



2024 Nursing Facility Care Provider Manual

Physician, Care Provider, Facility and Ancillary

**Texas STAR+PLUS and UnitedHealthcare Connected of Texas
(Medicare-Medicaid Plan)**

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

For UnitedHealthcare Connected (Medicare-Medicaid Plan): Harris County

Customer Service: 1-888-887-9003

September 1, 2024

UHCprovider.com and Provider Portal

HHSC Material File Name #:
PMG 20240807-104112 TX_NF_final
Doc#: PMG 20240807-104112
Archived: PMG 20240509-145403



**United
Healthcare®
Community Plan**

Welcome

Welcome

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

Click the following links to access different manuals:

- For Commercial and Medicare Advantage member information see [UnitedHealthcare Administrative Guide](#). Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to UHCprovider.com/guides

Easily find information in this manual using the following steps

1. Select CTRL+F.
2. Type in the key word.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF to search for information and topics. 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.

Important information about the use of this 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 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 manual

This 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](https://www.tmhp.com). The [State Mandated Requirements for STAR+PLUS Nursing Facility Providers](#) is another important source for Nursing Facilities. The provider manual is designed to assist with day-to-day operations of your practice in working with UnitedHealthcare Community Plan and UnitedHealthcare Connected.

The information contained in this manual applies as of the date it was published, and may be modified by UnitedHealthcare Community Plan at any time. The manual and updates are available at UHCprovider.com. 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.

Table of Contents

Welcome	3
Table of Contents	5
Chapter 1: Introduction	7
Chapter 2: Roles and responsibilities	8
Chapter 3: Eligibility	13
Chapter 4: Processing admissions	17
Chapter 5: Service coordination	19
Chapter 6: Health care delivery and availability	24
Chapter 7: Member rights and responsibilities	26
Chapter 8: Services and benefits	29
Chapter 9: Fraud, waste and abuse	36
Chapter 10: Billing	38
Chapter 11: Complaints and appeals	44
Chapter 12: Quality improvement	50
Chapter 13: Marketing	52
Chapter 14: Contracting	53
Chapter 15: Termination	54
Chapter 16: Termination for gifts and gratuities	55

Chapter 17: Provider relations	56
Chapter 18: Your demographics	57
Chapter 19: Abuse, neglect and exploitation	58
Chapter 20: UnitedHealthcare connected prior authorization	60
Chapter 21: Definition of terms	62
Appendix A: UnitedHealthcare connected disenrollment	65
Appendix B: UnitedHealthcare connected covered benefits	68
Appendix C: UnitedHealthcare connected claims and coordination of benefits	81

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. This manual also addresses nursing facility long-term care for UnitedHealthcare Connected (Medicare-Medicaid Plan) members in Harris County.

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 are Provider Manual or UnitedHealthcare Connected 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 Fax: 1-800-984-6585
ELIGIBILITY	
UnitedHealthcare Community Plan	1-877-842-3210
Texas Medicaid & Healthcare Partnership	1-800-925-9126
MAXIMUS	1-800-964-2777
PRIOR AUTHORIZATION	
Prior Authorization Requests	UHCprovider.com 1-877-842-3210 (available 24-hours a day) Fax: 1-877-940-1972
Authorization forms	UHCprovider.com
CLAIMS AND PAYMENT	
Texas Medicaid & Healthcare Partnership Billing (Long Term Care Portal)	TMHP.com
UnitedHealthcare Community Plan Billing (code: 87726)	UHCprovider.com
UnitedHealthcare Online Help Desk	1-866-842-3278
Texas Health and Human Services Provider Claims Hotline	1-512-438-2200

CARE PROVIDER CONTACT INFORMATION	
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 PCP

The success of UnitedHealthcare Community Plan depends on strong relationships with contracted care providers. Members should contact their 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.

Sign in to UnitedHealthcare Online application on the [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 PCP panel roster

Once a member has been assigned to a PCP, panel rosters can be viewed electronically on the UnitedHealthcare Community Plan [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 OB/GYN

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

UnitedHealthcare Community Plan allows the members to pick any 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; and
- 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.

(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.

Sexually transmitted diseases and human immunodeficiency virus

Advise members about their risk reduction responsibility and partner notification if syphilis, chancroid, 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

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 United 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. For information about termination and disenrollment from UnitedHealthcare Connected,

please see Appendix A in this manual.



Find medical policies and coverage determination guidelines at UHCprovider.com/TXCommunityPlan > 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 and UnitedHealthcare Connected 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.

UnitedHealthcare Connected Criteria:

- Must be dually eligible and enrolled in Medicare Part A, Medicare Part B, and Texas Medicaid;
 - A U.S. citizen, or a qualified legal alien, and a Harris County, Texas resident
 - Members must maintain a permanent residence within the service area, and must not reside outside the service area for more than 6 months.
6. Members of all ages who do not have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant) at time of application. HHS’ enrollment broker, MAXIMUS, ensures member enrollment to an MCO such as UnitedHealthcare Community Plan.

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:

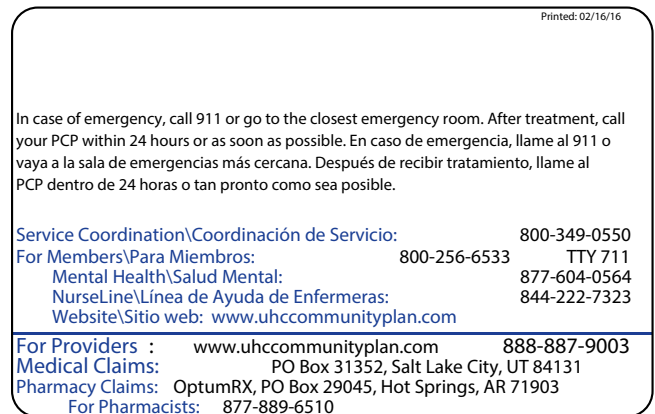
- Call UnitedHealthcare Community Plan at **1-888-887-9003** or check the [UnitedHealthcare Provider Portal](#)
- Use TexMedConnect on the TMHP website at tmhp.com
- Log into your TMHP user account and access Medicaid client portal for care providers.
- Call the TMHP Contact Center or the Automated Inquiry 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.



		Medicaid Program Name	
Medicaid ID Card		Medicaid plan / Plan Medicaid	
Member name / John Doe		Plan name / Nombre del plan 1-800-488-6888	
Member ID / Medicaid ID 123456789		Dental plan / Plan dental	
Social ID / Social XXXXXXXX	Date of birth / 03/15/2012	Plan name / Nombre del plan 1-800-488-6888	
State / ADN			
ID# / 881234			

			
Health Plan/Plan de salud (70340) 911-87726-04			
Member ID/ID del Miembro: 999999999		Group/group: TXSTPL	
Member/Miembro: SUBSCRIBER BROWN		Payer ID/ID del Pagador: 87726	
DOB/Fecha de nacimiento: 99/99/9999			
PCP Name/Nombre del PCP: PROVIDER BROWN			
PCP Phone/Teléfono del PCP: (999) 999-9999		Rx Bin: 610494 Rx Cgp: ACUTX Rx PGN: 9999	
Effective Date/ Fecha de vigencia 11/02/2014			
Administered by UnitedHealthcare Insurance Company			

In case of emergency call 911 or go to the closest emergency room. **Printed 01/16/11**



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

Service Coordination/Coordinación de servicio: 888-887-9003

For Members/Para Miembros: 888-887-9003 TDD 711

Mental Health/Salud Mental: 800-302-3995

NurseLine/Línea de Ayuda de Enfermeras: 877-830-5407

For Providers: www.uhcommunityplan.com 888-887-9003

Medical Claims: PO Box 21352, Salt Lake City, UT 84131

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903

For Pharmacists: 877-306-8052

Chapter 4: Processing admissions

UnitedHealthcare Community Plan has a membership category in which the member only qualifies for LTSS services 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.

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.

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,

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, 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 health and human services 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)

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.

- 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
- 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](https://www.hhs.texas.gov/laws-and-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.

We participate in the promoting independence initiative.

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. UnitedHealthcare Connected members may seek behavioral health services statewide. 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 customer service 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](https://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 as 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 sensitivity and literacy

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

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

UnitedHealthcare Community Plan believes that everyone should be able to understand health care materials we provide. This idea is key to informed treatment decisions and compliance. To support this belief, all health related member materials are written

at a 4th to 6th grade reading level and provided in English and Spanish. Materials will be published in additional languages, should enrollment reach at least 10% for another non-English speaking group.

Language translation services

Members with a limited English proficiency or reading skills require an interpreter. Customer Service can assist with accessing these services for them over the phone. Telephone interpreting service is also available for members who are deaf, hard-of hearing, deaf-blind or speech impaired.

We have interpreter services to help ensure effective communication for our members regarding treatment, medical history or health condition. This is at no cost to you or our members when the member is receiving services from a care provider in an office, other location or accessing emergency services. It includes written, spoken, and sign language interpretation.

Over-the-phone (OPI) interpretation, including 3-way calls facilitated between UnitedHealthcare Community Plan, you as the care provider and a phone interpreter, does not require advance notification by the you or the member.

Requests, for in-person interpreters for scheduled appointments can be arranged as quickly as possible, including for care in urgent conditions. For routine care, in-person requests are scheduled based on the requested date and time, or upon the next availability of the interpreter for the requested language, including American Sign Language (ASL). If an in-person interpreter is not available for the requested date and time, we'll notify and coordinate with you and the member to offer alternative interpretation options, such as OPI, Video Remote Interpretation, or the earliest availability of the an in-person interpreter.



Hearing impaired services are available. To arrange these services, call Customer Service at **1-888-887-9003, TTY 711.**

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
3. You must share information about your health with your PCP and learn about service and treatment options. That includes the responsibility to:
 - 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
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:
 - 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.
5. 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

preferences or instructions regarding mental health treatment.

- 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

Chapter 8: Services and benefits

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.	<ul style="list-style-type: none"> Request and coordinate prior authorizations for services with UnitedHealthcare Community Plan service coordinator <ul style="list-style-type: none"> No prior authorization is required for emergency dental services Submit clean claims within 95 days of service 	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> Request any necessary prior authorizations from UnitedHealthcare Community Plan Health Services for STAR+PLUS Submit clean claims within 95 days of service 	<ul style="list-style-type: none"> 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

Fax: 1-877-470-7613

(pediatric member submissions only)

Customized Power Wheelchair (CPWC): To be eligible for a 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 may be requested through UHCprovider.com/priorauth or by fax to 1-877-940-1972. Authorization request forms are located at UHCprovider.com/TXCommunityPlan > Prior Authorization and Notification Resources > [Prior Authorization Forms](#). 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/TXCommunityPlan > Prior Authorization and Notification Resources > [Prior Authorization Requirements](#). These requests should be directed through UHCprovider.com or by fax to 1-877-940-1972. Authorization request forms are located at UHCprovider.com/TXCommunityPlan > Prior Authorization and Notification Resources > [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 and UnitedHealthcare Connected 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 HHS

We are not responsible for payment of some Medicaid benefits, known as "carve-out" or "non-capitated" services, such as 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](https://www.tmhp.com). A complete list of these services is located at Texas Medicaid Provider Procedures Manual located at [TMHP.com](https://www.tmhp.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.

Flexible benefits and rewards and incentives

For our UnitedHealthcare Connected members, we offer additional services at no cost to the member. These special services are selected to address member needs and experiences in an effort to help them live healthier lives.

Examples of Flexible Benefits and Rewards and Incentives include:

- Alzheimer’s Care Planning
- Extra Dental Care
- Extra Vision Care

Members are informed of these services through their UnitedHealthcare Community Plan welcome packet. Flexible benefits and rewards and incentives are included in the member newsletter, listed in the member handbook and at

UHCprovider.com/TXCommunityPlan > [Reference Guides and Value-Added Services](#) > Value-Added Services, Flexible Benefits, Rewards and Incentives.

Some services require assistance from your office. All are limited to in-network care providers. Please note that benefits, rewards, and incentives are available once per calendar year unless otherwise noted. These services may change in January of each year.

For the most current Flexible Benefits and Rewards and Incentives, please visit UHCprovider.com/TXCommunityPlan > [Reference Guides and Value-Added Services](#) > Value-Added Services, Flexible Benefits, Rewards and Incentives.

You may also call customer service at **1-888-887-9003**.

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. Non-emergency 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. Please see Appendix A for a list of Covered Benefits for UnitedHealthcare Connected members.



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 eighteen. 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 waste, abuse and fraud 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.hhs.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](https://www.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](https://www.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 customer 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) through TexMedConnect located at [tmhp.com](https://www.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
- UnitedHealthcare Online® Help Desk: 1-866-842-3278, opt. 2

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. EDI Companion Guide Institutional is available there 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.



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

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.

HIPAA claims compliance

UnitedHealthcare Community Plan applies an enhanced level of WEDI Strategic National Implementation Process (SNIP) 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 questions or inquiries regarding a paid, denied or pended claim, please call Customer Service 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)

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 and Level of Service (RUG).

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](https://www.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, 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 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](https://www.uhcprovider.com) > Our Network > Find a Provider, 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](https://www.tmhp.com) or to [UHCprovider.com/claims](https://www.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, G0468, 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](https://www.tmhp.com) or to [UHCprovider.com/claims](https://www.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](https://www.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 or [UHCprovider.com](https://www.uhcprovider.com).
- **Adjustments:** In the event that a claim is suspected of having been denied incorrectly, you may call customer service 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](https://www.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 and UnitedHealthcare Connected 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 or UnitedHealthcare Connected. 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 **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 Customer Service 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 Customer Service 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 (send 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.

UnitedHealthcare Connected members appeal to independent review entity

Appeals for Medicare Parts A and B that result in

an upheld decision regarding Adverse Actions will be auto-forwarded to the Medicare Part C Independent Review Entity (IRE). If the resolution of the IRE is not wholly in favor of the member, the member or his/her authorized representative may then file a request for hearing with an Office of Medicare Hearings and Appeals Administrative Law Judge.

UnitedHealthcare Community Plan must respond to Part D drug denial appeals within seven calendar days of receipt. Should a decision not be provided within the seven days, the member's request will be automatically forwarded to the IRE.

Members who are using the fast appeal process for Part D denials will be provided an answer within 72 hours of receipt of the appeal. If an answer is not provided within the 72 hours, the member's request will be automatically forwarded to the IRE.

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](https://www.uhcprovider.com) > 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.



Claim reconsiderations and appeals may be submitted through UHCprovider.com/claims > [Submit a Corrected Claim, Claim Reconsideration/Begin Appeal Process](#).

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 or UnitedHealthcare Connected by submitting the Provider Complaint Form located at UHCprovider.com/TXCommunityPlan > Claims and Payments > Claim Administrative Disputes/ Appeals under Provider Form. Customer Service 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 and Payments > Submit a Corrected Claim, Claim Reconsideration/Begin Appeal Process. 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
- With Internet access, you can submit your complaint at: hhs.texas.gov/managed-care-help
- [The 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 member 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 our customer service toll-free 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. With Internet access, you can submit your complaint at hhs.texas.gov/managed-care-help

Chapter 12: Quality improvement

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 and UnitedHealthcare Connected members may call the Office of the Independent Ombudsman for State Supported Living Centers at 1-877-323-6466 or go to [HHS.Texas.gov](https://www.hhs.texas.gov/about-hhs/your-rights/office-of-the-ombudsman) > 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 e-mail 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/TXCommunityPlan > 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/TXCommunityPlan > 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.



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.



To report changes to UnitedHealthcare Community Plan visit UHCprovider.com/mypracticeprofile. 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 (HHSC) if the victim is an adult or child who resides in, or receives services, from

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – 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 (DFPS) 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](https://www.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/TXCommunityPlan > Provider Forms > Reporting Critical Incidents Including Abuse, Neglect and Exploitation. The completed form can be faxed to 1-855-371-7638 or 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: UnitedHealthcare connected prior authorization

Prior authorization for UnitedHealthcare Connected members

The prior authorization procedure are particularly important to the UnitedHealthcare Connected managed care program. Prior authorization is 1 of the tools used by UnitedHealthcare Connected to monitor the medical necessity and cost-effectiveness of the health care members receive. Care providers and hospitals are required to comply with UnitedHealthcare Connected prior authorization policies and procedures. Non-compliance may result in delay or denial of reimbursement. Because the PCP coordinates most services provided to a member, it is typically the PCP who initiates requests for prior authorization; however, specialists and ancillary care providers may also request prior authorization for services within their specialty areas.

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

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

The prior authorization department is also responsible for receiving and documenting

facility notifications of inpatient admissions and emergency room treatment.

Services that DO NOT require prior authorization

UnitedHealthcare Connected encourages members to work with their PCP to help coordinate access to these services. However, it is not required that the member see their PCP before they receive these services. Make sure the member shows both their Medicare and Texas ID cards when prior to service.

Services	Coverage
Chemotherapy	Covered.
Eye exams, routine vision (optical) services, including eyeglasses*	1 exam and 1 pair of glasses or retail allowance toward any type of contacts (must use the entire benefit at 1 time) every 24 months. Must be for vision correction and not for cosmetic reasons only.
Family planning services and supplies	Covered.
Free-standing birth center services at a free-standing birth center	Covered.
Mental health and substance use disorder services	Covered - The behavioral health crisis line can be reached 24/7 at 1-888-887-9003.
Physical exam required for employment or for participation in job training programs	Covered if the exam is not provided free of charge by another source.
Yearly well adult exams	Covered when Medicare does not cover these.

Services that DO require prior authorization

UnitedHealthcare Connected encourages members to work with their PCP to help coordinate access to these services. However, it is not required that the member see their PCP before they receive these services. Make sure the member shows both their Medicare and Texas ID cards when prior to service.

Services	Coverage
Assisted living services	Covered
Home and community-based (waiver) services	Covered
Medicaid home health and private duty nursing services	Covered
Medically necessary plastic or cosmetic surgery	Covered
Nursing facility and long-term care services and supports	Covered
Pain management procedures	Covered

Services that MAY require prior authorization

Depending on the level of care needed, these services may require an okay before a member can receive them. Make sure the member shows both their Medicare and UnitedHealthcare Connected Texas ID cards when receiving service.

Services	Coverage
Ambulance transportation	Covered
Durable medical equipment	Covered
Outpatient surgeries	Covered
Prescription drugs, including certain prescribed over-the-counter drugs	Please refer to the List of Covered Drugs that can be found on our website UHCprovider.com/TXCommunityPlan > Pharmacy Resources and Physician Administered Drugs .

- For information about Nursing Facility Medicare Part A readmissions, refer to: [UnitedHealthcare Readmission Review Program for Medicare Advantage Plans General Clinical Guidelines for Payment Review](#).
- For information about Medicare Part B, please refer to: [Step therapy prior authorization requirements](#).

Chapter 21: 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.

CMS: The Centers for Medicare and Medicaid Services.

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.

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.

HHS: Texas Health and Human Services.

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

Nursing Facility: 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 40 TAC § 19.101 and 1 TAC § 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 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 40 Tex. Admin. Code § 19.2601. 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 1 Tex. Admin. Code § 355.312. The Nursing Facility Unit Rate excludes Nursing Facility Add-on Services.

OIG: The Office of Inspector General.

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.

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.

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.

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 a 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.

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.

Appendix A: UnitedHealthcare connected disenrollment

When can members end their membership in our Medicare-Medicaid plan?

Members can end their membership in the UnitedHealthcare Connected (Medicare-Medicaid Plan) at any time. Membership will end on the last day of the month that we get the request to change the plan. For example, if we get the request on Jan. 18, coverage with our plan will end on Jan. 31. New coverage will begin the first day of the next month.

How do members end their membership in our plan?

Members must tell Texas Medicaid or Medicare that they want to leave UnitedHealthcare Connected by:

- Calling MAXIMUS at 1-877-782-6440, Monday – Friday, 8 a.m. – 6 p.m. CT. TTY users should call 7-1-1 or 1-800-735-2989; or
- Sending MAXIMUS an Enrollment Change Form. If a member needs this form mailed to him/her, they can call MAXIMUS at 1-877-782-6440 (TTY 7-1-1 or 1-800-735-2989); or
- Calling Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-877-486-2048. When a member calls 1-800-MEDICARE, he/she can also enroll in another Medicare health or drug plan.

What happens if the member leaves the plan and does not want a different Medicare-Medicaid plan? How do they get Medicare and Texas Medicaid services?

If a member does not want to enroll in a different Medicare-Medicaid plan after they leave UnitedHealthcare Connected, they will go back to getting your Medicare and Texas Medicaid services separately.

There are 3 options for getting Medicare services. By choosing 1 of the 3 options, members will automatically end their membership in our plan.

<p>1. Can change to: A Medicare health plan, such as a Medicare Advantage plan or Programs of All-inclusive Care for the Elderly (PACE)</p>	<p>Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. If more information or help is needed: <ul style="list-style-type: none"> • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-3439. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). Members will automatically be disenrolled from United Connected when the new plan’s coverage begins.</p>
<p>2. Can change to: Original Medicare with a separate Medicare prescription drug plan</p>	<p>Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If more information or help is needed: <ul style="list-style-type: none"> • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-3439. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP) Members will automatically be disenrolled from United Connected when the new plan’s coverage begins.</p>
<p>3. Can change to: Original Medicare without a separate Medicare prescription drug plan</p> <p>NOTE: If a member switches to Original Medicare and does not enroll in a separate Medicare prescription drug plan, Medicare may enroll him/her in a drug plan, unless they tell Medicare otherwise.</p>	<p>Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If more information or help is needed: <ul style="list-style-type: none"> • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-3439. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). Members will automatically be disenrolled from United Connected when the new plan’s coverage begins.</p>

Until membership ends, member will keep getting medical services and drugs through our plan

If a member leaves UnitedHealthcare Connected, it may take time before their membership ends and new Medicare and Texas Medicaid coverage begins. During this time, members will keep getting your health care and drugs through our plan.

- Members should continue to use our network pharmacies to get your prescriptions filled. Usually, prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.
- If a member is hospitalized on the day that membership ends, the hospital stay will usually be covered by our plan until the member is discharged. This will happen even if new health coverage begins before being discharged.

Membership will end in certain situations

These are the cases when UnitedHealthcare Connected must end membership in the plan:

- If there is a break in Medicare Part A and Part B coverage
- If the member no longer qualifies for Texas Medicaid. Our plan is for people who qualify for both Medicare and Texas Medicaid.
- If the member moves out of our service area
- If the member is away from our service area for more than 6 months
 - Members that move or take a long trip need to call Member Services to find out if the place he/she is moving or traveling to is in our plan's service area
- If the member goes to prison
- If the member lies about or withholds information about other insurance he/she has for prescription drugs

We can make you leave our plan for the following reasons only if we get permission from Medicare and Texas Medicaid first:

- If the member intentionally gives us incorrect information when enrolling in our plan and that information affects eligibility for our plan

- If the member continuously behaves in a way that is disruptive and makes it difficult for us to provide medical care for him/her and other members of our plan
- If the member lets someone else use your ID card to get medical care
- If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General

We cannot ask a member to leave our plan for any reason related to his/her health.

You may not take retaliatory action against a member for any reason, including disenrollment.

Where can members get more information about ending plan membership?

If members have questions or would like more information on when we can end membership, they can call Member Services at 1-800-256-6533 (TTY 7-1-1), 8 a.m. – 8 p.m. CT, Monday – Friday.

Appendix B: UnitedHealthcare connected covered benefits

Preventive services and screenings

Services covered by our plan	Limitations and exceptions
<p>Abdominal aortic aneurysm screening</p> <p>The plan covers abdominal aortic aneurysm ultrasound screenings if the member is at risk.</p>	
<p>Alcohol misuse screening and counseling</p> <p>The plan covers alcohol-misuse screenings for adults. This includes pregnant women. If a member screens positive for alcohol misuse, they can get face-to-face counseling sessions with a qualified PCP or practitioner.</p>	
<p>Bone mass measurements</p> <p>The plan covers certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan covers a doctor looking at and commenting on the results.</p>	
<p>Breast cancer screening</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • 1 baseline mammogram between the ages of 35 and 39 • 1 screening mammogram every 12 months for women age 40 and older • Women under the age of 35 who are at high risk for developing breast cancer may also be eligible for mammograms • Annual clinical breast exams 	
<p>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</p> <p>The plan covers visits with a PCP to help lower your risk for heart disease. During this visit, a care provider may:</p> <ul style="list-style-type: none"> • discuss aspirin use, • check a member's blood pressure, or • give a member tips to make sure they are eating well. 	
<p>Cardiovascular (heart) disease testing</p> <p>The plan covers blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease.</p>	

Services covered by our plan	Limitations and exceptions
<p>Cervical and vaginal cancer screening</p> <p>The plan covers pap tests and pelvic exams annually for all women.</p>	
<p>Colorectal cancer screening</p> <p>For people 50 and older or at high risk of colorectal cancer, the plan covers:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema) • Fecal occult blood test • Screening colonoscopy <p>For people not at high risk of colorectal cancer, the plan pays for 1 screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).</p>	
<p>Depression screening</p> <p>The plan covers depression screening.</p>	
<p>Diabetes screening</p> <p>The plan covers abdominal aortic aneurysm ultrasound screenings if the member is at risk.</p>	
<p>HIV screening</p> <p>The plan covers HIV screening exams for people who ask for an HIV screening test or are at increased risk for HIV infection.</p>	
<p>Immunizations</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Vaccines for children under age 21 • Pneumonia vaccine • Flu shots, once a year, in the fall or winter • Hepatitis B vaccine if a member is at high or intermediate risk of getting hepatitis B • Other vaccines if a member is at risk and they meet Medicare Part B or Medicaid coverage rules • Other vaccines that meet the Medicare Part D coverage rules. 	
<p>Obesity screening and therapy to keep weight down</p> <p>The plan covers counseling to help members lose weight.</p>	<p>Members must get the counseling in a primary care setting. That way, it can be managed with their full prevention plan.</p>
<p>Prostate cancer screening</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • A digital rectal exam • A prostate specific antigen (PSA) test 	

Services covered by our plan	Limitations and exceptions
<p>Sexually transmitted infections (STIs) screening and counseling</p> <p>The plan covers screenings for sexually transmitted infections, including but not limited to chlamydia, gonorrhea, syphilis, and hepatitis B. The plan also covers face-to-face, high-intensity behavioral counseling sessions for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long.</p>	<p>A PCP must order the tests. The plan covers these counseling sessions as a preventive service only if they are given by a PCP. The sessions must be in a primary care setting, such as a doctor’s office.</p>
<p>Ambulance and wheelchair van services</p> <p>Covered emergency ambulance transport services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance takes a member to the nearest place that can give them care. A member’s condition must be serious enough that other ways of getting to a place of care could risk their life, or if they are pregnant, their unborn baby’s life or health.</p> <p>In cases that are not emergencies, ambulance or wheelchair van transport services are covered when medically necessary.</p>	<p>Prior authorization is required for ambulance services in cases that are not emergencies.</p>
<p>Diabetic services</p> <p>The plan covers the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> • Training to manage your diabetes, in some cases • Supplies to monitor your blood glucose, including: <ul style="list-style-type: none"> - Blood glucose monitors and test strips - Lancet devices and lancets - Glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: <ul style="list-style-type: none"> - 1 pair of therapeutic custom-molded shoes (including inserts) and 2 extra pairs of inserts each calendar year, or - 1 pair of depth shoes and 3 pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) <p>The plan also covers fitting the therapeutic custom-molded shoes or depth shoes. The plan covers training to help members manage their diabetes at ADA.</p>	<p>Prior authorization may be needed.</p>

Services covered by our plan	Limitations and exceptions
<p>Emergency care (see also “urgently needed care”)</p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> • given by a care provider trained to give emergency services, and • needed to treat a medical emergency. <p>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> • placing the person's health in serious risk; or • serious harm to bodily functions; or • serious dysfunction of any bodily organ or part; or • in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur: <ul style="list-style-type: none"> - There is not enough time to safely transfer the member to another hospital before delivery. - The transfer may pose a threat to the health or safety of the member or unborn child. <p>In an emergency, a member should call 911 or go to the nearest emergency room (ER) or other appropriate setting.</p> <p>Please note that members are instructed that if they are not sure if they need to go to the ER, then they should call their PCP or the 24-hour toll-free nurse advice line. The PCP or the nurse advice line can give the member advice on what they should do.</p> <p>This coverage is within the U.S. and its territories only.</p>	<p>If a member gets emergency care at an out-of-network hospital and need inpatient care after the member's emergency is stabilized, we work with the doctor who wants you to stay to do what is best for them. The care provider needs to call us within 24 hours.</p>

Services covered by our plan	Limitations and exceptions
<p>Family planning services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Family planning supplies (condom, sponge, foam, film, diaphragm, cap) • Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions • Treatment for sexually transmitted infections (STIs) • Treatment for AIDS and other HIV-related conditions • Voluntary sterilization (a member must be age 21 or older, and they must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that the member signs the form and the date of surgery) • Screening, diagnosis and counseling for genetic anomalies and/or hereditary metabolic disorders <p>Note: The member can get family planning services from a network or out-of-network qualified family planning care provider (for example Planned Parenthood) listed in the Provider and Pharmacy Directory. The member can also get family planning services from a network certified nurse midwife, obstetrician, gynecologist, or PCP.</p>	<p>Prior authorization may be needed.</p>

Services covered by our plan	Limitations and exceptions
<p>Home and community-based waiver services</p> <p>The plan covers the following home and community-based waiver services:</p> <ul style="list-style-type: none"> • Adult day health services • Assisted living services • Cognitive Rehabilitation therapy • Emergency response services • Home delivered meals • Home medical equipment and supplemental adaptive and assistive devices • Minor Home modification, maintenance, and repair • Independent living assistance • Respite services • Personal Attendant services • Protective supervision • Self-Directed Personal Attendant services • Social work counseling • Specialized nursing services • Supported Employment Assistance • Transition Assistance services • Transportation • Vehicle Modification 	<p>These services are available only if the member’s need for long-term care has been determined by Texas Medicaid.</p> <p>The member may be responsible for paying a patient liability for waiver services. Texas Health and Human Services will determine if the member’s income and certain expenses require them to have a patient liability.</p>
<p>Home health services</p> <p>The plan covers the following services provided by a home health agency:</p> <ul style="list-style-type: none"> • Home health aide and/or nursing services • Physical therapy, occupational therapy, and speech therapy • Home infusion therapy for the administration of medications, nutrients, or other solutions intravenously or internally • Medical and social services • Medical equipment and supplies 	<p>Before members receive home health services, a doctor must certify that they need home health services and will order home health services to be provided by a home health agency.</p> <p>Prior authorization is needed.</p>

Services covered by our plan	Limitations and exceptions
<p>Hospice care</p> <p>A member can get care from any hospice program certified by Medicare. The member’s hospice doctor can be a network care provider or an out-of-network care provider.</p> <p>The plan covers the following:</p> <ul style="list-style-type: none"> • Drugs to treat symptoms and pain • Short-term respite care • Home care • Nursing facility care <p>For hospice services and services covered by Medicare Part A or B that relate to the member’s terminal illness:</p> <ul style="list-style-type: none"> • The hospice care provider will bill Medicare for the member’s services. Medicare covers hospice services and any Medicare Part A or B services. The member pays nothing for these services. <p>For services covered by Medicare Part A or B that are not related to the member’s terminal illness (except for emergency care or urgently needed care):</p> <ul style="list-style-type: none"> • The care provider bills Medicare for the member’s services. Medicare covers the services covered by Medicare Part A or B. The member pays nothing for these services. <p>For services covered by UnitedHealthcare Connected but not covered by Medicare Part A or B:</p> <ul style="list-style-type: none"> • UnitedHealthcare Connected covers plan-covered services not covered under Medicare Part A or B. The plan covers the services whether or not they are related to the member’s terminal illness. Unless the member is required to pay a patient liability for nursing facility services, the member pays nothing for these services. <p>Note: Except for emergency/urgent care, if the member needs non-hospice care, they should call their care manager to arrange the services. Non-hospice care is care that is not related to the member’s terminal illness.</p> <p>Our plan covers hospice consultation services for a terminally ill person who has not chosen the hospice benefit.</p>	<p>If a member wants hospice services in a nursing facility, they may be required to use a network nursing facility. Also, a member may be responsible for paying a patient liability for nursing facility services, after the Medicare nursing facility benefit is used. Texas Health and Human Services will determine if the member’s income and certain expenses require the member to have a patient liability.</p> <p>Prior authorization is needed.</p>

Services covered by our plan	Limitations and exceptions
<p>Inpatient behavioral health services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Inpatient psychiatric care in a private or public free-standing psychiatric hospital or general hospital <ul style="list-style-type: none"> - Limited to no more than 15 days per month for members ages 21-64, as described in HHSC’s UCM Chapter 16.1.15.13. - Inpatient psychiatric hospital services provided in a freestanding psychiatric hospital to members younger than 21 years or ages 65 and older are a covered Medicaid benefit. They are not provided “in lieu of,” and there is no day limitation for services. • Inpatient detoxification care 	<p>Prior authorization is needed.</p>
<p>Kidney disease services and supplies</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help the member make good decisions about their care • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area • Inpatient dialysis treatments if admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for the member and anyone helping them with their home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on the member’s home dialysis, to help in emergencies, and to check their dialysis equipment and water supply <p>Note: The member’s Medicare Part B drug benefit covers some drugs for dialysis.</p>	
<p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by a member’s doctor.</p> <p>The plan covers 3 hours of one-on-one counseling services during the member’s first year that they receive medical nutrition therapy services under Medicare (including our plan, any other Medicare Advantage plan, or Medicare). We cover 2 hours of one-on-one counseling services each year after that.</p> <p>Under the member’s Medicaid coverage, the plan covers counseling on medical nutrition by the member’s PCP.</p>	<p>The member may be able to get counseling if they do not have diabetes or kidney disease.</p>

Services covered by our plan	Limitations and exceptions
<p>Mental health and substance abuse services at addiction treatment centers</p> <p>The plan covers the following services at addiction treatment centers:</p> <ul style="list-style-type: none"> • Ambulatory detoxification • Assessment • Case management • Counseling • Crisis intervention • Intensive outpatient • Alcohol/drug screening analysis/lab urinalysis • Medical/somatic • Methadone administration • Office administered medications for addiction including vivitrol and buprenorphine induction <p>See “Inpatient behavioral health services” and “Outpatient mental health care” for additional information.</p>	<p>Prior authorization is needed for ambulatory detoxification, case management, intensive outpatient and methadone administration.</p>
<p>Mental health and substance abuse services at community mental health centers</p> <p>The plan covers the following services at certified community mental health centers:</p> <ul style="list-style-type: none"> • Mental health assessment/diagnostic psychiatric interview <ul style="list-style-type: none"> - Limited to 4 hours for non-physician assessment and 2 hours for physician interview per year • Community psychiatric supportive treatment (CPST) services • Counseling and therapy <ul style="list-style-type: none"> - Limited to 52 hours of combined individual/group therapy per year • Crisis intervention • Pharmacological management <ul style="list-style-type: none"> - Limited to 24 hours per year • Pre-hospital admission screening • Certain office administered injectable antipsychotic medications • Partial hospitalization <ul style="list-style-type: none"> - Partial hospitalization is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care the member gets in a doctor’s or therapist’s office. It may result in preventing a hospital admission. <p>See “Inpatient behavioral health services” and “Outpatient mental health care” for additional information.</p>	<p>Prior authorization needed for Community Psychiatric Support Treatment (CPST) service and Partial hospitalization.</p>

Services covered by our plan	Limitations and exceptions
<p>Nursing and skilled nursing facility care</p> <p>The plan covers the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • A semi-private room, or a private room if it is medically needed • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs the member gets as part of their plan of care, including substances that are naturally in the body, such as blood-clotting factors • Blood, including storage and administration beginning with the first pint of blood • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services <p>Members usually get their care from network facilities. However, they may be able to get their care from a facility not in our network. The member can get Medicaid nursing facility care from the following place if it accepts our plan’s amounts for payment:</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where a member resided the day he or she became a UnitedHealthcare Connected member <p>The member can get Medicare nursing facility care from the following places if they accept our plan’s amounts for payment:</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where the member lived before they went to the hospital (as long as it provides nursing facility care) • A nursing facility where the member’s spouse lives at the time he or she is discharged from an inpatient facility 	<p>The member may be responsible for paying a patient liability for room and board costs for nursing facility services. Texas Health and Human Services will determine if the member’s income and certain expenses require them to have a patient liability.</p> <p>Note that patient liability does not apply to Medicare-covered days in a nursing facility.</p> <p>Notification upon admission is required for skilled nursing facility care.</p>

Services covered by our plan	Limitations and exceptions
<p>Outpatient mental health care</p> <p>The plan covers mental health services provided by:</p> <ul style="list-style-type: none"> • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical nurse specialist, • a nurse practitioner, • a physician assistant, or • any other qualified mental care provider as allowed under applicable state laws. <p>The plan covers the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Clinic services and general hospital outpatient psychiatric services • Day treatment • Mental health rehabilitative services • Mental Health Targeted Case Management 	
<p>Physician/provider services, including doctor’s office visits and services by nurse practitioners and nurse midwives</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Health care or surgery services given in places such as a physician’s office, certified ambulatory surgical center, or hospital outpatient department • Consultation, diagnosis, and treatment by a specialist • Second opinion by another network care provider, if available, before a medical procedure • Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> - surgery of the jaw or related structures, - setting fractures of the jaw or facial bones, - pulling teeth before radiation treatments of neoplastic cancer, or - services that would be covered when provided by a physician. 	
<p>Podiatry services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Diagnosis and medical or surgical treatment of injuries and diseases of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma • Routine foot care for members with conditions affecting the legs, such as diabetes 	

Services covered by our plan	Limitations and exceptions
<p>Prosthetic devices and related supplies</p> <p>Prosthetic devices replace all or part of a body part or function. The following are examples of covered prosthetic devices:</p> <ul style="list-style-type: none"> • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Dental devices <p>The plan also covers some supplies related to prosthetic devices and the repair or replacement of prosthetic devices.</p>	
<p>Rehabilitation services</p> <ul style="list-style-type: none"> • Outpatient rehabilitation services <ul style="list-style-type: none"> - The plan covers physical therapy, occupational therapy, and speech therapy. - The member can get outpatient rehabilitation services from hospital outpatient departments, independent therapist/chiropractor/ psychologist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. • Cardiac (heart) rehabilitation services <ul style="list-style-type: none"> - The plan covers cardiac rehabilitation services such as exercise, education, and counseling for certain conditions. - The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. • Pulmonary rehabilitation services <ul style="list-style-type: none"> - The plan covers pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive 	<p>Rehabilitation services are covered with a doctor’s order. Prior authorization may be needed for some services.</p>
<p>Rural Health Clinics</p> <p>The plan covers the following services at Rural Health Clinics:</p> <ul style="list-style-type: none"> • Office visits for primary care and specialists services • Clinical psychologist • Clinical social worker for the diagnosis and treatment of mental illness • Visiting nurse services in certain situations 	

Services covered by our plan	Limitations and exceptions
<p>Urgently needed care</p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"> • a non-emergency, or • a sudden medical illness, or • an injury, or • a condition that needs care right away. <p>If a member requires urgently needed care, they should first try to get it from a network care provider. However, they can use out-of-network care providers when they cannot get to a network care provider.</p> <p>Coverage is within the U.S. and its territories only.</p>	
<p>Vision care</p> <p>The plan pays for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. This includes treatment for age-related macular degeneration.</p> <p>For people at high risk of glaucoma, the plan pays for 1 glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> • people with a family history of glaucoma, • people with diabetes, and • African-Americans who are age 50 and older. The plan covers 1 eye exam every 2 years. <p>The plan pays for 1 pair of glasses or contact lenses every 2 years. The plan also pays for corrective lenses, and frames, and replacements if they are needed after a cataract removal without a lens implant.</p>	<p>The benefit frequency is every 24 months, with the benefit period measured from the date of service</p>

Appendix C: UnitedHealthcare connected claims and coordination of benefits

Texas care providers contracted with Medicare and Medicaid lines of business, serving members enrolled with UnitedHealthcare Connected for Medicare and Medicaid benefits, are able to take advantage of single-claim submission. Claims submitted to UnitedHealthcare Connected for dual-enrolled members process first against Medicare benefits and then automatically process against UnitedHealthcare Connected Medicaid benefits. Care providers do not need to submit separate claims.

Claims submission requirements

UnitedHealthcare Connected requires that a claim be initially submitted within contracted deadline. Please consult your contract to determine your initial filing requirement. The timely filing limit is set at 95 days after the date of service. For nursing facilities for long term care, the deadlines are 365 days for unit rate and 95 days for acute and add-on services. Nursing facilities for long term care have 365 days to file for unit rates and 95 for acute and add-on services.



For additional information see the Texas Uniform Managed Care Manual Chapter 2.0, “Claims Manual” at hhs.texas.gov > Services > Health > Medicaid and CHIP > Provider Information > Contracts and Manuals > [Uniform Managed Care Manual](#) > Chapter 2: Claims Manual.

A “clean claim” is defined in Texas Revised Statutes as one that can be processed without obtaining additional information from the care provider of service or from a third party. It does not include a claim from a care provider who is under investigation for fraud or abuse or a claim selected for medical review by UnitedHealthcare Connected.

Please mail paper claims to:

UnitedHealthcare Connected
P.O. Box 31352
Salt Lake City, UT 84131-0352

For electronic submission of claims

Please access UHCprovider.com and sign up for electronic claims submission.

Submission of CMS-1500 form drug codes

Attach the current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in 24D field of the CMS-1500 Form or the LIno3 segment of the HIPAA 837 electronic form.

Please note this only applies to the Medicaid portion of the pharmacy claim. It does not apply to the Medicare portion of the pharmacy claim.

Practitioners

Participating care providers should submit claims to UnitedHealthcare Connected as soon as possible after service is rendered, using the standard CMS Claim Form or electronically as discussed below.

To expedite claims payment, identify the following items on your claims:

- Patient’s name, date of birth, address and ID number
- Name, signature, address and phone number of physician or physician performing the service, as in your contract document
- National Provider Identifier (NPI) number
- Physician’s tax ID number
- CPT-4 and HCPCS procedure codes with modifiers where appropriate
- ICD-9 diagnostic codes
- Revenue codes (UB-04 only)
- Date of service(s), place of service(s) and number of services (units) rendered
- Referring physician’s name (if applicable)
- Information about other insurance coverage,

including job- related, auto or accident information, if available

- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers
- Attach a description of the procedure/service provided for claims submitted with unlisted medical or surgical CPT codes or experimental or reconstructive services (if applicable)

Any electronic claims submitted to UnitedHealthcare Connected should comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements.

Hospitals

Hospitals should submit claims to the UnitedHealthcare Connected claims address as soon as possible after service is rendered, using the standard UB-92 Form or electronically using payer ID 87726.

To expedite claims payment, identify the following items on your claims:

- Member name
- Member's date of birth and sex
- Member's UnitedHealthcare Connected ID number
- Indication of: 1) job-related injury or illness, or 2) accident- related illness or injury, including pertinent details
- Appropriate diagnosis, procedure and service codes
- Date of services (including admission and discharge date)
- Charge for each service
- Care provider's ID number and locator code, if applicable
- Care provider's Tax ID Number
- Name/address of participating care provider

Any electronic claims submitted to UnitedHealthcare Connected should comply with HIPAA requirements.

Balance billing

The balance billing amount is the difference between Medicare's and Medicaid's allowed charge and the care provider's actual charge to the

patient. You are prohibited from billing, charging or otherwise seeking payment from enrollees for covered services.

Services to members cannot be denied for failure to pay copayments. If a member requests a service that is not covered by UnitedHealthcare Connected, you should have the member sign a release form indicating understanding that the service is not covered by UnitedHealthcare Connected and the member is financially responsible for all applicable charges.

This release must include the date of the service and the specific service being rendered.

You may bill the member when UnitedHealthcare Connected has denied prior authorization or referral for the services and the following conditions are met:

1. The member was notified by the care provider of the financial liability in advance of service delivery.
2. The notification by the care provider was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose.
3. The notification is dated and signed by the member.

For laboratory services, you are only reimbursed for the services for which you are certified through the Federal Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill the member for any laboratory services for which you lack the applicable CLIA certification. However, this requirement does not apply to laboratory services rendered by physicians, practitioners or medical groups in office settings that have been granted "waived" status under CLIA. We require that all contracted laboratory testing sites maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.