook, in this manual or is available from Provider Relations.

What is Optum?
Optum is made up of three market-leading business segments:

1. Optum
2. Optum Insight
3. OptumRx

All together they form a leading information and technology-enabled health services business dedicated to making the health system work better for everyone.

What Services Does Optum Insight and Optum Provide?
Optum Insight is one of the largest health information, technology and consulting companies in the world. They assist providers with electronic remittance advices. Optum is the leader in population health management serving the physical, mental and financial needs of both individuals and organizations. They provide our Physical, Occupational and Speech Therapies network as well as our behavioral health network in addition to NurseLine.
Who is the UnitedHealthcare Community Plan Contracted Pharmacy Benefit Plan?
OptumRx® (formerly Prescription Solutions) is the pharmacy vendor for all the plans in Texas. It is also a sister segment of UnitedHealth Group. See pharmacy information in this manual and in the Pharmacy Manual posted at UHCCommunityPlan.com.

Who is UnitedHealth Community Plan Dental Provider?
UnitedHealthcare® Dental is another individual company under the UnitedHealth Group parent company. It offers routine covered services and Value-added Services. UnitedHealthcare Dental is also referred to as Dental Benefit Plan (DBP). Their contact information is 877-378-5294 and www.myuhcdental.com.

What is THSteps?
Texas Health Steps is the Texas Medicaid health and wellness program for children on Medicaid (STAR and STAR+PLUS) from birth through 20 years of age. To serve this population you must be enrolled to provide THSteps through the Texas Medicaid and Health Partnership (TMHP).

How to Help a Member Find Dental Care.
The Dental Plan Member ID card will list 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 a member does not have a dental plan assigned or is missing a card from a dental plan, the member can contact the Medicaid Enrollment Broker’s toll-free telephone number at 800-964-2777 (Medicaid members).

Am I Expected to Coordinate Care With a Member’s Primary Care Physician?
Coordination of care is necessary for thorough service provision. All providers need to take responsibility for communicating findings, recommendations and treatments to the PCP and other health professionals that are involved in the overall member care. See Provider Responsibilities in this manual.

What are ECI and CCP?
Early Child Intervention (ECI) is a statewide service for families with children, birth to three years of age, with disabilities and developmental delays. Providers are responsible under federal law to identify and refer any child age three years or under who is suspected of having a developmental disability or delay, or who is at risk of delay, to an ECI program provider for screening and assessment as soon as possible, but no longer than seven days after identified. The Centers for Medicare and Medicaid Services (CMS) issued a clarification of this legislation that expanded Texas Health Steps Comprehensive Care Program (CCP) services to include treatment for problems identified by any health care professional, regardless of whether a formal Early Periodic Screening Diagnosis and Treatment (EPSDT) checkup has been performed.

Health Services Authorizations
Where Can I Find a List of Services That Require an Authorization?
Services requiring authorization are listed in the Quick Reference Guide posted at UHCCommunityPlan.com as well as in the Health Services section beginning on page 30 of this manual.

Will I be Notified if an Authorization is Going to Expire?
You will receive notification of the amount of time for which services are authorized. You will not receive a secondary notification when that authorization is about to expire.

What Guidelines Does UnitedHealthcare Community Plan Use to Determine Medical Necessity?
Medical necessity is established by nationally recognized guidelines developed from evidence based criteria, such as Milliman® Medical Index along with UnitedHealthcare Community Plan policies.
Can I Refer Members to in Network Providers Without a Referral?
Yes, refer to UHCCommunityPlan.com for our most current listing of contracted providers. You need to refer to providers that are contracted with UnitedHealthcare Community Plan and are therefore within network. Any referral to an out-of-network provider will need an authorization. Contact Health Services to discuss your specific case and continuity of care.

Can I Request a Retrospective Review of Services That Were Provided but Not Previously Authorized?
Retro-authorizations are not routinely authorized but may be considered through case-by-case exceptions based on regulatory requirements.

What is the Appeal Process for a Denial?
Members and providers have the right to appeal and file a complaint. If the member requests an Appeal or Fair Hearing within ten days of the adverse determination, then services may continue until further determination of the Appeal or Fair Hearing. The member will receive Appeal and Fair Hearing rights and processes with each Notification of Action (NOA) letter.

Are MD Signatures Required on Any Document When Requesting for Authorization?
The need for an MD signature is dependent on the service requested. For example, any authorization requiring a prescription would require the ordering MD signature.

Will UnitedHealthcare Community Plan Honor an Authorization From a Previous MCO?
To prevent disruption of services, the on-going authorization will be recognized. You will need to contact Health Services for a UnitedHealthcare Community Plan authorization for the claim to pay. For ongoing care, we reassess the member to determine if services will need to be continued or changed.

When are Peer-to-Peer Reviews Requested?
A Peer Clinical Review will be conducted for all cases that cannot be clinically certified or have coverage approved by initial screening or initial clinical review. The staff member who conducts the Peer Clinical Review needs to be a qualified health professional, with a current license to practice medicine, or current license in the same category as the treating/ordering provider.

Claims
With All of the Different Programs That UnitedHealthcare Manages, is There Some Easy Way For Me to Determine Where to Send My Claim?
Register at UnitedHealthcare Online where you can verify eligibility, file and check on claims. There are unique addresses for submitting paper claims that are posted at UHCCommunityPlan.com. Providers are encouraged to contact Customer Service with any questions. We have a dedicated team to answer provider questions.

What Rates Will I be Paid and How Can I Confirm the Rates That are in My Agreement?
Contact Network Management for information regarding reimbursement issues, fee schedules, coding or contract administration issues by calling 866-574-6088.

Do I Need to Enter an NPI Number on My Claims?
Per the Health Insurance Portability Accountability Act (HIPAA) – providers must have a National Provider Identifier (NPI) number and utilize that when filling electronic claims. Providers individually contracted must submit claims with an individual NPI number. Contact customer service to confirm NPI on file with UnitedHealthcare Community Plan.

May I Submit a Claim if a Member Does Not Show For an Office Visit?
You cannot bill the member or the Plan when a member does not show for an office visit. This needs to be documented in the member medical record along with any education provided by you and/or assistance to aid future compliance (i.e., assistance with arranging transportation). If the member is a child in the STAR or STAR+PLUS program below the age of twenty one (21) years, then you
need to submit a Texas Health Steps Provider Outreach Referral Form to MAXIMUS (enrollment broker). Also call Customer Service and we will outreach to that member to encourage compliance while offering any services that might be of assistance, such as transportation.

May I Submit a Claim For Telephone Counseling For After-hour Calls?
You may bill for after-hour services that fall within CPT codes applicable to the services provided. However, you may not bill for counseling services, unless you are verified as a telemedicine provider.

Can I Balance Bill Members?
You may not bill members above and beyond the rate to which you have contractually agreed to provide that service. The STAR and STAR+PLUS programs do not have copayments or coinsurance.

How Do I Request to Have a Claim Reconsidered?
If you believe you received an underpayment from UnitedHealthcare Community Plan, then you can re-submit at UnitedHealthcare Online for research and reconsideration. You may also call Customer Service to request an adjustment or consult your Provider Advocate.

How Do I Refund an Overpayment?
Overpayments may be submitted to;

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

A form with instructions is available at UHCCommunityPlan.com or contact Customer Service for assistance. (See Claims section of this manual.)

Does UnitedHealthcare Community Plan Accept Interim billing?
Interim billing is utilized for inpatient claims.

Is a POA Indicator Required For Claims?
Health care facilities, including general acute-care hospitals or other facilities are required to report code-able conditions that are Present on Admission (POA).

Can I Submit Claims Directly at UnitedHealthcare Online?
You can submit CMS Form 1500 claims directly through UnitedHealthcare Online or utilize a clearinghouse of your choice. CMS UB-04 forms must be submitted either in a paper format or through a clearinghouse.

Can I Submit Claims Directly to Texas Medicaid & Healthcare Partnership (TMHP)?
Yes. They will be forwarded to the appropriate MCO for processing. Some restrictions do apply.

What Is the UnitedHealthcare Community Plan Payer ID?
87726

Are There Any Types of Claims That Must Be Submitted On Paper?
Miscellaneous billing codes should be submitted as a paper claim if an invoice or receipt slip is needed. These are needed in order for us to verify the product/service and quantity. In addition, UB-O4 forms need to be submitted on paper.

How Do I Check the Status of Eligibility, Authorizations and Claims?
UnitedHealthcare Online is your primary resource for verifying eligibility, requesting authorizations and filing claims. You may also call Customer Service at 888-887-9003 to verify eligibility. Contact STAR and STAR+PLUS Health Services directly via phone or fax for authorizations.
To What Degree Am I Responsible For Coordination of Member Benefits?
UnitedHealthcare Community Plan and providers in its network agree that the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members. When a Medicaid member has other health insurance, then that other insurance must be billed by the provider before billing UnitedHealthcare Community Plan and thus the Texas Medicaid Program.

Which Provider Website Is the Correct One To Use?
UnitedHealthcareOnline.com is the website for determining eligibility, submitting and following up on claims. UHCCommunityPlan.com is the site dedicated to Medicare and Medicaid business. It is best utilized for provider policies, manuals, notifications, trainings, forms (including claims reconsiderations). Consult your Provider Advocate for additional assistance.

What Does UnitedHealthcare Community Plan Do To Increase Community Awareness?
UnitedHealthcare Community Plan participates in a variety of community events. These include events at schools, churches, community-based organizations, and most importantly, member appreciation.

Where Do I Go When I Have a Question?
Customer Service 888-887-9003 is the first source to contact UnitedHealthcare Community Plan. These operators are trained to assist members and providers. They can direct you to your assigned Provider Advocate. Provider Advocates are available via phone and in person to educate providers regarding the operations of UnitedHealthcare Community Plan.
Enrollment and Disenrollment Information

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

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

United Healthcare Community Plan members may change the assigned PCP, as needed by contacting Customer Service at 888-887-9003. The change will take place within 24 hours with UnitedHealthcare Community Plan. The PCP’s name does not need to be on the member’s card for the PCP to treat member. The change with Maximus will depend upon when the member called UnitedHealthcare Community Plan and was confirmed with the MCO. If a member calls to change his or her PCP on or before the 15th of the month, the change will be effective the first day of the following month. If a member calls after the 15th of the month, the change will take place the 1st day of the 2nd month thereafter.

Mandatory MCO Participation

Supplemental Security Income (SSI), SSI-related, and Medical Assistance Only (MAO) members must select an MCO. The MCO provides acute and long term care services. If the member also has Medicare, the MCO provides long term care services only. Mandatory participants are:

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

Voluntary MCO Participation

The following people are not required to participate but if they elect to do so, they must select an MCO:

- SSI dual eligible members under the age of 21
- SSI dual eligible members on the waiting list for Mental Health and Mental Retardation Authority’s (MHMRA) Home and Community Based Services (HCBS) waiver program
- SSI dual eligible members with severe and persistent mental illness receiving or on the waiting list to receive Medicaid-funded rehabilitation or targeted case management services.
**Ineligible For STAR and STAR+PLUS Participation**

The following people cannot participate in the STAR and STAR+PLUS Program:

- Members in any Medicaid 1915 Waiver, except for Community Based Alternatives (CBA) until Aug. 31, 2014 members
- Residents of Intermediate Care Facilities for the Mentally Retarded until Aug. 31, 2014
- Members not eligible for full Medicaid benefits (those in the Frail Elderly program, QMB, SLMB, QDWI, as well as documented and undocumented immigrants)
- Members not eligible for any Medicaid
- Children in State foster care
- Nursing facility residents until Feb. 28, 2015

HHSC makes the final decision on all disenrollment requests. Members who can be dis-enrolled from the STAR and STAR+PLUS Programs include:

- Members who disenroll 120 days after they are admitted to a nursing facility
- Members who are diagnosed with End Stage Renal Disease who also do not qualify for Medicare
- Members in an acute care facility and on continuous mechanical ventilation for 30 consecutive days and who cannot be safely managed in the home or in a long term care (non-acute) facility

**Automatic Re-enrollment**

Members who temporarily lose Medicaid eligibility and become dis-enrolled 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. Providers can check the TMHP Automated Inquiry Services (AIS) line to verify member eligibility status at 800-925-9126.

**Newborn Enrollment**

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

**PCP Assignment**

If the member does not select a PCP at the time of enrollment, MAXIMUS will automatically assign the member to a PCP based upon HHSC criteria. Dual eligible members, who are not assigned to a UnitedHealthcare Community Plan PCP, retain their traditional Medicare or Medicaid managed care plan PCP. MAXIMUS advises UnitedHealthcare Community Plan of all new members and their selected or assigned PCPs on a monthly basis. PCPs should review the current monthly roster/panel of the members assigned to their practice to see if the member’s name and Medicaid number appear on the list. This list may be viewed at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com).
PCP Reassignment/Noncompliant Members

PCP changes can occur at the request of the member, the PCP, or upon a PCP’s contract termination. Members may request a PCP change at any time during their enrollment by calling UnitedHealthcare Community Plan Customer Service. A new UnitedHealthcare Community Plan ID card is mailed out with the new PCP name imprinted on it and the member is allowed to see the new PCP immediately. PCPs can request a member reassignment for a pattern of the following:

- Disruptive or abusive behavior from a member, unrelated to a physical or behavioral health condition
- Member failure to keep or cancel scheduled appointments
- Member non-compliance with treatment plans recommended by PCP
- Member non-compliance with UnitedHealthcare Community Plan policies and procedures including loaning or allowing another member use of the UnitedHealthcare Community Plan membership card
- Other circumstances approved by HHSC justifying disenrollment

All member disenrollment/reassignment requests by the PCP must be submitted to UnitedHealthcare Community Plan Customer Service (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. Providers are strictly not allowed to take any retaliatory action against a member for any reason, including related to enrollment.

Dual Eligible Members

If the member gets Medicare, then 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 through UnitedHealthcare Community Plan STAR+PLUS program as a Dual Eligible member. This program coordinates the payment of the Medicare Advantage cost-sharing amounts for Dual eligible members up to the Medicaid fee schedule.

UnitedHealthcare Community Plan STAR+PLUS benefits will not change or reduce any Medicare benefits for which a member is eligible. Members with traditional Medicare coverage can choose to use their existing PCP, and can use specialty services without prior approval from UnitedHealthcare Community Plan. Members should tell their service coordinators when they have Medicare coverage and provide the name of their chosen PCP. UnitedHealthcare Community Plan service coordinators coordinate services with the member’s PCP to ensure continuity of care. Dual Complete members who have a separate managed care organization for acute services have identification cards that indicate Long Term Care Services only for UnitedHealthcare Community Plan. Verifying member Medicaid Eligibility.

Each person approved for Medicaid benefits is issued a Your Texas Benefits card. However, having a card doesn’t necessarily indicate current Medicaid coverage. Providers should verify eligibility for the date of service prior to services being rendered. There are several ways to do this:

- Swipe the member’s Your Texas Benefits Medicaid Card through a standard magnetic card reader, if your office uses that technology.
- Call the Your Texas Benefits provider helpline at 855-827-3747.
- Call the United Healthcare Community Plan Customer Service at 888-887-9003.
- Visit UnitedHealthcareOnline.com and see Patient Eligibility and Benefits.

Important: Do not send members who forgot or lost their cards to an HHSC benefits office for a paper form.
They can get a new card mailed to them by calling 855-827-3748. Medicaid members also can go online to order new cards or print temporary cards. The member may complete a 1027-A form for a replacement card. For instructions, visit www.YourTexasBenefits.com and click Learn more about the Your Texas Benefits Medicaid card. Temporary UnitedHealthcare Community Plan Member ID cards are able to be printed from www.myuhc.com. Select Common Questions then select “What if I don’t have my ID card?” UnitedHealthcare Community Plan Member ID cards may be obtained by calling Customer Service at 888-887-9003.

Check member eligibility at UnitedHealthcareOnline.com (see Patient Eligibility and Benefits and use your registered password).

Basic Magnetic Stripe Card Reader
A magnetic stripe card reader can be used to read the Your Texas Benefit Medicaid card to automatically enter it into the HHSC portal. Most USB-based card reader devices are compatible. Provider is responsible for the costs of these optional card readers.
UnitedHealthcare Community Plan Member ID Cards

STAR and STAR+PLUS Administrative Guide 2015
UHCCommunityPlan.com 888-887-9003
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Covered Services

Benefits

Health benefits are governed by UnitedHealthcare Community Plan’s contract with the Texas Health and Human Services Commission (HHSC) and include; medical, dental, vision, behavioral health and pharmacy services. All covered services are available regardless of pre-existing conditions, prior diagnoses, or receipt of any prior health care services. There are no co-payments for Medicaid members. UnitedHealthcare Community Plan provides a benefit package which includes Fee-for-Service (FFS) services currently covered under the Medicaid program. Please refer to the current Texas Medicaid Provider Procedures Manual located at www.TMHP.com for a listing of limitations and exclusions. Here is a non-inclusive list of covered services.

- Ambulance services
- Audiology services, including hearing aids, for adults and children
- Attention Deficit/Hyperactivity Disorder treatment, including follow up care for children prescribed ADHD medications and member reimbursement for out-of-pocket expenses
- Behavioral Health Services*, including:
  - Inpatient mental health services, include services in free-standing psychiatric facilities, for children (birth through age 20) in STAR and STAR+PLUS and for adults in STAR+PLUS
  - Acute inpatient mental health services (STAR membership specified for adults)
  - Outpatient mental health services
  - Psychiatry services
  - Counseling services for adults (21 years of age and over)
  - Outpatient substance use disorder treatment services including:
    - Assessment
    - Detoxification services
  - Counseling treatment
  - Medication assisted therapy
- Residential substance use disorder treatment services including:
  - Detoxification services
  - Substance use disorder treatment (including room and board)

*These services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service Medicaid coverage. The services may be subject to the MCO’s non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.

- 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 Prenatal care
- Prenatal care provided by a physician, certified nurse midwife (CNM), nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center
- Birthing services provided by a physician and certified nurse midwife (CNM) practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) in a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- 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 for Chiropractic services
- Dialysis
• Durable medical equipment and supplies
• Early Childhood Intervention (ECI) services
• Emergency Services
• Family planning services
• Home health care services
• Hospital services, including inpatient and outpatient
• Laboratory
• Primary care services
• Preventive services including an annual adult well check for patients 21 years of age and over
• Medical checkups and Comprehensive Care Program (CCP) Services for children (birth through age 20) through the Texas Health Steps Program
• Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
• Radiology, imaging, and x-rays
• Specialty physician services
• Therapies – physical, occupational and speech
• Transplantation of organs and tissues
• Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.)
• Telemedicine
• Telemonitoring

Community Based Long Term Care Services
The following is a non-exhaustive, high-level listing of Community Based Long Term Care Covered Services included under the STAR+PLUS Medicaid managed care program.

• Community Based Long Term Care Services for all Members
  • Personal Attendant Services – All Members of a STAR+PLUS MCO may receive medically and functionally necessary Personal Attendant Services (PAS).
  • Day Activity and Health Services – All Members of a STAR+PLUS MCO may receive medically and functionally necessary Day Activity and Health Care Services (DAHS).

• HCBS STAR+PLUS Waiver Services for those Members who qualify for these services
  • Personal Attendant Services (including the three service delivery options: Self-Directed; Agency Model, Self-Directed; and Agency Model)
  • In-Home or Out-of-Home Respite Services
  • Nursing Services (in home)
  • Emergency Response Services (Emergency call button)
  • Home Delivered Meals
  • Minor Home Modifications
  • Adaptive Aids and Medical Equipment
  • Medical Supplies not available under the Texas Medicaid State Plan/Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 Waiver
  • Physical Therapy, Occupational Therapy, Speech Therapy
  • Day Activity Health Services (DAHS) (for members in 217-Like STAR+PLUS eligibility group, as identified in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, whose income exceeds 150% FPL)
  • Adult Foster Care
  • Assisted Living
• Transition Assistance Services (These services are limited to a maximum of $2,500. If the MCO determines that no other resources are available to pay for the basic services/items needed to assist a Member, who is leaving a nursing facility, with setting up a household, the MCO may authorize up to $2,500.00 for Transition Assistance Services (TAS). The $2,500.00 TAS benefit is part of the expense ceiling when determining the Total Annual Individual Service Plan (ISP) Cost.)

• Dental Services (The annual cost cap of this service is $5,000 per waiver plan year. The $5,000 cap may be waived by the managed care organization upon request of the member only when the services of an oral surgeon are required. Exceptions to the $5,000 cap may be made up to an additional $5,000 per waiver plan year when the services of an oral surgeon are required.)

• Cognitive Rehabilitation Therapy
• Financial Management Services
• Support Consultation
• Employment Assistance
• Supported Employment
• Mental Health Rehabilitative Services
• Targeted Case Management

* This list is non-exhaustive.
Durable Medical Equipment

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

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must be contracted with UnitedHealthcare Community Plan as a DME provider (see Contracting in this manual). You also need to be contracted with OptumRx as a pharmacy provider (see Pharmacy in this manual). Claims are processed through UnitedHealthcare Community Plan (see Compensation in this manual). Call UnitedHealthcare Community Plan at 888-887-9003 for information about DME and other covered products commonly found in a pharmacy for children (birth through age 20).

Value-added Services

UnitedHealthcare Community Plan offers Value-added services that are free of charge to members that we have created based on member needs. Any member may access a Value-added service by calling Customer Service 888-887-9003. Please note that some Value-added services are based on PCP assessment and referral.

STAR+PLUS Covered Services

UnitedHealthcare Community Plan ensures that STAR+PLUS members needing community-based STAR+PLUS Covered Services are identified and that covered services are referred and authorized in a timely manner. UnitedHealthcare Community Plan also ensures that contracted providers offering LTSS are licensed to deliver those services.

Members have a PCP and a Service Coordinator who coordinate covered services including primary, acute, LTSS as well as family and community supports. Providers should contact UnitedHealthcare Community Plan for required authorization and referrals necessary prior to rendering LTSS to members. UnitedHealthcare Community Plan provides information about, and referrals to, Community Based organizations important to the health and well-being of members, and has processes in place to ensure prompt assessment of member needs upon discharge from a hospital or treatment facility. A benefit package is provided to members that include Fee-For-Service (FFS) services currently covered under the Medicaid program. Please refer to the Texas Department of Aging and Disability Services (DADS) Provider Manuals for a more inclusive listing of limitations and exclusions that apply to each benefit category.

Personal Attendant Services (PAS): provides in-home assistance as authorized on the member Plan of Care which addresses the functionality of performing Activities of Daily Living, household chores, and nursing duties delegated by a Registered Nurse (RN). Providers of these services are required to utilize the electronic visit verification (EVV) system to confirm visits. This telephone- and computer-based system documents the precise time when provision of service begins and ends. Guidelines for use are dictated by the Texas Health and Human Services Commission. Mis-use or non-compliance may affect provider reimbursement and could lead to termination.

Day Activity and Health Services (DAHS): include nursing and PAS along with any of the following services: physical; rehabilitative; nutrition; transportation and other supportive services. These services are provided by facilities licensed by DADS.
Attendant Compensation Rate Enhancement
UnitedHealthcare will reimburse providers who qualify. The Open Enrollment period for providers who wish to receive the Attendant Compensation Rate Enhancement will be Oct. 1 to Nov. 1. The enhancement will be paid at the prevailing DADS level of reimbursement or one set by the health plan. To qualify, providers should send written proof to Network Management or their Provider Advocate that they are currently eligible for the ACCP along with a written statement as to how the enhancement will be used to compensate direct care workers as intended by the Texas Legislature. Provider participation in this program is voluntary; however, you must follow the guidelines outlined by the Health and Human Services Commission and Department of Aging and Disability Services (DADS). To view the guidelines, refer to DADS.state.tx.us, HHSC.state.tx.us, or the Texas Medicaid & Healthcare Partnership (TMHP). During the re-credentialing process you will be asked to provide a written statement as to how these compensation funds will be used to compensate direct care workers. In order to receive these funds, you must include your compensation amount in the billed amount of your claim. Claims will be paid at the lesser of the allowed amount or billed charges. If charges billed are less than the contracted rate, the billed amount will be paid. All clean claim filing requirements and timely filing guidelines remain in place.
STAR+PLUS Home and Community-Based Waiver Services (for qualifying members):

- **Adaptive Aids and Medical Supplies**: include devices, controls, or medically necessary supplies that enable individuals with functional impairments to otherwise perform ADL or control the environment in which they live.

- **Adult Foster Care (AFC)**: a 24-hour living arrangement in a DADS-contracted foster home for individuals who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, minimal help with personal care, help with ADL and provision/arrangement of transportation. The unit of this service is one day.

- **Assisted Living and Residential Care (AL/RC)**: a 24-hour living arrangement in a licensed personal care facility in which the following services may be provided: personal care; home management; escort; social and recreational activities; twenty-four hour supervision; supervision/assistance/administration of medications and the provision/arrangement of transportation. Three distinct types of living arrangements may be offered under AL/RC: assisted living apartments, residential care apartments, or residential care non-apartment settings.

- **Cognitive Rehabilitation Therapy**: assists members in learning or relearning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions.

- **Emergency Response Services (ERS)**: provided through an electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in the community. In an emergency, the individual can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven-day-a-week monitoring capability, helps ensure that the appropriate person or service agency responds to an alarm call from the individual.

- **Employment Assistance and Supported Employment**: helps members find employment and Supported Employment helps members maintain employment. This program encourages employment in the general workforce as the preferred outcome of providing Medicaid services for members with disabilities, regardless of level of disability.

- **Home Delivered Meals**: Meal services provide hot, nutritious meals served in an individual’s home. The benefit limitation is one meal per day and the need for a home delivered meal must be part of the Individual Service Plan (ISP). Home delivered meals will be provided to individuals who are unable to prepare their own meals and for whom there are no other persons available to do so or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets are available. Menu plans are approved by a registered dietician or someone with a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management. Any agency providing home delivered meals must comply with all state and local health laws and ordinances concerning preparation.

- **In-home Skilled Nursing Care**: includes an assessment, evaluation of health problems and the delivery of nursing tasks which provide treatment overseen by a physician.

- **Mental Health Rehabilitative Services**: helps members with a serious and persistent mental illness or a serious emotional disturbance as defined in the current DSM who require rehabilitative services as determined by either the Adult Needs and Strengths Assessment or the Child and Adolescent Needs & Strengths. Services include Adult Day Program, Medication Training and Support, Crisis Intervention and Skills Training and Development. Members access these services though their service coordinator.
• **Minor Home Modifications**: modifications and/or improvements to an individual’s residence based on need and qualifying measures to enable them to reside in the community and to ensure safety, security, and accessibility.

• **Respite Care Services**: temporary relief to persons caring for functionally impaired adults in community settings other than AFC homes or AL/RC facilities. Respite services are provided in-home or out-of-home and are limited to thirty (30) days per ISP year. Room and board is included in the waiver payment for out-of-home settings.

• **Targeted Case Management**: helps members with a serious and persistent mental illness or a serious emotional disturbance as defined in the current DSM, to gain access to needed medical, social, educational, developmental, and other appropriate services. Severe and persistent mental illness, or SPMI, describes mental illnesses with complex symptoms that require ongoing treatment and management, most often varying types and dosages of medication and therapy. SPMI typically does not level off and remain at a steady state. Rather, symptoms come and go in relation to stress. As a result, people with SPMI may be able to function independently for periods of time but may need intensive support with housing, school, work, social functioning, and other everyday life concerns when they experience a stressful event. Serious emotional disturbances apply to children that experience functional impairment and are diagnosed for more than a year with a serious disorder such as pervasive developmental disorder, schizophrenia, conduct disorder, affective disorder, disorders with serious medical implications such as eating disorders, or persistent involvement with alcohol or drugs. Members access these case management services through their service coordinator and individual service plan.

• **Therapy (Occupational/Physical/Speech)**: services provided by a licensed Occupational or Physical Therapist, Speech or Language Pathologist, or a licensed Occupational or Physical Therapy Assistant.

• **Transitional Assistance Services (TAS)**: assists individuals who are nursing facility residents to discharge to the community and return to home living. A maximum of $2500 is available on a one-time basis to help defray the costs associated with setting up a household. TAS includes, but is not limited to, payment of security deposits to lease an apartment, purchase of essential furnishings (table, eating utensils), payment of moving expenses, etc.
The Health Services Program

UnitedHealthcare Community Plan maintains a Health Services Program to ensure that members have timely access to appropriate, medically necessary, and cost-effective health care services through the use of authorizations and Service Coordination/Care Management.

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<thead>
<tr>
<th>Program</th>
<th>Authorization Phone</th>
<th>Fax</th>
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<tbody>
<tr>
<td>STAR</td>
<td>866-604-3267</td>
<td>877-940-1972</td>
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<tr>
<td>Recorded message will indicate you have reached the Intake Line for UnitedHealthcare Community Plan</td>
<td></td>
<td></td>
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<tr>
<td>STAR+PLUS</td>
<td>877-285-9093</td>
<td>877-950-6886</td>
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<tr>
<td>Recorded message will indicate you have reached UnitedHealthcare Community Plan</td>
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*Customer Service may also direct your call 888-887-9003

Prior authorization requests may be made through UnitedHealthcareOnline.com (see Notifications and Prior Authorizations). At this time supporting document needs to be submitted via fax.

Health Services accepts authorization requests via fax or phone from 8:00 a.m. to 5:00 p.m. central time Monday through Friday. The Prior Authorization Form is available at UHCCommunityPlan.com. Pertinent medical documentation as appropriate should be submitted to support the request.

Prior Authorization Timeliness Standards:

- Determinations are made within three (3) business days from the receipt date of the receiving authorization request and all necessary information to make the determination.

- Determinations requiring expedited decisions are made within one (1) business day from the receipt date of the authorization request.

- Authorization requests that are post stabilization subsequent to an emergency room visit are made within one (1) hour from the time of the request.

**Note:** Providers are notified in writing of authorization decisions

Routine, Urgent and Emergency Services

**Routine**
Routine care is considered preventive and medically necessary covered health services that are not urgent or emergent.

**Urgent**
Treating a health condition, including behavioral, which is not an emergency but 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, evaluation or treatment within twenty our (24) hours to prevent serious deterioration.

**Emergency**
UnitedHealthcare Community Plan provides for all medically necessary emergency services for inpatient, outpatient and ambulance transportation at network hospitals for our members 24 hours a day, and seven (7) days per week. All medically necessary emergency services do not require prior authorization. Medical records for emergency and inpatient services will be reviewed retrospectively for medical necessity by UnitedHealthcare Community Plan prior to claims payment.
Emergency Services: Emergency medical services are defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person’s condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the member’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 woman, serious jeopardy to the health of the fetus

Medicaid Emergency Dental Services: UnitedHealthcare Community Plan is responsible for emergency dental services provided to Medicaid members in a hospital or ambulatory surgical center setting. We pay for devices for craniofacial anomalies, hospital, provider and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts
- Treatment of oral abscess of tooth or gum origin
- Related Radiology 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 Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for members aged 6 through 35 months.

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

- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist members with establishing a Main Dental Home and document member’s Main Dental Home choice in the members’ file.

Post-emergency stabilization of care: The attending physician decides when the condition is no longer an emergency and that the member is considered stabilized for discharge or transfer. Continuation of care after the condition is no longer an emergency requires coordination with UnitedHealthcare Community Plan. Post stabilization care is covered if:

- UnitedHealthcare Community Plan prior authorizes.
- Automatic authorization if UnitedHealthcare Community Plan could not be reached for prior authorization despite reasonable efforts. Such automatic approval of post stabilization care continues to be covered until UnitedHealthcare Community Plan has responded to the request and arranged for discharge or transfer.

Emergency Transportation
Emergency transportation is a method to access emergency treatment as defined in the emergency treatment section of this manual, for example an ambulance.

UnitedHealthcare Community Plan does not require prior authorization for or notification of the emergency transport.
Inpatient and Outpatient Services

Health Services must be notified of emergency room and inpatient admissions within twenty-four (24) hours. The hospital stay may not be paid if notification, along with clinical information is not received in a timely manner. Any direct, non-emergent or elective admissions require prior authorization to process claims. If a prior authorization request for inpatient or outpatient services is incomplete, we will contact the provider to request the required information. Clear authorization requests and all appropriate supporting documentation need to be received within two (2) business days from the Health Service request for any necessary additional information. For children under the age of twenty (20) are allowed seven (7) days are allowed to submit the information.

Hospital Admits/Stays/Discharge: Upon notice of admission, Health Services issues a reference number to the admitting facility along with an approved estimated length of stay. A Peer Clinical Review occurs if the member length of stay exceeds the number of days that was approved upon admission. Health Services is involved in hospital discharge planning.

Spell of Illness: STAR+PLUS Program benefits are subject to the same benefit limits and exclusions that apply to the traditional, fee-for-service Medicaid programs, with the following exception. For STAR+Plus members reimbursement to hospitals for inpatient services is limited to the Medicaid spell of illness. A $200,000 annual limit on inpatient services does not apply for STAR+PLUS members. Spell of Illness does not apply to STAR members.

Physical, Speech and Occupational Therapy

The initial evaluation, do not require an authorization for STAR+PLUS and STAR. All visits after the initial evaluation will require an authorization prior to services being rendered. Authorizations must be submitted with physician evaluation order. Authorization request for therapy need to include a Plan of Care along with a physician prescription signed and dated by PCP, Neurologist, Orthopedic Physician or Rehabilitation Physician). Physician script (signed by PCP and dated Neurologist, Orthopedic Physician, or Rehabilitation Physician) a Plan of Care must be submitted this includes:

- A brief history of therapy treatment
- A description of the member’s current level of functioning or impairment, and identification of any known primary or secondary health conditions
- A clear diagnosis and reasonable prognosis with short and long-term treatment goals
- Prescribed treatment modalities, anticipated frequency and duration; dates of service

For ongoing therapy requests, Physician script (signed and dated by PCP, Neurologist, Orthopedic Physician, or Rehabilitation Physician) and an updated Plan of Care must be received prior to the end of each authorized period of treatment, to include:

- Objective measures of the member’s progress relative to each Treatment Goal, and a comparison to the previous Progress Report
- An explanation of any changes to the member’s Plan of Care and the clinical rationale for revising the Plan
- Prescribed treatment modalities, their anticipated frequency and duration, and dates of service

These STAR and STAR+PLUS Services Require Prior Authorization

- Ambulance Services – Non emergency, Facility to Facility and other than Facility to Facility (Par and Non par)
- Dental-Comprehensive Services
- Initial Dialysis (STAR+PLUS only)
- Drugs – Contact OptumRx™
- Drugs – Botox
- DME (Value more than $500.00 and wheelchairs regardless of cost)
• Elective Inpatient Admissions
• Home Health Care – All services in the home (Aide, Private Duty Nursing, PT/OT/ST, Skilled Nursing, Social Worker, and Home Infusion)
• Intensive Outpatient Program IOP behavioral services
• Nursing Facilities
• MRA (Magnetic Resonance Angiogram)
• Outpatient Surgery – Gastric Bypass
• Pain Management
• Cosmetic Surgery
• Ablative Procedures for Venous Insufficiencies and Varicose Veins
• Blepharoplasty and Brow Ptosis Repair
• SPECT MPI
• Breast Reduction
• Panniculectomy and Body Contouring
• Rhinoplasty, Septoplasty and Turbinate Resection
• Gynomastia
• MRI (Magnetic Resonance Imaging), MRA (Magnetic Resonance Angiogram) and PET (Positron Emission Tomography)
• Sleep Study
• Therapy/Rehabilitation (OT, PT, ST)
• Transplant Services
• Vendor Specialist Services – Contact Vendor Directory
• Home Based Services
• Home Delivered Meals
• Emergency Response System – Installation with test and monthly rental
• Minor Home Modifications
• Primary Home Care
• Community Based Assistance (CBA) Primary Home Care
• Protective Supervision
• Self Directed Consumer Directed Services (CDS), Primary Home Care (PHC) and CBA
• Agency Model with member CDS PHC and CBA
• Day Activity and Health Services
• Adult Foster Care (Levels I, II, III)
• AL Apartment – single Occupancy (Not PCH)
• AL/RC Apartment – Double Occupancy (Not PCH)
• AL/RC Non-Apartment (PCH)
• In-Home Respite
• Adult Foster Care Out-of-Home Respite: Per day (level I, II, III)
• Respite: AL Apartment and Non Apartment – Single and Double Occupancy (not PCH)
• Personal Assistant Services
• Mental Health Rehabilitative Services
• Targeted Case Management
• Employment Assistance and Supported Employment
• Cognitive Rehabilitation Therapy
Service Coordination/Care Management Program

The UnitedHealthcare Community Plan Service Coordination/Care Management Program is designed to manage certain chronic and complicated diseases. All STAR+PLUS members are eligible to receive services from the STAR+PLUS Service Coordination Program. All eligible STAR members may receive services from the STAR Care Management Program. Members with Special Health Care needs have direct access to specialists and do not require a PCP referral to a specialist, however appropriate to the member’s condition and identified needs; such as a standing order for a specialty physician will be in place.

The primary objective is to support members to establish and maintain a stabilized, improved state of health and to prevent disease-related complications. The objective is achieved through the promotion of self-management in coordinating with the member and the PCP, member and provider education, improved monitoring and target interventions all contribute to reducing risk factors and improving overall member health.

The Service Coordination/Care Management program supports the PCP/members relationship; it is UnitedHealthcare Community Plan’s philosophy that the role of the Primary Care Physician is critical to the overall management of member health care. In keeping with this philosophy, the role of the PCP is a vital component of the Service Coordination/Care Management Program. UnitedHealthcare Community Plan coordinates all care related to Plan of Care with PCP including special access needs.

Level I Members
- Highest level of utilization
- Members receiving services through the HCBS STAR+PLUS Waiver and other Members with complex medical needs
- Single identified person as assigned service coordinator
- Two face-to-face visits annually

Level II Members
- Lower risk/utilization
- Members Receiving LTSS Personal Assistance Services or Day Activity and Health Services
- Behavioral health issues history
- Substance abuse history
- Single identified person as assigned service coordinator
- A minimum of one face-to-face visit and one telephonic contact annually
- Members dually eligible for Medicaid and Medicare must receive a minimum of two telephonic contacts annually

Level III Members
- Do not qualify as Level 1 or Level 2
- Members are not required to have a single identified person as their assigned service coordinator unless they request one
- A minimum of two telephonic contacts annually

Health Assessment
The health status of our members is very important. UnitedHealthcare Community Plan takes an active role in determining the health status of its members, including identifying any complex or serious conditions. Within thirty (30) days of a member’s enrollment to UnitedHealthcare Community Plan, every new STAR+PLUS member and qualifying STAR members receive an initial assessment, during which time appropriate interventions are initiated.

Each member in the Service Coordination/Care Management Program has in place a personalized Plan of Care that is the least restrictive, immediate and transitional, focused on strengths and needs in terms of plan and community resources. All parties are involved in the development, implementation and assessment of the Service Coordination/Care management activities outlined in the Plan of Care.
Service coordination is delivered with the philosophy of independent living, self-determination, and community integration. Service coordinators perform home visits and assess member needs. They authorize community-based long term services and supports. The role of the service coordinator is to arrange for other services (i.e. medical transportation) and coordinate community supports (i.e. housing, utilities, legal). Service Coordinators ensure members have a qualified primary care provider (PCP). Service coordinator works with PCP to coordinate all STAR+PLUS covered Services and any applicable noncapitated services. MCO identifies and trains members or families to coordinate their own care to the extent of the member’s or the family’s desire to coordinate care. Service coordination activities are organized according to member level of need.

**Discharge Planning**
Discharge planning involves the member’s PCP, the hospital, or nursing facility or other care settings discharge planner(s), the attending physician, the ember, and the member’s family or representatives to plan for discharge. Planning takes into consideration the next least restrictive level of care, resources available or needing to be obtained, available services in the community and follow up.

**Transition Plan for New STAR+PLUS Members**
Effective Sept. 1, 2014, UHCTX honors existing authorizations for the earliest of (1) six months the beginning of these services under managed care, (2) until the expiration date of the prior authorization, or (3) until the MCO has evaluated and assessed the Member and issued or denied a new authorization. The transition plan includes:

- The member’s history
- Summary of current medical, behavioral health, and social needs and concerns;
- Short-term and long term needs and goals
- A list of services required, their frequency
- Description of who will provide these services
Essential Public Health Services

UnitedHealthcare Community Plan is required through its contractual relationship with Texas Health and Human Services Commission (HHSC) to coordinate with Public Health Entities regarding the provision of services for essential public health services. Providers must assist UnitedHealthcare Community Plan in these efforts by:

- Meeting program rules on public health reporting requirements regarding communicable diseases, which are preventable by immunizations as defined by state law
- Assisting in notifying or referring to the local Public Health Entity, as defined by State law, any communicable disease outbreaks involving members
- Referring to the local Public Health Entity for TB contact investigation, evaluation and preventive treatment of people with whom the member has come into contact
- Referring to the local Public Health Entity for STD/HIV contact investigation, evaluation and preventive treatment of people with whom the member has come into contact
- Referring for Women, Infant and Children (WIC) services and information sharing
- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure
- Reporting of immunizations provided to the Statewide ImmTrac Registry including parental agreement to share data
- Cooperating with activities required of public health authorities to conduct the annual population and community based needs assessment
- Referring lead screening tests to the DSHS Laboratory
- THSteps medical case management

Coordination of Care

UnitedHealthcare Community Plan Member Advocates and Health Service Care Advocates are trained and experienced in helping members and providers find and access care. They are responsible for facilitating referrals/appointments with in-network providers, arranging transportation and/or translators when indicated and generally guiding members and providers to the proper departments within UnitedHealthcare Community Plan. To access these services call Customer Service: 888-887-9003.

INSPIRIS

A case management program that works closely with the PCP to assist with chronic STAR+PLUS member. Qualifying STAR+PLUS members with chronic health conditions may be assigned an INSPIRIS advocate. This is a voluntary program. An Advanced Practice Registered Nurse will support the member in the outpatient setting. Services will include at least one face-to-face visit a month. This program is designed to support the PCP in an effort to reduce emergency room and hospital visits. The program will not cost the member or affect their benefits.

House Calls

Physicians make house calls for both sick and preventative care, including members in foster care and/or assisted living. These providers are available for urgent issues, but they mainly function in a primary care capacity and are great resources to help treat those members who, for many reasons, are not able to make their medical appointments. Providers who make house calls also coordinate with the member’s other health care providers to ensure continuity of care. To make referrals contact UnitedHealthcare Health Services Department at 866-604-3267 for STAR members and 800-349-0550 for STAR+PLUS members.

NurseLine

Educating members who need help in choosing appropriate medical care, finding a physician or hospital, understanding treatment options, achieving a healthy lifestyle or asking medication questions. Members have 24/7 access to caring, registered nurses with an average of 15 years of clinical experience. The information members receive is trusted and physician approved to help guide them through their health care decisions. The numbers for 800-535-6714 STAR members or 877-839-5409 STAR+PLUS members and 800-855-2880 TTY/TDD.
Optum™
United Behavioral Health, operating under the brand Optum, is contracted to administer benefits for mental and substance use disorder services. You may contact Optum at 888-872-4205 for STAR members or 866-302-3996 for STAR+PLUS members or visit www.providerexpress.com

Coordination of Care With Non-medicaid Managed Care
UnitedHealthcare Community Plan is not directly contracted with the following listed programs but does coordinate services with these non-Medicaid managed care covered services.

Texas Medicaid Non–emergent Transportation
Services provided by the Medicaid Transportation Programs through the Texas Health and Human Services Commission (HHSC) are available to members covered by Medicaid who have no other means of transportation to get to the physician, dentist or pharmacy. Transportation services include prearranged van pickup, wheelchair accessibility, bus passes or money for gasoline. The program may pay for overnight lodging and meals for members younger than twenty one (21) years of age and the person with whom they are traveling. These services are available in all areas of Texas and are provided by a network of 62 contracting organizations and 11,000 authorized drivers.

To secure transportation, the family or a representative (such as a case manager or staff from a medical provider) can call 877-MED-TRIP (877-633-8747). 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 provider’s name, address and phone; the date and time of the health care appointment; and the health care service being provided. Weekend transportation to and from bus stations and airports is available if these rides are scheduled in advance and are related to hospital admission or discharge.

Members requiring an authorization form will need to contact UnitedHealthcare Community Plan Customer Service at 888-887-9003 who will triage member to member advocate. Member advocate will verify eligibility, provider visit and provide member with authorization form.

LogistiCare
Transportation assistance will be provided when determined medically necessary by the Plan Case Manager to achieve health outcomes and compliance, when the State of Texas Medical Transportation Program is not available. Hotel stay will be paid for trips that require an overnight stay. Must use designated network provider. May offer bus tokens or vouchers. Visits over 75 miles may require prior authorization.

Early Childhood Intervention (ECI)
The Texas Early Childhood Intervention (ECI) program is a statewide service for families with children, birth to three years of age, with disabilities and developmental delays. Families and professionals work as a team to plan appropriate services, based on the unique needs of the child and family. Services are provided in homes and community settings. Specialized Skills Training (SST) is provided to assist families with challenging behaviors such as tantrums, biting, picky eating, and sleep issues. ECI case management helps families access and receive the services, resources, and supports they need to support their child’s development. Supports include helping the child and family transition to special education services as appropriate for children exiting ECI at age 3. ECI programs provide comprehensive case management for all members of the child’s family as their needs relate to the child’s growth and development. Referrals can be based on family concerns or professional judgment. Providers are responsible under federal law to identify and refer any UnitedHealthcare Community Plan Member age three (3) or under who is suspected of having a developmental disability, delay, or who is at risk of delay, to an ECI program provider for screening and assessment as soon as possible, but no longer than seven days after identified, even if also referring to an appropriate specialist. To make a referral or
for more information, visit the ECI website. The provider may call UnitedHealthcare Community Plan Health Services department regarding referrals. Children who are three (3) years of age or older with a suspected developmental delay or disability should be referred to the local school district. For additional ECI information, visit the Texas Department of Assistive and Rehabilitative Services (DARS) website at www.DARS.State.tx.us/ecis. Members may to self-refer to local ECI service providers.

No PCP referral or authorization is required. For more information about ECI or to refer a child, call the DARS Inquiries Line at 800-628-5115.

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

Texas Health Steps Personal Care Services (PCS)
This Medicaid benefit provides assistance STAR members with everyday tasks. These tasks are called activities of daily living such as bathing or instrumental activities of daily living such as fixing the meal.

DSHS Case Management for Children and Pregnant Women
Texas Health Steps Case Management for Children and Pregnant Women. This is a case management program that provides health related case management services to eligible children and pregnant women. Service eligibility includes Children (birth to age 20) and pregnant women who get Medicaid and have health problems or are at a high risk for getting health problems. Additional information and referral directions can be found at the Texas Department of State Health Services (DSHS). Referrals for case management can be made by calling 877-847-8377 (1-877-THSTEPS) or by downloading a referral form at http://www.dshs.state.tx.us/caseman/forms.shtml and faxing it to 512-533-3867.

School Health and Related Services (SHARS)
Texas School Health and Related Services (SHARS) for children under age 21 with disabilities who need audiology services, medical services, occupational therapy, physical therapy, psychological services, speech therapy, school health services, assessment and/or counseling. Call the Texas Medicaid & Healthcare Partnership (TMHP) Contact Center at 800-925-9126 with any questions.

Texas Health Steps Personal Care Services (PCS)
This Medicaid benefit provides assistance STAR members with everyday tasks. These tasks are called activities of daily living such as bathing or instrumental activities of daily living such as fixing the meal.

Case Management Services for the Blind
Children’s Vocational Discovery and Development Program (BCVDDP)
The Texas Department of Assistive and Rehabilitative Services (DARS) Division for Blind Services (DBS) is the Medicaid provider of case management for children younger than sixteen (16) years of age who are blind or visually impaired. Any child with a suspected or diagnosed visual impairment may be referred to BCVDDP. DARS DBS assesses the impact the visual impairment has on the child’s development and provides blindness-specific services to increase the child’s skill level in the areas of independent living, communication, mobility, social, recreational, vocational discovery and development. For more information, visit the DARS website at www.DARS.State.tx.us or call 800-628-5115.

DARS-DBS providers do not need to enroll with UnitedHealthcare Community Plan. All claims for service provided by DARS-DBS are submitted to TMHP for all Medicaid members, including Medicaid managed care members.
Tuberculosis Services Provided by DSHS-Approved Physicians
Local health departments in selected urban and border counties receive funding from the Tuberculosis (TB) Program to establish a TB screening program in methadone drug treatment centers, HIV early intervention centers, homeless shelters and other organizations that serve high-risk groups. Individuals identified with latent TB infection are referred to the appropriate health department for treatment and other follow-up as appropriate. HHSC approved physicians directly observed therapy and provide contact investigation. For more information contact 512-533-3000.

DADS Personal Care Services
This program offers attendant services to aid with daily living skills, housekeeping and meals. Visit www.DADS.state.TX.us for regional representatives that are available to assist with referrals.

DADS Hospice Services
DADS Long Term Care Hospice Program services related to terminal illness. Hospice care includes medical and support services designed to keep member’s comfortable during the last weeks and months before death.

Nursing Facility Services
Services provided in a facility that provides nursing or rehabilitation services.

Coordination With Local Mental Health Authority (LMHA)
Community mental health centers, also referred to as Local Mental Health Authorities (LMHAs) provide services to a specific geographic area of the state, called the local service area. DSHS requires each authority to plan, develop policy, coordinate, allocate and develop resources for mental health services in the local service area. LMHAs are individually owned and operated. Specific referral criteria differ so for program and referral information visit www.dshs.state.tx.us/mhsa/lmha.

Texas Agency Administered Programs and Case Management Services
Members who are served by the Texas Department of Family Protective Services (DFPS) may transition into and out of UnitedHealthcare Community Plan more rapidly and unpredictably than the general population, experiencing placements and reunification inside and out of the UnitedHealthcare Community Plan service delivery areas. Each member has an individual case in which documentation and reporting requirements are unique. As a provider, you must coordinate with DFPS and foster parents for the care of a member who is receiving services from, or who has been placed in the conservatorship of DFPS. Your response may include medical records and recognition of abuse and neglect, and appropriate referral(s).

Reports of abuse or neglect should be made through www.txabusehotline.org and take up to 24 hours to process. Call the Texas Abuse Hotline at 800-252-5400 to report suspicions of abuse, neglect, and exploitation of children, adults with disabilities, or people who are elderly (65 years or older). For general questions you may contact DFPS at 800-720-7777.

DFPS often requires medical and/or behavioral health assessments, treatment plans and updates for children in foster care in order to find an appropriate residential placement for the child. These assessments must be provided within required time frames to minimize the disruption to the children. UnitedHealthcare Community Plan is contractually required to assist DFPS with scheduling appointments for these assessments within either three (3) or five (5) days of request, depending on the severity of the child’s needs. Providers must assist UnitedHealthcare Community Plan by prioritizing the scheduling of these appointments so that required time frames are met.

Children in foster care now have available to them a Texas Health Passport which is an electronic database record of medical services to assist as they move and to aid for when the exit placement services. Request for input to the Health
Passport require response in a timely manner. Contact the Texas Health and Human Services Commission (HHSC) for access information. Adhere to medical consent and the release of information as per DFPS policy.
The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is the Medicaid comprehensive preventive child health service for individuals from birth through 20 years of age. In Texas, EPSDT is known as Texas Health Steps (THSteps). THSteps was defined by federal law as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 and includes periodic screening, vision, hearing, and dental preventive and treatment services (including orthodontia). In addition, Section 1905(r) (5) of the Social Security Act (SSA) requires that any medically necessary healthcare service listed in the Act be provided to THSteps clients even if the service is not available under the state’s Medicaid plan to the rest of the Medicaid population. A service is medically necessary when it corrects or improves the client’s disability, physical or mental illness, or chronic condition. These additional services are available through the Comprehensive Care Program (CCP). CCP services are the diagnosis and treatment components of Texas Health Steps. STAR and STAR+PLUS members are eligible for THSteps services.

**Providers**

The following provider types may provide Texas Health Steps preventive services within his or her individual scope of practice:

- Physician or physician group (MD or DO)
- Physician assistant (PA)
- Clinical nurse specialist (CNS)
- Nurse practitioner (NP)
- Certified nurse midwife (CNM)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Health care provider or facility with physician supervision including but not limited to a:
  - Community-based hospital and clinic
  - Family planning clinic
- Home health agency
- Local or regional health department
- Maternity clinic
- Migrant health center
- School-based health center


**Texas Health Steps Services**

UnitedHealthcare Community Plan encourages members to use THSteps preventive medical checkups within 90 days from their enrollment date and each time thereafter when they are periodically due or overdue for their next medical checkup. Providers are encouraged to perform THSteps checkups on any client they identify as eligible for THSteps checkups. Notify members when they are due for the next checkup schedule and to inform them about the mileage reimbursement transportation option to avoid missed appointments due to lack of transportation. UnitedHealthcare Community Plan will assist members with securing appointments as well as locate after-hour locations.

THSteps checkups must take place in a timely manner based on the child’s age and in accordance with the following timeline presented on the periodicity schedule:

- Within fourteen (14) days of enrollment for newborn members
- Within ninety (90) days of enrollment for all other members
- THSteps dental checkups and services are encouraged to occur when children first become eligible for Medicaid, and each time children are periodically due for their next dental checkup.
• Routine primary care appointments within 14 days unless otherwise requested earlier by the Texas Department of Family and Protective Services

Texas Health Steps Medical Checkups Periodicity Schedule for Infants, Children and Adolescents (birth through 20 years of age) is posted at http://www.dshs.state.tx.us/thsteps/providers.shtm.

To receive services, the member must be a Medicaid recipient who is birth through twenty (20) years of age at the time of the service delivery. When a member turns twenty one (21) years of age after the first of a month, the member remains eligible for THSteps through the end of that month.

Medical checkups are a benefit of THSteps when all required components are completed. An incomplete checkup is not a benefit and cannot be billed for services. Components of checkups and visits are based on the American Academy of Pediatrics (AAP) and THSteps Periodicity Schedule.

First and Periodic Medical Screenings

Medical Checkups for Infants, Children, and Adolescents

Providers must ensure all five federally mandated elements of a Texas Health Steps checkup are performed and documented in accordance with the Texas Health Steps periodicity schedule. Below is a summary of the federally required components of a Texas Health Steps medical checkup which must be documented in the medical record as a condition for provider reimbursement by Medicaid:

1. Comprehensive health and developmental history
   (including assessment of both physical and mental health development)
2. Comprehensive unclothed physical exam
3. Appropriate immunizations according to age and health history
4. Laboratory tests (including lead blood level assessment appropriate for age and risk factors)
5. Health education (including anticipatory guidance)

Children with confirmed and persistent elevated blood lead levels may require an environmental lead investigation (ELI) to determine the source of the lead exposure. An ELI is completed in a client’s home or primary residence by a certified lead risk assessor to determine whether a lead hazard exists and, if so, whether the lead source could be the cause of the elevated blood lead level. A lead screening provider is a physician, nurse practitioner, clinical nurse specialist, or physician assistant that conducts blood lead screen(s) for a THSteps client. The lead screening provider may request an ELI by completing Form Pb-101 “Environmental Lead Investigation Request” and submitting it to the Texas Childhood Lead Poisoning Prevention Program (TX CLPPP). If a previous investigation of the current home or primary residence has been performed and there has been a change in the client’s residential environment, TX CLPPP will determine whether the criteria are met for an additional ELI. An ELI must be billed with procedure code T1029 and will be restricted to diagnosis codes V1586 and 9849. Laboratory analysis of environmental substances, such as water, paint, or soil, is not a benefit of Texas Medicaid.

For details regarding specific checkup and reimbursement requirements, please visit Texas Medicaid & Healthcare Partnership (TMHP) at TMHP.com, click on the Provider tab and then click on the Reference Material link to review the Texas Medicaid Provider Procedures Manual (TMPPM), Children’s Services Handbook.
Laboratory
All THSteps Laboratory services are performed by the Texas Department of State Health Services (DSHS) in accordance with their practice and handling procedures which are available at the DSHS website at www.DSHS.state.tx.us. Screening tests for type 2 diabetes, hyperlipidemia, syphilis, and HIV may be sent to a lab of the provider’s choice. Initial blood lead screenings may be sent to the DSHS Laboratory or may be conducted using point of service technology in the provider office.

Member Encouragement of THSteps
UnitedHealthcare Community Plan promotes timely THSteps checkups and other needed services to eligible members. Welcome calls are made to new members to encourage participation in THSteps. During the enrollment period, members, their families and providers receive educational material in welcome packets regarding THSteps and the Periodicity Schedule. Members are allowed to see any certified THSteps provider within our network.

THSteps providers are responsible for the following:

- Perform and document THSteps checkups per the THSteps Periodicity Schedule
- Initiate medically necessary treatment or referral of any identified problems to appropriate specialists, practitioners and/or community resources
- Schedule the next member appointment at the time of the current office visit for children aged twenty-four (24) months and younger
- Utilize acute care visits to address missed opportunities for assessing the health and immunization status of the child during each THSteps visit
- Educate members with regard to preventive services
- Maintain an office that is adequately equipped to provide THSteps
- Submit claims in accordance with THSteps encounter submission standards

- Document in the medical record any parent/guardian refusal to allow participation in THSteps
- Submit specific THSteps laboratory specimens to the DSHS laboratory for analysis
- Refer as appropriate to the Early Childhood Intervention Program if developmental delays are suspected

THSteps checkups performed in an FQHC or RHC setting are paid an all-inclusive rate per encounter including any immunizations or developmental screening procedures.

When submitting claims for THSteps checkups and services, RHC Providers must use the national Place of Service (POS) code 72.

FQHC providers must use modifier EP in addition to the modifiers used to identify who performed the medical checkup.

In accordance with the federal rules for RHCs and FQHCs, a Registered Nurse (RN) in an RHC or FQHC may not perform THSteps checkups independent of a physician’s interactions with the client. Nurses that do provide THSteps checkups need to bill using the SA modifier.
**Type of Service Billing Codes**

THSteps Quick Reference Guide outlines THSteps procedure codes for checkups and referral and condition indicators. Condition indicators must be used to describe the results of a checkup. A condition indicator is submitted on the claim with the periodic medical checkup visit procedure code. Indicators are required whether a referral was made or not. If a referral is made, then providers must use the Y referral indicator. If no referral is made, then providers must use the N referral indicator. A checkup must be submitted with the diagnosis code V202.

THSteps checkup procedure codes 99385 and 99395 are restricted to members who are 18 through 20 years of age. ST indicates a referral was made to another provider or the member is scheduled for another appointment with the same provider. S2 indicates the member is already under treatment for the finding.

Modifier AM, SA, TD, or U7 must be submitted with the THSteps checkup procedure code to indicate the practitioner who performed the unclothed physical examination during the medical checkup.

Checkups, with the exception of periodicity checkups, and follow-up visits are limited to once per day any provider.

A checkup and the associated follow-up visit may not be reimbursed on the same date of service. The follow-up visit will be denied. Refer to the Texas Medicaid Provider Procedures Manual for information regarding Texas Health Steps.

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**Children of Farmworkers**

UnitedHealthcare Community Plan performs member, provider, and community interventions quarterly to identify eligible members for THSteps and to encourage participation, including but, not limited to the following:

- Pediatric and pregnant women assessments completed upon enrollment
- Member orientation and educational material distributed during enrollment
- Member newsletter
- Provider Communications (Manuals, Letters, Newsletters, Webinars)
- Provider Advocate outreach

UnitedHealthcare Community Plan recognizes that Farmworker families may require additional care and accelerated services. Utilizing our team approach, we collaborate with members, community-based and state supported organizations as well as providers to promote timely and effective services. As we try to avoid potential gaps in care, we implement the following interventions:

- Coordination with Farmworker organizations to discover the migratory routes and timelines
- Coordination with providers in the pre-migration and post-migration locations
- Accelerated services with pre-migration and post-migration location providers
- Expedite authorizations for migratory families
- Telephone outreach and written communication to providers in an effort to facilitate identification of need
- Facilitation of medical record transfers
- Telephone outreach and written member correspondence to educate and promote awareness and compliance with THSteps
Children of Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup. Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

**Comprehensive Care Services**

Any federally allowable Medicaid benefit is covered under this component even if the services are not covered under the Texas Medicaid plan or not covered due to program limitations. These services are provided only to those children who are under the age of 21 and are eligible to receive THSteps services.

Regionally-based Department of State Health Services (DSHS) THSteps Provider Relations Representatives are available to respond to Medicaid providers’ questions and problems. Visit [http://www.dshs.state.tx.us/thsteps/default.shtm](http://www.dshs.state.tx.us/thsteps/default.shtm) for current THSteps program information, regional contacts and forms.

**Maternity Care**

UnitedHealthcare Community Plan provides a comprehensive maternity care program to eligible members of childbearing age. The program covers the provision of preconception counseling, identification of pregnancy, medically necessary prenatal care, treatment of pregnancy related conditions, labor and delivery services, postpartum care, and member outreach and education.

Each STAR+PLUS member who becomes pregnant is considered high risk. They are eligible for the services outlined below in addition to the Health Services Service Coordination/Care Management Program.

Physicians who furnish maternity care to members are responsible for:

- Adhering to UnitedHealthcare Community Plan’s prenatal and postpartum appointment standards
- Utilizing a pregnancy risk assessment form that meets the American Congress of Obstetricians and Gynecologists (ACOG) standards and conducting a comprehensive evaluation on all pregnant members that assesses psychosocial, nutritional, medical, and educational factors
• Providing ongoing pregnancy risk assessments
• Reporting high risk and noncompliant members to the appropriate service coordinator
• Referring pregnant members to appropriate specialists, as medically indicated
• Educating members with regard to issues related to healthy pregnancies, such as proper nutrition, the physiology of pregnancy, the process of labor and delivery, and breastfeeding
• Encouraging members, particularly those at risk for losing UnitedHealthcare Community Plan eligibility to utilize community maternity services that are available at low or no cost

Family Planning
STAR and STAR+PLUS members have the right to freely choose any qualified HHSC approved family planning provider without prior approval from their Primary Care Physician or UnitedHealthcare Community Plan. UnitedHealthcare Community Plan does not require an out-of-network provider to obtain authorization for family planning. Members who request contraception but cannot be seen immediately must be offered a non-prescriptive method without delay. Complete family planning services must be provided within thirty (30) calendar days after the member’s request, unless the desired method is unavailable. All brands of each major contraceptive category must be made available to the member. Family health planning services provided to members must be kept confidential and includes the following:

• A member assessment to include a health history, physical examination and laboratory tests for every member requesting family planning medical services or a surgical or prescriptive contraceptive method
• Education and counseling for every new member requesting contraceptive services or family planning medical services
• Office or medical clinic visits that require specific and defined protocol during any visit for a medical problem or follow-up visit
• Management and/or referral for abnormal findings required informing the member of a diagnosis, counseling and treatment for the diagnosis and/or abnormal findings
• Provision of contraceptive method protocol and procedure for a contraceptive method that is a medical contraindication for that member
• Pregnancy testing requirements to include an assessment, counseling and a referral, if indicated, for the member
# THSteps Medical Checkup Billing Procedure Codes

## THSteps Medical Checkups

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
<td></td>
</tr>
<tr>
<td>99382</td>
<td></td>
</tr>
<tr>
<td>99383</td>
<td></td>
</tr>
<tr>
<td>99384</td>
<td></td>
</tr>
<tr>
<td>99385</td>
<td></td>
</tr>
</tbody>
</table>

## THSteps Follow-up Visit

Use procedure code 99211 for a THSteps follow-up visit.

## Oral Evaluation and Flouride Varnish

Use procedure code 99429 with U5 modifier.

## Developmental and Autism Screening

Developmental screening with use of the ASQ, ASQ:SE or PEDS is reported using procedure code 96110.

Autism screening with use of the M-CHAT is reported using procedure code 96110 with U6 modifier.

## Tuberculin Skin Testing (TST)

Use procedure code 86580 for TST. Procedure code 86580 may be reimbursed on the same day as a checkup.

## Point-of-Care Lead Testing

Use procedure code 83655 with QW modifier to report that an initial blood lead level screening test was completed using point-of-care testing.

## Immunizations Administered

### Procedure Codes

- 90632, 90632* with (90460/90461 or 90471/90472)
- 90636 with (90460/90461 or 90471/90472)
- 90644
- 90647* or 90648* with (90460/90461 or 90471/90472)
- 90649* or 90650* with (90460/90461 or 90471/90472)
- 90654, 90655*, 90656*, 90657*, 90658*, 90686* with (90460/90461 or 90471/90472) or 90660* with (90460/90461 or 90473/90474) or 90672* with (90460/90461 or 90473/90474) or 90673 with (90471/90472)
- 90669 or 90670* with (90460/90461 or 90471/90472)
- 90680* or 90681* with (90460/90461 or 90473/90474)
- 90696* with (90460/90461 or 90471/90472)
- 90698* with (90460/90461 or 90471/90472)
- 90700* with (90460/90461 or 90471/90472)
- 90702* with (90460/90461 or 90471/90472)
- 90703 with (90460/90461 or 90471/90472)

### Vaccine

- Hep A
- Heb A/Hep B
- Hib-MenCY
- Hib
- HPV
- Influenza
- PCV7, PCV13
- Rotavirus
- DTaP-IPV
- DTaP-IPV-Hib
- DTaP
- DT
- Tetanus

### Notes

- * Indicates a vaccine distributed by TVFC

## Modifiers

### Performing Provider

Use to indicate the practitioner who is performing the unclothed physical examination component of the medical checkup.

- AM
- SA
- TD
- U7

### Exception to Periodicity

Use with THSteps medical checkups procedure codes to indicate the reason for an exception to periodicity.

- 23
- 32
- SC

### FQHC and RHC

Federally qualified health center (FQHC) providers must use modifier EP for THSteps medical checkups. Rural health clinic (RHC) providers must bill place of service 72 for THSteps medical checkups.

### Vaccine/Toxoids

Use to indicate a vaccine/toxoid not available through TVFC and the number of state defined components administered per vaccine.

- U1

### Condition Indicator Codes

Use one of the indicators below if a referral was made.

<table>
<thead>
<tr>
<th>Condition Indicator</th>
<th>Condition Indicator Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>NU</td>
<td>Not used (no referral)</td>
</tr>
<tr>
<td>Y</td>
<td>ST</td>
<td>New services requested</td>
</tr>
<tr>
<td>Y</td>
<td>S2</td>
<td>Under treatment</td>
</tr>
</tbody>
</table>

*CPT codes, descriptions, and other data only are copyright 2013 American Medical Association (or such other date of publication of CPT). All Rights Reserved. CPT is a trademark of the AMA. Applicable Federal Acquisition Regulation System/Department of Defense Regulation System (FARS/DFARS) restrictions apply to government use.*
## Contact Information

**THSteps Medical Checkup Claims Inquiries**

Call the following number to obtain answers to questions or determine the status of claims:

1-800-757-5691

For managed care clients, contact the client’s MCO.

**THSteps Website**

General information for THSteps providers including forms, details on the required components of checkups, and other helpful resources.

[www.dshs.state.tx.us/thsteps/default.shtm](http://www.dshs.state.tx.us/thsteps/default.shtm)

THSteps Child Health Record Forms and THSteps Provider Outreach Referral Form may be downloaded from the THSteps website at:

[www.dshs.state.tx.us/thsteps/forms.shtm](http://www.dshs.state.tx.us/thsteps/forms.shtm)

**THSteps Outreach & Informing Service**

Information for THSteps clients to expand awareness of existing medical, dental, and case management services. Provider information to include missed appointment referral services.

1-877-THSteps (847-8377), Monday to Friday, 8am-8pm

**THSteps Online Provider Education Website**

Free comprehensive online continuing education modules designed for health-care providers. All modules provide continuing education units (CEUs) for multiple disciplines and include information about Texas Health Steps, Medicaid for children and other health-care services.

[www.txhealthsteps.com](http://www.txhealthsteps.com)

**Case Management for Children and Pregnant Women**

(512) 776-2168 | [www.dshs.state.tx.us/caseman](http://www.dshs.state.tx.us/caseman)

**Texas Immunization Registry (ImmTrac)**

1-800-348-9158

[www.dshs.state.tx.us/immunize/immtrac/default.shtm](http://www.dshs.state.tx.us/immunize/immtrac/default.shtm)

**Texas Vaccines for Children Program (TVFC)**

1-800-252-9152

[www.dshs.state.tx.us/immunize/tvfc/default.shtm](http://www.dshs.state.tx.us/immunize/tvfc/default.shtm)

**Early Childhood Intervention (ECI)**

1-800-628-5115 | [www.dars.state.tx.us/ecis](http://www.dars.state.tx.us/ecis)

**Vendor Drug Program (fee-for-service)**

The Medicaid Vendor Drug Program makes payments to contracted pharmacies for prescriptions of covered outpatient drugs for Texas Medicaid, CSHCN Services Program, Kidney Health Care Program, and CHIP. Some Medicaid-covered drugs may require prior authorization (PA) through PA Texas.

Texas Prior Authorization Call Center:

1-800-728-3927

or online: [https://paxpress.txpa.hidinc.com](https://paxpress.txpa.hidinc.com)

(for prior authorizations of non-preferred drugs only)

General information, covered drug list, online pharmacy, and prescriber searches:

[www.txvendordrug.com](http://www.txvendordrug.com)

[www.hhsc.state.tx.us/medicaid/Chip-Pharmacy-Benefits.shtml](http://www.hhsc.state.tx.us/medicaid/Chip-Pharmacy-Benefits.shtml)

For managed care clients: Contact the client’s MCO.

**Laboratory**

Requests for THSteps laboratory supplies from the Department of State Health Services (DSHS) should be made on Form G399 and submitted to:

**Container Preparation**

Laboratory Services Section, MC 1947

Department of State Health Services

PO Box 149347

Austin, TX 78714-9347

For supply order inquiries, call (512) 776-7661 or 1-888-963-7111, Ext 7661

Fax: (512) 776-7672

For specimen shipment questions, call (512) 776-7569 or 1-888-963-7111, Ext 7569

For specimen collection and submission questions, call (512) 776-6236 or 1-888-963-7111, Ext 6236

For test result inquiries, call (512) 776-7578 or Fax (512) 776-7533.

Access THSteps test results online using the Clinical Chemistry Remote Data Services web application. To gain access, download, complete, and submit the required access forms are available at:

[www.dshs.state.tx.us/lab/remoteData.shtm](http://www.dshs.state.tx.us/lab/remoteData.shtm)

For NBS testing questions, call (512) 776-7333 or 1-888-963-7111 Ext 7333.

A written request for Newborn Screening (NBS) specimen collection form (NBS3) and NBS supplies is required. To obtain an order form for written requests, call Container Preparation.

Access Newborn Screening test results online using the DSHS Newborn Screening Remote Data Services web application. To gain access, download, complete, and submit the required access forms available at: [www.dshs.state.tx.us/lab/nbsRDSforms.shtm](http://www.dshs.state.tx.us/lab/nbsRDSforms.shtm)

For questions about submission requirements such as collection, supplies, and mailing of specimens for THSteps gonorrhea and chlamydia adolescent screening, contact DSHS Laboratory Customer Service at (512) 776-6030 or toll-free 1-888-963-7111, ext. 6030 or go to the DSHS website: [www.dshs.state.tx.us/lab/default.shtm](http://www.dshs.state.tx.us/lab/default.shtm)

**Medicaid Fraud**

To report potential Medicaid fraud:

HHSC Client or Provider Fraud Investigations:

1-800-436-6184

[https://oig.hhsc.state.tx.us/Fraud_Report_Home.aspx](https://oig.hhsc.state.tx.us/Fraud_Report_Home.aspx)

**Childhood Lead Poisoning Prevention Program**

1-800-588-1248

[www.hhsc.state.tx.us/lead/default.shtm](http://www.hhsc.state.tx.us/lead/default.shtm)

**Comprehensive Care Program (CCP)**

Telephone: 1-800-846-7470

Fax: (512) 514-4212

**Medical Transportation Program (MTP)**

1-877-633-8747 | [www.hhsc.state.tx.us/QuickAnswers](http://www.hhsc.state.tx.us/QuickAnswers)

**Texas Medicaid & Healthcare Partnership (TMHP)**

[www.tmhp.com](http://www.tmhp.com)

**Resource Catalog**

Online order system for THSteps publications.

[www.dshs.state.tx.us/thsteps/THStepsCatalog.shtm](http://www.dshs.state.tx.us/thsteps/THStepsCatalog.shtm)
Behavioral Health Services

United Behavioral Health operating under the brand Optum is the administrator of mental health and substance use disorder benefits for UnitedHealthcare Community Plan members. Behavioral Health covered services are for the treatment of mental, emotional and substance use disorders. Optum works closely with UnitedHealthcare Community Plan service coordinators to develop an integrated Care Management program with medical providers of the health plan. There are dedicated service coordinators at UnitedHealthcare Community Plan as well as Service Managers (STAR+PLUS), and Care Coordinators (STAR) at Optum to assist members and Primary Care Physicians in using and receiving services under STAR and STAR+PLUS. Optum maintains a clinician center with patient resources that is accessible from the provider website, providerexpress.com, see LAWW clinician center. Health Condition Centers located at the Clinical Resources tab at providerexpress.com. These centers provide information and instruments for several mental health and substance abuse diagnoses, symptoms, treatment options, prevention and other resources in one, easy-to-access area to both behavioral clinicians and PCPs to share with patients. They are available to both behavioral clinicians and medical physicians to share with patients.

The Provider Express Recovery and Resiliency page also includes tools for use by practitioners working with individuals who are addressing mental health and substance use issues.

The benefits available for STAR & STAR+PLUS members who seek services for mental health or substance use disorders are the following:

- Emergency hospitalization and treatment for acute psychiatric episodes, or medically necessary detoxification;
- Behavioral Health professional, e.g. Licensed Clinical Social Worker; Licensed Marriage Licensed Behavioral Health Professionals, Community Mental Health Centers, Federally Qualified Health Centers, Chemical Dependency Treatment Centers, Rural Health Centers, Residential Treatment Centers
- Inpatient treatment under the direction of a psychiatrist, in an inpatient hospital;
- Individual, group and/or family therapy;
- Immediate crisis intervention services are available 24 hours/day to provide support in situations where the member’s decision-making and coping patterns is temporarily impaired;
- Evaluation and diagnostic services by a behavioral health professional to find out if a behavioral health disorder exists;
- Authorized inpatient Hospital services, including Freestanding Psychiatric Facilities;
- Evaluation and monitoring of psychotropic medication;
- Laboratory and radiology services for diagnosis and medication regulation are covered under the medical benefit;
- Medication for injectables is covered under the medical benefit at the Medicaid Rate or
- Medication administration (96372) is covered under the behavioral health benefit.

Please Note that Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within 24 hours but which does not place the member in immediate danger to himself or herself or others and the member is able to cooperate with treatment.

Urgent Condition means a health condition including an urgent Behavioral Health Situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by a provider to prevent serious deterioration of the member’s condition or health.

Waste means practices that are not cost efficient.

Court-ordered inpatient admissions for members fewer than 21 years of age are not subject to admission and lengths of stay criteria. In general a court order is
considered sufficient evidence of medical necessity and Optum is responsible for covering these services when provided under court order. More specifically, court ordered treatment is a covered benefit if the member is truly suffering from a diagnosis that needs court-ordered admission. However, court ordered treatment is NOT covered if the member is given the choice of court-ordered admission vs. incarceration. Admissions to inpatient mental health facilities as a condition of probation are non-capitated services.

Practice Information
Your practice information should be verified and updated via Provider Express to ensure the most accurate information is on file and appears in the directory. Simply log in to the secure Transactions and select “My Practice Info.”

Authorizations

Claims
Claims for the delivery of behavioral health services by physicians and other providers can be accepted electronically or on paper. However, submitting electronic claims will reduce claim processing time.

Electronic claims can be submitted via providerexpress.com and claim status may be reviewed. Claim Adjustment Requests can also be submitted via the portal.

Visit providerexpress.com for online billing instructions for professional claims. For Electronic Data Interchange (EDI) claims submissions use payer ID is 87726. Claim forms can be found at https://providerexpress.com/html/claimTips/index.html.

Paper claims can be submitted to the following address:
United Behavioral Health
P.O. Box 30760
Salt Lake City, UT 84130-0760

For inpatient claims questions, please call Optum at 866-302-3996 for STAR+PLUS members or 888-872-4205 for STAR members.

Treatment Philosophy
Guidelines for Level of Care, Psychological/Neuropsychological Testing, Coverage Determination, and Best Practices can be found at https://providerexpress.com/html/guidelines/index.html#levelOfCareGuidelines.

Health Insurance Portability and Accountability Act (HIPAA)

Members Access to Services
Providers should refer members for behavioral health services when appropriate. Members are able to self-refer for behavioral health care appointments. A referral is not required for members to use services. With appropriate agreement for disclosure of information from the member, the Behavioral Health Provider can communicate with the appropriate provider or individual regarding diagnosis and treatment planning to ensure the continuity and coordination of behavioral health care. The Behavioral Health Provider will coordinate care with the Primary Care Physician and will send initial and quarterly summary reports of a members’ behavioral health status provided the member or member’s legal guardian has provided a release of information. Medical record documentation and referral information is documented using the current DSM (or its successor) classifications. An informed release of information must accompany any exchange of member information.

The member or the provider must call Optum’s toll-free number at 866-302-3996 for STAR+PLUS members and 888-872-4205 for STAR members to verify eligibility, benefits and request authorizations. This system provides for 24-hour, telephonic availability. Emergency services, service coordination and crisis services are centralized and available 24 hours per day, 7 days per week. Face-to-face assessment for acute and crisis situations are available.
24 hours a day, 7 days a week. All members who receive inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must happen within seven (7) days from the date of discharge. Behavioral health providers will contact members who have missed an appointment within 24 hours to reschedule the appointment.

Access to routine outpatient behavioral health care is never restricted and a member is able to use routine care without a referral from the Primary Care Physician. However, notification and/or certification is required for all non-emergent services. Primary Care Physicians have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. A Primary Care Physician can offer behavioral health services when clinically appropriate and are within the scope of the Primary Care Physician’s practice. These claims would be submitted to health plan.

**Behavioral Health Needs Identification**
A full assessment is included in a treatment episode for behavioral health services, both at the beginning of and throughout treatment. In emergent situations, a medical professional in an emergency setting identifies the need for behavioral health services. An emergency is defined as any situation that arises suddenly, and threatens the life or welfare of the members or others.

**Optum Quality Improvement**
The Quality Improvement (QI) Department of United Behavioral Health operating under the brand Optum monitors the performance in the following areas:

- Access to Care
- Satisfaction
- Utilization Management
- Quality Management Patterns and Quarterly Summary Reporting
- Coordination of care between member’s Primary Care Physician and Behavioral Health Provider Specialists

Optum’s QI Department monitors the quality of care delivered to members and the outcomes of treatment through several clinical focus studies. Examples of focus studies completed are: Major Depression, Anxiety Disorder, and Medication Management, Substance Abuse Treatment and Primary Care Physician Notification.

Another method of monitoring the quality of care delivered to members is through direct review of medical records. The QI Department reviews a sample of medical records at least annually. Providers are notified of audit results with strengths and weaknesses being identified. Corrective Action Plans are required of providers when performance falls below expected thresholds.

Issues resulting from providers’ availability, non-compliance, or diminished quality of care are forwarded to Optum’s Regional Peer Review Committee. The committee reviews such cases, decides the action and notifies the provider and the health plan of all such actions. The Peer Review process is strictly confidential.

**How are Appeals or Complaints Related to Behavioral Health Services Filed and Processed?**
Member and Provider Appeals and Complaints related to behavioral health services follow the same steps outlined in this manual but should be submitted to United Behavioral Health operating under the brand Optum at the following address:

Optum
Attn. Appeals Department
PO BOX 30512
Salt Lake City, UT 84130
Phone: 866-556-8166
Fax: 855-312-1470

Information outlined here provides an overview to assist behavioral health providers when working specifically with UnitedHealthcare Community Plan STAR and STAR+PLUS members. The general Network Manual located at [providerexpress.com](http://providerexpress.com) also includes information that is relevant when working in coordination with Optum.
Overview

OptumRx™ provides retail pharmacy network claims processing, mail order pharmaceuticals and specialty pharmaceuticals management in concert with its pharmacy benefit management programs. The company also provides retail network contracting, rebate contracting and management and clinical programs, such as step therapy, formulary management and disease/drug therapy management programs that assist customers in achieving a low-cost, high-quality pharmacy benefit. Drug prior authorizations go directly through OptumRx. Outlined here you will find the specifics of their program.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>When to call</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Providers</td>
<td>Should you have any questions or require assistance, please contact the OptumRx Help Desk</td>
<td>877-305-8952</td>
</tr>
<tr>
<td>Pharmacy Benefits</td>
<td>Contact the OptumRx Help Desk for questions or inquiries on Pharmacy Benefits</td>
<td>877-305-8952</td>
</tr>
</tbody>
</table>
| Physician Prescribers       | Questions on services requiring prior authorization may be made by calling our Pharmacy Prior Authorization Desk | Physician Prescribers: Phone: 800-310-6826 Fax: 866-940-7328
                                                                                       | Pharmacies: Phone: 877-305-8952
                                                                                       | For a list of all/preferred drugs to go http://www.uhccommunityplan.com/health-professionals/TX/pharmacy-program |
| OptumRx Network Department  | Questions on how to join our network of participating pharmacies             | 800-613-3591                             |
| Pharmacy DME Providers      | DME providers wanting to join the network will need to contact UnitedHealthcare Community Plan | 866-574-6088                             |
Joining the Pharmacy Network

Texas pharmacies that want to participate in the UnitedHealthcare Community Plan Drug Program for Medicaid must be contracted prior to providing outpatient prescription services. To join the UnitedHealthcare Community Plan Pharmacy network contact the OptumRx network department at 800-613-3591. Applications will be effective the date the contract is fully executed by both parties and contracts will not be backdated. Pharmacies can only submit claims for prescriptions filled on or after the effective date of the contract. Pharmacies must also have a Texas Provider Identification (TPI) number for serving Texas Medicaid members and participate with the Texas Vendor Drug Program.

Pharmacy Provider Responsibilities

In addition to the general provider responsibilities, Pharmacy providers will:

- Adhere to the Formulary and Preferred Drug List (PDL)
- Coordinate with the prescribing physician
- Ensure members receive all medications for which they are eligible
- Coordination of benefits when a member also receives Medicare Part D, services or other insurances benefits

Formulary Information

OptumRx will adhere to the state approved formulary and preferred drug list for Texas members enrolled in UnitedHealthcare Community Plan and who are eligible for STAR and STAR+PLUS. You may view the list of covered drugs at [UHCCommunityPlan.com](http://www.uhccommunityplan.com/health-professionals/TX/pharmacy-program).

Prescriber requests for authorizations can be made by calling the Pharmacy Help Desk 800-310-6826 or by fax 866-940-7328. Prior authorization request forms can be found at [UHCCommunityPlan.com](http://www.uhccommunityplan.com). Certain drugs have limitations on coverage as described below:

Prior Authorization

Some drugs on the state approved formulary and preferred drug list may require prior authorization. Pharmacists receiving prescriptions for drugs requiring Prior Authorization (PA) should work with the prescribing physician if the prescription can be changed to a preferred alternative medication. If a preferred alternative is not appropriate the physician should then contact the Pharmacy Help Desk at 800-310-6826 with questions concerning the prior authorization process. The drugs that are preferred and those that require prior authorizations are designated in the list of drugs at [UHCCommunityPlan.com](http://www.uhccommunityplan.com).

Step Therapy

Some drugs are routinely covered only after a sufficient trial of an indicated first-line agent has been adequately tried and failed. These medications may also be requested through the prior authorization process. While lower cost Preferred Drug List (PDL) alternatives may be appropriate in many instances, other non-PDL alternatives are available with prior authorization.

Days’ Supply Dispensing Limitation

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

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

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

Additions to the quantity limitations program drug list will be made from time to time and providers notified accordingly. As always, we recognize that 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 UHCCommunitiyPlan.com.

Formulary Information Available For Handheld Devices

The free service 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 www.epocrates.com and sign up for free Evocates Rx. After signing up, be sure to 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.

Multisource Drug Prescription Processing

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

DAW “1” will reimburse at normal calculated cost including comparison to Usual & Customary and Gross Amount Due.

Multi-source brand drugs will pay. The pharmacy submits a “5” in a “Dispense as Written” (DAW) Field 408-D8).

The Multi-source brand drug will be subject to Maximum Allowable Cost (MAC) Pricing.

E-Prescribing

Electronic Prescribing (e-prescribing or eRx) is a prescribing physician’s ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy. It 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 PBM or Payer and the prescriber.

E-prescribing helps providers save time, money and most importantly, eliminates medication confusion. UnitedHealthcare Community Plan supports e-prescribing for pharmacy claims via superscripts®. The NCPDP E1 transaction electronically verifies member eligibility.
Pharmacies should ensure they are submitting the “Prescription Origin Code” (Field 419-DJ) on all billing submissions in support for e-prescribing transactions. While the field is optional for National Council for Prescription Drug Programs (NCPDP) B1 transactions in version 5.1, it is required for D.0 B1 transactions.

**Pharmacy Dispensing of 72-hour Supply Emergency Prescriptions**

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (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 prior authorization (PA) cannot be resolved within 24 hours for a medication that is listed 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 prior authorization (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: When submitting a 72-hour supply, please submit the following:

- “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’

Call 800-310-6826 for more information about the 72-hour emergency prescription supply policy. A 72-hour emergency prescription will be paid in full to the pharmacy.

- A 72-hour supply prescription will be issued on a one-time basis per member per drug
- The quantity of medication dispensed must be limited to a 72-hour supply
- When dealing with products that cannot be dispensed as an exact 72-hour supply, the minimum quantity must be dispensed as a 72-hour supply
- Examples of such products include, but are not limited to:
  - Metered dose inhalers
  - Nasal sprays
  - Topical preparations
  - Powders for reconstitution

**Home Health Supplies**

Pharmacies enrolled with the Vendor Drug Program (VDP) and Medicaid managed care organizations (MCOs) will be able to dispense a limited set of home health supplies commonly found in a pharmacy to Medicaid clients. The project will provide Medicaid clients greater access to these pharmacy home health supplies by giving them the option to obtain this home health benefit through a pharmacy or through a DME provider. It is an extension of the Frew v. Janek agreement, which requires HHSC to make efforts to increase the number of pharmacy providers authorized to provide DME items. The following items are included in this list of Limited Set of Home Health Supplies (LHHS).
### LHHS Item

<table>
<thead>
<tr>
<th>LHHS Item</th>
<th>*HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin Syringes</td>
<td>A4206</td>
</tr>
<tr>
<td>Insulin Needles</td>
<td>A4215</td>
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<tr>
<td>Diabetic Test Strips</td>
<td>A4253</td>
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<tr>
<td>Diabetic Monitor &amp; Test Strips</td>
<td>A9275</td>
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<tr>
<td>Diabetic Lancets</td>
<td>A4259</td>
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<tr>
<td>Aerosol Holding Chamber</td>
<td>A4627</td>
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<tr>
<td>Diabetic Monitor (talking)</td>
<td>E2100</td>
</tr>
<tr>
<td>Spring Powered Device for Lancet</td>
<td>A4258</td>
</tr>
<tr>
<td>Oral Electrolyte</td>
<td>B4103</td>
</tr>
<tr>
<td>Hypertonic saline (hyper-sal)</td>
<td>T1999</td>
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</tbody>
</table>

A prescription (faxed, written, or electronic) is required with the following information: client’s name, description of the supply to be provided, quantity to dispense (quantity per day or month) and prescribed dosage. UnitedHealthcare Community Plan billing requirements, reimbursement rates and coverage limitations apply. If you have any questions about how to bill a managed care claim, please contact UnitedHealthcare Community Plan at 888-887-9003.

### Pharmacy Payment

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

Follow these simple steps to enroll in the OptumRx Pharmacy EFT Program:

- Log on to [www.PrescriptionSolutions.com/PharmacyEft](http://www.PrescriptionSolutions.com/PharmacyEft) 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
  - or Fax: 800-732-7601
- Click on the online link to complete the EFT Trading Partner Information Request. This form will be used to set up the 835 electronic remittance advice file transfer
- Refer to the OptumRx Pharmacy Manual for EFT Program requirements and enrollment information or call the Help Desk at 877-305-8952.

### Pharmacy Claims Processing

Please refer to the OptumRx Pharmacy Provider Manual and payer specification documents for complete claims submission requirements and guidelines, including NCPDP format. Electronically submitted pharmacy claims are processed within eighteen (18) days and all other claims are processed within thirty (30) days. Pharmacy claims that are not submitted electronically are processed within twenty one (21) days.

### Pharmacy Reference

Processor Information for UnitedHealthcare Community Plan STAR and STAR+PLUS Programs:

- **Name of Processor:** OptumRx™
- **Bank Identification Number (BIN):** 610494
- **Processor Control Number (PCN):** 9999
- **Submitted Group:** ACUTX
Quality Management

Quality Improvement Overview

UnitedHealthcare Community Plan maintains a Quality Assessment and Performance Improvement (QAPI) Program to address both clinical and non-clinical processes and outcomes including quality assessments and performance improvement standards. Specific activities of the QAPI Program designed to improve clinical and non-clinical processes and outcomes include the following:

- Foster data-driven decision making
- Focus studies and utilization management which require all encounter data to be submitted
- Solicit member and provider input on performance and QAPI activities
- Establish annual objectives for planned projects or activities including clinical and nonclinical programs or initiatives and measurement activities
- Evaluate performance using objective quality and utilization management indicators
- Support continuous ongoing measurement of clinical and nonclinical focus study effectiveness and member satisfaction
- Support programmatic improvements of clinical and nonclinical processes based on findings from on-going measurements
- Support the measurement of effectiveness and member satisfaction, and continued development and implementation of improvement interventions as appropriate

The UnitedHealthcare Community Plan Executive Committee and governing body delegate’s authority for the operational implementation of the QAPI to the UnitedHealthcare Community Plan Quality Management Committee (QMC) and the Medical Director with involvement from senior executive management.

UnitedHealthcare Community Plan Network providers are contractually obligated to participate in QAPI activities including Performance Improvement Projects. Providers may also participate by becoming a member of the QMC or its subcommittees. Results of the QAPI are available upon request from Provider Relations.

As part of the quality improvement process, UnitedHealthcare Community Plan adopts Clinical Practice Guidelines from the National Guideline Clearinghouse that are based on valid and reliable clinical evidence. UnitedHealthcare Community Plan reviews and updates the appropriateness of adopted Clinical Practice Guidelines in consideration of the needs of the UnitedHealthcare Community Plan membership. A full listing of the guidelines is located at UHCCommunityPlan.com.

Provider Profiling Performance Summaries

UnitedHealthcare Community Plan collects utilization, quality of care, and quality of service data as part of its Quality Improvement Program (QIP) for each physician on an annual basis. The Provider Profile Performance Summary is a physician-specific report that details provision of care during the previous measurement year. The profile is a multidimensional assessment of a physician’s performance that serves as individual practice feedback and, when complied with other physician summaries, provides a view of performance for the overall provider network. The reports are designed to help identify strengths as well as potential opportunities that may improve member health care outcomes. Profiling data does not affect a physician’s standing with UnitedHealthcare Community Plan and physicians are encouraged to provide input regarding the performance results that may assist in enhancing member quality of care.
Provider profiling performance indicators may include, but are not limited to, the following:

Utilization Indicators

• Hospital Admissions
• Emergency Room Visits

Clinical Indicators

• Adherence to Clinical Practice Guidelines
• Quality Indicators
• Preventive Health – Adult Men and Women

Member Satisfaction Indicators

• Plan average for member satisfaction with Provider/office staff and access to care

**Health Effectiveness Data and Information Set (HEDIS®)**

HEDIS is a tool to measure performance on dimensions of care and service which was developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS is designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans. Presented here is an abbreviated pocket resource for primary HEDIS standards. Detailed information is available at UnitedHealthcareonline.com and www.NCQA.org.
### 2012 HEDIS Measures at a Glance – Children/Adolescents ages Birth to 17 – Preventive Care

**Ages Birth to Age 2**

- **Childhood Immunization Status before Age 2**
  - Before Age 2:
    - 4 Dtap
    - 3 IPV
    - 1 MMR
    - 3 HiB
    - 3 HepB
    - 1 Varicella Zoster Virus
    - 4 PCV
    - 2 HepA
    - 2 RV
    - 2 flu vaccines

- **Well-Child Visits in the First 15 Months**
  - Six or more well-care visits by age 15 months

- **Lead Screening in Children**
  - Capillary or venous blood test for lead before age 2
  - (Many states require two capillary or venous tests by age 2).

- **Annual Dental Visit**
  - Refer for dental care at age 2
  - Refer for dental care annually
  - Refer for dental care annually
  - Refer for dental care annually

- **Children and Adolescents’ Access to Primary Care Practitioners**
  - Patients seen at least once annually after age 1
  - Patients seen at least once annually
  - Patients seen at least once annually
  - Patients seen at least once annually

- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life**
  - One or more well-care visits each year

- **Weight Assessment and Counseling**
  - Body Mass Index (BMI) percentile
  - Counsel for nutrition
  - Counsel for physical activity
  - BMI percentile
  - Counsel for nutrition
  - BMI percentile
  - Counsel for nutrition

**Ages 3 to 6**

- **Immunizations for Adolescents Ages 11-12**
  - Before Age 13:
    - One Meningococcal
    - One Tdap or Td (Tetanus and diphtheria)

- **Adolescent Well-Care Visits**
  - One or more well-care visits each year

- **Chlamydia Screening in Women Ages 16 or Older**
  - Chlamydia test annually if patient is sexually active

- **Frequency of Ongoing Prenatal Care**
  - Greater than or equal to 81% of expected prenatal visits*

- **Postpartum Care**
  - Postpartum care visit between 21 and 56 days after delivery (not the C-section suture removal appointment)

- **Timeliness of Prenatal Care**
  - Initial prenatal visit in the first trimester (or within 42 days of enrollment in plan)

- **HPV vaccine**
  - Three doses of HPV before age 13

**Ages 7 to 10**

- **Appropriate Treatment for Children With Upper Respiratory Infection (URI) Ages 3 Months and Older**
  - Avoid antibiotic medication prescription for URI

- **Appropriate Testing for Children With Pharyngitis Ages 2 and Older**
  - Group A streptococcus test with a diagnosis pharyngitis and a prescribed antibiotic

- **Use of Appropriate Medications for People With Asthma Ages 5 and Older**
  - One or more formulary prescriptions for a preferred therapy for patients with asthma

- **Attention deficit hyperactivity disorder (ADHD) Medication Management Ages 6-12**
  - Follow-up visit within 30 days of prescribing an ADHD medication
  - Two follow-up visits within nine months
  - Monitor medication compliance

- **Medication Management for People with Asthma Ages 5 and Older**
  - Monitor asthma controller medication compliance

**Ages 11 to 17**

- **Condition Management**
  - Initial treatment within 14 days of engagement of assistance

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*Refer to the American Academy of Pediatrics and The American College of Obstetricians and Gynecologists, Sixth Edition, Guidelines for Perinatal Care for recommended number of perinatal visits.
Contracting/Credentialing

Provider Network

UnitedHealthcare Community Plan is responsible for arranging the provision of a comprehensive spectrum of health services for our member. In order to fulfill this responsibility, UnitedHealthcare Community Plan monitors a network consisting of licensed qualified professionals from all disciplines. These providers represent an array of clinical and cultural specialties. For questions regarding our credentialing process contact 877-842-3210.

Non-Discrimination

UnitedHealthcare Community Plan does not deny or limit the participation of any provider or facility in the network, and/or otherwise discriminate against any provider for facility based solely on any characteristic protected under state or federal discrimination laws.

Furthermore, UnitedHealthcare Community Plan has never had a policy of terminating any provider who: 1) advocated on behalf of a member; 2) filed a complaint against UnitedHealthcare Community Plan; 3) appealed a decision of UnitedHealthcare Community Plan; or 4) requested a review of a termination decision or challenged a termination decision of UnitedHealthcare Community Plan.

Credentialing

UnitedHealthcare Community Plan is required to credential providers according to rigorous criteria that reflect professional and community standards as well as applicable laws and regulations. These criteria include (but are not limited to) satisfaction of the following standards:

- Current state license (if applicable)
- Medicare Participation Certification (if applicable)
- Certifications and/or Accreditation Certificates (e.g. JCAHO, Medicare, etc.)
- Declaration Sheet and/or Certificate of Insurance for BOTH Current Professional Malpractice and Comprehensive General Liability Insurance Policies
- W-9
- National Provider Identification number
- Texas Provider Identification number for those providers serving Medicaid

Providers are re-credentialed every thirty six (36) months unless state law or client policies require different re-credentialing cycle. During re-credentialing, you will be required to provide a current copy of the following:

- All licenses required by your state for the services you offer
- Accreditation certificate and/or letters from accrediting body
- General and professional liability insurance certificates
- W-9 Forms
- Signed malpractice claims statement/history
- Staff roster, including attending physicians
- Updated demographics, if applicable

Medical Office Standards

Providers are expected to adhere to UnitedHealthcare Community Plan medical office standards. Following are the criteria for provider offices in which members receive services.

Exterior Site

- Easily accessible
- Adequate parking for size and style of practice
- Handicapped accessible
- Sign is visible
- Site exterior is safe, free of debris, and adequately maintained
Interior Office

- Adequate seating in waiting area for size and style of practice
- Office is clean and safe
- Handicapped access to examination room and bathroom
- Adequate examination rooms for size and style of practice
- Exit sign is visible
- All building and fire certifications are current

Quality Controls

- Proper disposal of bio-hazardous material
- Quality control and certification for laboratory and x-ray equipment
- Sample medications are not accessible to patients
- Prescription pads are not accessible to patients
- Narcotics are controlled and secured
- Proper disposal of expired medications
- Biologics are refrigerated, separate and apart from food
- Office evacuation or emergency plan is posted
- Properly maintained crash cart

Confidentiality

- Policy in place and enforced
- Confidentiality agreement signed and renewed annually by all employees
- Physical environment conducive to confidential treatment and exchanges of information
- Member medical records have proper storage and environment for handling

Provider Termination

Involuntary Termination

Providers will need to refer to the terms of termination and timeframes presented in their UnitedHealthcare Community Plan Provider Agreement.

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

You must notify us, in writing, at the address stated in your Provider Agreement within ten (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

Termination for Gifts and Gratuities

Network providers may not offer or give anything of value to an officer or employee of UnitedHealthcare Community Plan or HHSC as this would be in violation of state law. A “thing of value” is defined as any item of tangible or intangible property that has a monetary value of more than $50.00. This includes, but is not limited to cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and federal law. UnitedHealthcare Community Plan may terminate any provider contracted at any time for violation of this stated requirement.
Voluntary Termination
Providers are required to provide advanced written notice ninety (90) days to UnitedHealthcare Community Plan and the affected members. For the purpose of the continuity of care, providers shall 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 provider and that referral completed prior to the termination date. In some instances UnitedHealthcare Community Plan may make reasonable and medically appropriate provisions for the assumption of covered services to another in network provider.

If the provider has already received compensation for future services, then the provider shall continue providing those covered services to any member assigned to the provider as of the termination notice until the end of the period for which the provider received the advanced payment, unless otherwise instructed by UnitedHealthcare Community Plan. The provider shall be compensated during this period according to the rate established in the Provider Agreement.

Transition Member Care Following Termination of Your Participation
If your network participation terminates for any reason, you are required to participate in the transition of your members toward timely and effective care. This requirement may include providing service(s) for a reasonable time at our contracted rate. Customer Service is available to help you and our members with the transition.

UnitedHealthcare Community Plan Provider Resources

Network Management
UnitedHealthcare Community Plan Agreement begins in Network Management. This is your resource for contractual issues, fee schedules and ensuring that your contact information is correct. Your information should match your claims submission. If you have any changes or updates, such as tax ID or name change, contact Network Management at 866-574-6088. Changes also need to be communicated to Texas Medicaid & Healthcare Partnership by mail or fax to the following address:

Texas Medicaid & Healthcare Partnership (TMHP)
Provider Enrollment
P.O. Box 200795
Austin, TX 78720-0795
Fax: 512-514-4214

Physician and Provider Advocates
Physician and provider advocates are responsible for education and guidance when interfacing with UnitedHealthcare Community Plan. They can also be reached via email (providerservicesTX@uhc.com). They conduct town halls, host webinars and are also available for office visits. Our Advocates are in the community working with our network providers. For immediate assistance, please contact Customer Service where we have a dedicated team to answer provider questions.
Provider Engagement
The Provider Engagement team is an innovative approach by UnitedHealthcare Community Plan to engage our High Volume PCPs, Federally Qualified Health Centers and Rural Health Clinics to offer a concierge experience and a high level of customer service. The provider engagement team focuses on providing a thorough explanation of health plan attributes processes, health education programs and outcomes to the provider community.

We strive to share and implement our innovative programs that provide a unique positioning in the market and action plans that deliver a competitive advantage, this to distinguish UnitedHealthcare Community Plan among other MCOs.

Provider Engagement Specialists create a provider experience that leads high volume physician practices to partner with UnitedHealthcare Community Plan, resulting in improved provider satisfaction. We work closely with our provider relations team to provide a streamline customer service experience and meeting the needs of network PCPs.

Member Advocates
Member Advocates support the member experience of UnitedHealthcare Community Plan. They are Bi-lingual in English and Spanish, but are able to secure other language translation as necessary. A Member Advocate becomes involved upon request as the result of a call to Customer Service 888-887-9003. Some of their services include the following:

- Maintain or renew membership
- Secure a PCPs that meets member cultural and language needs
- Locate a specialist, hospitals and other providers
- Obtain covered services
- Change PCP if necessary
- File a complaint
- Note a name or address change
- Secure transportation
Provider Responsibilities

Communication Between Providers and Members

Provider Agreements executed by UnitedHealthcare Community Plan contain language that encourage providers to discuss treatment options and associated risks/benefits with members and/or their representatives as appropriate, regardless of whether the treatment is covered under the member’s benefit contract. Nothing in the Provider/Facility Agreement is intended to interfere with the provider’s relationship with members as patients or with UnitedHealthcare Community Plan’s ability to administer quality improvement, utilization management and credentialing programs.

Members, and/or their representatives have the right to actively participate in the planning and implementation of their care. To ensure this opportunity, UnitedHealthcare Community Plan developed a policy that requires the provider to do the following.

• Educate members, and/or their representatives, regarding member health needs
• Share findings of history and physical examinations
• Discuss potential treatment options (without regard to plan coverage), side effects of treatment, and management of symptoms
• Recognize that members, and/or their representatives, have the right to choose the final course of action among clinically acceptable choices

Responsibilities

The following responsibilities apply to all UnitedHealthcare Community Plan providers including Primary Care Physicians (PCPs), specialists, ancillary care providers, long term services and support providers and other health care providers.

• Verify member eligibility prior to service delivery
• Coordinate services in line with the PCP as the host of the member’s medical home
• Refer to in network health care providers, including specialists, facilities and contractors
• Provide justification to UnitedHealthcare Community Plan regarding requests for out-of-network/referrals for providers that are NOT contracted with UnitedHealthcare Community Plan
• Adhere to UnitedHealthcare Community Plan authorization policies
• Provide appropriate health education and instructions to the member or, if applicable, to primary caregivers or patient representatives
• Adhere to UnitedHealthcare Community Plan appointment availability and accessibility standards
• Adhere to the UnitedHealthcare Community Plan medical record keeping and chart review standards by documenting in member medical record the appropriate transfer of medical information with other health care providers, including specialists. UnitedHealthcare Community Plan may request copies of medical records; these should be submitted in accordance to the guidelines in your Provider Agreement. Providers must document prominently in the member medical record whether or not the member has in place an Advance Directive
• Use electronic medical records in compliance with requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws
• Coordinate with UnitedHealthcare Community Plan regarding member special access requirements
• Provide services in compliance with generally accepted medical and behavioral health standards for the community in which the services are rendered
• Educate members about their right to access a contracted OB/GYN without a referral

• Provide services to all members in a nondiscriminatory manner. Not to discriminate against any member on the basis of race, color, creed, religion, sex, sexual preference, national origin, health status, income level, or basis that they are members of UnitedHealthcare Community Plan

• Advocate for members as needed

• Notify UnitedHealthcare Community Plan of any member capacity changes (i.e., not accepting any new patients, otherwise unavailable status)

• Notify UnitedHealthcare Community Plan of any member changes relating to physical condition, behavioral health or eligibility

• You must not charge a co-payment for any UnitedHealthcare Community Plan STAR or STAR+PLUS Program member. Provider may not balance bill member

• Participate in UnitedHealthcare Community Plan Quality Improvement initiatives, including adopted Best Practice Guidelines (See Quality Improvement in this manual)

• Abide by state and federal laws relating to member advance directives and document in a prominent location in the member’s medical record whether or not the member has executed an advance directive. See member Rights & Responsibilities and Medical Records in this manual.

• Ensure that discharge planning is in place for each member admitted to hospital

• Ensure that home and community arrangements are secured prior to member hospital discharge

• Provide timely follow-up post emergency care or hospitalization within seven days

Abuse/Neglect/Violence

A report needs to be filed with the Texas Department of Protective and Regulatory Services (DFPS) within 48 hours of even suspecting abuse and/or neglect. Document the report in the member medical record.

Phone: 800-252-5400

Report online at: txabusehotline.org

Member medical records will be made available for inquest.

PCPs/Medical Home

UnitedHealthcare Community Plan members are required to identify a PCP that will coordinate the use of health care services. The designated PCP is responsible for providing and coordinating medical care for UnitedHealthcare Community Plan members.

A PCP may practice in any of the following areas:

• General Practice
• Internal Medicine
• Family Practice
• Pediatrics
• Obstetrics/Gynecology (OB/GYN)
• Certified Nurse Midwives (CNM) *
• Provider Assistants (PA) *
• Rural Health Clinics (RHC)
• Federally Qualified Health Centers
• Specialists who are willing to serve as PCPs for selected members with special health care needs

*Practicing under the supervision of a physician.
Members may change their assigned PCP, by contacting Customer Service at 888-887-9003. New member ID cards identifying the newly selected PCP will be issued. Members may access any contracted PCP, even if the PCP’s name is not listed on the member ID card.

**PCP Medical Home**

PCPs are expected to deliver their care of UnitedHealthcare Community Plan members according to the Medical Home model:

**To provide and coordinate care that is:**
- Comprehensive
- Preventative
- Accessible in time of need
- Collaborative

**Members Right to Designate an OB/GYN:**

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

**Attention Female Members**

Members have the right to select an OB/GYN without a referral from their Primary Care Physician. 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

**PCP Responsibilities**

**Service Provision and Coordination of Care**

In addition to the previously listed UnitedHealthcare Community Plan provider responsibilities, the provider is responsible for the following:

- Offer behavioral health assessments, and when clinically appropriate and the services are within professional scope of practice
- Conform to the guidelines of the Americans with Disabilities Act (ADA)
- Provide pediatric services in accordance with the American Academy of Pediatrics (AAP) recommendations and the and the Agency for Healthcare Research and Quality (AHRQ) – Put Prevention into Practice
- Perform physical examinations as appropriate given the subjective and objective information for presenting complaints, the Clinical Practice Guidelines adopted by UnitedHealthcare Community Plan, Health Effectiveness Data and Information Set (HEDIS) and the Texas Medicaid Provider Procedures Manual located at [TMHP.com](http://TMHP.com)
- Members with Special Health Care Needs to have direct access to a specialist as appropriate for the Member’s condition and identified needs, such as a standing referral to a specialty physician
- As your practice is the member Medical Home, educate members as to the appropriate use of emergency rooms and facilities. Assess and treat any members that present in your office during office hours after first presenting in an emergency room or facility
- Every new member needs a comprehensive initial health assessment
- Become a certified Texas Health Steps (THSteps) provider and adhere to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Periodicity Schedule for members through twenty (20) years of age or provide documentation of member refusal
• If not a certified Texas Health Steps provider, refer STAR and STAR+PLUS members up through twenty (20) years of age to a certified THSteps provider

• Provide preventive care and physical examinations, including breast exams and routine gynecological care, Pap smear and pelvic exam as indicated by checkup schedule

• Ensure continuity of care for members related to pregnant women, when a member moves out of the service area and surrounding pre-existing conditions not imposed.

• Members or Providers may contact our customer service department with any questions at 888-887-9003

• Incorporate family member in decision making at least in those situations where they are the primary care givers of the member

• Refer to the Early Childhood Intervention (ECI) program when developmental delays are suspected

• Refer to Personal Care Services or Personal Assistance Services when necessary

• Coordinate the care of members and provide social support information with Medicaid programs, public health agencies and community resources that make medical, nutritional, behavioral, educational land outreach services available to members

• This includes coordination with the Women Infant and Children (WIC) Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin

• Ensure a member’s right to obtain medication from any network pharmacy

• Ensure a member’s right to select and have access to, without a PCP referral, a network ophthalmologist or therapeutic optometrist to provide health care services other than surgery

• Regularly review for accuracy the UnitedHealthcare Community Plan panel of members assigned to your practice as the PCP, available monthly at UnitedHealthcare Online

• Recognize that members can access a second opinion regarding the use of any health care service. The second opinion must be provided by a network provider

• It is the obligation of the PCP to notify the member of the second opinion consultation once it is approved and to forward copies of relevant records to the consulting provider

• The PCP then notifies UnitedHealthcare Community Plan and the member of the outcome of the second opinion

Long Term Services and Supports (LTSS) Provider Responsibilities

LTSS providers responsible for the following specific responsibilities in addition to general provider responsibilities already listed.

• Contact UnitedHealthcare Community Plan to verify member eligibility or authorizations for service

• Continuity of Care

• Medicaid/Medicare coordination

• Coordination of benefits for members dually eligible for Medicare

• Notify UnitedHealthcare Community Plan of any change in member physical or mental condition

• Provide covered Medicaid services to eligible UnitedHealthcare Community Plan members in the same manner, to the same extent, and the same quality as services provided to other patients

• Services made available to other patients must be made available to members, if the services are covered by UnitedHealthcare Community Plan

• Members must be treated in a nondiscriminatory manner, without fear or threat of retaliation

Specialist Provider Responsibilities

In addition to the general provider responsibilities, the specialist is responsible to coordinate with the PCP when a member requires additional treatment. The
specialist must contact the PCP to coordinate service referrals.

• The treating or consulting specialist must first seek prior authorization or notify UnitedHealthcare Community Plan in the event of member hospitalization and for other necessary prior authorizations or notifications pertaining to specialist service provision.

Employment Assistance and Supported Employment Provider Responsibilities

Providers must develop and update quarterly a plan for delivering employment assistance services that includes specified components.

Contracted providers of long-term services and supports for individual who have intellectual or developmental disabilities qualify as Optum network providers or as employment assistance and supported employment providers. Contracted providers of case management or service coordination services for individuals who have intellectual or developmental disabilities qualify as Optum network providers.

Providers of Targeted Case Management and Mental Health Rehabilitation

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

Mental Health Rehabilitative Services Qualified Providers

Qualified Mental Health Professionals for Community Services (QMHP-CS)
The requirement minimums for a QMHP-CS are as follows:

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

A Licensed Practitioner of the Healing Arts (LPHA) is automatically certified as a QMHP-CS
1. A physician;
2. A licensed professional counselor;
3. A licensed clinical social worker;
4. A licensed psychologist;
5. An advanced practice nurse; or
6. A licensed marriage and family therapist

A Community Services Specialist Provider (CSSP) can be a QMHP-CS if acting under the supervision of an LPHA. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by an LPHA.

Mental Health Targeted Case Management Qualified Providers

A qualified provider of mental health targeted case management must:

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

• Be a Registered Nurse (RN).

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

• High school diploma or high school equivalency;

• Three continuous years of documented full-time experience
  in the provision of mental health case management services
  as of August 30, 2004; and

• Demonstrated competency in the provision and
documentation of case management services.

• A case manager must be clinically supervised by another
  qualified case manager who meets the criteria.

The MCO is prohibited from establishing additional
supervisory protocols with respect to the above-listed
provider types. Further, the MCO may not require the name
of a performing provider on claims submitted to the MCO if
that provider is not a type that enrolls in Medicaid (such as
CSSPs, PPs, FPs, non-LPHA QMHPs, and Targeted
Case Managers).

How to Help a Member Find Dental Care
The Dental Plan member ID card lists the name and phone
number of a member’s Main Dental Home provider. The
member can contact the dental plan to select a different Main
Dental Home provider at any time. If the member selects a
different Main Dental Home provider, the change is reflected
immediately in the dental plan’s system, and the member is
mailed a new ID card within 5 business days.

If a member does not have a dental plan assigned or is
missing a care from a dental plan, the Member can contact
the Medicaid Enrollment Broker’s toll-free telephone number
at 800-964-2777 (Medicaid members).

Comply with Protocols
All providers will cooperate with UnitedHealthcare
Community Plan and payer’s protocols including those
protocols contained in this manual. These procedures
and protocols are updated as necessary. A thirty (30) day
notification will be provided for material changes. As a
contracted Managed Care Organization (MCO) with the
Texas Health and Human Services Commission, we are
required to make mandated updates per state and
federal changes.

Participate in Quality Initiatives
Cooperation with UnitedHealthcare Community Plan Quality
Improvement programs and initiatives (including member
safety, risk reduction and data confidentiality procedures)
is a requirement of network participation. This includes
observance of the UnitedHealthcare Community Plan adopted
Clinical Practice Guidelines - available in this manual and
posted at UHCCommunityPlan.com.
Access and Availability

A PCP has the responsibility to ensure that necessary health care services are available to members 24 hours a day/7 days a week. This includes the responsibility to return member after-hour phone calls within thirty (30) minutes of the phone call. When unable to provide this level of care for the member, you must arrange with another in network PCP to cover this availability, Note: A hospital emergency room is not an acceptable substitute for a covering provider. All providers need to adhere to the Access Standards in emergencies and when scheduling appointments (see chart).

UnitedHealthcare Community Plan Access Standards

<table>
<thead>
<tr>
<th>Condition*</th>
<th>Description</th>
<th>Timeframe (Requirements for Scheduling Appointments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine</td>
<td>Primary Care (including specialists, such as behavioral health providers)</td>
<td>Within 14 days</td>
</tr>
<tr>
<td>Routine</td>
<td>Specialty Care Referrals</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>Adults and children</td>
<td>Within 90 days</td>
</tr>
<tr>
<td>Behavioral Health Post Hospitalization</td>
<td>Adults and children</td>
<td>Within 7 days from the date of discharge</td>
</tr>
<tr>
<td>First Prenatal Care</td>
<td>Routine (High Risk or new members in 3rd Trimester should be seen within 5 days or immediately if it is an emergency)</td>
<td>As soon as practicable but in no case longer than 14 days of request or within 5 days if in the 3rd trimester</td>
</tr>
<tr>
<td>Return Prenatal Care</td>
<td>In first 28 weeks</td>
<td>Every 4 weeks</td>
</tr>
<tr>
<td></td>
<td>28 – 36 weeks</td>
<td>Every 2 – 3 weeks</td>
</tr>
<tr>
<td></td>
<td>37 weeks plus</td>
<td>Weekly</td>
</tr>
<tr>
<td></td>
<td>Postpartum</td>
<td>Within 60 days</td>
</tr>
<tr>
<td>Well-Child Checkup</td>
<td>Newborns</td>
<td>Within first 14 days</td>
</tr>
<tr>
<td>New Member</td>
<td>Birth through age 20, overdue or upcoming well-child checkups, including Texas Health Steps medical checkups</td>
<td>As soon as practicable but in no case longer than 90 days</td>
</tr>
<tr>
<td>Texas Health Steps Medical Checkup</td>
<td>The Texas Health Steps medical checkup for a member age 36 months and older is due on the child’s birthday</td>
<td>As soon as practicable but in no case later than 14 days</td>
</tr>
<tr>
<td>Well-Adult Checkup</td>
<td>Wellness exams and preventative services</td>
<td>Within 10 weeks</td>
</tr>
<tr>
<td>Urgent</td>
<td>If not addressed in a timely, could escalate to an emergency situation (specialists also)</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency</td>
<td>Assessment or care is needed to stabilize a condition or situation (specialists also)</td>
<td>Immediately at the service delivery site</td>
</tr>
</tbody>
</table>

*Initial assessment for new members need to be completed within 90 days of enrollment
Domestic Violence, Abuse and Neglect

All Providers need to report within forty-eight (48) hours any suspicion, or threat of potential, abuse or neglect. The provider or licensed/certified health professional should file a report with the Texas Department of Family and Protective Services (DFPS) at 800-252-5400 or by contacting their local or State law enforcement agency. Reports should be documented in the member medical record and the medical record must be made available upon request from DFPS. Providers must schedule medical and behavioral health appointments within fourteen (14) days unless requested earlier by DFPS.

Providers must cooperate and coordinate with the DFPS and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS, including requests to provide medical records and testifying in court for child protection litigation and submitting Health Passport information in a timely manner.

Providers must be compliant with all provisions of the DFPS service plan. Any modification or termination of ordered services must be presented and approved by the court with jurisdiction over the matter for decision. A member, or the parent, or guardian whose rights are subject to an Order or Service Plan cannot appeal the necessity of the services ordered through UnitedHealthcare Community Plan Appeals process or to HHSC.

After Hour Care

While true emergencies and life threatening situations require the immediate services of an emergency department, treatment after hours can be provided quickly and efficiently at an urgent care center or a provider with extended hours, if applicable. In the event that you are not able to provide services at that time, where available and appropriate utilize urgent care centers or other providers that do offer extended hours.

Provider-initiated Member Transfers

A provider may wish to transfer a member due to an inability to establish or maintain a professional relationship. To initiate the transfer, the provider needs to contact UnitedHealthcare Community Plan in writing, via fax, mail, or email to include the specific documentation of the event(s). Documentation needs to include the following information: date(s) of failed appointments and/or a detailed account of the reason(s) for the termination request; member identifying information (i.e. name, date of birth, Medicaid number address and telephone number) and provider name. Upon receipt of the request, UnitedHealthcare Community Plan will outreach to the member to notify them of the request and to offer assistance in obtaining a new provider.

- Work with any non-compliant member toward resolution of concerns and the UnitedHealthcare Community Plan Service Coordination/Care Management representative if the member is in that program.
- Any requests to remove members from panel due to noncompliance are required in writing at least thirty (30) days in advance of the effective date. See Enrollment information in this manual for further detail.
- Provider is responsible for transitioning member medical record and treatment plan, including active prescriptions to accepting provider.
Fraud, Waste and Abuse

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

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

**Waste** is defined as billing or other information submitted for items or services where there was no intent to deceive or misrepresent, but the outcome resulted in an overpayment of funds.

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

- Federal False Claims Act prohibits knowingly submitting false or fraudulent claims or claims-related information to the federal government. The Act permits any person who knows of fraud against the United States Government to file a lawsuit on behalf of the Government against the person or business that committed the fraud.
- Texas False Claims Act, a person may also be liable if he presents a claim for payment under the Medicaid program for a product or service that was rendered by an unlicensed Provider or that has not been approved by a 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.
- Whistleblower Act, it 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 his or her employer because the employee investigates, files, or participates in a qui tam action. The protections includes reinstatement and damages of double the amount of lost wages if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against.

Any of the following avenues may be used to report the suspected fraud, waste, and/or abuse.

- Health and Human Services Commission Office of Inspector General 800-436-6184
- Visit [https://oig.hhsc.state.tx.us/](https://oig.hhsc.state.tx.us/) and select “I want to...” then select “Report fraud, waste or abuse” to complete the online form
- UnitedHealthcare Community Plan 888-887-9003
- UnitedHealthcare Community Plan
  Attn: Compliance
  14141 Southwest Freeway, Ste. 800,
  Sugar Land, TX 77478

The Centers for Medicare & Medicaid Services (CMS) provides Medicaid program integrity education for providers through the Center for Program Integrity. Available educational resources promote best practices and increase awareness of Medicaid fraud, waste, and abuse.

These resources are located on the CMS website on the Medicaid Program Integrity Education web page.
Medical Records

Protect Confidentiality of 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. Providers agree to comply in all relevant respects with the applicable requirements of the Health Insurance Portability Accountability Act of 1996 (HIPAA) and associated regulations, including applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations, and payment. UnitedHealthcare Community Plan safeguards the information to prevent unintentional disclosure of Protected Health Information (PHI). These safeguards include passwords, screensavers, firewalls and other computer protection, including restricted access to confidential conversations and shredding of information that includes PHI. All UnitedHealthcare Community Plan personnel are periodically trained on HIPAA and confidentiality requirements.

All member information is created and handled must be in accordance with the Health Insurance Portability Accountability Act (HIPAA), including all Protected Health Information (PHI) that is any information about health status, provision of health care, or payment for health care that can be linked to a specific individual.

UnitedHealthcare Community Plan is concerned with protecting member privacy and is committed to meeting the program rules for HIPAA privacy regulations. Generally, covered health plans and covered providers are not required to obtain individual member agreement or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. Activities that fall into this category include service coordination, and referral to specialists and health-related services reviewing the competence of health care professionals, billing/claims management and quality improvement.

Records have a secured location that is locked when staff are not present. All member information is treated with the strictest confidentiality standards (i.e., records and content out of sight other than to the documenting staff, screens set so they are not visible to others, conversations are conducted in tones intended only for the applicable member and/or representative). A confidentiality agreement is signed and renewed annually by all employees and a complaint system is in place.

In addition to the criteria presented in this manual, member medical records need to be recorded and maintained according to the standards of the provider’s licensing board and affiliate facilities and/or practice groups in which the provider delivers services.
Chart Organization

- There is a separate and permanent medical record for each member
- Protect member medical records against loss, tampering or unauthorized use
- Contents are filed by category
- Visits are filed chronologically and dated
- Contents are secured to the chart
- Missed appointments and procedures are noted and notation of it being addressed with member
- All entries contain handwritten, stamped, or electronic author identification
- All entries and each page or electronic file in the record contain the member name or ID
- All entries are dated
- The record is legible to someone other than the writer

Each Member Medical Record Contains the Following:

- Biographical data includes member age, gender, marital status, address, employer, occupation, emergency contact, insurance information, home and work telephone numbers
- Identification of member as a child of farm worker(s), if appropriate
- Whether or not the member has executed an Advance Directive and a copy posted therein
- Medication allergies and adverse reactions. Note also if the member has No Known Allergies (NKA) or history of adverse reactions
- Current medications
- Immunization record
- Medical history (for members seen three or more times), includes serious accidents, operations and illnesses
- Family History

- For children and adolescents (age twenty one (21) years and younger), past medical history relates to prenatal care, birth, operations, childhood illnesses, family medical history, and social history
- For members age fourteen (14) years and over – use of cigarettes, alcohol and substance use
- The medical history reflects appropriate subjective and objective information pertinent to the member’s presenting complaints

All member medical records* must be maintained for up to six (6) years from the later of the following:

- The final date of the applicable contract period
- Ending of an audit
- A date otherwise deemed by HHSC

*including Rural Health Centers and Federally Qualified Health Centers

Treatment Information

- Chief complaint or reason (if wellness) for each encounter or visit Include Present on Admission (POA) for acute settings
- Unresolved problems from previous office visits are addressed in subsequent
- Physical examination performed is appropriate given the subjective and objective information for presenting complaints, the Clinical Practice Guidelines adopted by UnitedHealthcare Community Plan, Health Effectiveness Data and Information Set (HEDIS) and the Texas Medicaid Provider Procedures Manual located at TMHP.com
- Vital signs
- Laboratory and other screenings
- A working diagnoses that is consistent with findings
• Treatment recommendation (Treatment Plan where applicable) consistent with diagnoses

• Referrals and coordination of care

• Family planning information that is offered in accordance with the age of member, the Clinical Practice Guidelines adopted by UnitedHealthcare Community Plan and the Texas Medicaid Provider Procedures Manual located at TMHP.com

• Member education and follow-up instructions

• Return visits scheduled in accordance with the UnitedHealthcare Community Plan Access Standards. See Provider Responsibilities in this Manual

• Post-visit follow-up (i.e., calls, or visits)

Specialized Medical, Including Surgical Services
• All appropriate documentations as listed above need to be listed in the member medical record created and maintained by each provider (such as ancillary and specialists. Providers within the same practice maintain one record)

• Communications between all providers, including referrals

• Hospital discharge summaries are filed in the chart and initialed by physician upon review

• Evidence of post hospitalization or emergency treatment within seven (7) days of discharge
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 providers will be kept private and confidential.

2. You have the right to a reasonable opportunity to choose a health care plan and PCP. 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 PCP.
   b. Choose any health plan you want that is available in your area and choose your PCP from that plan.
   c. Change your PCP.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your PCP.

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

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your 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 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, 7 days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider’s office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else’s convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

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

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

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

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

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services toll-free at 800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at [hhs.gov/ocr](http://hhs.gov/ocr). HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Health Care Directives

UnitedHealthcare Community Plan is required to maintain written policies and procedures regarding advance directives. Our written policies include any limitations on implementation of an advance directive due to a matter of conscience. We clarify whether any conscientious objections are raised by UnitedHealthcare Community Plan or by individual providers, and describe the range
of medical conditions or procedures affected by the conscientious objection. If you have a conscientious objection relating to the execution of an advance directive, please contact the Customer Service 888-887-9003 to notify us of your specific issue.

Members are encouraged to discuss their wishes with their PCP. Providers must document in a prominent part of the member medical record whether or not the member has a executed an advance directive. The provision of care cannot be conditioned, and a member may not be otherwise discriminated against, based on whether or not the member has executed an advance directive.

Member Rights and Responsibilities Related to Advance Directives

• Members have the right to receive medical care, even if the member does not have an advance directive

• Members have the right to change or cancel advance directives at any time

• Members have the right to obtain clear and concise information with regard to the different types of advance directives available to them, and when an advance directive will take effect

• Members are expected to discuss advance directives with their Primary Care Physicians as well as family members, friends, and other individuals who are involved in their health care

• Members must comply with state and federal laws regarding the witnessing and notarizing of advance directive documents

• Members must keep advance directives in a safe place that is accessible to family members or other responsible individuals

• Members are expected to give copies of the advance directives to their Primary Care Physicians, as well as family members, friends and other individuals who are involved in their health care

• Members must inform doctors and other health care providers if they have formulated advance directives

• Members have the right to execute an advance written directive to doctors and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life sustaining treatment in the event of a terminal or irreversible condition

• Members have the right to make a written or non-written out of hospital Do Not Resuscitate (DSR) orders

• Members have the right to execute a Medical Power of Attorney; to appoint an agent to make healthcare decisions on the member’s behalf if the member becomes incompetent

• Members have the right to execute a Declaration for Mental Health Treatment; in a document making a declaration of preferences or instructions regarding mental health treatment

• Members have the right to make recommendations regarding UnitedHealthcare Community Plan Member Rights and Responsibilities policies
Provider Responsibilities Related to Advance Directives

• Providers must comply with all state and federal laws regarding advance directives.

• Providers must ask if adult members have advance directives, and document in the member medical record whether or not the member has executed an advance directive.

• Providers cannot require a member to have an advance directive in order to receive medical care, nor can they prevent a member from having an advance directive.

• Providers must maintain written policies for their office staff regarding advance directives.

Cultural Sensitivity and Literacy Program

Cultural competency is the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual and protects and preserves dignity.

UnitedHealthcare Community Plan promotes cultural competency. Racial and ethnic minorities face many barriers in receiving adequate care. These barriers include difficulties with language and communication, feelings of isolation, encounters with service providers lacking knowledge of the member’s culture and challenges related to socioeconomic. Providers have a responsibility to provide a voice for members who cannot speak for, or represent, themselves.

UnitedHealthcare Community Plan believes that everyone should be able to understand health care materials we provide. This idea is key to informed treatment decisions and compliance. To support this belief, all health related member materials are written at a 4th to 6th grade reading level and provided in English and Spanish. Materials will be published in additional languages, should enrollment reach at least 10 percent for another non-English speaking group.

Reporting Fraud, Waste and Abuse

The following information is presented to members:

• Fraud Information

• Medicaid Managed Care and CHIP

• Reporting Waste, Abuse or Fraud by a Provider or Client
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 ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To Report Waste, Abuse, or Fraud, Choose One of the Following:

- Call the OIG Hotline at 800-436-6184.
- Visit https://oig.hhsc.state.tx.us/ select “I want to...“ and then select “Report fraud, waste or abuse” 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 888-887-9003

To Report Waste, Abuse or Fraud, Gather as Much Information as Possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person’s name
  - The person’s date of birth, Social Security number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse or fraud

Member Complaint & Appeals Process
The following is information regarding Appeals and Complaints which our member receive through the Member Handbook. Members have a right to file complaints with UnitedHealthcare Community Plan and the Texas Health and Human Services Commission.

What Should I Do If I Have a Complaint?
We want to help. If you have a complaint, please call us toll-free at 888-887-9003 to tell us about your problem. A UnitedHealthcare Community Plan Member Services Advocate can help you file a complaint. Just call 888-887-9003.

You may complain to the Texas Health and Human Services Commission (HHSC) by calling toll-free 866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission Health Plan Operations – H320 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 Customer Service for help at 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 number, your telephone number and address, and the reason for your complaint. Please send your letter to:

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

Ombudsman Program
UnitedHealthcare Community Plan member can access an independent ombudsman through our new internal complaints unit. Referrals can be made by a member advocate based on interaction with member 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 member of their organization needing help. UnitedHealthcare Community Plan has contracts with several non-profit entities to provide support for member.

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 was received by UnitedHealthcare Community Plan.

Can Someone From UnitedHealthcare Community Plan Help Me File a Complaint?
Yes, a UnitedHealthcare Community Plan Member Services representative can help you file a complaint, just call 1-888-887-9003. Most of the time, we can help you right away or at the most within a few days.

What Can I Do if My Doctor Asks for a Service or Medicine That Is Covered but UnitedHealthcare Community Plan Denies or Limits It?
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 ensure continuity of services. 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 Customer Service and get help with your appeal. When you call Customer Service, 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.

How Will I Find out if Services Are Denied?
UnitedHealthcare Community Plan will send you a letter if a covered service requested by your PCP is denied, delayed, limited or stopped.

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. The 30 calendar day
deadline may be extended up to 14 calendar days upon your request or if UnitedHealthcare Community Plan shows that there is a need for additional information and the delay is in your interest. If UnitedHealthcare Community Plan needs to extend, you will receive written notice of the reason or delay.

If your provider requests, we must give you a quick decision. You can get a quick decision if your health or ability to function could be seriously hurt by waiting.

**When Do I Have the Right to Request an Appeal?**
You may request an appeal for denial of payment for services in whole or in part. If you ask for a State Fair Hearing within 10 days from the time you get the hearing notice from the health plan, you have the right to keep receiving any service the health plan denied or reduced at least until the final hearing decision is made. The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. If you do not request a fair hearing within 10 days from the time you get the hearing notice, the service the health plan denied will be stopped.

**Does My Appeal Request Have to Be in Writing?**
Every oral Appeal received must be confirmed by a written, signed Appeal by the member or his or her representative, unless an Expedited Appeal is requested.

**Can Someone From UnitedHealthcare Community Plan Help Me File an Appeal?**
Member Services is available to help you file a complaint or an appeal. You can ask them to help you when you call 888-887-9003. They will send you an appeal request form and ask that you return it before your appeal request is taken.

**What Is an Expedited Appeal?**
An Expedited Appeal is when UnitedHealthcare Community Plan has to make a decision quickly based on the condition of your health, and taking the time for a standard appeal could jeopardize your life or health.

**How Do I Ask for an Expedited Appeal?**
You may ask for this type of appeal in writing or by phone. Make sure you write "I want a quick decision or an expedited appeal," or "I feel my health could be hurt by waiting for a standard decision." To request a quick decision by phone, call UnitedHealthcare Community Plan Customer Service at 888-887-9003.

**Does My Request Have to Be in Writing?**
We can record your verbal request and convert it into a written request. We will send a form to you to complete, sign and return to us as soon as possible.

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

**What Are the Timeframes for an Expedited Appeal?**
UnitedHealthcare Community Plan must decide this type of appeal 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 in Filing an Expedited Appeal?**
If you are 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 Customer Service at 888-887-9003 and ask someone to help you start an appeal or ask your doctor to do it for you.
**Can I Ask for a State Fair Hearing?**

Members can request a state fair hearing at any time during or after the health plan’s appeals process. If you, as a member of the health plan, disagree with the health plan’s decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the fair hearing within 90 days of the date on the health plan’s letter with the decision. If you do not ask for the fair hearing within 90 days, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should call UnitedHealthcare Community Plan at 888-887-9003 or send a letter to:

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

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision is made if you ask for a fair hearing by the later of:

1. 10 days from the date you get the health plan’s decision letter, or  
2. The day the health plan’s letter says your service will be reduced or end. If you do not request a fair hearing by this date, the service the health plan denied will be stopped.

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

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

**State Fair Hearing Information**

**Can a Member Ask For a State Fair Hearing?**

If a member, as a member of the health plan, disagrees with the health plan’s decision, the member has the right to ask for a 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 90 days of the date on the health plan’s letter that tells of the decision being challenged. If the member does not ask for the fair hearing within 90 days, the member may lose or her 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:

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

Or call toll-free 888-887-9003.

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

If the member asks for a 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.
Compensation and Claims

Providers must submit all member claims data encounters to UnitedHealthcare Community Plan or Texas Medicaid & Healthcare Partnership (TMHP) using the approved CMS 1500 or UB-04 forms. Please refer to the current Texas Medicaid Provider Procedures Manual UnitedHealthcareonline.com Network News for listing of limitations and exclusions. If you are reimbursed via capitation, those services are included within your contract with UnitedHealthcare Community Plan. For information and/or questions about your contract, call Network Management at 866-574-6088. The claims data enables us to:

• Adjudicate accurate payment
• Adhere to state and federal MCO regulation requirements
• Track utilization and analyze member care patterns
• Provide quality assurance studies

A clean claim must be received within ninety five (95) days of service or date of discharge. Ongoing services should be submitted every thirty (30) days. Providers may not bill any eligible member for services provided if the provider fails to submit a claim. Members may decide to pursue services that are not covered by Medicaid Program and private pay, in this event, they must sign an acknowledgement statement that they understand that the services will not be paid by UnitedHealthcare Community Plan or Health and Human Services Commission. Statement must be signed prior to service, dated and filed in member’s medical record. Sample wording of this may include:

Sample Acknowledgement Statement

I [enter member name] understand that [enter service] is not a covered service and will not be paid by MCO or State. I understand that this services is something chosen by me and is not considered necessary. I agree to pay [enter specified cost] for this service which will terminate [enter timeframe or number of service provision incidents].

If the provider files with the wrong Managed Care Organization (MCO) and produces documentation verifying claims were filed within ninety five (95) calendar days of the date of service, UnitedHealthcare Community Plan will process the provider’s claim without denying for failure to meet timely filing deadline. For claims submitted electronically; include confirmation that MCO or one of its affiliates received and accepted the claim. For claims submitted on paper; include a screen print from the provider’s accounting software to show the date the claim was submitted. For example, proof should show that the claim was filed for the correct member and the correct visit date. UnitedHealthcare Community Plan pays claims for health services provided to members in accordance to the contractual agreement. Clean claims are paid within thirty (30) calendar days. days for professional and institutional (excluding Nursing Facility’s) claim submission. Non-electronic pharmacy clean claims are paid within twentyone (21) days of submission. Electronic pharmacy clean claims are paid within eighteen (18) calendar days.

Providers are to ensure that the correct codes, modifiers and units are included on the claim. If specific units are authorized then claim will need to match authorization in order to pay.

A member cannot be balance billed for services covered under the contractual agreement at a predetermined contracted rate. If a claim is filed within the time period allowed under Medicaid and the service is UnitedHealthcare Community Plan’s liability, the claim must be paid by us even if the contract between the Texas Health and Human Services Commission and UnitedHealthcare Community Plan is no longer in effect; or if the member has terminated his/her UnitedHealthcare Community Plan membership, provided that the member’s eligibility was effective at the time that the service(s) were rendered and that the service was a covered benefit through UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan gives contracted providers at least ninety (90) calendar days’ notice prior to implementing a change in the above referenced claim guidelines, unless the change is required by statute or regulation in a shorter timeframe.
Guidelines For Submitting Claims

• Claims should be submitted for only one member and one provider per claim form
• Providers are able to bill for an acute care visit and a medical checkup in the same visit, if appropriate. The modifier (25) should be listed on the sick visit claim
• Revenue codes are billed with four digits, for example Rev Code 0100
• CPT Code Books are available at most book stores or they can be ordered by from the American Medical Association
• HCPCS Reference Guide is available from the Center for Medicaid and Medicare Services
• International Classification of Diseases Clinical Modification (ICD-CM) coding system is available at most bookstores or by contacting the Center for Disease Control and Prevention
• Modifiers are located at the beginning of each major section of CPT. They provide a means by which the definition of a particular service can be modified to better describe the circumstances of the service. When appropriate, the two-digit modifier should be used immediately following the five-digit procedure code. (Do not insert a space or a dash.)
• When submitting modifiers that require further explanation, supporting documentation should be included such as operative report, progress notes, etc. (i.e., "22" Unusual Service)

• If two exact claims are received for the same service on the same date (for the same member), one will not be approved because of being considered an exact duplicate
• Use the correct UnitedHealthcare Community Plan Member ID number

Tips Specific to CMS Form 1500

• Multiple visits rendered by providers over several days (such as hospital visits) should be itemized by date of service on its own line.
• Unlisted procedure codes should be submitted only when a specific code to describe the service is not available or when indicated in the contract. Submit these codes with complete description when indicated, in some cases an invoice may be required.
• When billing multiple units of the same procedure code, utilize the Unit Column.

What Claim Form to Use

CMS Form 1500
• Physicians
• Group Practices
• Ancillary Health Care Providers

CMS Form UB-04
• Hospitals Facilities CORF/ORF
• Dialysis and Surgical Centers

CMS Forms 1500 and UB-04 can be obtained by contacting the U.S. Government Printing Office at 866-512-1800, local printing companies or office supply stores.
Your Contact Information

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

If so, let us know by submitting Provider Address and Tax ID Updated form located at UHCCommunityPlan.com.

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: 713-778-8798

It is important to remember to update your information with Texas Medicaid & Healthcare Partnership (TMHP) by visiting www.TMHP.com and completing the Provider Information Change Form. Directions are available at the site.
### How to Bill an Approved CMS FORM 1500

This list contains the **minimum** amount of information required to process a claim on a CMS Form 1500. Any missing or invalid data will result in the claim not being paid. Claim information must match referral information. For additional information see the Texas Medicaid Provider Procedures Manual post at TMHP.

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Insured’s ID No. (for program checked above, include all letters)</td>
<td>Enter the client’s nine-digit patient number from the Medicaid identification form.</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s name</td>
<td>Enter the client’s last name, first name, and middle initial as printed on the Medicaid identification form. If the insured uses a last name suffix (e.g., Jr, Sr) enter it after the last name and before the first name.</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s date of birth and sex</td>
<td>Enter numerically the month, day, and year (MM/DD/YYYY) the client was born. Indicate the client’s gender by checking the appropriate box. Only one box can be marked.</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s address</td>
<td>Enter the client’s complete address as described (street, city, state, and ZIP code).</td>
</tr>
<tr>
<td>9</td>
<td>Other insured’s name</td>
<td>For special situations, use this space to provide additional information such as: If the client is deceased, enter “DOD” in block 9 and the time of death in 9a if the services were rendered on the date of death. Enter the date of death in block 9b.</td>
</tr>
<tr>
<td>10a 10b 10c</td>
<td>Is patient’s condition related to: a. Employment (current or previous)? b. Auto accident? c. Other accident?</td>
<td>Check the appropriate box. If other insurance is available, enter appropriate information in blocks 11, 11a, and 11b.</td>
</tr>
</tbody>
</table>
| 11 11a 11b | Other health insurance coverage | • If another insurance resource has made payment or denied a claim, enter the name of the insurance company. The other insurance EOB or denial letter must be attached to the claim form.  
• If the client is enrolled in Medicare attach a copy of the MRAN to the claim form. |
| 11c | Insurance plan or program name | Enter the benefit code, if applicable, for the billing or performing provider. |
| 12 | Patient’s or authorized person’s signature | Enter “Signature on File,” “SOF” or legal signature. When legal signature is entered, enter the date signed in eight digit format (MMDDYYYY). TMHP will process the claim without the signature of the patient. |
| 14 | Date of current | Enter the first date (MM/DD/YYYY) of the present illness or injury. For pregnancy enter the date of the last menstrual period.  
If the client has chronic renal disease, enter the date of onset of dialysis treatments. Indicate the date of treatments for PT and OT. |
<p>| 17 17b | Name of referring physician or other source | Enter the complete name (block 17) and the NPI (block 17b) of the attending, referring, ordering, designated, or performing (freestanding ASCs only) provider. |</p>
<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Reserved for local use</td>
<td><strong>Transfers of Multiple Clients</strong>&lt;br&gt;If the claim is part of a multiple transfer, indicate the other client’s complete name and Medicaid number.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Ambulance Hospital-to-Hospital Transfers</strong>&lt;br&gt;Indicate the services required from the second facility and unavailable at the first facility.</td>
</tr>
<tr>
<td>20</td>
<td>Outside lab</td>
<td>Check the appropriate box. The information may be requested for retrospective review.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If “yes”. enter the provider identifier of the facility that performed the service in block 32.</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or nature of illness or injury</td>
<td>Enter up to four ICD-10-CM diagnosis codes to the highest level of specificity available.</td>
</tr>
<tr>
<td>22</td>
<td>Re submissions</td>
<td>Enter original claim number.</td>
</tr>
<tr>
<td>23</td>
<td>Prior authorization number</td>
<td>Use authorization number issued by UnitedHealthcare Community Plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For Workers Compensation and other property and casualty claims, this is required when prior authorization, referral, concurrent review, or voluntary certification was received.</td>
</tr>
<tr>
<td>24</td>
<td>(Various)</td>
<td>General notes for blocks 24a through 24j:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unless otherwise specified, all required information should be entered in the unused portion.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If more than six line items are billed for the entire claim, a provider must attach additional claim forms with no more than 28-line items for the entire claim.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For multi-page claim forms, indicate the page number of the attachment.</td>
</tr>
<tr>
<td>24a</td>
<td>Date(s) of service</td>
<td>Enter the date of service for each procedure provided in a MM/DD/YYYY format.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If more than one date of service is for a single procedure, each date must be given on a separate line. National Drug Code (NDC) In the shaded area, enter the NDC qualifier of N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do not enter hyphens or spaces within this number. Example: N400409231231.</td>
</tr>
<tr>
<td>24b</td>
<td>Place of service</td>
<td>Select the appropriate POS code for each service from the table under subsection 6.3.1.1, “Place of Service (POS) Coding” located at TMHP.</td>
</tr>
<tr>
<td>24c</td>
<td>EMG (THSteps medical checkup condition indicator)</td>
<td>Enter the appropriate condition indicator for THSteps medical checkups.</td>
</tr>
<tr>
<td>24d</td>
<td>Fully describe procedures, medical services, or supplies furnished for each date given</td>
<td>Enter the appropriate procedure codes and modifier for all services billed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If a procedure code is not available, enter a concise description.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NDC: In the shaded area, enter a 1- through 12-digit NDC quantity of unit. A decimal point must be used for fractions of a unit.</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>24e</td>
<td>Diagnosis pointer</td>
<td>Enter the line item reference (1, 2, 3, or 4) of each diagnosis code identified in block 21 for each procedure. Indicate the primary diagnosis only. Do not enter more than one diagnosis code reference per procedure. This can result in denial of the service.</td>
</tr>
<tr>
<td>24f</td>
<td>Charges</td>
<td>Indicate the usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay clients.</td>
</tr>
<tr>
<td>24g</td>
<td>Days or units</td>
<td>If multiple services are performed on the same day, enter the number of services performed (such as the quantity billed). Note: The maximum number of units per detail is 9,999. NDC Optional: In the shaded area, enter the National Drug Code (NDC) unit of measurement code.</td>
</tr>
<tr>
<td>24j</td>
<td>Rendering provider ID# (performing)</td>
<td>Enter the provider identifier of the individual rendering services unless otherwise indicated in the provider specific section of this manual. Enter the TPI in the shaded area of the field. Entered the NPI in the unshaded area of the field.</td>
</tr>
<tr>
<td>26</td>
<td>Patient’s account number</td>
<td>Optional: Enter the client identification number if it is different than the subscriber/insured’s identification number. Used by provider’s office to identify internal client account number.</td>
</tr>
<tr>
<td>27</td>
<td>Accept assignment</td>
<td>All providers of Texas Medicaid must accept assignment to receive payment by checking</td>
</tr>
<tr>
<td>28</td>
<td>Total charge</td>
<td>Enter the total charges. For multi-page claims enter “continue” on initial and subsequent claim forms. Indicate the total of all charges on the last claim.</td>
</tr>
<tr>
<td>29</td>
<td>Amount paid</td>
<td>Enter any amount paid by an insurance company or other sources known at the time of submission of the claim. Identify the source of each payment and date in block 11. If the client makes a payment, the reason for the payment must be indicated in block 11.</td>
</tr>
<tr>
<td>30</td>
<td>Balance due</td>
<td>If appropriate, subtract block 29 from block 28 and enter the balance.</td>
</tr>
<tr>
<td>31</td>
<td>Signature of physician or supplier</td>
<td>The physician, supplier, or an authorized representative must sign and date the claim. Billing services may print “Signature on File” in place of the provider’s signature if the billing service obtains and retains on file a letter signed by the provider authorizing this practice.</td>
</tr>
<tr>
<td>32</td>
<td>Service facility location information</td>
<td>If services were provided in a place other than the client’s home or the provider’s facility, enter name, address, and ZIP code of the facility where the service was provided.</td>
</tr>
<tr>
<td>32A</td>
<td>NPI</td>
<td>Enter the NPI of the service facility location.</td>
</tr>
</tbody>
</table>
### How to Bill an Approved CMS UB-04 Form

This list contains the minimum amount of information required to process a claim on a CMS UB-04 Form. Any missing/invalid data will result in the claim not being paid. Claim information must match referral information. For additional information see the Texas Medicaid Provider Procedures Manual post at TMHP.

<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unlabeled</td>
<td>Enter the hospital name, street, city, state, ZIP+4 Code, and telephone number.</td>
</tr>
<tr>
<td>3a</td>
<td>Patient control number</td>
<td>Optional: Any alphanumeric character (limit 16) entered in this block is referenced on the R&amp;S Report.</td>
</tr>
<tr>
<td>3b</td>
<td>Medical record number</td>
<td>Enter the patient’s medical record number (limited to ten digits) assigned by the hospital.</td>
</tr>
<tr>
<td>4</td>
<td>Type of Bill (TOB)</td>
<td>Enter a TOB code. See TMHP for codes listing.</td>
</tr>
<tr>
<td>6</td>
<td>Period covered</td>
<td>Enter the beginning and ending dates of service billed.</td>
</tr>
<tr>
<td>8a</td>
<td>Patient identifier</td>
<td>Optional: Enter the patient identification number if it is different than the subscriber/insured’s identification number. Used by providers office to identify internal patient account number.</td>
</tr>
<tr>
<td>8b</td>
<td>Patient name</td>
<td>Enter the patient’s last name, first name, and middle initial as printed on the Medicaid identification form.</td>
</tr>
<tr>
<td>9a–9b</td>
<td>Patient address</td>
<td>STAR and STAR+PLUS in 9a, enter the patient’s complete address as described (street, city, state, and ZIP+4 Code).</td>
</tr>
<tr>
<td>10</td>
<td>Birthdate</td>
<td>Enter the patient’s date of birth (MM/DD/YYYY).</td>
</tr>
<tr>
<td>11</td>
<td>Sex</td>
<td>Indicate the patient’s gender by entering an “M” or “F”.</td>
</tr>
<tr>
<td>12</td>
<td>Admission date</td>
<td>Enter the numerical date (MM/DD/YYYY) of admission for inpatient claims; date of service (DOS) for outpatient claims; or STAR and STAR+PLUS of care (SOC) for home health claims. Providers that receive a transfer patient from another hospital must enter the actual dates the patient was admitted into each facility.</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>13</td>
<td>Admission hour</td>
<td>Military time for the time of admission for inpatient claims or time of treatment for outpatient claims.</td>
</tr>
<tr>
<td>14</td>
<td>Type of admission</td>
<td>Enter the appropriate type of admission code for inpatient claims (code 1-5).</td>
</tr>
<tr>
<td>15</td>
<td>Source of admission</td>
<td>Enter the appropriate source of admission code for inpatient claims.</td>
</tr>
<tr>
<td>16</td>
<td>Discharge hour</td>
<td>For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of “30”), leave the block blank.</td>
</tr>
<tr>
<td>17</td>
<td>Patient Status</td>
<td>For inpatient claims, enter the appropriate two-digit code to indicate the patient’s status as of the statement “through” date.</td>
</tr>
<tr>
<td>18-28</td>
<td>Condition codes</td>
<td>Enter the two-digit condition code “05” to indicate that a legal claim was filed for recovery of funds potentially due to a patient.</td>
</tr>
<tr>
<td>29</td>
<td>ACDT state</td>
<td>Optional: Accident state.</td>
</tr>
<tr>
<td>31-34</td>
<td>Occurrence codes and dates</td>
<td>Enter the appropriate occurrence code(s) and date(s).</td>
</tr>
<tr>
<td>35-36</td>
<td>Occurrence span codes and dates</td>
<td>For inpatient claims, enter code “71” if this hospital admission is a readmission within seven days of a previous stay. Enter the dates of the previous stay.</td>
</tr>
<tr>
<td>39-41</td>
<td>Value codes</td>
<td>Accident hour – For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6.</td>
</tr>
<tr>
<td>42-43</td>
<td>Revenue codes and description</td>
<td>For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. NDC Enter N4 and the 11-digit NDC number (number on packaged or container from which the medication was administered). Optional: The unit of measurement code and the unit quantity.</td>
</tr>
<tr>
<td>Block No.</td>
<td>Description</td>
<td>Guidelines</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 44       | HCPCS/rates          | **Inpatient:**
|          |                      | Enter the accommodation rate per day.                                       |
|          |                      | Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. |
|          |                      | **Home Health Services:**
|          |                      | Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. |
|          |                      | **Outpatient:**
<p>|          |                      | Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. |
| 45       | Service date         | Enter the numerical date of service that corresponds to each procedure for outpatient claims. Multiple dates of service may not be combined on outpatient claims. |
| 45 (line 23) | Creation date   | Enter the date the bill was submitted.                                     |
| 46       | Service units        | Provide units of service, if applicable.                                   |
|          |                      | For inpatient services, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation. |
| 47       | Total charges        | Enter the total charges for each service provided.                         |
| 47 (line 23) | Totals            | Enter the total charges for the entire claim.                              |
| 48       | No covered charges   | If any of the total charges are no covered, enter this amount.             |
| 50       | Payer Name           | Enter UnitedHealthcare Community Plan.                                     |
| 51       | Health Plan ID       | Enter the health plan identification number.                               |
| 54       | Prior payments       | Enter amounts paid by any TPR, and complete Blocks 32, 61, 62, and 80 as required. |
| 56       | NPI                  | Enter the NPI of the billing provider. (Must match NPI on file with UnitedHealthcare Community Plan for our claims.) |
| 57       | Other identification (ID) number | Enter the TPI number (non-NPI number) of the billing provider.         |
| 58       | Insured’s name       | If other health insurance is involved, enter the insured’s name.          |
| 60       | Medicaid identification number | Enter the patient’s nine-digit Medicaid identification number.          |
| 61       | Insured group name   | Enter the name and address of the other health insurance.                 |
| 62       | Insurance group number | Enter the policy number or group number of the other health insurance.    |</p>
<table>
<thead>
<tr>
<th>Block No.</th>
<th>Description</th>
<th>Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>63</td>
<td>Treatment authorization code</td>
<td>Enter the prior authorization number if one was issued.</td>
</tr>
<tr>
<td>65</td>
<td>Employer name</td>
<td>Enter the name of the patient’s employer if health care might be provided.</td>
</tr>
<tr>
<td>67</td>
<td>Principal diagnosis (DX) code and present on admission (POA) indicator</td>
<td>Enter the ICD-CM diagnosis code in the unshaded area for the principal diagnosis to the highest level of specificity available.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>POA Indicator – Enter the applicable POA indicator in the shaded area for inpatient claims.</td>
</tr>
<tr>
<td>67A-67Q</td>
<td>Secondary DX codes and POA indicator</td>
<td>Enter the ICD-CM diagnosis code in the unshaded area to the highest level of specificity available for each additional diagnosis. Enter one diagnosis per block, using Blocks A through J only.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A diagnosis is not required for clinical laboratory services provided to nonpatients (TOB “141”).</td>
</tr>
<tr>
<td>69</td>
<td>Admit DX code</td>
<td>Enter the ICD-CM diagnosis code indicating the cause of admission or include a narrative.</td>
</tr>
<tr>
<td></td>
<td>Note: The admitting diagnosis is only for inpatient claims.</td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Principal procedure code and date</td>
<td>Enter the ICD-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.</td>
</tr>
<tr>
<td>74a-74e</td>
<td>Other procedure codes and dates</td>
<td>Enter the ICD-CM procedure code for each surgical procedure and the date (MM/DD/YYYY) each was performed.</td>
</tr>
<tr>
<td>76</td>
<td>Attending provider</td>
<td>Enter the attending provider name and identifiers. NPI number of the attending provider.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services that required an attending provider are defined as those listed in the ICD-CM coding manual volume 3, which includes surgical, diagnostic, or medical procedures.</td>
</tr>
<tr>
<td>77</td>
<td>Operating</td>
<td>Enter operating provider’s name (last name and first name) and NPI number of the operating provider.</td>
</tr>
<tr>
<td>78-79</td>
<td>Other</td>
<td>Other provider’s name (last name and first name) and NPI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other operating physician – An individual performing a secondary surgical procedure or assisting the operating physician. Required when another operating physician is involved.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rendering provider – The health care professional who performed, delivered, or completed a particular medical service or nonsurgical procedure.</td>
</tr>
</tbody>
</table>
CMS UB-04 Form

- Use correct Bill Type
- Member number as stated on Your Texas Benefits Card
- Always use Revenue Code
- These fields are both for the group - the name (left) and the group NPI (right)
- Always include latest ICD Code. Note CPT and Modifiers net to it as appropriate
### Sample CMS 1500

- **This cell needs to read “UnitedHealthcare Community Plan”**
- **This column needs NPI number that is the same NPI number on file with UnitedHealthcare Community Plan**
- **For Resubmissions enter original claim**
Submitting Claims

There are three methods to submit electronic claims to UnitedHealthcare Community Plan: Electronic Data Interchange (EDI); UnitedHealthcare Online; and Texas Medicaid & Healthcare Partnership (TMHP).

Electronic Data Interchange (EDI)
EDI enables you to submit claims electronically to UnitedHealthcare. The information is transferred from the provider’s terminal to a secure clearinghouse, where it is checked for errors and data omissions. If there is an issue with the submission, the information is immediately sent back to the provider for correction. This significantly reduces your wait time for claims that are denied due to errors or missing information. The clearinghouse then submits the data to us, and the provider receives a report of the electronic activity, including confirmation of information sent by UnitedHealthcare Community Plan and a listing of any problems encountered.

Connectivity Director – free direct connection allows providers to batch claims submissions to UnitedHealthcare. For more information visit UnitedHealthcare Online.

Ingenix EDI Solutions – All-Payer Gateway is a seamless, low-cost connection from UnitedHealthcare Online to Ingenix, where providers are able to upload and submit batch claim files, verify eligibility, check claim status, track claims, and make referrals and authorizations. Claims must be submitted in CMS 1500 or claim form UB-04. For more information visit UnitedHealthcare Online.

Also visit UHCCommunityPlan.com for UnitedHealthcare Community Plan-specific forms necessary for these transactions.

To submit claims electronically, have your office software vendor or clearinghouse make connection to our clearinghouse, OptumInsight. For more information visit OptumInsight at www.enshealth.com or call 800-341-6141 or e-mail to optimize@ingenix.com. Payer ID is 87726. If you do not have office software and would like to submit directly, at no cost please submit directly through UnitedHealthcare Online.
UnitedHealthcare Online

We are proud of this state-of-the-art online service for providers. This website has a wealth of resources and information available for you to use in your day to day interactions with UnitedHealthcare Community Plan. After a simple sign on process, providers can take a tour of the portal. You will be shown how to verify eligibility, submit authorizations, submit claims and check claims status. In addition we offer many resources regarding clinical practice guidelines and best practices as well as tips on how to submit your claims. Listed below are four samples from our web site.

Our Homepage outlines the resources areas available to you.

**Note:** Lower right In The Spotlight provides real time notifications.
Member eligibility should be verified monthly.
Eligibility and benefit information are easy to use at UnitedHealthcare Online.
Submit authorizations and check the status of previously submitted authorizations in one convenient location.
The 837 Companion Guide, posted along with other online resources, at UHCCommunityplan.com provides instructions for submitting CMS 1500 claims electronically to UnitedHealthcare Online.

Providers submitting directly to UnitedHealthcare Online need to register with OptumInsight for electronic remittance.

**Note:** CMS UB-04 Form Claims need to go through a clearinghouse of your choice.
To submit claims through UnitedHealthcare Online, first visit UnitedHealthcareOnline.com as a New User (top left-hand corner of the main page). This will allow for a protected exchange of information.

Various formats are available to walk you through learning how to submit claims at UnitedHealthcare Online. From the menu on the main page, select Tools & Resources, then select Training and Education. There you will find interactive demos, tours, quick reference cards and registration for live trainings held monthly to present the various components of UnitedHealthcare Online. The Help Desk is also available toll-free at 866-842-3278, option 2.

For assistance with online claim submissions or user access to UnitedHealthcare Online you may call the UnitedHealthcare Online Support Services at 866-842-3278. For all other inquiries regarding Electronic Data Interchange (EDI), including Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA), please call 800-210-8315 or e-mail to ac_edi_ops@uhc.com. Contact your Provider Advocate for further assistance with online claims submission.

UnitedHealthcare Online presents tutorials, guides and live trainings to aid in provider utilization of all that is available including eligibility, benefits and clinical resources.

Texas Medicaid & Healthcare Partnership (TMHP) Single Portal Billing
TMHP will accept claim submissions and forward the claims to the correct Managed Care Organization (MCO) based on the patient’s eligibility. TMHP will not forward the following claims submissions, which must be submitted directly to UnitedHealthcare Community Plan:

- Paper claim forms
- Electronic submissions for Pharmacy and Long-Term Care Services

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, no more transmissions from TMHP will be sent out. Notices for all payment determinations will be sent by UnitedHealthcare Community Plan or the dental plan.

If a claim is rejected, an electronic claim status report from TMHP will generate. Please correct the submission and submit the claim to TMHP until the claim is accepted.

Important: TMHP will not have access to UnitedHealthcare claims, benefits, or processes.

Paper claims: CMS Forms 1500 and UB-04 should be mailed to the respective addresses below.

STAR+PLUS Paper Claims
UnitedHealthcare Community Plan
P.O. Box 31352
Salt Lake City, UT 84131-0352

STAR Paper Claims
UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402-5270

Claim Payment Deadlines
Payment deadlines refer to the maximum time afforded to pay a claim. Claims are to be processed within thirty (30) days of receipt. Original claims submissions and adjustments processed after the thirtieth day will include interest payments according to HHSC guidelines. The TMHP is the current Medicaid Claims Administrator assuming responsibilities for the State of Texas, under contract with the HHSC. TMHP provides functions such as claims processing, the Automated Inquiry System (AIS), TDHConnect (electric funds transfer software), and other services. TMHP is required to finalize all claims, including appeals, within 24 months.

The 110 Day Rule – When a Medicaid member has other health insurance, the other insurance must be billed by the provider before billing the Texas Medicaid Program. If a third party resource has not responded to or has delayed payment on provider’s claim for more than 110 days from
the date the claim was billed, Medicaid considers the claim for reimbursement. These 110 days are included in the 24 month claim payment deadline. Providers should submit the claim to Medicaid as soon as disposition is received from the third party, or once the 110 days has elapsed, to ensure the payment deadlines are not missed.

- Claims must be received by UnitedHealthcare Community Plan within 95-days of the date of service on the claim to be considered for payment
- Providers must file appeals or adjustment requests within 120 days from the date of disposition
- When a Medicaid client has other health insurance, the other insurance must be billed by the provider before billing the Texas Medicaid Program
- If that third party resource has not responded to or has delayed payment on a provider’s claim for more than 110 days from the date the claim was billed, Medicaid considers the claim for reimbursement

To learn more about Medicaid eligibility, claim information, provider enrollment, Medicaid bulletins etc., visit the TMHP website at [www.TMHP.com](http://www.TMHP.com) or call their general inquiries line at 800-925-9126. For questions or concerns relating to UnitedHealthcare Community Plan claims, please call Customer Service at 888-887-9003.

### Provider Remittance Advice (PRA)

Provider Remittance Advice (PRA) is a summary of payments made on all claims processed. The PRA is a patient by patient accounting of the amount billed, the amount disallowed (if any), and co-payments or deductible amounts and reserves, as well as the amount paid. An amount disallowed is a denial for portions of the claimed amount. (Examples of amounts disallowed: non covered benefits or amounts over the fee maximum).

A paper PRA is issued for each unique provider number for which a claim was paid or not approved. UnitedHealthcare Community Plan sends the PRA, with applicable payments to the address listed in the UnitedHealthcare Community Plan claim processing system.

The claim form address must match either the place of service or the billing address listed in the UnitedHealthcare Community Plan claims processing system in order for the claim to be processed in a timely manner.

Providers that are capitated via agreement, receive a PRA with the dates of service submitted though no payment is issued with this PRA. Call Customer Service with any questions regarding PRA or other billing. Your Provider Advocate is a good source for billing or appeal inquires. The PRA serves as a utilization tool to enable providers to post itemized services to the necessary account.

### Electronic Remittance Advice

Electronic Remittance Advice (ERA) provides information for the payee regarding claims in their final status. The content on the ERA meets HIPAA requirements, containing nationally recognized HIPAA-compliant remark codes used by Medicare and other healthcare payers. Virtual images of your remittance advice are available online. We have a dedicated team of professionals with an in-depth understanding of the electronic solutions available to meet your needs. Contact your software vendor or Clearinghouse to enroll in ERA. You can find the EFT enrollment form and FAQs located at [UHCCommunityPlan.com](http://UHCCommunityPlan.com) or contact our EDI Support Services Team directly at 800-210-8315 or e-mail to [c_edi_ops@uhc.com](mailto:c_edi_ops@uhc.com). The Electronic Remittance Advice Payer ID is TEX01.

### Electronic Funds Transaction

Electronic Funds Transaction (EFT) is an electronic deposit of funds into the provider’s bank account. This will take the place of a paper check which is mailed to the provider via the US postal system. The funds are generally available for provider access at the bank writing two (2) business days. We employ a variety of security measures that are in place to protect your account information. We also send a PRA within three to four business days after payment is processed. Actual delivery depends on postal delivery.
Coordination of Benefits (COB)

UnitedHealthcare Community Plan is the primary payer, except in case of:

- Medicare
- TRICARE UMVS
- Veterans
- Other insurance carriers
- Workers’ Compensation insurance
- Black lung benefits
- Automobile medical insurance
- No fault insurance
- Any liability insurance

State specific guidelines will be followed when Coordination of Benefits (COB) procedures are not parallel with UnitedHealthcare Community Plan procedures. UnitedHealthcare Community Plan agrees to utilize, whenever available, covered medical and hospital services or other public or private sources of payment for services rendered to members in the UnitedHealthcare Community Plan. UnitedHealthcare Community Plan and providers in its network agree that the Medicaid program will be the payer of last resort when third party resources are available to cover the costs of medical services provided to Medicaid members.

When UnitedHealthcare Community Plan is aware of these resources prior to paying for a medical service, it will avoid payment by rejecting a provider’s claim and redirecting the provider to bill the appropriate insurance carrier. If UnitedHealthcare Community Plan becomes aware of additional resources sometime after payment for the service, UnitedHealthcare Community Plan will pursue recovery of the expenditure. Providers must not seek recovery in excess of the Medicaid payable amount. Additionally, if a provider receives payment from a third party payer, the provider agrees to refund to UnitedHealthcare Community Plan the payments expended on the member related to the third party liability, or in the alternative, and a provider agrees to permit UnitedHealthcare Community Plan to offset the amount of third party payments in future claims reimbursements. UnitedHealthcare Community Plan will avoid payment of claims where third party resources are payable. UnitedHealthcare Community Plan will assist HHSC in the identification, pursuit and collection of third party resources and will notify HHSC within thirty (30) days upon identification of health or casualty insurance coverage available to a member, or any change in a member’s health insurance coverage.

Claims for Covered Services subject to coordination of benefits will be paid in accordance with the member’s Benefit Plan and applicable law. For questions or inquiries regarding a paid, not approved or pended claim, please call Customer Service at 888-887-9003.

Medicare Coinsurance Claim Information

Medicare coinsurance and deductible claims (i.e., crossovers) for members who have Medicare and Medicaid dual eligibility must continue to be submitted on paper if the claims were not originally crossed over from the Medicare Intermediary or the Coordination of Benefits Administrator (COBA).

Special Billing for Value-added Services: For dental, vision, and behavioral health services, UnitedHealthcare...
Community Plan’s value-added partners administer the health care services and pay claims to these contracted providers for these services.

UnitedHealthcare Community Plan will inform providers if any special billing is required such as for newborns, SSI, value-added services, compound medications.

**Emergency Service Claims:** UnitedHealthcare Community Plan must be contacted immediately for authorization for all inpatient and outpatient services.

**Mixed Service Protocol**
This chart offers a guideline as to which entity to bill when services involve behavioral services.

<table>
<thead>
<tr>
<th>Clinical Markers</th>
<th>Placement/Determinant</th>
<th>Financial Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Emergency Room</td>
<td>UnitedHealthcare Community Plan Behavioral Health (Optum) shall be responsible for psychiatric and other mental health consultations. UnitedHealthcare Community Plan shall be responsible for all other professional, ancillary and emergency room charges.</td>
</tr>
<tr>
<td>Member is referred to or presents at an emergency room and obtains services, which are not followed by an admission to the hospital.</td>
<td>Medical Bed / Services</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Member is referred to or presents at emergency room and such services are followed by an admission to the hospital</td>
<td>Psychiatric or Substance Abuse bed/services, or if not available, a medical bed.</td>
<td>Optum</td>
</tr>
<tr>
<td>Inpatient Admission for Suicide Attempt Stabilization of the medical complications of a suicide attempt, that require admission to a medical unit or Intensive Care Unit (ICU)</td>
<td>Medical or ICU bed</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td><strong>Psychiatric Consultation Services</strong></td>
<td>Medical psychiatric or Substance Abuse Bed</td>
<td>Optum</td>
</tr>
<tr>
<td><strong>Substance Use Disorders</strong></td>
<td>Psychiatric or Substance Abuse bed with UBH physician</td>
<td>Optum</td>
</tr>
<tr>
<td>1. Detoxification. Patient admitted for observation/detox by UBH physician</td>
<td>Medical bed or detox unit with Medical Provider</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>2. Acute withdrawal, seizures, delirium tremens, Medical instability</td>
<td>Psychiatric or Substance Abuse bed</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>3. Medical consultations and/or tests</td>
<td>Medical beds</td>
<td>Optum</td>
</tr>
<tr>
<td>4. Psychiatric consultations and/or tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Markers</td>
<td>Placement/Determinant</td>
<td>Financial Responsibility</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>Emergency Room Determinant is type of service, place of service and authorizing organization</td>
<td></td>
</tr>
<tr>
<td>Primary reason for hospitalization is for the active treatment of a medial co-morbidity, e.g. arrhythmia treated on a telemetry unit, hypotension treated with pressor agents, hematemesis requiring upper GI endoscopy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Determinant is type of service, place of service and authorizing organization</td>
<td></td>
</tr>
<tr>
<td>Medical diagnosis or treatment Psychiatric evaluation/consultation and ongoing treatment of co-morbid behavioral health conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Injury</td>
<td>Medical bed or residential</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Medical, or medical rehab ilitation programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultations</td>
<td>NA</td>
<td>Optum</td>
</tr>
<tr>
<td>Outpatient psychotherapy, groups, Psychiatric consultations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geriatric/Alzheimer Disease</td>
<td>Medical or specialized unit: includes need or awaiting placement for nursing home and discharge planning</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Diagnosis/treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric assessment consultation/Stabilization/ medication management</td>
<td>Psychiatric unit and services and Nursing Homes</td>
<td>Optum</td>
</tr>
<tr>
<td>Diagnostic Procedures</td>
<td>NA</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Medical Outpatient diagnostic procedures including labs, EKG, X-rays, EEG, CT scans and MRI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>To Medical bed</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Transport to the hospital prior to Admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport to the hospital prior to Admission</td>
<td>To Psychiatric or Substance bed</td>
<td>Optum</td>
</tr>
<tr>
<td>Secure transfer during hospital stay or from one facility to another (medical to behavioral health or one behavioral health facility to another)</td>
<td>NA</td>
<td>Optum</td>
</tr>
<tr>
<td>Transfer from behavioral health facility to medical facility for a medical emergency</td>
<td>NA</td>
<td>UnitedHealthcare Community Plan</td>
</tr>
</tbody>
</table>

Note: The financial responsibility for each clinical marker is either UnitedHealthcare Community Plan or Optum. The specific details of the financial responsibility vary depending on the clinical marker and the situation described.
Overpayments
If you identify an overpayment of a claim, you must refund the overpayment within thirty (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. A form is available at UHCCommunityPlan.com.

Claims Adjustments
If a claim was not paid according to your contract, please call Customer Service at 888-887-9003. This is called an Adjustment. Providers may access necessary forms online at UHCCommunityPlan.com. A Customer Service Representative will assist in reviewing your claim and has having it reprocessed, if appropriate. This process should be completed prior to filing an appeal.

If your claim was billed incorrectly, you may refile your claim. You must indicate it is a “corrected claim” and send it to the UnitedHealthcare Community Plan claims submission address. All requests for claims to be reprocessed, or to file a “corrected claim” must be made within 120 calendar days from the date on the PRA.

• Adjustments: If you disagree with the adjudication reason code and the claim does not need to be corrected, you may call Customer Service to request an adjustment.

• Reconsiderations: Providers are also encouraged to submit a Reconsideration form found at UHCCommunityPlan.com or submit directly via UnitedHealthcareOnline.com to have claims reviewed; If attachments are required, these must be submitted as paper claims or through Optum Cloud.

Reconsiderations
Complete this form for an initial reconsideration. This request is handled as a Claim Reconsideration for previously denied claims for reasons of “exceeds filing time,” previously denied for “additional information needed,” previously processed as “rate applied incorrectly resulting in over/underpayment,” or previously processed as “bundled claim” and other reasons for denial you feel are incorrect. Use a separate form for each request for a reconsidered claim.

For Negative Balance Issues please call 888 866-2599.
Appeals and Complaints

Appeals

Members and providers have the right to appeal should a request for services be denied. Appeals are submitted under two categories:

1. Services not yet rendered-adverse determination; and
2. Claims/administrative denials.

Adverse Determination Appeals

Providers may appeal on behalf of the member with regard to adverse determination appeals.

Adverse determination appeals must be submitted within 30 days of receipt of the adverse determination. Notification of receipt of request will be given within five (5) days. A decision is rendered within thirty (30) days.

Extensions – members or their representative may request up to an additional 14 days for the decision to be made for an appeal. Additionally, UnitedHealthcare Community Plan can request up to 14 days for an extension if able to show that there is a need for additional information and how the delay is in the member’s best interest. Extensions do not apply to provider claims appeals.

Expeditied Appeal – Reserved for denials of inpatient hospital, continued stays or life-threatening conditions. An independent physician of the same or similar specialty will perform the review. Upon receiving all information necessary to perform the review, the decision will be rendered within 24 hours. Contact Customer Service to request the expedited appeal at 888-887-9003.

Fair Hearings – Providers appealing on behalf of the member as their authorized representative have the right to request a State Fair Hearing. Fair Hearings may be requested any time during the appeals process. Additionally, Fair Hearings may be requested upon receipt of the appeal decision. Fair Hearings must be requested within 90 days of the date on the UnitedHealthcare Plan’s final decision letter. To request a Fair Hearing on behalf of the member, please contact UnitedHealthcare Community Plan at 888-887-9003 or send a letter to the health plan at:

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

More information regarding adverse determination appeals may be found in the Member Rights & Responsibilities section of this manual.

Claims/Administrative appeals

Administrative appeals and adjustment filing deadline – Providers must file appeals or adjustment requests within 120 calendar days from the date of disposition. This applies to both electronic and paper submissions. The date of disposition refers to the date of the Remittance and Status (R&S) Report on which the last action on the claim appears. HHSC and TMHP will not process appeals or adjustment requests received more than 120 calendar days after the date of disposition. UnitedHealthcare Community Plan also adheres to TMHP claims payment and appeals deadlines.

Claims/administrative Appeals include, but are not limited to, timely filing denials, denials due to lack of notification/ authorization claims not paid in accordance with your contract, etc. Claims appeals must be mailed no later than 120 calendar days from the date on the PRA and an Appeal Request Form (located at UHCCommunityPlan.com) must be completed and mailed to the address shown on the form.

Claims/Administrative appeals are processed within 30 calendar days from receipt of the appeal. If the original decision to deny the claim was reversed, then the claim is reprocessed and a PRA is re-issued with the claim detail. If, after review, the claim is still not approved, in whole or in part, a written explanation is sent to the provider.
Specialty Review – For claims/administrative appeals which continue to be denied and for which the provider believes the service was medically necessary, providers have the option to request a specialty review.

Providers must request a specialty review within 30 days of the appeal decision date. Notification of receipt of request will be given within five (5) days. The review is performed by an independent physician of the same or similar specialty. The process will be completed within 15 days after the request is received.

Complaints
Providers may file complaints with UnitedHealthcare Community Plan by submitting the Provider Complaint Form located at UHCCommunityPlan.com under Provider Form. Customer Service is available to provide direction (888-887-9003).

Notification of receipt of request will be given within five (5) days. A decision is rendered within thirty (30) days.

Complaints to HHSC
Providers have the right to submit complaints to HHSC Provider Resolution Services. Further direction is available by calling the Ombudsman at 877-787-8999.

HHSC investigates complaints related to Medicaid Managed Care Organizations, based on the Medicaid Uniform Managed Care contract between HHSC and UnitedHealthcare Community Plan.

If after completing this process, the provider believes they did not receive full due process from the respective managed care health plan, they may file a complaint or inquiry at HPM_complaints@hhsc.state.tx.us, or by mailing to the below address:

Texas Health and Human Services Commission
Provider Complaints
Health Plan Operations, H-320
P.O. Box 85200
Austin, Texas 78708
Definitions

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid Program.

Behavioral Health covered services for the treatment of mental, emotional or substance use disorders.

Cultural Competency means the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves their dignity.

Emergency Medical Condition a medical condition manifesting 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:

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

Emergency Services covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post stabilization Care Services.

Fraud an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Health Care Services means the acute care, behavioral health care, and health-related services that an enrolled population might reasonably require in order to be maintained in good health.

Medical Necessity (Physical Health) covered services must meet the definition of “medically necessary.” “Medically necessary” health services are:

- In accordance with health care practice guidelines and standards that are endorsed by professionally recognized healthcare organizations or governmental agencies;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member’s illness, injury or disease; and
- Not primarily for the convenience of the member or doctor, or other doctor, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member’s illness, injury or disease i.e., reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life;
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member’s health conditions;
- Consistent with the diagnoses of the conditions; and,
• No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency. Preventative care might be medically necessary but coverage for medically necessary preventative care is governed by terms of the applicable health plan documents.

**Routine Care** means health care for covered preventative and medically necessary health care services that are non-emergent or non-urgent.
## Forms

### Forms May Be Accessed at UHCCommunityPlan.com

<table>
<thead>
<tr>
<th>Form</th>
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<tbody>
<tr>
<td>JOIN for ME. Child Obesity Program. Physician Referral Form</td>
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<tr>
<td>Physician Referral</td>
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<tr>
<td>Do Not Resuscitate Order</td>
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<tr>
<td>Request for Taxpayer Identification Number and Certification</td>
</tr>
<tr>
<td>Disclosure and Consent (Authorization for Release and Use of Confidential Information)</td>
</tr>
<tr>
<td>Disclosure and Consent (Authorization for Release and Use of Confidential Information) Espanol</td>
</tr>
<tr>
<td>Disclosure and Consent (Authorization for Release and Use of Health Information)</td>
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<tr>
<td>Disclosure and Consent (Authorization for Release and Use of Health Information) Espanol</td>
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<tr>
<td>Obstetrical Needs Assessment Form Instructions</td>
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<tr>
<td>Obstetrical Health Risk Assessment</td>
</tr>
<tr>
<td>STAR and STAR+PLUS Prior Authorization Fax Request</td>
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<tr>
<td>STAR and STAR+PLUS+PLUS Prior Authorization Fax Request</td>
</tr>
<tr>
<td>Provider Acknowledgment of Receipt of Manual</td>
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<tr>
<td>Provider Address and Tax Updates</td>
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<tr>
<td>Sterilization Consent – English</td>
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<tr>
<td>Sterilization Consent Form – Instructions</td>
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<tr>
<td>Sterilization Consent – Espanol</td>
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<td>DNR</td>
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<td>Power of Attorney</td>
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<td>Living Will</td>
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<td>Appeal Request Form</td>
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<td>Provider Complaint</td>
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<td>Reconsideration Request</td>
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<tr>
<td>Out of Network Referrals/Elective Admissions Prior Authorization Request</td>
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**Note:** All Texas Medicaid Forms are posted at TMHP Forms web page.
Value-added Services

We offer our members extra services to add value to benefit package. Every one of these services is available at absolutely no cost to the member. These special services are selected to address our member’s needs and experiences in an effort to help them live healthier lives. The following Services begin September 1, 2014.

<table>
<thead>
<tr>
<th>Service</th>
<th>Item</th>
<th>How it works</th>
<th>Eligibility</th>
<th>Note</th>
</tr>
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<tbody>
<tr>
<td>Incentive Gift Cards</td>
<td>$20.00 H-E-B Gift Card</td>
<td>Pre-paid postage postcard is provided to member in member welcome packet. The postcard is signed by the physician at time of well visit or test then mailed to us. Member then receives gift card in the mail.</td>
<td>• STAR, • STAR+PLUS</td>
<td>If an H-E-B is not conveniently located to member, then a comparable grocery card may be supplemented.</td>
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<td>(general wellness)</td>
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<tr>
<td>Incentive Gift Cards</td>
<td>$20.00 H-E-B Gift Card</td>
<td>Pre-paid postage postcard is provided to member identified with these diagnoses. The postcard is signed by the physician at time of well visit or test then mailed to us. Member then receives gift card in the mail.</td>
<td>• STAR and STAR+PLUS members diagnosed with Type II Diabetes</td>
<td>If an H-E-B is not conveniently located to member, then a comparable grocery card may be supplemented.</td>
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<td>(condition-specific)</td>
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<td>Pre-paid postage postcard is provided to member identified with these diagnoses. The postcard is signed by the physician at time of well visit or test then mailed to us. Member then receives gift card in the mail.</td>
<td>• STAR and STAR+PLUS members diagnosed with diabetes and certain cardiovascular conditions (i.e. a medical history of ischemic heart disease, myocardial, coronary bypass surgery, and/or coronary stent procedure) eligible for LDL Cholesterol test incentive</td>
<td>If an H-E-B is not conveniently located to member, then a comparable grocery card may be supplemented.</td>
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| Weight Watchers*              | 9-week membership                             | • PCP may fax referral along with current weight and weight goal to 866-883-0724.  
• Member may self-refer by calling Customer Service 888-887-9003 (in which case we will contact PCP for referral and weight information).  
• A parent or guardian must sign the health notice portion of the Weight Watchers registration form for members ages 10-16.  
• Member receives a gift card ($50 value) to purchase workout clothes upon successful completion of this program. |                      |                                                                                                                                   |
| Join for Me Childhood Obesity Program | 16 weekly group classes held in the community. Trained facilitators teach tools and strategies to adopt healthier habits that lead to lifelong healthier weight. Family support utilized. | • PCP signature is necessary on referral form posted at UHCCommunityPlan.com (see Provider Forms) to attest to member meeting BMI criteria.  
• Member receives a gift card ($50 value) to purchase workout clothes upon successful completion of this program. | STAR, STAR+PLUS     | Ages 6 through 17                                                                                                                      |
| Physical Exam                 | Annual physical for participation in sports, school extracurricular activities or camps | In-network physician to bill with one of the following codes to apply this visit as a Value-added Service for member:  
• CPT-4 code 97005 – Athletic Training Evaluation  
• 97006 – Athletic Training Re-Evaluation  
• ICD-10 code V70.3 – Other Medical Exam for Administrative Purposes | STAR, STAR+PLUS     | Through ages 4-19  
• One visit in a twelve-month period  
• Not a replacement for annual wellness visit or Texas Health Step medical checkup                                                                 |
| Youth Recreation Membership   | Membership to local Boys and Girls Club       | Members may self-refer by calling Customer Service at 888-887-9003.                                                                                                                                 | STAR, STAR+PLUS     | Through age 18  
• Includes basic membership (additional costs not included).  
• Similar organization membership may be substituted where local Boys and Girls Club is not available.                                                                                                  |
| Camp and Activity Book        | Mikey's Guide to Summer Camps and Activities for Children with Disabilities | Members may self-refer by calling Customer Service at 888-887-9003 to receive this guide booklet ($25.00 value).                                                                                       | STAR, STAR+PLUS     | Through age 20  

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| **Wristband Identification** | A pack of disposable identification wristbands to help keep kids safe when away from their caregiver. The wristband contains name, emergency contact, allergies and any medical conditions. | Pre-paid postage postcard is provided to member when identified. The postcard is signed by the member at returned to us. Member then receives the waistbands in the mail. | STAR+PLUS members through age 20 and in at least one of the following waiver programs:  
  - Community Living and Support Services (CLASS)  
  - Home and Community-Based Services (HCS)  
  - Texas Home Living (TxHml)  
  - Deaf Blind with Multiple Disabilities (DBMD)  
  - Intermediate Care Facilities for individuals with an Intellectual Disability or Related Condition (ICF-IID) | Members living in a nursing facility are not eligible for this care consultation. |
| **Care Consultation**    | A personalized service for individuals and families who are facing many decisions and challenges associated with Alzheimer’s disease and related disorders. The goal is for each family to develop a better understanding of the disease, make a plan to secure needed care, and develop strategies for the best possible symptom management and communication. | All identified members will receive a mailer with information about how to get their consultation.  
  The member or caregiver can contact the Alzheimer’s Association directly for scheduling of the consultation. | • STAR+PLUS  
• Living in the community | Members living in the community |
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| **MedicAlert®+ Alzheimer's Association Safe Return®** | • Individualized bracelet or necklace emblem engraved with MedicAlert + Safe Return's 24-Hour emergency response number  
• Live 24-hour emergency response service for wandering and medical emergencies  
• 24-hour family notification service during wandering incidents and medical emergencies  
• 24-hour relaying of key medical information to emergency responders  
• 24-hour care consultation services provided by master's level counselors | Members may self-refer by calling Customer Service at 888-887-9003.            | • STAR+PLUS, and  
• Age 19 and older  
• Living in the community |                                           |
| **Respite**                   | Eight hours of in-home respite care available to offer caregiver relief for members who live in their own home or a home of a relative. | Member requires supervision or personal attendant care when not under the direct care of care-taker. | STAR+PLUS non waiver                 | STAR+PLUS non waiver                      |
| **Home Delivered Meals**      | Ten meals delivered are available to be the member’s home following an acute inpatient hospital stay. | Member or representative may self-refer by calling their service coordinator directly or call the service coordination department at 800-349-0550. | STAR+PLUS non waiver                 | • Member must be able to receive all 10 frozen meals at one time.  
• Member must have ability to have meals heated and served. |
| **Diabetic Insoles**          | Two pair of full-length foot insoles designed to prevent complications, which can include strain, ulcers, calluses, or even amputations for patients with diabetes and poor circulation | • Members diagnosed with diabetes receive a mailer explaining this benefit.  
• Member, representative or Nursing Facility will mail the self-addressed postage paid post card to the address on the card. | • STAR+PLUS  
• Age 18 and older  
• Living in the community  
• Diabetes diagnosis |                                           |
<table>
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<tr>
<td>Assistance for Asthmatics</td>
<td>A quality allergy mattress covers and a pillow case traps allergens from dust mites, animal dander and pollen.</td>
<td>Members may self-refer by calling Customer Service at 888-887-9003 to have bed coverings delivered to their home.</td>
<td>• STAR or&lt;br&gt;• STAR+PLUS, and&lt;br&gt;• Under the care of our STAR+PLUS Service Coordination or STAR Care Management programs to address asthma</td>
<td></td>
</tr>
<tr>
<td>Infant Care Book</td>
<td>Infant care book mailed to all pregnant members.</td>
<td>We mail a book, such as <em>What to Expect when you’re expecting</em> to the member’s home address.</td>
<td>• STAR&lt;br&gt;• STAR+PLUS</td>
<td>One book per pregnancy</td>
</tr>
</tbody>
</table>
| Baby Shower            | • Pregnant mothers are invited to a baby shower where they receive health and safety education and are eligible to receive gifts such as strollers.  
|                        | • We host baby showers quarterly in the following areas of service (Central, Northeast, Harris, Hidalgo, Jefferson, Nueces and Travis).    | We invite pregnant members who reside in the area where we are hosting a baby shower.                                                                                                                        | • STAR<br>• STAR+PLUS                                                                                                                                       |                                                                                                                                 |
| Diaper Rewards         | Member receives coupons for six free Pampers Jumbo Pack diapers when they participate in their postpartum and the first 5 well baby checkups. | • Mother receives a pack of pre-paid postage postcards.  
|                        |                                                                                                                                  | • With her postpartum visit and each of the first five well baby visits, she asks physician to sign postcard to verify visit.  
|                        |                                                                                                                                  | • Cards are mailed to us and we send the mother the coupon for diapers in the mail.                                                                      | • STAR<br>• STAR+PLUS                                                                                                                                       |                                                                                                                                 |
| Postpartum Home Health | New mothers may access two home health visits without a physician order or medical necessity determination. These visits may assist with lactation support, newborn care, postpartum depression and more. | Members may self-refer by calling Customer Service at 888-887-9003.                                                                                                                                          | • STAR<br>• STAR+PLUS                                                                                                                                       | These visits are independent of home health benefits.  
<p>|                        |                                                                                                                                  |                                                                                                                                                                                                             | • Two visits available per delivery.                                                                                                                   |                                                                                                                                 |</p>
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<tr>
<td><strong>Mental Health Community Services</strong></td>
<td>Mental health services designed to help reduce or avoid inpatient admissions are offered through a community-based, mobile multi-disciplinary team. Services include home and school-based services, and intensive case management.</td>
<td>Members or representatives may self-refer by calling Optum at 800-496-5841.</td>
<td>• STAR</td>
<td>• STAR+PLUS</td>
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<td></td>
<td></td>
<td></td>
<td>• Age 21 and older</td>
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<td><strong>Dental Care For Adults</strong></td>
<td>Dental care is often not a benefit and dental problems can lead to secondary issues. We offer a maximum annual $500.00 to cover:  • Routine exam and cleaning full mouth x-ray  • Scaling and root planning if medically necessary  • Routine silver and white colored fillings  Access to discounted fee schedule for non-covered services.</td>
<td>Members may self-refer by calling Customer Service at 888-887-9003 or finding their own network dentist by visiting UnitedHealthcareCommunityPlan.com (see Find a Physician).</td>
<td>• STAR</td>
<td>• STAR+PLUS</td>
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<td></td>
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<td></td>
<td>• Age 21 and older</td>
<td>Providers must be in UnitedHealthcare Dental network.</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>Corrective lenses are prescribed because they are required to view the world. Base benefits don’t always cover enhancements or loss of these necessary items. We provider an annual maximum $105.00 to cover:  • Upgraded selection on types of frames and lenses  • Damage, loss or theft replacement frames and lenses due to loss, theft or damage for members. Contact Lenses provided in lieu of spectacle lens and frames</td>
<td>Members may self-refer by calling Customer Service at 888-887-9003 or finding their own network eye care provider by visiting UnitedHealthcareCommunityPlan.com (see Find a Physician).</td>
<td>• STAR,  • STAR+PLUS</td>
<td>• Age 21 and older</td>
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<td>• If the Member chooses the contact lens program, the benefit will cover the fitting/evaluation fees, contacts (disposable contacts up to four boxes, depending on prescription and plan selected), and up to two follow-up visits.</td>
<td>• Providers must be in Block Vision.</td>
</tr>
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<tr>
<td>Live and Work Well Website Access</td>
<td>Confidential, registered access to mental health and substance use self-help programs, interactive tools, educational resources and network provider searches to help with life’s changes and challenges. This Value-added benefit makes it available to members. Visit <a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a>.</td>
<td>Member will be able to access site by calling the behavioral health number on the back of their UnitedHealthcare Community Plan member ID card for assistance for secure site registration.</td>
<td>• STAR</td>
<td>A sister site is available in Spanish <a href="http://www.mentesanacuerposano.com">www.mentesanacuerposano.com</a>.</td>
</tr>
<tr>
<td>Nurse Line</td>
<td>• Toll-free access to registered nurses, including Spanish speaking nurses, 24 hours a day, 365 days a year. • Information for health and medical questions, including self-care recommendations, including when to go to the emergency room and alternatives if applicable.</td>
<td>Members can call anytime. (STAR) 800-535-6714 (STAR+PLUS) 877-839-5407</td>
<td>• STAR</td>
<td>• STAR+PLUS</td>
</tr>
<tr>
<td>Transportation</td>
<td>Transportation assistance will be provided when determined medically necessary by the Plan Case Manager to achieve health outcomes and compliance, when the State of Texas Medical Transportation Program is not available.</td>
<td>• Members or representatives may self-refer by calling Customer Services 888-887-9003 for authorization.</td>
<td>• STAR</td>
<td>• Visits over 75 miles may require prior approval. • Routine visits require 72-hour advanced scheduling and may be scheduled up to 30 days ahead. • Offers of bus tokens or vouchers may be used. • Visits over 75 miles may require prior authorization. • Hotel stay will be paid for trips that require an overnight stay. Must use designated network provider. • STAR+PLUS</td>
</tr>
</tbody>
</table>