### DOCUMENT HISTORY LOG

<table>
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<tr>
<th>STATUS</th>
<th>DOCUMENT REVISION</th>
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<tr>
<td>Baseline</td>
<td>N/A</td>
<td>April 1, 2010</td>
<td>Initial version Uniform Managed Care Manual Chapter 3.21, &quot;Medicaid MCO’s Notices of Actions Required Critical Elements.&quot;</td>
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<tr>
<td>Revision</td>
<td>2.0</td>
<td>November 15, 2014</td>
<td>Revision 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042. Applicability is updated to include Medicaid Dental.</td>
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<tr>
<td>Revision</td>
<td>2.1</td>
<td>November 15, 2015</td>
<td>Revision 2.1 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-12-0002, 529-12-0003, 529-13-0042, 529-13-0071, and 529-15-0001. Applicability is updated to include the STAR Kids Program.</td>
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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represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.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.
I. Applicability and Purpose of Chapter 3.21

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS, STAR Kids, and the STAR Health Programs, and Dental Contractors providing Children’s Medicaid Dental Services to Members through dental health plans (collectively the “Medicaid Programs”). References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR, STAR+PLUS, STAR Kids, and STAR Health Programs, and the Medicaid Dental Contractors. The term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Dental Contractors, and any other entities licensed or approved by the Texas Department of Insurance. The requirements in this chapter apply to all Medicaid Programs, except where noted.

This chapter defines the critical elements that MCOs must use to notify members of the MCO’s actions and intended actions. The managed care contracts define “action” to include:

(1) the denial or limited authorization of a requested Medicaid service, including the type or level of service;

(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;

(5) the failure of an MCO to act within the timeframes set forth in the Contract and 42 C.F.R. §438.408(b); or

(6) for a resident of a rural area with only one MCO, the denial of a Medicaid member’s request to obtain services outside of the network.

By way of example, the managed care contracts explain that an adverse determination is one type of action.

This chapter consolidates the member notice requirements set forth in various sections of the managed care contracts, including the requirement to comply with 1 T.A.C. Chapter 357, 42 C.F.R. §438.404, and the Alberto N. Partial Settlement Agreement and the Modified Second Partial Settlement Agreement. To the extent that this chapter includes required language for member notices, such language is excepted from HHSC's reading level requirements.
II. Content of Member Notice of Intended Action

The MCO’s notice of an action or intended action must include the following information, at a minimum:

1. The dates, types and amount of service requested.

2. The type of action the MCO has taken or intends to take (e.g., denial or limited authorization of a requested service; reduction, suspension or termination of a previously authorized service, etc.).

3. The date the MCO will take the action.

4. An explanation of the reasons for the MCO’s decision. At a minimum, the MCO should include all of the following:

   ➢ The MCO’s policies and procedures that support the action.

   ➢ If applicable, the provisions of the Texas Medicaid Provider Procedures Manual that support the action.

   ➢ If the decision is based on state or federal laws, the MCO must explain how the laws:
     o apply to the member’s request, and
     o support the action.

   ➢ If the basis for the decision is that the requested service is not a covered service for the member* (therefore no federal financial participation is available for the service), the MCO must:
     o cite the particular federal law that prohibits federal financial participation for the requested service (for children and adults); and/or
     o explain that the requested service is not a covered item for adults under the State Plan (for adults enrolled in STAR Health) or applicable waiver(s) (for adults enrolled in STAR or STAR+PLUS).

   *NOTE: If the requested item qualifies as durable medical equipment (DME), the MCO cannot deny the item on this basis. If a requested item qualifies as DME, then the denial must be based on medical necessity (see below).

   ➢ If the basis for the decision is that the requested service is not medically necessary for the member, the MCO must:
MEDICAID MCO’S NOTICES OF ACTIONS
REQUIRED CRITICAL ELEMENTS

- Explain the medical basis for the decision, applying the MCO’s policy or accepted standards of medical practice to the Member’s particular medical circumstances.
- Explain how the requested service does not meet one or more of the criteria for medical necessity, as set forth in the managed care contract’s definition of “Medically Necessary.”

- If a denial is based on lack of supporting documentation from a provider, identify the provider and describe the supporting documentation that needs to be submitted.

- For Medicaid beneficiaries under 21 years of age, if the MCO determines that a requested nursing service is not a nursing service and that documentation may support authorization of personal care services, in addition to the reasons for denial described above, the notice must contain the following required language:

  The medical information received may support authorization of personal care services. Personal care services are support services provided to Medicaid beneficiaries under 21 years of age who require assistance with activities of daily living and health related functions because of a physical, cognitive, or behavioral limitation related to their disability or chronic health condition. For more information and to find out how to obtain personal care services for a Medicaid beneficiary under 21 years of age, you should contact [insert MCO’s name] or the PCS Client Line at 1-888-276-0702.

- For Medicaid beneficiaries under 21 years of age, if the MCO determines that requested private duty nursing services could be provided on a per-visit basis through home health skilled nursing services, in addition to the reasons for denial described above, the notice must contain the following required language:

  The medical information received may support authorization of Home Health Skilled Nursing services. Home Health Skilled Nursing services are nursing services provided on a per-visit basis. Home Health Skilled Nursing services may be provided to meet acute care needs or on an ongoing basis to meet chronic needs. For more information and to find out how to obtain Home Health Skilled Nursing services, you should contact [insert MCO’s name].
5. The following required language about contacting the MCO:

If you need help understanding this notice or if you want to learn more, you or your representative can call or write [insert MCO's name] at [insert the MCO's toll free telephone number and address].

6. Explain the MCO's internal appeals process, including the following information at a minimum:

- The member's right to access the MCO's appeals process.
- The MCO's toll-free number and address for filing an appeal.
- The procedures and deadline for requesting an appeal.
- The member may represent himself or herself, or use legal counsel, a relative, friend or other spokesman.
- The circumstances under which the member may continue to receive benefits pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.
- The circumstances under which an expedited appeal is available and how to request it.
- The MCO's deadline for making its decision (within 30 days from the date the appeal is received by the MCO, or 3 business days in the case of an expedited appeal).

7. Use the following required language concerning the State fair hearing process:

If you disagree with [insert MCO's name] decision, you have the right to ask for a Medicaid fair hearing from the Health and Human Services Commission (HHSC). You may represent yourself at the fair hearing, or name someone else to be your representative. This could be a doctor, relative, friend, lawyer, or any other person. You may name someone to represent you by writing a letter to [insert MCO's name] telling them the name of the person that you want to represent you.

If you want to challenge a decision made by [insert MCO's name], you or your representative must ask for the Medicaid fair hearing by [insert
date that is 90 days after the date of the notice]. If you do not ask for the fair hearing by this date, you may lose your right to a fair hearing. To ask for a fair hearing, you or your representative should write or call [insert MCO’s name] at [insert MCO’s address and toll-free telephone number].

If you believe that waiting for a fair hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an expedited fair hearing by writing or calling [insert MCO’s name]. To qualify for an expedited fair hearing through HHSC, you must first complete [insert MCO’s name]’s internal appeals process.

If you ask for a fair hearing by [insert date that is the later of: (1) 10 days after the date of the notice or, (2) the intended effective date of the action], you may be able to keep getting any service or benefit that is being terminated, suspended, or reduced by [insert MCO’s name], at least until the final hearing decision is made. If you do not request a fair hearing by this date, the service or benefit will be terminated, suspended, or reduced. If you lose your fair hearing appeal, [insert MCO’s name] may be able to recover the costs of providing the service or benefit to you while the appeal was pending.

If you ask for a fair hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most hearings are held by telephone. You can also contact the HHSC hearings officer if you would like the hearing to be held in-person. During the hearing, you or your representative can tell why you need the service or why you disagree with the [insert MCO’s name]’s action.

You have the right to examine, at a reasonable time before the date of the fair hearing, the contents of your case file and any documents to be used by [insert MCO’s name] at the hearing.

Before the hearing, [insert MCO’s name] will send you all of the documents to be used at the hearing.

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

8. Use the following required language about legal services available in the community.
Option 1:

You may qualify for free or low cost legal services. The following legal aid providers may be able to help you: *insert names, addresses, and telephone numbers of legal aid providers in the Service Area,*.

Option 2:

You may qualify for free or low cost legal services. A list of legal aid providers that may be able to help you is included in *insert reference to the attachment that includes the names, addresses, and telephone numbers of legal aid providers in the Service Area*.

*MCOs should list all legal aid providers in the Service Area. A directory of legal aid providers is available at the following website: www.texaslawhelp.org.*

9. Information about accessing medical case management (such as the case management services identified in the contract’s provisions regarding Medicaid Non-capitated Services, Case Management for Children and Pregnant Women, and Service Coordination).