**DOCUMENT HISTORY LOG**

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| **STATUS1** | **DOCUMENT**  **REVISION2** | **EFFECTIVE**  **DATE** | **DESCRIPTION3** |
| Baseline | 2.0 | March 1, 2015 | Initial version Uniform Managed Care Manual, Chapter 3.31 “Medicaid Managed Care Nursing Facility Provider Manual Required Critical Elements.”  Version 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-12-0002, and 529-13-0042. |
| Revision | 2.1 | March 1, 2015 | Section XII Medicaid Managed Care Encounter Data, Billing, And Claims Administration “Medicare Coinsurance” is modified to remove the bullet regarding claims being processed through the administrative services contractor. |
| Revision | 2.2 | July 1, 2016 | Version 2.2 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-12-0002, and 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.  Applicability to the Medicare-Medicaid Dual Demonstration is added.  Section III. is modified to add role of the MMP Service Coordinator.  Section IV.D. is modified to add MMP Behavioral Health Services.  Section IV.E. is modified to add Flexible Benefits.  Section IV.F. is modified to add STAR+PLUS only to Behavioral Health Services in the Dallas SDA.  Section VI.A. is modified to remove “(APS)” from the designation for Abuse, Neglect, or Exploitation, and to add required language.  Section VI.D. is modified to add applicability to MMP to Emergency Prescription supply.  Section VII. is modified to add applicability to MMP.  Section VIII.A. is modified to remove HHSC’s Administrative Services Contractor and DADS and to add applicability to MMP.  Section VIII.B. is modified to add applicability to MMP and to add MMP enrollee’s right to appeal to an Independent Review Entity.  Section VIII.C. is modified to clarify that timeframes apply to both STAR+PLUS and MMP.  Section XIII. is modified to add applicability to MMP.  Section XV. “Additional MMP Specific Critical Elements” is added.  Attachment B “Reporting Abuse, Neglect, or Exploitation (ANE)” is added and all subsequent attachments are re-lettered. |
| Revision | 2.3 | December 1, 2016 | Section IV.F. is modified to include language regarding the discontinuation of NorthSTAR.  Attachment I "Verifying Member Medicaid Eligibility" is modified to add section on Your Texas Benefits, a system that gives providers access to Medicaid health information. |
| Revision | 2.4 | March 15, 2019 | Attachment I “Verifying Member Medicaid Eligibility” is modified to update the ways to verify eligibility and remove reference to the Your Texas Benefits Card provider portal. |
| Revision | 2.5 | November 25, 2019 | Attachment I “Verifying Member Medicaid Eligibility” is modified to add a new option for the provider to verify Medicaid eligibility. |
| Revision | 2.5.1 | April 1, 2020 | Accessibility approved version posted. |
| Revision | 2.6 | May 1, 2022 | Revised to include information on the Medicaid External Medical Review process  Section VIII(B). Adds Member option to request an External Medical Review.  Section VIII(C) revises the term ‘expedited’ to ‘emergency’.  Section VIII(D) adds the word ‘only’ to the sentence.  Section VIII(E) Adds the reference to Attachment M.  Added required language Attachment M for “External Medical Review”.  Amended the term “fair hearing” to contract-defined term “State Fair Hearing” throughout the document.  Added section titled, “GENERAL INSTRUCTIONS TO MCO” to provide guidance to MCOs on the use of the term ‘emergency’.  Section VIII.B. page 12 - removal of requirement to confirm an internal appeal request in writing.  Attachment J – Revisions made to Member Rights, item 5. Pages 29-30 adding external medical review information. |
| Revision | 2.7 | May 2, 2022 | Administrative Update – Language deleted from Attachment M that reads, “Go in person to a local HHSC office”. |
| Revision | 2.8 | July 17, 2023 | Attachment M is modified to remove the language that the Member may request an IRO be present at the State Fair Hearing.  Attachment M is modified to clarify who the Member must contact for a State Fair Hearing withdrawal. |

1 Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.

2 Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.

# Applicability of Chapter 3.31

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR+PLUS Program (including the Medicare-Medicaid Dual Demonstration (MMDD)).

MCOs are required to create a separate Provider Manual for Nursing Facility (NF) providers in STAR+PLUS containing the elements described in this chapter. STAR+PLUS MCOs should consult UMCM Chapter 3.3 for requirements for the Provider Manual for all other STAR+PLUS providers.

MCOs participating in the Dual Demonstration must add provisions to the Nursing Facility Provider Manual that clearly differentiates the Medicare-Medicaid Plan (MMP) and STAR+PLUS Programs. Please refer to Section XV for additional requirements.

**GENERAL INSTRUCTIONS TO MCO**

As used in this chapter, “emergency appeal” and “emergency state fair hearing” have the same meaning as “Expedited MCO Internal Appeal” or “expedited State Fair Hearing,” respectively.

| Required Element | Page Number |
| --- | --- |
| The following items must be included in the NF Provider Manual, but not necessarily in this order (unless specified). |  |
| This table is to be completed and attached to the NF Provider Manual when submitted for approval. Include the page number of the location for each required critical element. |  |
| 1. FRONT COVER |  |
| The front cover must include, at a minimum: |  |
| * MCO name |  |
| * MCO logo |  |
| * STAR+PLUS |  |
| * Service Area |  |
| * The words “NURSING FACILITY PROVIDER MANUAL” |  |
| * Provider services telephone number |  |
| * Date of current publication |  |
| * Website address |  |
| 1. TABLE OF CONTENTS |  |
| The NF Provider Manual must include a Table of Contents. |  |
| 1. INTRODUCTION |  |
| * Background |  |
| * Quick reference phone list |  |
| * Objectives of Program |  |
| * Role of Nursing Facilities |  |
| * Role of Primary Care Provider |  |
| * Role of specialty care Provider |  |
| * Role of MCO and MMP Service Coordinator |  |
| * Role of pharmacy |  |
| * Network limitations (e.g., Primary Care Providers and specialists as applicable) |  |
| 1. COVERED SERVICES |  |
| * 1. Nursing Facility Unit Rate |  |
| Nursing Facility Unit Rate means the types of services included in the Department of Aging and Disability Services (DADS) daily rate for Nursing Facility Providers, such as 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 rate enhancements and professional and general liability insurance. Nursing Facility Unit Rates exclude Nursing Facility Add-on Services. |  |
| * 1. Nursing Facility MCO Add-on Services |  |
| Nursing Facility Add-on Services means the types of service that are provided in the facility setting by the Provider or another Network Provider, but are not included in the NF Unit Rate, including but not limited to emergency dental services; physician ordered rehabilitation services; customized power wheel chairs; and augmentative communication devices. (MCO will use HHSC's provided language - **Attachment A.**) |  |
| * 1. MCO Service Coordination for NF Members |  |
| MCOs must include an explanation/description of Service Coordination, including the following: |  |
| * The role and responsibilities of the MCO Service Coordinator for Members in a NF |  |
| * The role and responsibilities of a NF care coordinator and/or other NF staff in coordinating with the MCO Service Coordinator |  |
| * The required number and frequency of MCO Service Coordinator visits to NF Members and expectations for the visits |  |
| * An explanation of MCO service planning and how it functions with NF care planning |  |
| * Promoting independence requirements |  |
| * Discharge and transition planning |  |
| * 1. Behavioral Health |  |
| * Medical records documentation and referral information (required to document using the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications. If applicable, MCO should use the multi-axial classification system.) |  |
| * Coordination with the Local Mental Health Authority (LMHA) and state psychiatric facilities |  |
| * Utilization management reporting requirements (specify by individual mental health service type) |  |
| * MMP Behavioral Health Services – MMP covers behavioral health services statewide, including Dallas SDA |  |
| * 1. Value Added Services |  |
| * 1. Coordination with Providers of Non-Capitated Services |  |
| * MCO must include the references to the Texas Medicaid Provider Procedures Manual (TMPPM) for coordination of the following services: |  |
| * + Behavioral Health Services in the Dallas SDA (will be delivered through fee-for-service) – STAR+PLUS only  Effective January 1, 2017, NorthSTAR will be discontinued and MCOs in the Dallas Service Area will be responsible for Medicaid Behavioral Health Services consistent with all other Service Areas. |  |
| * + Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation) |  |
| * + Hospice services provided by Home and Community Support Service Agencies contracted with DADS |  |
| * + Preadmission Screening and Resident Review (PASRR) Level 1 screenings, Level 2 evaluations, and specialized services provided by DADS-contracted local authority (LA) and DSHS-contracted Local Mental Health Authority (LMHA). Specialized services provided by the LA include: Service Coordination, alternate placement, and vocational training. Specialized services provided by the LMHA 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 PASRR specialized services are non-capitated, fee-for-service. |  |
| * + Long-Term Services and Supports for individuals who have intellectual or developmental disabilities provided by DADS contracted providers |  |
| 1. QUALITY MANAGEMENT |  |
| * Include practice guidelines |  |
| * Focus studies |  |
| * Utilization management reporting requirements for NF add-on and Acute Care Services |  |
| 1. PROVIDER RESPONSIBILITIES |  |
| * 1. General Responsibilities |  |
| * Coordination with a Member's assigned Primary Care Provider |  |
| * 24 hour availability |  |
| * Updates to contact information.Network providers must inform both the MCO and DADS of any changes to the provider’s address, telephone number, group affiliation, etc. |  |
| * Provide MCO access to Members' medical records and access to facility |  |
| * + Must comply with the timelines, definitions, formats, and instructions specified by HHSC |  |
| * + Provide records requested within three business days of the request |  |
| * + If at the time of request for access to medical records HHSC or OIG or another state or federal agency believes records are about to be altered or destroyed, the nursing facility must provide records at the time of request or in less than 24 hours |  |
| * Plan termination |  |
| * Provide notice to the MCO's designated Service Coordinator via phone, facsimile, email, or other electronic means no later than one business day after the following events |  |
| * + a significant, adverse change in the Member's physical or mental condition or environment that could potentially lead to hospitalization |  |
| * + an admission to or discharge from the Nursing Facility, including admission or discharge to a hospital or other acute facility, skilled bed, long term services and supports provider, non-contracted bed, another nursing or long term care facility |  |
| * + an emergency room visit |  |
| * + Nursing Facility initiates an involuntary discharge of a Member from a facility |  |
| * Must submit Form 3618 or Form 3619, as applicable, to HHSC's administrative services contractor |  |
| * Must submit MDS assessments, as required to federal CMS, and associated MDS Long Term Care Medicaid Information Section to HHSC's administrative services contractor |  |
| * Must complete and submit PASRR level I screening information to HHSC's administrative services contractor |  |
| * Must coordinate with LAs and LMHAs 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 |  |
| * For Members in a Nursing Facility, the right to designate a specialist as their PCP, as long as the specialist agrees |  |
| * Member’s right to select and have access to, without a Primary Care Provider referral, a Network ophthalmologist or therapeutic optometrist to provide eye Health Care Services other than surgery |  |
| * Member’s right to obtain medication from any Network pharmacy |  |
| * Member information on advance directives and powers of attorney |  |
| * Informing Members of Covered Services and the costs for non-covered services prior to rendering these services by obtaining a signed private pay form from the Member |  |
| * Referral to specialists and health-related services (documentation of coordination of referrals and services provided between Primary Care Provider and specialist) |  |
| * Primary Care Provider may provide behavioral health-related services within the scope of practice |  |
| * Referral to Network facilities and contractors |  |
| * + Access to second opinion |  |
| * Specialty Care Provider responsibilities (must include availability and accessibility standards) |  |
| * + Verify Member eligibility or authorizations for service |  |
| * + Continuity of Care related to: |  |
| * + - Hospitalization |  |
| * + - Facility transfer |  |
| * + - Pregnant woman information |  |
| * + - Member moves out of Service Area |  |
| * + - Preexisting condition not imposed |  |
| * + Medical records: standards that medical records must reflect all aspects of patient care, including ancillary services. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws |  |
| * + Justification to MCO regarding Out-of-Network referrals, including partners not contracted with MCO |  |
| * + Required to inform Members on how to report Abuse, Neglect and Exploitation (ANE) as defined in Attachment A of the Contract (MCO will use HHSC’s provided language – Attachment B) |  |
| * + Required to train staff on how to recognize and report ANE as defined in Attachment A of the Contract (MCO will use HHSC’s provided language – Attachment B) |  |
| * + Applied income: The Provider must make reasonable efforts to collect applied income, document those efforts, and notify the Service Coordinator or the MCO's designated representative when it has made two unsuccessful attempts to collect applied income in a month |  |
| * 1. Routine, Urgent, and Emergency Services |  |
| * Definitions |  |
| * Requirements for scheduling appointments |  |
| * Emergency prescription supply (MCO/MMP will use HHSC’s provided language – **Attachment C**) |  |
| * Emergency transportation (explanation) |  |
| * Non-emergency ambulance transportation (MCO will use HHSC's provided language - **Attachment D**) |  |
| * Emergency dental services (MCO will use HHSC’s provided language – **Attachment E**) |  |
| * Non-emergency dental services (MCO will use HHSC’s provided language – **Attachment F**) |  |
| * Durable medical equipment and other products normally found in a pharmacy (MCO will use HHSC’s provided language – **Attachment G**) |  |
| **VII. MEDICAID MANAGED CARE PROVIDER COMPLAINT/APPEAL PROCESS** |  |
| * Provider Complaints Process to MCO/MMP |  |
| * Provider appeals process to MCO/MMP |  |
| * + MCO Provider portal |  |
| * Provider Complaint process to HHSC |  |
| VIII. MEDICAID MANAGED CARE MEMBER COMPLAINT/APPEAL PROCESS |  |
| * 1. Member Complaint Process |  |
| * The Member’s right to file Complaints to MCO/MMP and Texas Long Term Care Ombudsman |  |
| * The requirements and timeframes for filing a Complaint |  |
| * The availability of assistance in the filing process |  |
| * The toll-free numbers that the Member can use to file a Complaint |  |
| * 1. Member Appeal Process |  |
| * What can I do if the MCO/MMP denies or limits my Member’s request for a Covered Service? |  |
| * How will I find out if services are denied? |  |
| * Timeframes for the appeals process – the MCO must complete the entire standard appeal process within 30 days after receipt of the initial written or oral request for Appeal, including the option to extend up to 14 calendar days if Member requests an extension; or the MCO shows that there is a need for additional information and how the delay is in the Member’s interest. If MCO needs to extend, Member must receive written notice of the reason for delay. |  |
| * When does Member have the right to request an appeal – include option for the request of an appeal for denial of payment for services in whole or in part |  |
| * Include notification to Member that in order to ensure continuity of current authorized services, the Member must file the appeal on or before the later of: 10 days following the MCO’s mailing of the notice of the Action, or the intended effective date of the proposed Action |  |
| * The Member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member |  |
| * Appeals must be accepted orally or in writing. |  |
| * Can someone from (insert MCO name) help me file an appeal? |  |
| * Member’s option to request an External Medical Review and State Fair Hearing no later than 120 days after the MCO mails the internal appeal decision notice.   Member’s option to request a State Fair Hearing only, no later than 120 days after the MCO mails the internal appeal decision notice. |  |
| * MMP Enrollee right to appeal to an independent review entity |  |
| * For appeals related to level of care determinations, the Member should contact the Administrative Services Contractor (the MCO should include information regarding how the MCO will coordinate with HHSC's Administrative Services Contractor for MDS Medical Necessity Level of Care) |  |
| * 1. Member Expedited MCO Appeal |  |
| * How to request an emergency Appeal (must be accepted orally or in writing) |  |
| * Timeframes – STAR+PLUS and MMP |  |
| * What happens if the MCO denies the request for an emergency Appeal? |  |
| * Who can help me file an emergency Appeal? | \_\_\_\_\_\_\_\_\_ |
| * 1. Member request for State Fair Hearing only (MCO will use HHSC’s provided language – Attachment H).   **E. Member request for an External Medical Review and State Fair Hearing (MCO will use HHSC’s provided language – Attachment M.)** |  |
| **IX. MEDICAID MANAGED CARE MEMBER ELIGIBILITY AND ADDED BENEFITS** |  |
| * 1. Eligibility |  |
| * + Determination by HHSC |  |
| * 1. Verifying Eligibility |  |
| * + Verifying Member Medicaid Eligibility (MCO will use HHSC’s provided language – **Attachment I**) |  |
| * 1. Added Benefits |  |
| * + Unlimited prescriptions for adults (Benefit is only available for Members who are NOT covered by Medicare) |  |
| * + Value-Added Services |  |
| **X. MEMBER RIGHTS AND RESPONSIBILITIES** |  |
| * 1. Medicaid Managed Care Member Rights and Responsibilities (MCOs will use HHSC's provided language – Attachment J) |  |
| * 1. Member's Right to Designate an OB/GYN (MCOs will use HHSC's provided language – Attachment K) |  |
| * 1. Fraud Reporting (MCO will use HHSC's provided language – Attachment L) |  |
| **XI. MEDICAID MANAGED CARE ENCOUNTER DATA, BILLING, AND CLAIMS ADMINISTRATION** |  |
| * Provider relations specialist role and contact information * Where to send claims/Encounter Data |  |
| * Provider portal functionality |  |
| * Online and batch claims processing |  |
| * Form/format to use |  |
| * Taxonomy |  |
| * Modifier requirements (refer to LTSS Billing Matrix, NF Section) |  |
| * Adjusted claims |  |
| * + Automated process for NF unit rate |  |
| * + Process for all other claims |  |
| * Special claims processing for Value-Added Services if applicable |  |
| * Claims questions/appeals (see Section VII - included in the complaint and appeals processes) |  |
| * Process for requesting a prior authorization (PA) |  |
| * + MCO portal |  |
| * + Continuity of Care |  |
| * Standard Continuity of Care requirements will remain in place for Acute Care services for 90 days and LTSS for up to 6 months or until a new assessment is completed and new authorizations issued |  |
| * Out-of-Network provider requirements |  |
| * Nursing Facility (NF) Unit Rate |  |
| * + What services are included in the NF unit rate (Include note to call MCO for information or questions) |  |
| * + Claims submitted for NF unit rate will continue to be authorized by DADS. MCO will not reassess or authorize services resulting from the MDS and covered under the NF Unit Rate |  |
| * + Applied Income |  |
| * + 10-day Clean Claim payment for NF |  |
| * + NFs must file a claim with the MCO by the later of: (1) 365 days after the date of service, or (2) 95 days after the date on the Remittance and Status (R&S) Report or explanation of payment from the other carrier or contractor |  |
| * + Claims submitted by a NF must meet DADS' criteria for clean claims submission as described in UMCM Chapter 2.3, "Nursing Facility Claims Manual" |  |
| * + The MCO will make adjustments to previously-adjudicated claims within 30 days from the date of receipt of an adjustment from the State to reflect changes to such things as: NF Daily Rates, Provider contracts, service authorizations, applied income, and level of service (RUG). |  |
| * Nursing Facility Add-on Services |  |
| * + NF in-house providers delivering rehabilitative add-on services (including assessments) |  |
| * + 30-day Clean Claim payment for professional and institutional claim submission for add-on services |  |
| * + NFs must file a claim with the MCO by the later of: (1) 95 days after the date of service, or (2) 95 days after the date on the Remittance and Status (R&S) Report or explanation of payment from the other carrier or contractor |  |
| * Medicare Coinsurance |  |
| * + NF files claim for Medicare coinsurance |  |
| * + NFs must file a claim with the MCO by the later of: (1) 365 days after the date of service, or (2) 95 days after the date on the Remittance and Status (R&S) Report or explanation of payment from the other carrier or contractor |  |
| * + NF must submit an electronic version of the Medicare Remittances and Advice form |  |
| * Acute Care Service (See STAR+PLUS Provider Manual) |  |
| **XII. MANAGED CARE MEMBER ENROLLMENT AND DISENROLLMENT FROM MCO/MMP** |  |
| * 1. Enrollment |  |
| Span of Coverage |  |
| * 1. Automatic Re-enrollment |  |
| * Six months (include information that Member may choose to switch plans) |  |
| * 1. Disenrollment |  |
| * Inform the Provider that he or she cannot take retaliatory action against a Member |  |
| * Member’s disenrollment request from managed care will require medical documentation from Primary Care Provider or documentation that indicates sufficiently compelling circumstances that merit disenrollment |  |
| * HHSC will make the final decision |  |
| **XIII. MEDICAID MANAGED CARE SPECIAL ACCESS REQUIREMENTS** |  |
| * General transportation and ambulance/wheelchair van |  |
| * Interpreter/translation services |  |
| * MCO/Provider coordination |  |
| * Reading/grade level consideration |  |
| * Cultural sensitivity |  |
| * The MCO must have a mechanism in place to allow Members with Special Health Care Needs to have direct access to a specialist as appropriate for the Member’s condition and identified needs, such as a standing referral to a specialty physician |  |
| **XIV. Additional MMP Specific Critical Elements** |  |
| MMPs may incorporate Dual Demonstration critical elements into their existing Provider Manuals or may develop a Provider Manual specific to MMP. The following are elements MMPs must include in addition to the elements referenced in I through XIV (where applicable): |  |
| **Section I Front Cover** |  |
| 1. MMP logo |  |
| 1. County/Counties |  |
| 1. MMP Provider contact telephone numbers |  |
| **Section IV Covered Services** |  |
| 1. MMP Covered Services for skilled care (Medicare Parts A & B) |  |
| 1. MMP Covered Services (wrap services) |  |
| 1. MMP covered supplies under Part B |  |
| 1. MMP services requiring prior authorization and process |  |
| 1. MMP eligibility and added benefits |  |
| 1. Description of flexible benefits |  |
| 1. Description of rewards and incentives |  |
| 1. Description of nominal gifts |  |
| **Section XI MMP Claims** |  |
| 1. Skilled care daily rate submission timelines and payment timelines |  |
| 1. Handling of co-insurance on MMP claim |  |
| 1. Billing of Medicare Part B services and supplies |  |
| **Section XII MMP Enrollment/Disenrollment Information** |  |

**REQUIRED LANGUAGE**

# ATTACHMENT A

## NURSING FACILITY MCO ADD-ON SERVICES

**Ventilator Care add-on service:** To qualify for supplemental reimbursement, a Nursing Facility Member must require artificial ventilation for at least six 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 that have been impaired by illness. Rehabilitative services must be provided with the expectation that the Member’s functioning will improve measurably in 30 days.

The provider must 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.

**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 NF that has a Medicaid contract with DADS;
* eligible for and receiving Medicaid services in a NF;
* 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 NF;
* 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 NF add-on therapy services, **[Insert MCO name here]** will accept claims received (1) from the NF on behalf of employed or contracted therapists; and (2) directly from contracted therapists who are contracted with the MCO. All other NF add-on providers must contract directly with and directly bill the MCO.

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

**REQUIRED LANGUAGE**

# ATTACHMENT B

## REPORTING ABUSE, NEGLECT, OR EXPLOITATION (ANE)

MEDICAID MANAGED CARE

**Report suspected Abuse, Neglect, and Exploitation:**

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

**Report to the Department of Aging and Disability Services (DADS) if the victim is an adult or child who resides in or receives services from:**

* Nursing facilities;
* Assisted living facilities;
* Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and DADS;
* Adult day care centers; or
* Licensed adult foster care providers

Contact DADS at 1-800-647-7418.

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

* An adult who is elderly or has a disability, receiving services from:
  + Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DADS;
  + Unlicensed adult foster care provider with three or fewer beds
* An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
  + Local intellectual and developmental disability authority (LIDDA), Local mental health authority (LMHAs), community center, or mental health facility operated by the Department of State Health Services
  + a person who contracts with a Medicaid managed care organization to provide behavioral health services;
  + a managed care organization;
  + an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
* An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org

**Report to Local Law Enforcement:**

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

**Failure to Report or False Reporting:**

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

**REQUIRED LANGUAGE**

# ATTACHMENT C

## EMERGENCY PHARMACY SERVICES

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 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: [*MCO inserts claim submission process here*].

Call [*insert the appropriate MCO provider hotline number*] for more information about the 72-hour emergency prescription supply policy.

**REQUIRED LANGUAGE**

# ATTACHMENT D

## NON-EMERGENCY TRANSPORTATION

The Nursing Facility (NF) is responsible for providing routine non-emergency transportation services. The cost of such transportation is included in the NF Unit Rate. Transports of NF Members for rehabilitative treatment (e.g., physical therapy), to outpatient departments, or to physicians’ offices for recertification examinations for NF care are not reimbursable services by (Insert MCO name).

(Insert MCO name) 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).

**REQUIRED LANGUAGE**

# ATTACHMENT E

## EMERGENCY DENTAL SERVICES

**Medicaid Emergency Dental Services:**

(Insert MCO’s name) is responsible for emergency dental services provided to Medicaid Members in a hospital or ambulatory surgical center setting. We will pay for hospital, physician, and related medical services (e.g., anesthesia and drugs) for 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.

**REQUIRED LANGUAGE**

# ATTACHMENT F

## NON-EMERGENCY DENTAL SERVICES

**Medicaid Non-emergency Dental Services:**

(Insert MCO’s name) is **not responsible** for paying for routine dental services provided to Medicaid Members.

(Insert MCO’s name) is **responsible**, however, for paying for treatment and devices for craniofacial anomalies.

**REQUIRED LANGUAGE**

# ATTACHMENT G

## DURABLE MEDICAL EQUIPMENT AND OTHER PRODUCTS NORMALLY FOUND IN A PHARMACY

(Insert MCO name) 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 NF unit rate includes: medically necessary items such as nebulizers, ostomy supplies or bed pans, and medical accessories (such as canulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids, IV equipment, and equipment that can be used by more than one 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).

**REQUIRED LANGUAGE**

# ATTACHMENT H

## STATE FAIR HEARING INFORMATION

* Can a Member ask for a State Fair Hearing?

If a Member, as a Member of the health plan, disagrees with the health plan’s decision, the Member has the right to ask for a State Fair Hearing. The Member may name someone to represent them by contacting the health plan giving the name of the person the Member wants to represent him or her. A provider may be the Member’s representative. The Member or the Member’s representative must ask for the 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 his or her right to a State Fair Hearing. To ask for a State Fair Hearing, the Member or the Member’s representative should either send a letter to the health plan at (address for health plan) or call (number for health plan).

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, at least until the final hearing decision is made. If the Member does not request a State Fair Hearing within 10 days from the time the Member gets the hearing notice, the service the health plan denied will be stopped.

If the Member asks for a State Fair Hearing, the Member will get a packet of information letting the Member know the date, time, and location of the hearing. Most State Fair Hearings are held by telephone. At that time, the Member or the Member’s representative can tell why the Member needs the service the health plan denied.

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

**REQUIRED LANGUAGE**

# ATTACHMENT I

## 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. A provider should verify the Member’s eligibility for the date of service before rendering services. There are multiple ways to do this:

* Call (Insert Name of MCO) or check MCO Provider Portal.
* Use TexMedConnect on the TMHP website at www.tmhp.com.
* Log into your TMHP user account and accessing Medicaid Client Portal for 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)
  + (Insert name of MCO) ID Card
    - STAR+PLUS Dual Eligible - If the Member has Medicare, Medicare is responsible for most primary, acute, and behavioral health services. Therefore, the Primary Care Provider's name, address, and telephone number are not listed on the Member's MCO ID card. The Member receives long-term services and supports through (Insert Name of MCO).

REQUIRED LANGUAGE

# ATTACHMENT J

## MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   1. Be treated fairly and with respect.
   2. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   1. Be told how to choose and change your health plan and your primary care provider.
   2. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
   3. Change your primary care provider.
   4. Change your health plan without penalty.
   5. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   1. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
   2. 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:
   1. Work as part of a team with your provider in deciding what health care is best for you.
   2. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   1. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
   2. Get a timely answer to your complaint.
   3. Use the plan’s appeal process and be told how to use it.
   4. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
   5. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   1. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   2. Get medical care in a timely manner.
   3. Be able to get in and out of a health care provider’s office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   4. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   5. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else’s convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment.  Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services.  Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

MEMBER RESPONSIBILITIES:

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

**REQUIRED LANGUAGE**

# ATTACHMENT K

## MEMBER’S RIGHT TO DESIGNATE AN OB/GYN:

MCO ***DOES NOT LIMIT*** TO NETWORK

(Insert MCO’s name) allows the Member to pick any OB/GYN, whether that doctor is in the same network as the Member’s Primary Care Provider or not.

## ATTENTION FEMALE MEMBERS

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

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

**REQUIRED LANGUAGE**

# ATTACHMENT L

## FRAUD INFORMATION

REPORTING WASTE, ABUSE, OR FRAUD BY A 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 health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

* Getting paid for services that weren’t given or necessary.
* Not telling the truth about a medical condition to get medical treatment.
* Letting someone else use their Medicaid.
* 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 https://oig.hhsc.state.tx.us/ Under the box labeled “I WANT TO” click “Report Waste, Abuse, and Fraud” to complete the online form; or
* You can report directly to your health plan:
  + MCO’s name
  + MCO’s office/director address
  + MCO’s toll free phone number

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

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

**ATTACHMENT M** (for MCOs serving MMC Members

**EXTERNAL MEDICAL REVIEW INFORMATION**

* **Can a Member ask for an External Medical Review?**

If a Member, as a member of the health plan, disagrees with the health plan’s internal appeal decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the Member wants to represent him or her. A provider may be the Member’s representative if the provider is named as the Member’s authorized 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 his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member’s representative should either:

* Fill out the ‘State Fair Hearing and External Medical Review Request Form’ provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to <MCO name> by using the address or fax number at the top of the form.;
* Call the MCO at <MCO telephone number>;
* Email the MCO at <MCO email address>; or

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision 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 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 your 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 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, it is the State Fair Hearing decision that 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 <insert MCO’s name>. To qualify for an emergency External Medical Review and emergency State Fair Hearing, the Member must first complete <insert MCO’s name>’s internal appeals process.