2026 Nursing Facility Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Texas STAR+PLUS

For STAR+PLUS, serving the following service delivery areas: Bexar, Dallas, Harris, Hidalgo, Tarrant and Travis, as well as Medicaid Rural Service Area (MRSA) Central and MRSA Northeast

Customer Service: 1-888-887-9003

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TEXAS STAR+PLUS
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

United Healthcare Community Plan

Welcome

Welcome to the UnitedHealthcare Community Plan® care provider manual. This complete and up-to-date reference PDF care provider manual allows you and your staff to find important information such as how to process a claim and submit prior authorization requests. This care provider manual also includes important phone numbers and websites on the **Roles and responsibilities** pages in **Chapter 2**.

Click the following links to access different care provider manuals

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

View the **Medicaid glossary** for definitions of terms commonly used throughout the care provider manuals. For state specific glossary information, see **definition of terms** section of this manual.

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

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

Important information about the use of this care provider manual

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This care provider manual will be amended as policies change.

Welcome to UnitedHealthcare Community Plan

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

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

About this care provider manual

This care provider manual does not replace your Provider/Facility Agreement. Your Provider/Facility Agreement incorporates the provider manual as well as the Texas Medicaid Provider Procedures Manual located at Texas Medicaid & Healthcare Partnership at TMHP.com. The State Mandated Requirements for STAR+PLUS Nursing Facility Providers is another important source for Nursing Facilities. The care provider manual is designed to assist with day-to-day operations of your practice in working with UnitedHealthcare Community Plan.

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 care provider manual and updates are available at **UHCprovider.com/guides**. Contact your provider advocate or Customer Service at **1-888-887-9003** for a paper copy of this manual. Visit **UHCprovider.com/TXCommunityPlan** for important provider alerts and updates.

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Chapter 1: Introduction

Background

This manual addresses nursing facility long-term care for STAR+PLUS members of UnitedHealthcare Community Plan for the following service delivery areas (SDAs): Bexar, Dallas, Harris, Hidalgo, Tarrant and Travis, as well as Medicaid Rural Service Area (MRSA) Central and MRSA Northeast.

UnitedHealthcare Community Plan is a trade name of United Healthcare Insurance Company in Central MRSA and Northeast MRSA and UnitedHealthcare Community Plan of Texas L.L.C. In all other contracted SDAs.

Objectives

UnitedHealthcare Community Plan service coordinators partner with nursing facilities to ensure member-centered care is holistically integrated and coordinated. Our focus is supporting the primary care physician-led medical home in which health care services are accessible and sensitive to cultural differences, comprehensive, coordinated, and compassionate. We strive to achieve the following objectives:

- Preventive care
- Improved access to care
- Appropriate utilization of services
- Improved health outcomes, quality of care
- Cost-effectiveness
- Improved member and care provider satisfaction

Service coordinators look for opportunities to reduce preventable hospital admissions, readmissions, and emergency room visits. Additionally, we look to ensure appropriate care settings for individuals with disabilities, as well as the provision of a system of services and supports that foster independence and productivity, including meaningful opportunities for an individual with a disability to live in the most appropriate care setting. UnitedHealthcare Community Plan works closely with the Texas Health and Human Services Commission (HHSC) in the Promoting Independence Initiative.

Resources

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

Chapter 2: Roles and responsibilities

Texas Health and Human Services

The following responsibilities are maintained by Texas Health and Human Services (HHS) regarding nursing facilities:

- Medicaid eligibility
- Authorization of nursing facility unit rate
- Oversight of UnitedHealthcare Community Plan as a contracted managed care organization
- Reviewer of complaints
- Nursing facility licensing and certification
- Minimum data set (MDS) function
- Trust fund monitoring

Care provider contact information	
Customer service	**1-888-887-9003**
Service coordination hotline	**1-800-349-0550**
Provider relations	Email: **Nhpra3@optum.com** **1-866-858-3546**
Eligibility	
UnitedHealthcare Community Plan	**UHCprovider.com/eligibility** **1-877-542-9235**
Texas Medicaid & healthcare partnership	1-800-925-9126
MAXIMUS	1-800-964-2777
Prior authorization	
Prior authorization requests	**UHCprovider.com/priorauth** **1-800-310-6826** (available 24-hours a day)
Authorization forms	**UHCprovider.com/forms**
Claims and payment	
Texas Medicaid & healthcare partnership billing (long term care portal)	tmhp.com
UnitedHealthcare Community Plan billing (code: 87726)	**UHCprovider.com/claims**

Claims and payment	
One Healthcare ID support center	Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. **1-855-819-5909**
Texas Health and Human Services care provider claims hotline	1-512-438-2200
Hearing aids (non-implantable)	HearUSA fulfills hearing aid requests for our Texas Medicaid members. Submit claims directly to our contractor. 1-888-887-9003
Refunds and overpayments	**UnitedHealthcare Community Plan** P.O. Box 740804 Atlanta, GA 30374-0800
Fraud waste, and abuse hotline	**1-800-436-6184** Health and Human Services Office of Inspector General. **1-888-887-9003** UnitedHealthcare Community Plan.
Member and care provider complaints and appeals	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364
UnitedHealthcare Community Plan	**UHCprovider.com/TXCommunityPlan** 2950 North Loop W, Suite 200 Houston, TX 77092-8843

Our role and responsibilities

UnitedHealthcare Community Plan contracts with nursing facilities for network participation. The role of provider relations advocates is to contract and maintain care provider network, including care provider training, claims education and communication. Our health services department utilizes service coordination to ensure appropriate utilization of services and to promote the members' choice and ability to reside in the least restrictive appropriate environment. We determine prior authorizations for add-on services and process reimbursement for these services. See Service coordination section for additional information.

Nursing facility role and responsibilities

Nursing facilities provide overall care for all members including but not limited to the following: room and board, interdisciplinary healthcare needs, and access to hospice services. Following are additional responsibilities:

- Participation with our service coordination
- Coordinate care with the member's assigned PCP
- Observe necessary notifications to us, including admission and change in member status and/or condition
- Determine eligibility and securing necessary authorizations prior to service delivery

- Accurately and timely documentation and completion of the following:
  - Minimum data set (MDS) assessments, as required to federal Centers for Medicare & Medicaid Services, and associated MDS Long Term Care Medicaid Information Section to HHS's administrative services contractor (the Texas Medicaid & Healthcare Partnership [TMHP])
  - Long term care Medicaid information (LTCMI) completion
  - Forms 3618 and 3619 Resident Transaction Notice, as applicable, to TMHP
  - Preadmission Screening and Resident Review (PASRR) to TMHP. Coordinate with Local Authority (LA)/Local Behavioral Health Authority (LBHA) to complete a PASRR level 2 evaluation when an individual has been identified through the PASRR level 1 screen as potentially eligible for PASRR specialized services.
  - When making necessary referrals, refer to facilities and contractors in the network of UnitedHealthcare Community Plan. If the member accesses care through a non-contracted care provider without prior authorization, note that the services may not be reimbursed unless the service meets out of network care provider requirements in being an emergency, urgently needed service, post-stabilization or out-of-area renal dialysis. To submit a justification of an out-of-network referral go to **UHCprovider.com/referrals.**
  - Ensure continuity of care for members related to:
    - Hospitalization
    - Pregnant women
    - Facility transfer
    - When a member moves out of the service area
    - Surrounding pre-existing conditions not imposed

Role and responsibilities of primary care provider

The success of UnitedHealthcare Community Plan depends on strong relationships with contracted care providers. Members should contact their primary care provider (PCP), also known as the medical home, to coordinate their care and help them access their benefits in a manner that takes into consideration member special access requirements. PCPs are required to assess the medical and behavioral health needs of members and when appropriate refer to other care providers, including specialists who are in network. Referrals must be documented in member chart. PCPs coordinate member care and follow-up with the member and/or representatives, the nursing facility, UnitedHealthcare Community Plan service coordinators, and any other care providers involved in the member's care. Referrals do not require an authorization so long as the care provider is in network with UnitedHealthcare Community Plan. If the member accesses care through a non-contracted care 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.

To submit a justification of an out-of-network referral, visit **UHCprovider.com/referrals.**

The PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. A PCP can offer behavioral health services when clinically appropriate and are within the scope of the PCP's practice. These claims would be submitted to health plan.

Members in a nursing facility have the right to designate a specialist as their PCP, as long as the specialist agrees to provide PCP services to the Member. The specialist physician must agree to perform all PCP duties required in the contract, and PCP duties must be within the scope of the specialist's license. Any interested person may initiate the request through the MCO for a specialist to serve as a PCP for a member with disabilities, special health care needs, or chronic or complex conditions.

Panel roster

PCPs may print a monthly PCP panel roster by visiting **UHCprovider.com/reports**.

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

The PCP panel roster provides a list of UnitedHealthcare Community Plan® members currently assigned to the care provider.

Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, physician assistants, or nurse practitioners for women's health care services and any non-women's health care issues discovered and treated in the course of receiving

women's health care services. This includes access to ancillary services ordered by women's care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

UnitedHealthcare Community Plan works with members and care providers to help ensure that all participants understand, support, and benefit from the primary care case management system. The coverage shall include availability of 24 hours, 7 days per week. During non-office hours, access by telephone to a live voice (i.e., an answering service, physician on-call, hospital switchboard, PCP's nurse triage) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems. Recorded messages are not acceptable.

Assignment to primary care provider panel roster

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

Role and responsibilities of specialty care provider

Specialist consultations do not require authorization as long as the specialist is an in network care provider. Medical specialists are responsible for providing covered health services within the scope of their UnitedHealthcare Community Plan agreement and within the scope of their specialty license.

Verify member eligibility and ensure an authorization or services is in place at **UHCprovider.com/priorauth.**

Care 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 manual. It is the responsibility of the specialist to report 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.

Role of the 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 that the 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 (DME) with UnitedHealthcare Community Plan.

Network limitations

UnitedHealthcare Community Plan has no network limitation on referrals to any in-network care provider. If a care provider is contracted with UnitedHealthcare Community Plan® through an Independent Practice Association (IPA) or Medical Group, the care provider is not limited to referring within that IPA for specialist services.

Member's right to designate an obstetrician-gynecologist

UnitedHealthcare Community Plan **DOES NOT LIMIT** to network.

UnitedHealthcare Community Plan allows the members to pick any obstetrician-gynecologist (OB/GYN), whether that doctor is in the same network as the member's PCP or not.

Attention female members

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

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

Tuberculosis

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

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

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

Procedures Manual > Clinics and Other Outpatient Facility Services Handbook.

Confirmed or suspected cases of TB require mandatory reporting to the local TB control program within 1 working day of identification. Use the most current DSHS forms and procedures for reporting TB and cooperate with member records investigation. For more information about mandatory reporting of infectious diseases to the Center for Disease Control, visit dshs.texas.gov > Disease Prevention > Infectious Disease Prevention > Disease Reporting > Notifiable Conditions. For TB prevention, detection, and treatment visit the World Wide Medical Association at wma.net > What We Do > Education > Tuberculosis Refresher Course.

Find more TB service coordination information in this manual.

Communicable diseases

Members with communicable diseases require prompt appointment access and care, including confidentiality assurances. Minors may seek confidential treatment and give consent for these diseases. Prior authorization and/or a PCP referral are not necessary, members may self-refer.

Find more information about infectious diseases mandatory reporting to the Center for Disease Control at dshs.texas.gov > Disease Prevention > Infectious Disease Prevention > Disease Reporting > Notifiable Conditions. Find additional information at the Texas Administrative Code Title 25, Part 1, Chapter 97 Communicable Diseases.

Sexually transmitted diseases and human immunodeficiency virus

Advise members about their risk reduction responsibility and partner notification if syphilis, cancroid, gonorrhea, chlamydia and/or HIV are confirmed. You must have office policies and procedures, of which your staff is knowledgeable, to protect member confidentiality of those screened and treated for sexually transmitted diseases (STD) or human immunodeficiency virus (HIV)/AIDS. These procedures must include, but are not limited to:

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

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

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

Interacting with capitated/ delegated groups

In your market, you may work with entities that have capitated or delegated arrangements with UnitedHealthcare ("capitated organization"). If your patient is assigned to one of these capitated organizations, specific utilization management or claims processing rules may apply.

What is capitation?

Capitation is a payment model in which providers receive a fixed per-member, per-period payment, regardless of services rendered. Common capitated entities include Independent Practice Associations (IPAs), medical groups, and occasionally hospital systems or ancillary providers.

What is delegation?

Delegation is the transfer of authority to perform specific functions on our behalf.

We may delegate:

- Medical management
- Credentialing
- Utilization management
- Claims processing and payment
- Complex case management
- Other clinical and administrative functions

When responsibilities are delegated to a provider, they become a "delegated entity" or "delegate." UnitedHealthcare retains accountability to regulators for all delegated activities.

Delegated entities may contract with other providers, but those agreements must follow UnitedHealthcare's product-specific regulations. To obtain and maintain delegation, providers must comply with our standards and best practices. Non-compliance may result in revocation of delegated responsibilities.

Capitated organizations are often also delegated entities, making them responsible for both delivering care and administering delegated functions, such as processing and paying claims for other providers.

What does it mean for you if you are not a capitated/delegated provider?

You may enter into direct agreements with capitated or delegated organizations. These agreements may differ from your Participation Agreement with UnitedHealthcare and should clearly define applicable protocols and procedures.

Key principles:

- **If you participate with both UnitedHealthcare and a capitated organization, and provide designated covered services to a capitated member:** The capitated organization is solely responsible for payment, based on your agreement with them.
- **If you participate with UnitedHealthcare but not with the capitated organization, and provide designated covered services to a capitated member:** The capitated organization remains solely responsible for payment. Reimbursement follows your UnitedHealthcare Participation Agreement.
- **If you participate with both UnitedHealthcare and a capitated organization, and provide services to a non-capitated member:** UnitedHealthcare (or the financially responsible entity) is solely responsible for payment, per your UnitedHealthcare Participation Agreement.

Chapter 3: Eligibility

Medicaid eligibility

Eligibility for payment for nursing facility long term care for all applicants depends on proof of both financial need and the need for medical care in an institution. HHS is responsible for determination of Medicaid eligibility.

Medicaid eligibility is determined through the Texas Integrated Eligibility Redesign System (TIERS) after the initial 30-day stay that establishes residency. The HHS Medicaid eligibility worker (MEW) is responsible for the financial eligibility for Medicaid. This process should be completed within 45 days, except in unusual situations. Please note that members may choose to switch plans within a 6-month time frame.

If an applicant is determined eligible, an applied income amount may be determined that the individual must pay toward to the cost of the nursing facility care. Denial of Medicaid eligibility may be appealed. Medicaid payment does not begin until HHS establishes a record of eligibility in its central computer.

The Form 1230, Notification of Eligibility – Regular Medicaid Benefits, indicates the date benefits begin and the amount of applied income the individual must pay to the facility each month. Applied income information is also provided in the Medicaid Eligibility Service Authorization Verification (MESAV) system. See the Billing section of this manual for additional information regarding applied income.

A member may request to dis-enroll from managed care. This would require a medical documentation form from the member's PCP, or documentation that indicates sufficiently compelling circumstances that merit disenrollment. HHS will make the final decision regarding disenrollment. Care providers may not take retaliatory action against a member for any reason including disenrollment.

Member disenrollment

We have the limited right to request a member be disenrolled from our health plan without the member's consent. HHS must approve any such request for disenrollment of a member for cause. We must take reasonable documented measures to correct member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors. HHS may permit disenrollment of a member under the following circumstances:

1. Member misuses or loans member's MCO membership card to another person to obtain services.
2. Member's behavior is disruptive or uncooperative to the extent that member's continued enrollment in our plan seriously impairs our plan's or the care provider's ability to provide services to either the member or other members, and the member's behavior is not related to a developmental, intellectual, or physical disability or behavioral health condition.
3. Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow us to treat the underlying medical condition).
4. HHS must notify the member of HHS' decision to dis-enroll the member if all reasonable measures have failed to remedy the problem.
5. If the member disagrees with the decision to dis-enroll them from UnitedHealthcare Span of coverage.

The following table shows payment responsibility for Medicaid enrollment changes that occur during a nursing facility stay, beginning on the member's effective date of coverage with the new MCO.

	Scenario	Nursing facility UnitedHealthcare rate and/ or Medicare coinsurance	All other covered services
1	Member moves from FFS to STAR+PLUS or Dual Demonstration.	New STAR+PLUS or Dual Demonstration MCO.	New STAR+PLUS or Dual Demonstration MCO.
2	Member moves between STAR+PLUS MCOs.	New STAR+PLUS MCO.	New STAR+PLUS MCO.
3	Member moves between Dual Demonstration MCOs.	New Dual Demonstration MCO.	New Dual Demonstration MCO.
4	Member moves from STAR+PLUS to Dual Demonstration.	New Dual Demonstration MCO.	New Dual Demonstration MCO.
5	Member moves from Dual Demonstration to STAR+PLUS.	New STAR+PLUS MCO.	New STAR+PLUS MCO.
6	Member moves from STAR+PLUS to Dual Demonstration to FFS.	FFS.	FFS.

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 6 months. After automatic re-enrollment, members may choose to change MCOs. You can check the TMHP Automated Inquiry Services (AIS) line to verify member eligibility status at 1-800-925-9126.

Find medical policies and coverage determination guidelines at **UHCprovider.com/policies** > Policies and Clinical Guidelines > UnitedHealthcare Community Plan Medical & Drug Policies & Coverage Determination Guidelines.

Managed care organization membership

Nursing facility long term care for STAR+PLUS members is managed by UnitedHealthcare Community Plan for adults age 21 and older who are in nursing facilities, and who meet certain criteria.

STAR+PLUS Criteria:

- Must be eligible for Medicaid
- Must be at least age 65 or older or, if younger than 65, receive Social Security, Railroad Retirement or SSI disability benefits
- A U.S. citizen, or a qualified legal alien, and a Texas resident
- Members with Medicare Part A who are below certain income requirements may qualify for the state to pay their Medicare premiums
- Ages 21 and older

It is the nursing facility's responsibility to verify member eligibility for authorizations for service.

- Current resident nursing home Medicaid recipient's MCO enrollment should be verified at least every 30 days
- Residents who transfer from another nursing facility need verification of MCO membership prior to admission and at least every 30 days thereafter

Verifying member Medicaid eligibility

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

- Call **Provider Services** at **1-888-887-9003** or check the **UnitedHealthcare Provider Portal**
- Use TexMedConnect on the TMHP website at tmhp.com
- Log into your TMHP user account and access Medicaid client portal for care providers.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at 1-800-925-9126 or 1-512-335-5986
- Your Texas Benefits Medicaid Card
  - **Temporary ID (Form 1027-A) UnitedHealthcare Community Plan ID card**
    - STAR+PLUS Dual Eligible: If the member has Medicare, Medicare is responsible for most primary, acute, and behavioral health services. Therefore, the PCP's name, address, and telephone number are not listed on the member's UnitedHealthcare Community Plan ID card. The member receives long-term services and supports (LTSS) through UnitedHealthcare Community Plan.

The member will have both a Your Texas Benefits Medicaid card and a UnitedHealthcare Community Plan card.

Member ID cards

UnitedHealthcare Community Plan has a membership category in which the member only qualifies for LTSS through UnitedHealthcare Community Plan. Their health care is managed by another managed care organization. The member ID cards for these members indicates long-term care services only.

Note that STAR+PLUS waiver members and LTSS-only members are dis-enrolled from these programs after 120 days of residing in the nursing facility. They maintain their STAR+PLUS status.

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Note that STAR+PLUS waiver members and LTSS-only members are dis-enrolled from these programs after 120 days of residing in the nursing facility. They maintain their STAR+PLUS status.

The Form 3618/3619 Resident Transaction Notice can only be submitted electronically by completing it on the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Portal. The purpose is to inform HHS about transactions and status changes for Medicaid applicants and recipients and to provide HHSC information necessary to initiate, close or adjust vendor.

A nursing facility must electronically submit to the state Medicaid claims administrator a resident transaction notice within 72 hours after a recipient's admission, discharge, or payer change from the Medicaid nursing facility vendor payment system.

The nursing facility administrator prepares Form 3618 and 3619 for recipients who are eligible Medicaid recipients, applicants for medical assistance, or Medicaid recipients who are being discharged from the Medicaid program. Form 3618 and 3619 is not used to report transactions involving private-pay residents, except when a resident who has been private pay is applying for Medicaid or when a recipient has been receiving Medicaid and is denied.

The nursing facility administrator prepares a separate Form 3618 and 3619 for each transaction. Each admission into or discharge from the facility requires a Form 3618 and 3619 except approved therapeutic passes. An admission or discharge between payer sources also requires Form 3618 and 3619, Medicare/ Skilled Nursing Facility Patient Transaction Notice. Example: Form 3619 discharge from Medicare and Form 3618 admission to Medicaid to change payer source from Medicare to Medicaid.

The nursing facility must print out and complete all items on Form 3618 and 3619, including the nursing facility administrator's State Board license number, and have the nursing facility administrator sign and date Forms 3618 and 3619.

Preadmission screening and resident review

The preadmission screening and resident review (PASRR) Level 1 screenings, Level 2 evaluations, and specialized services provided by HHSC-contracted local authority (LA) and DSHS-contracted local behavioral health authority (LBHA). Specialized services provided by the LA include: service coordination, alternate placement, and vocational training. Specialized services provided by the LBHA include mental health rehabilitative services and targeted case management. Specialized services provided by a NF for individuals

identified as IDD include physical therapy, occupational therapy, speech therapy, and customized adaptive aids. All specialized services are non-capitated, fee-for-service.

Preadmission screening and resident review

The preadmission screening and resident review (PASRR) Level 1 screenings, Level 2 evaluations, and specialized services provided by HHSC-contracted local authority (LA) and DSHS-contracted local behavioral health authority (LBHA). Specialized services provided by the LA include: service coordination, alternate placement, and vocational training. Specialized services provided by the LBHA include mental health rehabilitative services and targeted case management. Specialized services provided by a NF for individuals identified as IDD include physical therapy, occupational therapy, speech therapy, and customized adaptive aids. All specialized services are non-capitated, fee-for-service.

Medical records

Confidentiality

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. You agree to comply in all relevant respects (including the use of electronic medical records) 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.

Access to records and information

The nursing facility provides, at no cost to HHS or UnitedHealthcare Community Plan:

- All information required under UnitedHealthcare Community Plan's managed care contract with HHS, including the reporting requirements and other information related to the care provider's performance of its obligations under the contract; and
- Any information in its possession sufficient to permit HHS to comply with the federal Balanced Budget Act of 1997 or other Regulatory Requirements

The nursing facility will comply with the timelines, definitions, formats, and instructions specified by HHS.

Upon receipt of a record review request from the HHSC or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, the nursing facility will provide, at no cost to the requesting agency, the records requested within 3 business days of the request (or within the time of the request of otherwise stated).

If at the time of the request for access to medical records HHS, or the Texas Office of Inspector General, Healthcare Program Enforcement Division (HPED) of the Texas Attorney General's Office, or another state or federal agency believes records are about to be altered or destroyed, the nursing facility must provide the records at the time of the request or in less than 24 hours.

The request for record review may include:

- Members' clinical records
- Other records pertaining to the member

- Any other records of services provided to Medicaid or other HHS program recipients and payments made for those services
- Documents related to diagnosis, treatment, service, lab results, charting
- Billing records, invoices, documentation of delivery items, equipment, or supplies
- Business and accounting records or reports with backup support documentation
- Financial audits
- Statistical documentation
- Computer records and data contracts with care providers and subcontractors

The nursing facility must keep the original Forms 3618 and 3619 based on its Medicaid Nursing Facility Provider Agreement, which states, medical records and documents will be kept for a minimum of 5 years after the termination of the contract period.

The goals of managed care include an emphasis on preventive care, improved access to care, appropriate utilization of services, improved client and care provider satisfaction, and improved health outcomes, quality of care, and cost- effectiveness. In the nursing facility context, the role of the UnitedHealthcare Community Plan service coordinator is to partner with the nursing facility to ensure member care is holistically integrated and coordinated. Additionally, they consider ways to reduce preventable hospital admissions, readmissions, and emergency room visits.

Chapter 5: Service coordination

Our service coordinator participates in person- and family-centered service planning with the nursing facility, PCP, vendors, and other state and community agencies to coordinate managed and non-managed services, including non-Medicaid community resources to develop a plan of care. Our service coordinators also participate with the member and family or representative, nursing facility and other members of the interdisciplinary team to provide input for the development of the nursing facility plan of care. They also attend meetings surrounding member care and serve as a resource, or advocate for the member. Service coordinators conduct a face-to-face visit with the member at a minimum of quarterly, and more frequently as determined by the member's condition, situation, and level of care. Service coordinators for STAR+PLUS Level 1 members in a nursing facility may determine it is appropriate to use an audio-visual service visit in place of an in-person visit. Members will have at least 1 annual face-to-face service coordination visit.

The UnitedHealthcare Community Plan Service Coordinator role includes:

- Coordinating services when a member transitions into a nursing facility for long term care
- Partnering with the member, family, nursing facility staff and others in the development of a service plan, including services provided through the Nursing Facility, add-on services, acute medical services, behavioral health services, and primary or specialty care. The approval of additional services outside of the nursing facility daily unit rate is based on medical necessity and benefit structure. Participating in nursing facility care planning meetings telephonically or in person, provided the member does not object
- Comprehensively reviewing the member's service plan, including the nursing facility plan of care, at least annually, or when there is a significant change in condition
- Visiting members living in nursing facilities in person at least quarterly. Visits should include, at a minimum, a review of the member's service plan and when possible, a person-centered discussion with the member about the services and supports the member is receiving, any unmet needs or gaps in the person's service plan, and any other aspect of the member's life or situation that may need to be addressed. Assisting with the collection of applied income when a nursing facility has documented unsuccessful efforts, per the state-mandated requirements
- Cooperating with representatives of regulatory and investigating entities including HHSC Regulatory Services, the LTC Ombudsman Program, Adult Protective Services, the Office of the Inspector General, and law enforcement
- Fulfilling requirements of the Texas Promoting Independence
- Coordinating with the nursing facility to plan discharge and transition from the nursing facility

The nursing facility is responsible for notifying the UnitedHealthcare Community Plan service coordinator of the following:

- Admission to or discharge from the nursing facility, including admission or discharge to a hospital or another acute facility, skilled bed, long-term services and supports care provider, non-contracted bed, another nursing or long term facility (within 1 business day)
- An unplanned admission or discharge to a hospital or other acute facility, skilled bed, or another nursing home (within 1 business day)
- A significant, adverse change in a member's physical or mental condition or environment that could potentially lead to hospitalization (within 1 business day)
- When the member's interdisciplinary team is scheduled to meet for a nursing facility plan of care
- An emergency room visit (within 1 business day)
- Discharge or transition from a nursing facility (within 1 business day)
- When the nursing facility initiates an involuntary discharge of a member from a facility
- A member's death (within 72 hours)
- Any other important circumstances, such as the relocation of residents due to a natural disaster

[1] Information on person-centered practices can be found at: learningcommunity.us and personcenteredpractices.org

[2] For the purposes of this document, service plan is a comprehensive set of services and supports, including Medicaid-covered services, informal or family supports, and non-Medicaid community resources. The MCO SC is responsible for a member's service plan. A NF plan of care is the Medicaid-covered services provided in a nursing facility. The nursing facility is responsible for its plan of care but the nursing facility plan of care may include add-on services authorized by the MCO. The nursing facility plan of care is included in the MCO's service plan.

- After 2 unsuccessful attempts to collect applied income from a resident

In addition, the nursing facility care coordinator role and responsibilities include following:

- Inviting the UnitedHealthcare Community Plan service coordinator to provide input for the development of the nursing facility care plan, subject to the member's right to refuse. Nursing facility care planning meetings should not be contingent on our service coordinator's participation.
- Providing our service coordinator access to the facility, nursing facility staff, and members' medical information and records.

Form 2067 Case Information is to be completed upon admission and when a request or share information about case record transfers or in coordination with other care providers. Fax the following information within 72 hours of admission to UnitedHealthcare Community Plan to 1-866-785-1651:

- HHSC Form 2067 Case Information
- Member name as it appears on UnitedHealthcare Community Plan member identification (ID) card
- Medicaid ID number as it appears on UnitedHealthcare Community Plan member ID
- Diagnosis
- Admission date
- Family contact information (name, phone number)
- Nursing home contact (name, title, phone number)
- Plan of care

Find the HHSC Form 2067 at HHS.Texas.gov > Laws & Regulations > Forms > 2000-2999 > Form 2067 Case Information. One of our Health Service coordinators will call the family's contact person to arrange a visit with the member to perform a service coordination assessment.

Inpatient concurrent review: clinical information

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

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

You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director. You must provide all requested and complete clinical information and/or documents as required within 4 hours of receipt of our request if it is received before 1 p.m. Central time (CT), or make best efforts to provide requested information within the same business day if the request is received after 1 p.m. CT (but no later than 12 p.m. CT the next business day).

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

Promoting independence

We participate in the promoting independence initiative. The philosophy is that aged and disabled individuals remain in the most integrated setting to receive LTSS. Promoting Independence is Texas' response to the U.S. Supreme Court ruling in Olmstead v. L.C., which requires states to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services, when:

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

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

If the initial review does not support a return to the community, the service coordinator will conduct a second assessment 90 days after the initial assessment to determine any changes in the member's condition or circumstances that would allow a return to the community. The service coordinator will develop and implement the transition plan.

Discharge and transition planning

When a member is ready to return to community living, our service coordinator will develop and implement a member- centered transition plan which will include the following: Coordination with

- Member and member's family (or other social supports)
- The nursing facility social worker
- The HHSC relocation specialist
- The Long Term Care ombudsman
- Member's PCP and other healthcare professionals
- Community resources

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

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

The plan will include utilization of appropriate and available LTSS as appropriate. The services are provided by HHSC-contracted, UnitedHealthcare Community Plan network care providers:

- Personal attendant services
- Emergency response
- Home and/or vehicle modifications
- Home delivered meals
- Adult day healthcare services
- Adult day foster care
- Assisted living or residential care
- Respite
- Employment assistance and/or supported employment
- Community first choice

Behavioral health

You 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 using the current DSM (or its successor) classifications. An information from the member. The behavioral health care specialists can communicate with the appropriate care provider or individual regarding diagnosis and treatment planning to ensure the continuity and coordination of behavioral health care. The behavioral health care provider coordinates care with the PCP and will send initial and quarterly summary reports of a member's behavioral health care 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.

To refer a member for mental health or substance use disorder services, please call **Provider Services** at **1-888-887-9003**, 24/7.

Emergency services, service coordination and crisis services are centralized and available 24 hours per day, seven days per week. Face-to-face assessment for acute and crisis situations are available 24 hours a day, seven 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 days from the date of discharge. Behavioral health care providers contact members who have missed an appointment within 24 hours to reschedule the appointment

Local behavioral health authorities

Community mental health centers, also referred to as local behavioral health authorities (LBHAs), provide services to a specific geographic area of the state, called the local service area. DSHS requires each authority to plan, develop policy, coordinate, allocate and develop resources for mental health services in the local service area. LBHAs are individually owned and operated. Specific referral criteria differ so for program and referral information visit hhs.texas.gov.

Coordination with care providers of non-capitated services

The Texas Medicaid Provider Procedures Manual outlines details for the coordination of the following services. Visit tmhp.com > Providers > Medicaid Provider Manual.

Long-term services and supports

LTSS for individuals who have intellectual or developmental disabilities provided by HHSC-contracted care providers.

Tuberculosis

You must coordinate with the local tuberculosis (TB) control program to ensure all members with confirmed or suspected tuberculosis have a contact investigation and receive directly observed therapy. You must report to the Texas Department of State Health Services or the local tuberculosis control program any member who is noncompliant, drug resistant, or who is or may be posing a public health threat.

TB clinics must be enrolled in Texas Medicaid and provide services based on 1 TAC, §354.1371. To enroll in Texas Medicaid, a TB clinic must be either:

- A public entity operating under an HHS tax identification number (TB regional clinic)
- A public entity operating under a non-HHS tax identification number (city/county/local clinic)
- A non-hospital-based entity for private care providers

Care providers of TB-related clinic services must complete a provider application from the TB Services Branch within DSHS. Per Texas DSHS policy, provide services.

Observed therapy and contact investigation: Following the initial new patient physician E/M visit, an established patient physician E/M visit (procedure code 99212, 99213, 99214, or 99215) must be billed every 90 days throughout the course of treatment, or subsequent reimbursement for DOT (procedure code H0033) will be denied.

Clients with latent TB infection, including those in a high-risk group (children who are 4 years of age and younger, those who are immunocompromised, and clients who are HIV-positive), and those with active TB disease, must be seen by a physician every 90 days throughout the course of treatment.

A physician must evaluate each client with active or latent TB disease prior to discharge from TB treatment.

Hospice

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

Medicaid hospice provides palliative care to all Medicaid- eligible clients (no age restriction) who sign statements electing hospice services and are certified by physicians to have 6 months or less to live if their terminal illnesses run their normal courses. Hospice care includes medical and support services designed to keep clients comfortable and without pain during the last weeks and months before death. Texas Medicaid clients who are 21 years of age and older and who elect hospice coverage waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services that are unrelated to their terminal illness.

Chapter 6: Health care delivery and availability

PCPs, specialists and other care providers providing care to members in nursing facilities will be required to contract with UnitedHealthcare Community Plan, to be considered in-network care providers. The PCP must have a national provider identification number and a Texas provider identification number, which qualifies them to serve Texas Medicaid members.

We foster the Medical Home model in which health care services are accessible, family-centered, and sensitive to cultural differences, comprehensive, coordinated, and compassionate. Care for every member integrates health education, wellness, and prevention. The CP coordinates the medical home, which includes participation in the plan of care with the service coordinator, member, member family, and specialists as appropriate.

PCPs, specialists and other care providers providing care should ensure continuity of care for members related to:

- Hospitalization
- Pregnant women
- Facility transfer
- When a member moves out of the service area
- Surrounding pre-existing conditions not imposed

Members in a nursing facility have the right to designate a specialist as their PCP as long as the specialist agrees to that designation. UnitedHealthcare Community Plan network will establish the PCP designation in the provider agreement contract. UnitedHealthcare Community Plan will 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 and ensure a member's right to obtain medication from any network pharmacy. Female members have the right to access an OB/ GYN in network care provider in addition to their PCP. UnitedHealthcare Community Plan recognizes that members can access a second opinion regarding the use of any health care service. The second opinion must be provided by a network care provider. Members with Special Health Care Needs need to have access to a specialist as appropriate for the member's condition and identified needs, such a standing referral to a specialty physician.

Access to care standards

A PCP has the responsibility to ensure that necessary health care services are available to members 24 hours a day and 7 days a week. This includes the responsibility to return member after-hour phone calls within 30 minutes of the phone call. When unable to provide this level of care for the member, you must arrange with another in network PCP to cover this availability.

Note: A hospital emergency room is not an acceptable substitute for a covering care provider. All care providers need to adhere to the access standards in emergencies and when scheduling appointments (see chart).

Access and availability	
Condition	Time frame (requirements for scheduling appointments.
Routine: primary care	Within 14 days.
Specialty care referrals (including therapy)	Within 21 days.
Preventive health services	Within 90 days.
Behavioral health post hospitalization	Within 7 days from the date of discharge.
Urgent care	Within 24 hours.
Emergency	Upon member presentation.

Cultural sensitivity

Our care providers adhere to the American with Disabilities Act standards governing the ready access and usability of facilities by individuals You are expected to comply with the Title I of the American with Disabilities of 1990 and Title VII of the Civil Rights Act of 1964. This person-centered approach to care requires physical access to buildings, services, and equipment and flexibility in scheduling and processes.

You are expected to comply with the Title I of the American with Disabilities of 1990 and Title VII of the Civil Rights Act of 1964. This person-centered approach

to care requires physical access to buildings, services, and equipment and flexibility in scheduling and processes.

- Communication with members needs to be in a manner that accommodates their individual needs, including providing interpreters (for those who are deaf, hard of hearing or do not speak English) and accommodations for members with cognitive limitations
- It's important that staff receive competent training on accessibility and accommodation, independent living and recovery models, cultural competency, and wellness philosophies
- We expect our members to receive culturally competent care delivered in the same manner as other patients which is free of discrimination of the member's race, color, religion, national origin, or sex

Cultural resources

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

- **Cultural competency training and education**
  - Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources.
  - Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process.**
- **Translation/interpretation/auxiliary aide and services**
  - You must provide language services and auxiliary aide and services, including but not limited to, sign language interpreters to members as required, to provide members with an equal opportunity to access and participate in all health care services.
  - If the member requests translation/interpretation/auxiliary aide services, you must promptly arrange these services at no cost to the member.
  - Members have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of members with limited English proficiency, or members who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the member refuses. Document the refusal of professional interpretation services in the member's medical record.
  - Any materials you have a member sign, and any alternative check-in procedures (like a kiosk), must be accessible to an individual with a disability.
  - If you provide Virtual Visits, these services must be accessible to individuals with disabilities. Post your Virtual Visits procedures for members who are deaf or hard of hearing, so they receive them prior to the Virtual Visit.
- **Care for members who are deaf or hard of hearing**
  - You must provide a sign language interpreter if a member requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits to members who are deaf or hard of hearing.

UnitedHealthcare Community Plan provides the following:

- **Language interpretation line**
  - We provide interpreter services Monday–Friday from 8 a.m.–8 p.m. ET
  - To arrange for interpreter services, please call **1-877-842-3210**, TTY **711**
- **I Speak language assistance card**
  - This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.
- **Materials for limited English-speaking members**
  - We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

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

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® for medical care determinations.

Online resources

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

Learn the differences by viewing the **digital solutions comparison guide**. Care providers in the UnitedHealthcare network will conduct business with us electronically.

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

Application Programming Interface

Application Programming Interface (API) is a free digital solution that allows health care professionals to automate administrative transactions. API is designed to help your organization improve efficiency, reduce costs and increase cash flow. Automatic data feeds are created to share information between your organization and UnitedHealthcare on a timetable you set, and transfer the data to your practice management system, proprietary software, portal, spreadsheets or any application you prefer.

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

Electronic data interchange

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

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

It makes it possible to:

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

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

Getting started

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

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

Point of Care Assist

When made available by UnitedHealthcare Community Plan, you will do business with us electronically.

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

UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal**. You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information — all at no cost without calling.

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

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

Here are the most frequently used tools on the **UnitedHealthcare Provider Portal**:

- **Eligibility and benefits**
  View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.
- **Claims**
  Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.
- **Prior authorization and notification**
  Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/priorauth**.
- **Specialty pharmacy transactions**
  Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.
- **My Practice Profile**
  View and update the provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.
- **Document Library**
  Access claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, which can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.

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

Direct Connect

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

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

All users will access Direct Connect using the **UnitedHealthcare Provider Portal**.

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

Privileges

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

Provider Services

Provider Services is the primary contact for care providers who need help. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan. They can answer your questions about Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more. Provider Services works closely with all departments in UnitedHealthcare Community Plan.

Chapter 7: Member rights and responsibilities

Member rights

The following information is intended for UnitedHealthcare Community Plan members.

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   - Be treated fairly and with respect.
   - Know that your medical records and discussions with your care providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and PCP. This is the doctor or 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 care provider in a reasonably easy manner. That includes the right to:
   - Be told how to choose and change your health plan and your PCP
   - Choose any health plan you want that is available in your area and choose your PCP from that plan
   - Change your PCP
   - Change your health plan without penalty
   - 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
   - Have your care provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated
   - 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:
   - Work as part of a team with your care provider in deciding what health care is best for you
   - Say yes or no to the care recommended by your care provider
   - Get a second opinion with a care provider
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   - Make a complaint to your health plan or to the state Medicaid program about your health care, your care provider, or your health plan
   - Get a timely answer to your complaint
   - Use the plan's appeal process and be told how to use it
   - Ask for an external medical review and State Fair Hearing from the state Medicaid program and get information about how that process works
   - Ask for a State Fair Hearing without an external medical review from the state Medicaid program and receive information about how that process works
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   - Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need
   - Get medical care in a timely manner
   - Be able to get in and out of a care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, based on the Americans with Disabilities Act.
   - Have interpreters, if needed, during appointments with your care providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   - Be given information you can understand about your health plan rules, including the health care services you can get and how to get them
7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do, or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
10. You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
11. You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

Member responsibilities

The following information is intended for UnitedHealthcare Community Plan members.

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   - Learn and understand your rights under the Medicaid program
   - Ask questions if you do not understand your rights.
   - Learn what choices of health plans are available in your area
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   - Learn and follow your health plan's rules and Medicaid rules
   - Choose your health plan and a PCP quickly
   - Make any changes in your health plan and PCP in the ways established by Medicaid and by the health plan
   - Keep your scheduled appointments
   - Cancel appointments in advance when you cannot keep them
   - Always contact your PCP first for your non-emergency medical needs
   - Be sure you have approval from your PCP before going to a specialist
   - Understand when you should and should not go to the emergency room
3. You must share information about your health with your PCP and learn about service and treatment options. That includes the responsibility to:
   - Tell your PCP about your health
   - Talk to your care providers about your health care needs and ask questions about the different ways your health care problems can be treated
   - Help your care providers get your medical records
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
   - Work as a team with your care provider in deciding what health care is best for you
   - Understand how the things you do can affect your health
   - Do the best you can to stay healthy
   - Treat care providers and staff with respect
   - Talk to your care provider about all of your medications
5. You have a responsibility to follow plans and instructions for care that you have agreed to with your practitioners.

Advance directives

Members are encouraged to discuss their wishes with their PCP. You must document in a prominent part of the member medical record whether or not the member has 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 PCP 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 PCPs, as well as family members, friends and other individuals who are involved in their health care
- Members must inform doctors and other 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 (OOHDNR) order
- 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, which is a document making a declaration of preferences or instructions regarding mental health treatment

Service coordinator services

Services secured and authorized by the member's service coordinator are outlined in the member plan of care. For these services, the nursing facility does not need to request prior authorization. Verify the authorization is in place before service delivery.

Verification of authorizations is available through **UHCprovider.com/priorauth.**

Code removals from existing prior authorization categories

15876, 21282, 67916, 21137, 21295, 67917, 21138, 21296, 67921, 21139, 36468, 67922, 21208, 67911, 67923, 21209, 67911, 67923, 21209, 67914, 67924, 21280, 67915.

Although, prior authorization requirements are being removed, post-service determinations may still be applicable based on criteria published in medical policies and/or local and national coverage determination criteria.

Billing and authorizations chart

Service	Nursing facility	UnitedHealthcare Community Plan
Nursing facility unit rate The types of services included in the HHSC daily rate for nursing facility care providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The NF Unit Rate also includes applicable nursing facility rate enhancements and professional and general liability insurance.	Complete and submit Minimum Data Set (MDS) and Long Term Care Medical Information (LTCMI).	Adjudicate the Nursing Facility Unit Rate, including the daily rate, the staff rate enhancement, and insurance components. Clean claims are adjudicated within 10 days of submission.
Add-on services The types of services that are provided in the Facility setting but are not included in the NF Unit Rate. These include but not limited to emergency dental services; physician- ordered rehabilitative services; customized power wheel chairs; and augmentative communication devices.	• Request and coordinate prior authorizations for services with UnitedHealthcare Community Plan service coordinator – No prior authorization is required for emergency dental services • Submit clean claims within 95 days of service	• Contract directly with care providers of add-on services • Authorize eligible services • Adjudicate clean add-on services claims within 30 days of submission
Acute care Preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration.	• Request any necessary prior authorizations from UnitedHealthcare Community Plan Health Services for STAR+PLUS • Submit clean claims within 95 days of service	• Contract directly with physicians, prescribers and specialists • Authorize eligible claims for Acute services • Adjudicate clean Add-on Services claims within 30 days of submission

Nursing facility add-on services

Ventilator care add-on service: To qualify for supplemental reimbursement, a nursing facility member must require artificial ventilation for at least 6 consecutive hours daily and the use must be prescribed by a licensed physician.

Tracheostomy care add-on service: To qualify for supplemental reimbursement, a nursing facility member must be less than 22 years of age; require daily cleansing, dressing and suctioning of a tracheostomy; and be unable to do self-care. The daily care of the tracheostomy must be prescribed by a licensed physician.

PT, ST, OT add-on services: Rehabilitative services are physical therapy, occupational therapy, and speech therapy services (not covered under the NF Unit Rate) for Medicaid nursing facility members who are not eligible for Medicare or other insurance. The cost of therapy services for members with Medicare or other insurance coverage or both must be billed to Medicare or other insurance or both. Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and treatment of functions impaired by illness. Rehabilitative services must be provided with the expectation that the member's functioning will improve measurably in 30 days.

You must help ensure that rehabilitative services are provided under a written plan of treatment based on the physician's diagnosis and orders, and that services are documented in the member's clinical record.

PT, OT, ST services require prior authorization requests to Optum before delivery of these services.

Provide specialty therapy evaluations within 21 days of submission of a signed referral. If an additional assessment is required (e.g. audiology testing) as a condition for authorization of therapy evaluation, schedule the other assessment to occur within 21 days from date of submission of a signed referral.

Optum Utilization Review/Clinical Submissions may be requested through:
myoptumhealthphysicalhealth.com.

Mail: Optum
P.O. Box 212
Minneapolis, MN 55440-0212

Customized power wheelchair: To be eligible for a customized power wheelchair (CPWC), a member must be:

- Medicaid eligible;
- Age 21 years or older;
- Residing in a licensed and certified nursing facility that has a Medicaid contract with the Texas HHSC;
- Eligible for and receiving Medicaid services in a nursing facility;
- Unable to ambulate independently more than 10 feet;
- Unable to use a manual wheelchair;
- Able to safely operate a power wheelchair;
- Able to use the requested equipment safely in the nursing facility;
- Unable to be positioned in a standard power wheelchair;
- Undergoing a mobility status that would be compromised without the requested CPWC; and
- Certified by a signed statement from a physician that the CPWC is medically necessary.

Augmentative Communication Device (ACD): An ACD is a speech-generating device system. A physician and a licensed speech therapist must determine if the ACD is medically necessary.

Note: For nursing facility add-on therapy services, UnitedHealthcare Community Plan will accept claims received (1) from the nursing facility on behalf of employed or contracted therapists; and (2) directly from contracted therapists who are contracted with UnitedHealthcare Community Plan. All other nursing facility add-on care providers must contract directly with and directly bill UnitedHealthcare Community Plan. Assessment is included in these services.

Nursing facility add-on care providers (except nursing facility add-on therapy services providers) must refer to the STAR+PLUS Provider Manual for information including credentialing and re-credentialing.

These services require a prior authorization request to our service coordination department before the delivery of these services.

These authorizations and authorization requests may be requested through **UHCprovider.com/priorauth**.

You may call the service coordination hotline regarding authorization requests at **1-800-349-0550**.

To ensure continuity of care, be sure to request prior authorizations for on-going services prior to the authorization end date.

Please note that from the time of March 1, 2015, standard continuity of care requirements will remain in place for acute care services for 90 days and for LTSS for up to 6 months or until a new assessment is completed and new authorizations issued.

Acute care services

These services include preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration. Prior authorization requests may be necessary for some of these services.

Examples of services not requiring prior authorization is wellness exams and screenings.

For a complete list of services that require an authorization, visit **UHCprovider.com/priorauth** > Prior Authorization Requirements. These requests should be directed through **UHCprovider.com**. Authorization request forms are located **UHCprovider.com/priorauth** > Prior Authorization Forms. You may call health services regarding an authorization request at **1-877-285-9093.**

Covered benefits

The following are covered services:

- Ablative procedures for venous insufficiencies and varicose veins*
- Ambulance services, emergency
- Ambulance services, non-emergency (excluding to higher level of care)*
- Audiology services, including hearing aids*
- Behavioral Health Services*
  - Inpatient mental health services, include services in free-standing psychiatric facilities
  - Outpatient mental health services
  - Psychiatry services
  - Counseling services for adults
  - 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)

Behavioral health 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.

- 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 *
- Blepharoplasty and brow ptosis repair*
- Breast reduction*
- Cancer screening, diagnostic, and treatment services*
- Cosmetic surgery*
- Chiropractic - 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 (over $500.00*)
- Elective inpatient services*
- Emergency Services
- Family planning services, including member counseling and education
- Gynecomastia*
- Hospital services, including inpatient and outpatient*
- Inpatient services (elective)*
- Laboratory
- Magnetic Resonance Imaging, Magnetic Resonance Angiogram and Positron Emission Tomography*
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
  - Pain management*
  - Panniculectomy and body contouring*
- Mental Health Targeted Case Management
- Mental Health Rehabilitative Services
- Prenatal care - 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*
- Preventive services including an annual adult well check
- Primary care services
- Radiology, imaging, and X-rays
- Rhinoplasty, septoplasty and turbinate resection*
- Specialty physician services*
- Telemedicine
- Telemonitoring
- Therapies – physical, occupational and speech*
- Transition Assistance Services – These services are limited to a maximum of $2,500.00. If the MCO determines that no other resources are available to pay for the basic services/items needed to assist a member, who is leaving a nursing facility, with setting up a household, the MCO may authorize up to $2,500.00 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.
- Transplantation of organs and tissues*
- Ultrasound
- Ultrasound after 3 ultrasounds*
- Vision – Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction that cannot be accomplished by glasses.

*Denotes necessary authorization request

Added benefits

Adult members have unlimited prescriptions (benefit is only available for members who are not covered by Medicare).

Durable medical equipment and other products normally found in a pharmacy

UnitedHealthcare Community Plan reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy and not covered under the nursing facility unit rate. DME covered under the nursing facility unit rate includes: medically necessary items such as nebulizers, ostomy supplies or bed pans, and medical accessories (such as cannulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids, IV equipment, and equipment that can be used by more than 1 person, such as wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars, walkers, and oxygen equipment, such as tanks, concentrators, tubing, masks, valves, and regulators).

Emergency pharmacy services

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

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

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

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

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

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

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 hospital, physician, and related medical services (e.g., anesthesia and drugs) for covered emergency dental procedures.

Covered emergency dental procedures include, but are not limited to:

- Alleviation of extreme pain in oral cavity associated with serious infection or swelling;
- Repair of damage from loss of tooth due to trauma (acute care only, no restoration);
- Open or closed reduction of fracture of the maxilla or mandible;
- Repair of laceration in or around oral cavity;
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
- Incision and drainage of cellulitis;
- Root canal therapy. Payment is subject to dental necessity review and pre- and post- operative x-rays are required; and
- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

Medicaid non-emergency dental services

UnitedHealthcare Community Plan is not responsible for paying for routine dental services provided to Medicaid members.

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

Other services paid by Health and Human Services

We are not responsible for payment of some Medicaid benefits, known as “carve-out” or “non-capitated” services, such as Health and Human Services (HHSC) hospice services and PASRR screenings, evaluations, and specialized services. You must submit claim for these services to the Texas Medicaid & Healthcare Partnership at TMHP.com. A complete list of these services is located at Texas Medicaid Provider Procedures Manual located at thmp.com > Providers > Reference Material.

Value-added services

We offer additional services which add value to members’ benefit package. Every 1 of these services is available at absolutely no cost to the member. These special services are selected to address our members’ needs and experiences in an effort to help them live healthier lives. Value-added services are available at no cost to members and are limited to a 1 benefit within a 12-month period unless otherwise indicated. Certain restrictions apply.

Below are sample Value-added Services, for a complete listing, visit **UHCprovider.com/TXCommunityPlan** > Reference Guides and Value-Added Services > Value-Added Services, Flexible Benefits, Rewards and Incentives.

- **Welcome Kit** – Includes toiletries, a $20 gift card towards a puzzle subscription and conveniences such as magnifier, night light and coffee cup
- **Additional Dental Services** – This $500 benefit for the following services provided by a UnitedHealthcare Dental network dentist in the UnitedHealthcare Community Plan network: Routine exam and cleaning; Full mouth x-ray; Scaling and root planing if medically necessary; Routine silver and white fillings
- **Additional Vision Services** – This $105.00 benefit for the following products and services from Block Vision care providers in the UnitedHealthcare Community Plan network: frames and lenses; damage, loss and theft replacement frames and lenses; contact lenses (includes fitting and evaluation, up to 4 boxes of disposable contacts, and up to 2 follow-up visits.
- **Adult Activity Book** – Members may receive an adult activity book featuring: word search, sudoku, coloring and dot-to-dot. Members will also receive a pack of colored pencils

Non-covered services

Members may decide to pursue services not covered by Medicaid. If a member decides to proceed with the service and pay out of pocket, they must sign an acknowledgment statement or private pay form that they understand that the services will not be paid by

UnitedHealthcare Community Plan or Health and Human Services. Statement must be signed prior to service, dated and filed in member’s medical record. Sample wording of this may include:

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].

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.

Non-emergency transportation

The nursing facility is responsible for providing routine non-emergency transportation services. The cost of such transportation is included in the nursing facility unit rate.

Transports of nursing facility members for rehabilitative treatment (e.g., physical therapy), to outpatient departments, or to physicians' offices for recertification examinations for nursing facility care are not reimbursable services by UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan is responsible for authorizing non-emergency ambulance transportation for a member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contra-indicated).

Nursing facilities are responsible for providing or arranging transportation for their residents. Arranging transportation for Medicaid clients includes obtaining prior authorizations for non-emergency ambulance transports. Ambulance care providers may assist nursing facilities in obtaining prior authorizations (e.g., faxing the required documentation to TMHP). Ambulance care providers, however, may not call TMHP's Ambulance Prior Authorization Unit to request prior authorization.

Transports from a nursing facility to a hospital are covered if the client's condition meets emergency criteria.

A return trip to a nursing facility following an emergency transport is not considered routine; therefore, transport back to the facility must be requested by the discharging hospital. Nonemergency transport for the purpose of required diagnostic or treatment procedures that are not available in the nursing facility (such as dialysis treatments at a freestanding facility) are also allowable only for clients whose medical condition is such that the use of an ambulance is the only appropriate means of transport (e.g., alternate means of transport are medically contraindicated).

The cost of routine non-emergency transportation is included in the nursing facility vendor rate. This non-emergency transport requires the nursing facility to request and obtain a PAN from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Transports of nursing facility residents for rehabilitative treatment (e.g., physical therapy) to outpatient departments or physicians' offices for recertification examinations for nursing facility care are not reimbursable ambulance services.

Claims for services to nursing facility residents must indicate the medical diagnosis or problem requiring treatment, the medical necessity for use of an ambulance for the transport, and the type of treatment rendered at the destination (e.g., admission or X-ray).

If a client is returned by ambulance to a nursing facility following inpatient hospitalization, the acute condition requiring hospitalization must be noted on the ambulance claim form.

This transport is considered for payment only if the client's medical condition is appropriate for transport by ambulance. This non-emergency transport requires the nursing facility to request and obtain a PAN from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Ambulance providers may bill a nursing facility or client for a non-emergency ambulance transport only under the following circumstances:

Care providers may bill the nursing facility when the nursing facility requests the non-emergency ambulance transport without a PAN.

Care providers may bill the client only when the client requests transport that is not an emergency and the client does not have a medical condition such that the use of an ambulance is the only appropriate means of transport (i.e., alternate means of transport are medically contraindicated). The care provider must advise the client of acceptance as a private pay patient at the time the service is provided, and the client is responsible for payment of all services. Care providers are encouraged to have the client sign the Private Pay Agreement.

You may refer questions about a nursing facility's responsibility for payment of a transport to the TMHP Contact Center at 1-800-925-9126 or TMHP provider relations representative.

Chapter 9: 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** states that 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 care 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 18. The Act includes provisions to prevent employers from retaliating against employees who report their employer's false claims.
- **Whistleblower Act** provides protection to an employee who is retaliated against by an employer because of the employee's participation. The protection is available to any employee who is fired, demoted, threatened, harassed or otherwise discriminated against by 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.

Reporting fraud, waste, and abuse by a care provider or client Medicaid managed care

Do you want to report waste, abuse, or fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other 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
- Using someone else's Medicaid
- Not telling the truth about the amount of money or resources he or she has to get benefits

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

- Call the OIG Hotline at 1-800-436-6184
- Visit oig.hhsc.texas.gov to complete the online form, or you can report directly to your health plan:
- **UnitedHealthcare Community Plan**
  Attn: Compliance
  2950 North Loop W, Suite 200
  Houston, TX 77092-8843
  or call **1-888-887-9003**

To report waste, abuse or fraud, gather as much information as possible. When reporting about a care provider (a doctor, dentist, counselor, etc.) include:

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

Chapter 10: Billing

Billing codes and modifiers

The bill code crosswalk is a cross-referenced code set used to match the Texas Long-term Care (LTC) Local Codes (i.e., bill codes) to the National Standard Procedure Codes (e.g., procedure, item, revenue codes). You must use information on the bill code crosswalk (associated with the bill code which reflects the service billed) to claim payment for services. Refer to the Long Term Care Billing Crosswalk posted to HHSC for the most current billing codes and modifiers.

Go to HHS.Texas.gov > Laws & Regulations > Legal Information > HIPAA and Privacy Laws > Bill Code Crosswalks > Long-term Care Bill Code Crosswalk.

Nursing facility unit rate services

Visit hhs.texas.gov > Providers > Long-term Care Providers > Nursing Facilities.

The types of services included in the HHSC unit rate for nursing facility care providers are room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The NF Unit Rate also includes applicable nursing facility rate enhancements and professional and general liability insurance.

For questions call UnitedHealthcare Community Plan **Provider Services** at **1-888-887-9003.**

Clean claims

We abide by the following HHSC claims adjudication requirements.

- The nursing facility care provider had to be in good standing for the dates of service billed (i.e., not on vendor payment hold for any reason)
- The nursing facility resident must be:
  - Medicaid-eligible for the dates of service billed;
  - In the nursing facility for the dates of service billed;
  - Have a current medical necessity determination for the dates of service billed.

Submitting claims and encounter data

Nursing facility claims using the electronic accommodation of CMS Form UB04 (institutional) may be submitted using the following methods:

- Texas Medicaid & Healthcare Partnership (TMHP) though TexMedConnect located at tmhp.com.
- Claims may be submitted to **UHCprovider.com** through an office software vendor and/or a clearinghouse in connection with OptumInsight™ clearinghouse. Nursing facilities may use the clearinghouse of their choice. Office Ally is one clearinghouse that allows for institutional claims. Our electronic billing help desk for clearinghouses can be reached at **1-800-210-8315**.
  Taxonomy for online claims submissions include the following:
  - The UnitedHealthcare Community Plan Claims Payer ID: 87726
  - The Electronic Remittance Advice (ERA) Payer ID is TEX01
  - For chat options and contact information, visit **UHCprovider.com/contactus**

Online and batch claims are available for acute-care and add-on services through the clearinghouse Office Ally.

Electronic Data Information trainer-led presentations are available at **UHCprovider.com/edi** and the companion documents are located on **UHCprovider.com/edi** > **EDI transaction and code sets.** EDI Companion Guide Institutional is available along with other helpful information such as frequently asked questions, fact sheets and a UnitedHealthcare Community Plan specific Electronic Funds Transfer form. For further assistance contact EDI Performance Management for UnitedHealthcare Community Plan by calling **1-800-210-8315** or email **ac_edi_ops@uhc.com.**

Member billings

Members may not be balanced-billed and are responsible for pre-specified copayments. Though, they may have an applied income responsibility.

A member may decide to pursue services not covered by the Medicare and Medicaid Program and thereby select to private pay. In this event, the member must sign an acknowledgment statement that they understand the services will not be paid by UnitedHealthcare Community Plan or Texas Health and Human Services. The statement must be signed before the service, dated and filed in member's medical record.

Health Insurance Portability and Accountability Act claims compliance

UnitedHealthcare Community Plan applies an enhanced level of WEDI Strategic National Implementation Process (SNIP) Health Insurance Portability and Accountability Act (HIPAA) edits to professional (837p) and institutional (837i) claims submitted electronically to most UnitedHealthcare Community Plan and affiliate payer IDs. A complete list of HIPAA edits are posted to **UHCprovider.com**.

Visit **UHCprovider.com** for more information about tracking your electronic claims. Rejections that may occur from the enhanced edits will appear at a clearinghouse level. Your Electronic Data Interchange vendor or clearinghouse should be your first point of contact for assistance regarding these edits or to resolve rejections.

For more information, please contact EDI Support at UnitedHealthcare Community Plan **ac_edi_ops@uhc.com** or **1-800-210-8315**

Coordination of benefits

State specific guidelines will be followed when Coordination of Benefits (COB) procedures are not parallel with UnitedHealthcare Community Plan procedures.

UnitedHealthcare Community Plan public or private sources of payment for services rendered to members in the UnitedHealthcare Community Plan. Together with our network care providers, including nursing facilities, we 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 we become aware of these resources before paying for a medical service, payment of a care provider's claim will be rejected and the care provider will be directed to bill the appropriate insurance carrier. If we become aware of additional resources sometime after payment for the service, we will pursue recovery of the expenditure. Nursing facilities must not seek recovery in excess of the Medicaid payable amount.

We avoid payment of claims where third party resources are payable. We assist HHS in the identification, pursuit and collection of third party resources and will notify HHS within 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 based on the member's benefit plan and applicable law.

For questions or inquiries regarding a paid, denied or pended claim, please call **Provider Services** at **1-888-887-9003.**

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

It is the nursing facility's responsibility to file claims for Medicare coinsurance.

The 110-day rule

When a service is billed to a third party and no response has been received, you must allow 110 days to elapse before submitting a claim to TMHP or UnitedHealthcare Community Plan. If the third party has not responded, delays payment or denies a care provider's claim for more than 110 days after the date the claim was billed, the claim will be considered for reimbursement. However, the 365-day federal filing deadline requirement must still be met. The following information is required when re-submitting the claims:

- Name and address of the TPR
- Date the TPR was billed

- Statement signed and dated by the care provider that no disposition has been received from the TPR within 110 days of the date the claim was billed

When TMHP denies a claim because of the client's other coverage, information that identifies the other insurance appears on the care provider's Remittance & Status Report. The claim is not to be refiled until disposition from the third party has been received or until 110 days have lapsed since the billing of the claim with no disposition from the third party. A statement from the client or family member which indicates that they no longer have this resource is not sufficient documentation to reprocess the claim.

When a care provider is advised by a third party that benefits have been paid to the client, the information must be included on the claim with the date and amount of payment made to the client if available. If a denial was sent to the client, refer to the verbal denial guidelines above for required information. This enables TMHP or UnitedHealthcare Community Plan to consider the claim for reimbursement.

Claims submitted for the Medicare nursing facility rate will continue to be processed through the administrative services contractor. UnitedHealthcare Community Plan will not reassess or authorize services resulting from the MDS and covered under the Nursing Facility Unit Rate. The nursing facility must submit an electronic version of the Medicare Remittances and Advice form.

Unit rate claims deadlines

Unit rate claims must be received by UnitedHealthcare Community Plan within 365 days of the date of service on the claim to be considered for payment. In-network nursing facility unit rate clean claims are processed within 10 days of receipt. Non-network nursing facility unit rate clean claims are processed within 30 days of receipt and are subject to 95% reimbursement. Claims meet HHSC criteria for clean claims submission as described in the Uniform Managed Care Manual, Chapter 2.3, nursing facility Claims Manual. Original claims submissions and adjustments processed for in-network nursing facilities after the tenth day will include interest payments according to HHS guidelines. If a claim is not received within 365 days, we must deny the claim unless excepted from the claims filing deadline.

If you file with the wrong health plan or the wrong HHSC portal within the 365 day submission requirement and produce documentation to that effect, we will honor the initial filing date and process the claim without denying the resubmission for the sole reason of passing the filing timeframe. The claim must be filed with us by the later of 365 days after the date of service, or 95 days after the date on the R&S Report or explanation of payment from the other carrier or contractor.

We will submit a request to you for additional information necessary to allow adjudication of a deficient claim within 10 days from the date of original claim. We will adjudicate deficient-pended or deficient-denied claims for which additional information is requested within 10 days from the date of receipt of the requested information.

We determine claims to be adjudicated-denied when any deficient-pended or deficient-denied claims for which requested additional information is not received within 10 days from the date the information was requested from you.

Once an initial claim has been adjudicated to a paid status, we automatically adjust claims to reflect changes to such things as:

- Nursing Facility Unit Rates
- Provider Contracts, Service Authorizations
- Applied Income, Level of Service (RUG)
- Patient Driven Payment Model Long-Term Care (PDPM LTC) classification

Claims in progress should complete adjudication. We can only adjust an adjudicated-paid claim. We will not require nursing facilities to submit updated claims once a claim is an adjudicated-paid claim. We will not directly or indirectly charge or hold a member or a network or non-network care provider responsible for a fee for the adjudication of a claim.

We will make adjustments to previously adjudicated claims within 30 days from the date of receipt of an adjustment from HHSC to reflect changes to such things as: Nursing Facility Unit Rates, Provider Contracts, Service Authorizations, Applied Income, Level of Service (RUG), Patient Driven Payment Model Long-Term Care (PDPM LTC) classification.

We make every effort to avoid making more than 1 request to you for additional information in connection with a specific claim. Our claim procedures include processes intended to prevent a care provider claim from being repeatedly deficient-denied for reasons that were present on the original claim submission. Whenever possible, we identify each applicable reason code and specific information requirements to inform you of the precise data fields and issues related to each claim.

We withhold all or part of payment for a claim for the following reasons:

- The claim for a care provider-administered drug is missing the National Drug Code (NDC) information, or the NDC is not valid for the corresponding HCPCS code
- Exclusion or suspension from the Medicare or Medicaid programs for fraud, waste or abuse
- A full or partial payment hold under the authority of HHSC or its authorized agent(s) is in effect with debts, settlements, or pending payments due to HHSC, or the state or federal government
- The claim for nursing facility Unit Rates does not comply with HHSC criteria for processing clean claims

Payment for nursing facility unit rate

The unit rate is the contract rate in effect on each day of service. For covered services rendered by network nursing facility to a member, the contract rate will be 100% of the HHS's rate.

Their website includes information concerning HHS's prevailing rates: hhs.texas.gov > Providers > Long-term Care Providers > Nursing Facilities > Nursing Facility Frequently Asked Questions. HHS prevailing Nursing Facility Unit Rates are subject to change, including retroactive adjustments.

We will update any codes, such as revenue codes, HHS resource utilization group (RUG) codes, Patient Driven Payment Model Long-Term Care (PDPM LTC) classification, ICD-10-CM codes (or successor version), HCPCS codes and/or CPT codes from time to time according to changes in the industry, including among other things:

- The latest edition of the Current Procedural Terminology (CPT) manual which is revised by the American Medical Association
- The latest edition of the HCPCS manual which is revised by the Centers for Medicare and Medicaid Services (CMS)
- The latest edition of the ICD-10-CM manual, or successor version, which is issued by the U.S. Department of Health and Human Services
- The latest revenue code guidelines from the National Uniform Billing Committee
- Texas STAR+PLUS program

Add-on services

The in-network nursing facility is responsible for paying for services provided in a nursing facility setting that are included in the nursing facility Unit Rate. Nursing facility add-on services refers to types of services that are provided in a nursing facility setting by the nursing facility or another network care provider but are not included in the nursing facility Unit Rate, such as emergency dental, physician-ordered rehabilitative services, augmentative communication devices, and custom power wheel chairs. Add-on services require prior authorization through the UnitedHealthcare Community Plan service coordinator.

Medical necessity is determined and if appropriate, it is then included in the Individual Service Plan. Once an add-on service is authorized, the nursing facility will secure the service. UnitedHealthcare Community Plan will pay authorized add-on services directly to the care provider of these services.

Nursing facility claims for add-on services should be received no later than 95 days from the date the service. For services that the nursing facility is not able to provide in-house, see **UHCprovider.com/findprovider**, for a listing of UnitedHealthcare Community Plan network care providers that are contracted to deliver these services in the nursing facility or otherwise for nursing facility member residents. CMS Form 1500 claims are submitted to the Texas Medicaid & Healthcare Partnership at tmhp.com or to **UHCprovider.com/claims**.

Clean claims are to be processed within 30 days of receipt. Original claims submissions and adjustments processed after the thirtieth day will include interest payments according to HHSC guidelines. Claims must be received by within 95 days of the date of service on the claim to be considered for payment.

Added-on services	
Code	Service description
N0400s	Medicare skilled
N0500s	Ventilator-full
N0501s	Ventilator-partial
N0600s	Emergency dental
G0452, G0453, G0467, GO468, G0480	Occupational therapy
G0454, G0455, G0469, G0470, G0957	Physical therapy
G0456, G0457, G0457, G0471, G0472	Speech therapy
G0500	DME
G0955, G0958, G0959, G0970	Wheelchairs, etc.

For complete listings of services, codes and see hhs.texas.gov.

Acute care services

Claim payment deadlines

CMS Form 1500 claims are submitted to the Texas Medicaid & Healthcare Partnership at tmhp.com or to **UHCprovider.com/claims**. Clean claims are to be processed within 30 days of receipt.

Original claims submissions and adjustments processed after the thirtieth day will include interest payments according to HHSC guidelines. Claims must be received by within 95 days of the date of service on the claim to be considered for payment.

- Appeals or adjustment requests need to be filed within 120 days from the date of disposition
- When a Medicaid client has other health insurance, the other insurance must be billed by the care provider before billing the Texas Medicaid Program
- If that third party resource has not responded to or has delayed payment on a care provider's claim for more than 110 days from the date the claim was billed, Medicaid considers the claim for reimbursement

Please see our STAR and STAR+PLUS Administrative Provider Manual located at **UHCprovider.com/TXCommunityPlan** > Care Provider Manuals > Texas for complete details surrounding acute care services.

Applied income collection

We will work with members, or their representatives, to help in-network nursing facilities collect applied income where applicable. Our provider relations advocates will also inform members of their responsibility to pay the costs for any non-covered services which the member may elect to receive. A nursing facility must make reasonable efforts to collect applied income. Document those efforts and notify our service coordinator when 2 unsuccessful attempts to collect applied income have occurred in a month's time. This provision in no way subrogates the nursing facility's existing regulatory and licensing responsibilities related to the collection of applied income.

Nursing facilities will inform members of costs for any non-covered services prior to rendering such services and obtain a signed private pay form from such members. Members may decide to pursue services that are not covered by Medicaid Program and pay privately. In this event, they must sign an acknowledgment statement that they understand that the services will not be paid by UnitedHealthcare Community Plan or Texas Health and Human Services. Statement must be signed prior to service, dated, and filed in member's medical record.

Overpayments

If you receive payment from a third party payer, you agree to refund to UnitedHealthcare Community Plan the payments expended on the member related to the third party liability, or in the alternative, you agree to permit UnitedHealthcare Community Plan to offset the amount of third party payments in future claims reimbursements. Send refunds to:

UnitedHealthcare Community Plan
Attn: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

Claim resubmissions

- **Corrected claims**: A corrected claim occurs if a care provider needs to make a change to an original claim submission. Corrected claims may be submitted through tmhp.com or **UHCprovider.com**
- **Adjustments:** In the event that a claim is suspected of having been denied incorrectly, you may call **Provider Services** at **1-888-887-9003**. The operator will review the claim with you to help ensure it denied incorrectly. If the claim was denied incorrectly, it is transferred to our adjustment department to reprocess. You will be provided a tracking number. The claim should be corrected in 15 business days and the care provider will be contacted to confirm processing. Note: this process is for claims not otherwise automatically reprocessed by us.
- **Claims reconsiderations**: These may be submitted electronically at **UHCprovider.com/claims** > Submit a Claim Reconsideration

Chapter 11: Complaints and appeals

Care providers and members have the right to appeal. Appeals are submitted under 2 categories:

- Services not yet rendered-adverse benefit determination
- Claims and administrative denials

Adverse benefit determination appeals

You may appeal on behalf of the member with regard to adverse benefit determination appeals. See the Member Appeal section of this manual for more information about the member appeal process.

Adverse benefit determination appeals must be submitted within 60 days from the date on the adverse benefit determination notice. Notification of receipt of request will be given within 5 business days. A decision is rendered within 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, we 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 care provider claim appeals.

UnitedHealthcare Community Plan member appeals

The following information is intended for UnitedHealthcare Community Plan members.

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

You will receive 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 60 days from the date on the adverse benefit determination notice. You must appeal within 10 business days of the date on the letter to ensure continuity of services. You can appeal by sending a letter or 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, you will be notified in writing the reason for the delay. You can call Customer Service and get help with filing your appeal. Note that there is no timeline in which a member may file a complaint.

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 time frames for the appeal process?

UnitedHealthcare Community Plan has up to 30 calendar days for standard appeals 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 an expedited appeal which gives you the right to a decision within 1 business day. The 30 calendar day deadline may be extended up to 14 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 care provider requests it, then 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.

State Fair Hearings and External Medical Reviews

The member may request an external medical review and State Fair Hearing or a State Fair Hearing ONLY at any time during or after the UnitedHealthcare Community Plan appeals process, but no later than 120 days after UnitedHealthcare Community Plan mails the

appeal decision notice. A member may also request an external medical review and/or a State Fair Hearing if United does not make a decision on an appeal within the requested time frame. If you ask for an external medical review and/or a State Fair Hearing within 10 days from the time you get the appeal decision letter 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. You 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 State Fair Hearing within 10 days from the time you get the hearing notice, the service the health plan denied will be stopped.

Can someone from UnitedHealthcare Community Plan help me file a complaint or appeal?

Member Services is available to help you file a complaint or an appeal. You can ask them to help you when you call **Provider Services** at **1-888-887-9003**.

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 **Provider Services** at **1-888-887-9003.**

Can my standard appeal request be in writing?

Yes. Mail or email written requests to:

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

What are the time frames for an expedited appeal?

UnitedHealthcare Community Plan must decide this type of appeal within in 72 hours for expedited appeal and 1 business day for expedited appeals related to ongoing emergency and continued hospitalizations 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 **Provider Services** at **1-888-887-9003** and ask someone to help you start an appeal or ask your doctor to do it for you.

Level of care appeals

Level of Care determination appeals should be directed by the member, or member representative to the Texas Medicaid & Healthcare Partnership (TMHP) through their standard appeal process to:

Texas Medicaid & Healthcare Partnership,
Appeals/Adjustments Dept.
P.O. Box 200645
Austin, TX 78720-0645

UnitedHealthcare Community Plan will coordinate with TMHP to address Minimum Data Set (MDS) Medical Necessity Level of Care.

Can a member ask for an external medical review?

If a member, as a member of the health plan, disagrees with the health plan's internal appeal decision, the member has the right to ask for an external medical review. An external medical review is an optional, extra step the member can take to get the case reviewed for free before the State Fair Hearing. The member may name someone to represent them by writing a letter to the health plan telling the MCO the name of the person the member wants to represent them. A provider may be the member's representative. The member or the member's representative must ask for the external medical review within 120 days of the date the health plan mails the letter with the internal appeal decision. If the member does not ask for the external medical review within 120 days, the member may lose their right to an external medical review. To ask for an external medical review, the member or the member's representative should:

- Fill out the "State Fair Hearing and External Medical Review Request Form" provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to UnitedHealthcare by using the address or fax number at the top of the form
- Call the MCO at **1-888-887-9003**
- Email the MCO at **uhctx_fairhearings_appeals@uhc.com**

If the member asks for an external medical review within 10 days from the time the health plan mails the appeal decision, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final State Fair Hearing decision is made. If the member does not request an external medical review within 10 days from the time the member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

The member, the member's authorized representative or the member's LAR may withdraw the member's request for an external medical review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the member's external medical review request. The member, the member's authorized representative or the member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail, email or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an external medical review during member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An external medical review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the external medical review decision is received, the member has the right to withdraw the State Fair Hearing request. The member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the member continues with a State Fair Hearing, and the State Fair Hearing decision is different from the Independent Review Organization decision, the State Fair Hearing decision is final. The State Fair Hearing decision can only uphold or increase member benefits from the Independent Review Organization decision.

Can a member ask for an emergency external medical review?

If a member believes that waiting for a standard external medical review will seriously jeopardize the member's life or health, or the member's ability to attain, maintain or regain maximum function, the member or member's representative may ask for an emergency external medical review and emergency State Fair Hearing by writing or calling UnitedHealthcare. To qualify for an emergency external medical review and emergency State Fair Hearing, the member must first complete UnitedHealthcare Community Plan's internal appeals process.

Can a member ask for a State Fair Hearing?

If a member, as a member of the health plan, disagrees with the health plan's decision, the member has the right to ask for a State Fair Hearing. The member may name someone to represent them by contacting the health plan and giving the name of the person the member wants to represent them. A provider may be the member's representative if the provider is named as the member's authorized representative. The member or their representative must ask for the State Fair Hearing within 120 days of the date on the health plan's letter that tells of the decision being challenged. If the member does not ask for the State Fair Hearing within 120 days, the member may lose their right to a State Fair Hearing. To ask for one, the member or their representative should either send a letter to the health plan:

UnitedHealthcare Community Plan
Attn: State Fair Hearings Coordinator
2950 North Loop W, Suite 200
Houston, TX 77092-8843
Or call **1-888-887-9003**

If the member asks for a State Fair Hearing within 10 days from the time the member gets the hearing notice from the health plan, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final hearing decision is made. If the member does not request a State Fair Hearing within 10 days from the time they get the hearing notice, the service the health plan denied will be stopped.

If the member asks for a State Fair Hearing, the member will get a packet of information letting them know the date, time, and location of the hearing. Most State Fair Hearings are held by telephone. At that time, the member or their 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

Claims and administrative appeals

Care providers must file appeals or adjustment requests within 120 calendar days from the date of disposition. The date of disposition refers to the date of the Remittance and Status 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. We adhere to TMHP claims payment and appeals deadlines.

Claims and administrative appeals include, but are not limited to, timely filing denials, denials due to lack of notification/ authorization, claims not paid based on your contract, etc. Claims appeals must be mailed no later than 120 calendar days from the date on the electronic payment statement and an Appeal Request Form must be completed and mailed to the address shown on the back of the member's ID card. For more information go to **UHCprovider.com/claims** > Claims and Payments > Submit a Corrected Claim, Claim Reconsideration/Begin Appeal Process. Claims and 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 an electronic payment statement 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 care provider.

Most care providers in your state must submit reconsideration requests electronically.

For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide**

Specialty review

For claims and adverse benefit determination appeals which continue to be denied and for which the care provider believes the service was medically necessary, you have the option to request a specialty review. You must request a specialty review within 30 days of the appeal decision date. Notification of receipt of request will be given within 5 days. The review is performed by an independent physician of the same or similar specialty. The process will be completed within 15 days after the request is received.

Complaints

You may file complaints with UnitedHealthcare Community Plan by submitting the Provider Complaint Form located at **UHCprovider.com/TXCommunityPlan** > Claims and Payments > Claim Administrative Disputes/ Appeals under Provider Form. **Provider Services** is available to provide direction at **1-888-887-9003**. Notification of receipt of request will be given within 5 days. A decision is rendered within 30 days.

A member may file a complaint with HHSC if still not satisfied after going through the United complaint process.

Complaint and appeals filing locations

Members and care providers have the right to file a complaint to:

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

Or **UHCprovider.com/claims**

Texas Health and Human Services

Send an email to HPM_Complaints@hhsc.state.tx.us or mail the complaint to:

- Texas Health and Human Services Commission
  Ombudsman Managed Care Assistance Team
  P.O. Box 13247
  Austin, TX 78720-4270
  Or at: hhs.texas.gov/managed-care-help
- Texas Medicaid & Healthcare Partnership TMHP
  Complaints Resolution Department
  P.O. Box 204270
  Austin, TX 78720-4270

Member complaints

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

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

Complaints may be filed orally or through written correspondence. For oral complaints, members are requested to call **Provider Services** at **1-888-887-9003**. Written complaints may be mailed to:

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

We have member advocates available to assist a member in filing a complaint (if needed). Member advocates may be reached by calling **Provider Services** at **1-888-887-9003** and requesting to speak to a member advocate.

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

Members will receive a letter acknowledging their complaint within 5 business days of complaint receipt. Members will receive a letter detailing their complaint investigation results within 30 calendar days of resolution.

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

Written complaints may be mailed to:

Texas Health and Human Services Commission
Attn: Ombudsman Managed Care
Assistance Team
P.O. Box 13247
Austin, TX 78711-3247

Complaints may also be emailed to HPM_Complaints@hhsc.state.tx.us. With internet access, you can submit your complaint at hhs.texas.gov/managed-care-help.

Ombudsman

Long term care ombudsmen promote quality care by serving as advocates for residents of nursing facilities and assisted living facilities. Services include complaint resolution by a long term care ombudsman, who represents the residents' interests to the management of the facility. Advocacy activities also include development of resident and family councils, in addition to education for long-term care facility staff and community organizations. Long-term care ombudsmen also protect resident rights by advocating for change in policy, rule, and law. If they have concerns, UnitedHealthcare Community Plan members may call the Office of the Independent Ombudsman for State Supported Living Centers at 1-877-323-6466 or go to HHS.Texas.gov > About HHS > Your Rights > Office of the Ombudsman.

Quality Monitoring Program

The Quality Monitoring Program promotes positive partnerships with care providers to assess and strengthen systems to improve outcomes for residents. The goal of the program is to provide technical assistance to care providers regarding evidence-based best practices, approaches, and systems that can improve outcomes. Quality Monitoring Program staff schedule visits in advance with facility staff or upon request by care providers. The Quality Monitoring Program contact information is below:

Email: QMP@hhsc.state.tx.us

Fax: 1-512-438-5768 (Faxes should be sent to the attention of the Quality Monitoring Program)

Mail: Texas Health and Human Services Commission
Quality Monitoring Program
Mail Code W-510
P.O. Box 149030
Austin, Texas 78714-9030

Quarterly reporting

Nursing Facility Reports – Beginning in SFY 2015, the STAR+PLUS MCO must file quarterly Nursing Facility Utilization Reports based on Uniform Managed Care Manual Chapter 5.4.5.3., "STAR+PLUS Nursing Facility Report." Quarterly reports are due 30 days after the end of each quarter. Utilization management reporting requirements will specify by individual mental health service type.

Minimum data set

HHSC receives federal funds to administer 2 federal systems in the state of Texas: Minimum Data Set (MDS) and Outcome and Assessment Information Set (OASIS). Certified nursing facilities are required to use the MDS to assess residents and certified home health agencies are required to use the OASIS. HHSC provides technical support, education, consultation, and monitoring to care providers and HHSC staff on the use of these systems. More basic information about MDS can be found in Chapter 1 of the CMS Long-Term Care Resident Assessment Instrument User's Manual, found on the CMS website. Reference the MDS 3.0 RAI Manual, effective October 1, 2010.

Technical support is available through the Centers for Medicare and Medicaid Services (CMS) Quality Information Enterprise System (QIES) at 1-877-201-4721 or email help@qtso.com.

Best practice guidelines

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 **UHCprovider.com/policies** > Policies and Clinical Guidelines > View Current Reimbursement Policies.

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 are designed to improve clinical and non-clinical processes and outcomes. 2 such activities are focus studies and utilization management which require all encounter data to be submitted.

Chapter 13: Marketing

As part of our agreement with HHSC, we and our network care providers avoid engagement in the following prohibited marketing practices:

- Distributing marketing materials without prior HHSC approval
- Distributing marketing materials written above the 6th grade reading level to members
- Offering incentives or giveaways valued over $10.00 to potential members
- Providing incentives or giveaways to care providers for the purpose of distributing them to the members or potential members
- Directly or indirectly, engaging in door-to-door, telephone, and other cold call marketing activities
- Marketing in or around public assistance offices, including eligibility offices
- Using “Spam”
- Making any assertion or statement (orally or in writing) that UnitedHealthcare Community is endorsed by the CMS, a federal or state government agency, or similar entity
- Marketing to currently enrolled members
- Inducing or accepting member enrollment or disenrollment
- Using terms that would influence, mislead, or cause potential members to contact UnitedHealthcare Community Plan, rather than the Administrative Services Contractor, for enrollment
- Portraying competitors in a negative manner
- Making any written or oral statements containing material misrepresentations of fact or law relating to
- UnitedHealthcare Community Plan and Medicaid managed care programs, services or benefits
- Making giveaways conditional based on enrollment with UnitedHealthcare Community Plan
- Charging members for goods or services distributed at events
- Charging members a fee for accessing the MCO’s website
- Influencing enrollment in conjunction with the sale or offering of any private insurance
- Using marketing agents who are paid solely by commission
- Posting UnitedHealthcare Community Plan specific, non- health related materials or banners in care provider offices
- Conducting member orientation in common areas of care providers’ offices
- Allowing care providers to solicit enrollment or disenrollment in UnitedHealthcare Community Plan, or distribute UnitedHealthcare Community Plan-specific materials at a marketing activity (this does not apply to health fairs where care providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific UnitedHealthcare Community Plan materials)
- Making charitable contributions or donations from Medicaid funds
- Purchasing or otherwise acquiring mailing lists from third party vendors, or for paying HHSC contractors or sub-contractors to send plan specific materials to potential members
- Referencing the commercial component of UnitedHealthcare Community Plan in any of its Medicaid managed care marketing materials
- Discriminating against a member or potential member because of race, creed, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care
- Assisting with enrollment form or influencing managed care organization selection
- Making false, misleading or inaccurate statements relating to services or benefits of the UnitedHealthcare Community Plan or Medicaid managed care programs, or relating to the care providers or potential providers contracting with UnitedHealthcare Community Plan
- Direct mail marketing to potential members

Chapter 14: Contracting

Provider Relations contracts with you as a credentialed HHSC nursing facility. We also contract with acute care providers, specialists and vendors. Re-credentialing of contracts occurs every 3 years.

Acute care providers and specialists should consult our STAR and STAR+PLUS Administrative Provider Manual for pertinent information related to network participation, roles and responsibilities.

It is located at **UHCprovider.com/guides** > Provider Administrative Manual and Guides > Texas.

Chapter 15: Termination

If we terminate your contract, at least 90 days before the effective date of the proposed termination of a Nursing Facility Provider Agreement, we provide a written explanation to you of the reasons for termination. We may terminate immediately, however, in a case involving:

- Imminent harm to patient health;
- An action by a state licensing board or government agency against the facility, or an action by a State Medical Board against the care provider's Medical Director, that effectively impairs the care provider's ability to provide services; or
- Fraud or malfeasance.

Involuntary termination care providers need to refer to the terms of termination and timeframes presented in their UnitedHealthcare Community Plan Provider Agreement. In the event 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 care provider contract with no recourse of an Advisory Review Panel. You must notify us, in writing, at the address stated in your Provider Agreement within 10 calendar days of your knowledge of any of the following occurrences:

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

No later than 30 days following receipt of the termination notice, you may request a review of our proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a license, or Fraud or malfeasance. The advisory review panel must be composed of physicians and care providers, as those terms are defined in §843.306 of the Texas Insurance Code, including at least 1 representative in your specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or our utilization review committee. Within 60 days following your receipt request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and we will communicate our final decision to you. We will assist in arranging continuity of care for members under the care of a care provider at the time of termination.

Chapter 16: Termination for gifts and gratuities

You 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 based on state and federal law. UnitedHealthcare Community Plan may terminate any care provider contracted at any time for violation of this stated requirement.

Chapter 17: Provider relations

Each nursing facility is assigned a Provider Relations Advocate (PRA). The Provider Relations Advocate's role is to be responsible for the full range of provider relations and service interactions within UnitedHealthcare Community Plan. This includes, but is not limited to, working end-to-end care provider claim and call quality and training & development of external provider education programs. PRAs design and implement programs to build and nurture positive relationships between the health plan, care providers, and Nursing Facilities. The PRA makes required contacts and visits to the facilities as per the guidelines set forth by HHS.

We notify the nursing facility within 10 days of a change to the assigned provider relations specialist.

You may reach your Provider Relations Advocate at **1-866-858-3546.**

Chapter 18: Your demographics

Changes to the following demographic information need to be updated with both UnitedHealthcare Community Plan and HHSC. Demographic information includes billing and/or service address, telephone number(s), and group affiliation.

You can update your practice information through the UnitedHealthcare Provider Portal on **UHCprovider.com**.

Go to **UHCprovider.com**, then Sign In > My Practice Profile. Or submit your change by:

- Visiting **UHCprovider.com/attestation** to view ways to update and verify your care provider demographic data electronically
- Calling our general provider assistance line at **1-877-842-3210**

To report to HHSC via form 3720, visit How to Become an ALF Provider > License Applications Forms > Go to Tulip.

Update demographic information with Texas Health and Human Services. This includes the same demographic information above, as well as changes involving identification numbers, such as tax identification numbers, additional office location addresses and names.

To report changes in identification numbers or names, you will fill out the Provider Information Change Form. To print this form go to tmhp.com > Providers > Forms > Provider Information Change Form.

To report all other changes visit tmhp.com > Providers > I would like to... > Provider Information Management System (PIMS) User Guide.

Chapter 19: Abuse, neglect and exploitation

Medicaid managed care

Report suspected abuse, neglect, and exploitation

UnitedHealthcare Community Plan and care providers must report any allegation or suspicion of abuse, neglect and exploitation (ANE) that occurs within the delivery of LTSS to the appropriate entity. The managed care contracts include UnitedHealthcare Community Plan and care provider responsibilities related to identification and reporting of ANE. Additional state laws related to UnitedHealthcare Community Plan and care provider requirements continue to apply.

Report to Texas Health and Human Services Commission if the victim is an adult or child who resides in, or receives services, from

- Nursing facilities
- Assisted living facilities
- Home and Community Support Services Agencies (HCSSAs) – you are required to report ANE allegations to both DFPS and HHSC
- Adult day care centers or
- Licensed adult foster care providers

Contact HHSC at 1-800-458-9858.

Report to the Department of Family and Protective Services if the victim is an adult or child who:

- Is elderly or has a disability, receiving services from:
  - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to HHSC;
  - Unlicensed adult foster care provider with 3 or fewer beds
- An adult with a disability or child residing in or receiving services from 1 of the following care providers or their contractors:
  - Local intellectual and developmental disability authority (LIDDA), local mental health authority (LBHAs), community center, or mental health facility operated by the Department of State Health Services
  - A person who contracts with a Medicaid managed care organization to provide behavioral health services;
  - A managed care organization;
  - An officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option
- Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at txabusehotline.org

Report to local law enforcement:

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

Report to UnitedHealthcare Community Plan

In addition to reporting to DFPS and HHSC, within 48 hours of knowledge of an incident, a care provider must report it to UnitedHealthcare Community Plan.

The form is located at **UHCprovider.com/forms** > Reporting Critical Incidents Including Abuse, Neglect and Exploitation. The completed form can be emailed to **critical_incidents@uhc.com**.

You must provide us with a copy of the abuse, neglect, and exploitation report findings from DFPS within 1 business day of receipt.

Failure to report or false reporting

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHSC, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109)
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHSC, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.053; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107)

Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Chapter 20: Definition of terms

Abuse in claims:

Care provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Medicaid 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 Medicaid.

Adjudicate:

To deny or pay a clean claim.

Adjudicated-denied claim:

A clean claim that has been denied for payment.

Adjudicated-paid claim:

A clean claim for which a payment has been made to the care provider.

Adjusted claim:

A claim that has been previously adjudicated as a clean claim by the MCO and has had a subsequent payment adjustment.

Adverse benefit determination:

1. The denial or limited authorization of member or care provider requested services, including the type or level of service, medical necessity requirements, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial in whole or in part of payment for service;
4. The failure to provide services in a timely manner as determined by the state;
5. The failure of an MCO to act within the timeframes set forth in the contract and 42 C.F.R. §438.408(b);
6. For a resident of a rural area with only 1 MCO, the denial of a Medicaid member's request to obtain services outside of the network; or
7. The denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appealed claim:

A claim that has been previously adjudicated as a clean claim and the care provider is appealing the disposition through written notification to the MCO and based on the appeal process as defined in UnitedHealthcare Community Plan Administrative Provider Manual.

Applied income:

The portion of the earned and unearned income of the STAR+PLUS member, or if applicable the member and the member's spouse, that is paid under the Medicaid program to an institution or long-term care facility in which the member resides.

Behavioral health:

Services for the assessment and treatment of mental health and substance use disorders.

Change in condition:

A significant change in a STAR+PLUS member's health, informal support, or functional status that will not normally resolve itself without further intervention and requires review of an revision of the current Individual Service Plan (ISP) and/or overall Plan of Care (POC).

Clean claim:

A claim a physician or care provider submits for health care services rendered to a member, with the data necessary for the MCO or subcontracted claims processor to adjudicate and accurately report the claim. A clean claim other than a NF unit rate services clean claim must meet all requirements for data as defined in the appropriate claim type encounter guides as follows:

- 837 Professional Combined Implementation Guide;
- 837 Institutional Combined Implementation Guide;
- 837 Professional Companion Guide;
- 837 Institutional Companion Guide; or
- National Council for Prescription Drug Programs (NCPDP) Companion Guide.

Centers for Medicare and Medicaid Services:

CMS: a federal agency within the U.S. Department of Health and Human Services that administers Medicare, Medicaid and SCHIP programs.

Covered services:

Health care services the MCO must arrange to provide members, including all services required by the MCO's contracts with HHS for STAR+PLUS and all value-added services offered by the MCO.

Day:

A calendar day unless otherwise specified.

Deficient-denied claim:

A claim denied for the purpose of obtaining additional information. A claim may be denied if it does not contain accurate and complete data in all claim fields that are required to adjudicate as a clean claim.

Deficient-pended claim:

A claim pended for the purpose of obtaining additional information. A claim may be pended if it does not contain accurate and complete data in all claim fields that are required to adjudicate as a clean claim.

Discharge:

A formal release of a member from an inpatient stay when the need for continued care at an inpatient level has ended. Transfer from 1 acute care hospital or long-term care hospital or facility and readmission to another within 24 hours for continued treatment is not a discharge under this contract.

Department of State Health Services:

DSHS: The Texas Department of State Health Services.

Dual eligible:

A Medicaid recipient who is also enrolled in Medicare.

Emergency care services:

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

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

Form 3618 or resident transaction notice:

The form the care provider must use to inform Texas Health and Human Services about transactions and changes (admissions or discharges) for Medicaid applicants and recipients in nursing facilities.

Fraud:

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

Health and Human Services:

HHS: Texas Health and Human Services.

Intellectual and Developmental Disability:

IDD: means one or more of the following conditions:

1. An intellectual disability (ID) as defined in 26 TAC §304.102;
2. A developmental disability (DD) as defined in 42 USC 15002; and
3. A related condition (RC) as defined in 26 TAC §304.102.

Member:

An individual enrolled with UnitedHealthcare Community Plan entitled to receive STAR+PLUS covered services.

Nursing facility:

(Also called nursing home or skilled nursing facility) means an entity or institution that provides organized and structured nursing care and services and is subject to licensure under Texas Health and Safety Code, Chapter 242, as defined in 26 Tex. Admin. Code § 554.101 and 1 Tex. Admin. Code § 358.103.

Nursing facility add-on services:

The types of services that are provided in the Facility setting by the care provider or another network care provider, but are not included in the Nursing Facility Unit Rate, including but not limited to emergency dental services; physician-ordered rehabilitative services; customized power wheel chairs; and augmentative communication devices; tracheostomy care for members age 21; and ventilator care.

Nursing facility cost ceiling:

The annualized cost of serving a client in a nursing facility. A per diem cost is established for each Medicaid nursing facility resident based on the level of care needed. This level of care and associated resource allocation is referred to as the Patient Driven Payment Model Long-term Care (PDPM LTC) Resource Utilization Group (RUG). The per diem cost is annualized to achieve the nursing facility ceiling.

Nursing facility level of care:

The determination that the level of care required to adequately serve a STAR+PLUS member is at or above the level of care provided by a nursing facility.

Nursing facility Medicare coinsurance:

The state's Medicare coinsurance obligation for a qualified dual eligible member's Medicare-covered NF stay. NF Medicare coinsurance does not include the state's cost-sharing obligation for a dual eligible member's Medicare covered NF add-on services.

Nursing facility services:

The services included in the NF unit rate, NF Medicare coinsurance and NF add-on services.

Nursing facility unit rate:

The rate for the type of services included in the Medicaid Fee-for-Service daily rate for nursing facility care providers, as defined by change to 26Tex. Admin. Code § 554.2601(b). This includes room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The Nursing Facility Unit Rate also includes applicable nursing facility staff rate enhancements, as described in 1 Tex. Admin. Code § 355.308, and professional and general liability insurance add-on payments as described in as 1 Tex. Admin. Code § 355.312. The Nursing Facility Unit Rate excludes Nursing Facility Add-on Services.

Office of Inspector General:

OIG: The Office of Inspector General.

Patient Driven Payment Model Long-Term Care:

PDPM LTC: The reimbursement rate for nursing facilities which vary according to the assessed characteristics of Medicaid recipients based on the MDS assessment data.

Peer-to-peer:

Discussion held between the physician requesting, ordering or intending to provide a prior authorized service and our medical director or their physician designee regarding the medical necessity, appropriateness or the experimental or investigational nature of a healthcare service.

Preadmission Screening and Resident Review:

PASRR: The Preadmission Screening and Resident Review, a federally mandated program applied to all individuals seeking admission to a Medicaid-certified nursing facility. PASRR helps ensure that individuals are not inappropriately placed in nursing facilities for long-term care, and requires that all applicants to a Medicaid-certified nursing facility: (1) be evaluated for mental illness, intellectual disability, or both; (2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (3) receive the services they need in those settings.

Processing or claims processing:

The action(s) taken on a claim by UnitedHealthcare Community Plan.

Provider agreement:

Nursing Facility Provider Agreement, together with all amendments, attachments, and incorporated documents or materials.

Provider relations advocate:

A designated UnitedHealthcare Community Plan representative who is proficient in nursing facility billing matters and able to resolve billing and payment inquiries.

Qualified Mental Health Professional for Community Services:

QMHP-CS: Means QMHP-CS as defined in 1 Texas Administrative Code (TAC) §353.1415 for Medicaid and 26 TAC §301.303(48) for CHIP, a staff member who has a Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, educational psychology, early childhood education, or early childhood intervention; or is a registered nurse, or a Licensed Practitioner of the Healing Arts.

Requirements for scheduling appointments:

The time between when a member or member representative contacts a care provider with a request for services and the time at which those services are delivered. Time requirements vary according to type of service requested. See Access and Availability Standards in this manual.

Received date:

The date that the claim was received by the MCO or the HHSC-designated portal, whichever occurs first. The MCO may receive the claim directly or through the HHSC-designated portal.

Regulatory requirements:

All state and federal laws, rules, regulations, waivers, policies and guidelines, and court- ordered consent decrees, settlement agreements, or other court orders that apply to: this Agreement, MCO's managed care contract with HHSC, the STAR+PLUS Program, nursing facility services, and all persons or entities receiving state and federal funds.

Rejected claim:

A claim filed with the HHSC-designated portal or the MCO for services rendered to a patient who was not a member of the MCO at the time of service, or a claim that was filed with the MCO in error (wrong carrier), or a claim for which the MCO is not responsible for processing but the claim is for a member of the MCO as of the date of service.

Routine care services:

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

Rural emergency hospital:

REH: A Medicare-enrolled facility that delivers emergency hospital, observation, and other services to Medicare patients on an outpatient basis. Texas Medicaid, effective Sept. 1, 2025, began to allow providers to enroll as an REH. To enroll, providers must obtain a Limited Services Rural Hospital license from HHSC. REH services include the following:

- Emergency department services
- Observation care
- Additional outpatient medical and health services if elected by the REH, that do not exceed an annual per patient average length of stay of 24 hours

Service coordinator:

The MCO representative with primary responsibility for providing service coordination and care management to STAR+PLUS Program members.

Specialty therapy:

Physical therapy, speech therapy, or occupational therapy. **STAR+PLUS program:**

The State of Texas Medicaid managed care program that provides and coordinates covered services for preventive, primary, acute and long-term services and supports, and nursing facility care, to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through the SSI program and/or the MAO program. Children birth through age 20 who reside in nursing facilities will not participate in STAR+PLUS.

Supplemental Security Income

SSI: A federal income supplement program funded by general tax revenues (not Social Security taxes) designed to help aged, blind and disabled people with little or no income by providing cash to meet basic needs for food, clothing and shelter.

Transfer:

The movement of the member from 1 acute care hospital or LTC hospital or facility and readmission to another acute care hospital or LTC hospital or facility within 24 hours for continued treatment.

Uniform Managed Care Manual:

UMCM: HHSC's Uniform Managed Care Manual, which is available on HHSC's website.

Unexplained death:

A death with unknown causes including a death not caused by a previously identified diagnosis or a death that occurred during or after an unusual incident.

Urgent care services:

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

Waste:

Practices that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items or services.