COMMUNITY FIRST
HEALTH PLANS

STAR Kids
Billing Guidelines

CFHP Network Management
Updated: 10/20/2020

Contents

Who is Community First Health Plans?

Community First Health Plans (CFHP) was established in 1995, by the University Health System, specifically to begin providing health care coverage to the citizens of Bexar and the surrounding seven counties. As the only locally owned and managed, non-profit health plan in the area, our commitment to our members is to provide great health care benefits backed by outstanding service, delivered by people who live right here in South Texas. Our goal is to make San Antonio have more successful health outcomes by putting the community first.

CFHP is a Managed Care Organization (MCO) administering STAR Medicaid, STAR Kids, CHIP and Commercial HMO.

What is STAR Kids?

STAR Kids is a Medicaid Managed Care Program for youth and children who get disability-related Medicaid.

- Mandated through HB 7 the 83rd Legislature, regular session 2013. Children and youth ages 20 or younger who either receive Supplementary Security Income (SSI), Medicaid or enrollment in the MDCP. These services will be covered through a STAR Kids Health Plan
- STAR Kids will provide services for those enrolled in the Medically Dependent Children's Program (MDCP) and Texas Sate plan services for those enrolled in other 1915 (c) waiver programs.
- Will eventually incorporate all services provided through the Youth Empowerment Services (YES) waiver.
- Provides comprehensive medical and behavioral health benefits and service coordination.
- STAR Kids will be tailored to the needs of youth and children with disabilities. The program will provide benefits such as prescription drugs, hospital care, primary and specialty care, preventive care, personal care services, private duty nursing, and durable medical equipment and supplies. Children and youth who get additional services through MDCP will receive additional long-term services and supports through STAR Kids.
- Through STAR Kids, families also can expect coordination of care. Each health plan will provide service coordination, which will help identify needs and connect members to services and qualified providers. Each member will have their service needs assessed, which will form the basis of that member's individual service plan.

STAR Kids Program Expectations

- Creates an **integrated program** that addresses a member's acute and functional needs through Person Centered Planning in the least restrictive environment.
- **CFHP Service Coordination** model to coordinate all care and services to better coordinate care of recipients and improve access to services and overall health outcomes.
- Provides a coordinated **plan for transitioning** youth from childhood programs to the adult LTSS programs such as STAR+PLUS.
- Hopes to achieve **cost containment, cost efficiency** and reduce administrative complexity.

STAR Kids Eligibility

- Children or youth ages 0–21 years of age who receive SSI, receive disability related Medicaid services and/or are enrolled in the MDCP program waiver will be required to enroll in a STAR Kids health plan in their area.
- Children or youth currently enrolled in STAR and receiving SSI or enrolled in STAR+PLUS will be required to enroll into STAR Kids, which **may** require them to select a new health plan.
- Children or youth currently enrolled in an IDD/IID waiver such as CLASS, DBMD, HCS or Texas Home Living will be required to enroll in a STAR Kids health plan in their area and receive all acute care services through a STAR Kids health plan and all LTSS services from their waiver program.
- Children or youth currently enrolled in the Youth Empowerment Services (YES) mental health and substance abuse waiver will be required to enroll in a STAR Kids health plan in their area and will continue to receive their waiver services from the Department of State Health Services (DSHS), but their acute care and State plan LTSS services such as CFC will be provided through STAR Kids.
- Children who receive SSI and are enrolled in STAR Health will continue to receive Medicaid benefits through the STAR Health program

What are Long-Term Services & Supports?

- Defined as the home and community based services and supports these
- types of services are used by individuals with functional limitations and chronic illnesses who need assistance to live in an independent setting versus a facility or institution.
- Common assistance can include help with performing routine daily activities such as bathing, dressing, preparing meals, and administering medications.
- Long-Term Services and Supports were created to help alleviate high health care costs by providing services to individuals who require long term care in their home rather than a facility.

STAR Kids LTSS Services

STAR Kids Non-Waiver LTSS State Plan Benefits

- Private Duty Nursing
- Day Activity Health Services (age 18–20)
- Personal Care Services (PCS)
- Prescribed pediatric extended care centers (PPECC)
- Financial Management Services to support the Consumer Directed Services delivery model services

STAR Kids Community First Choice (CFC) LTSS Benefits

- Personal Attendant Services
- Habilitation Services
- Emergency Response Services
- Support Management
- Financial Management Services to support the Consumer Directed Services delivery model services

All LTSS services are subject to the SK-SAI Assessment process and require Authorizations prior to the service being provided.

STAR Kids MDCP Waiver LTSS Benefits

- Flexible Family Supports
- Respite Care
- Adaptive Aids
- Employment Assistance
- Supported Employment
- Minor Home Modification
- Transition Assistance Services
- Financial Management Services to support the Consumer Directed Services delivery model

All LTSS services are subject to the SK-SAI Assessment process and require Authorizations prior to the service being provided.

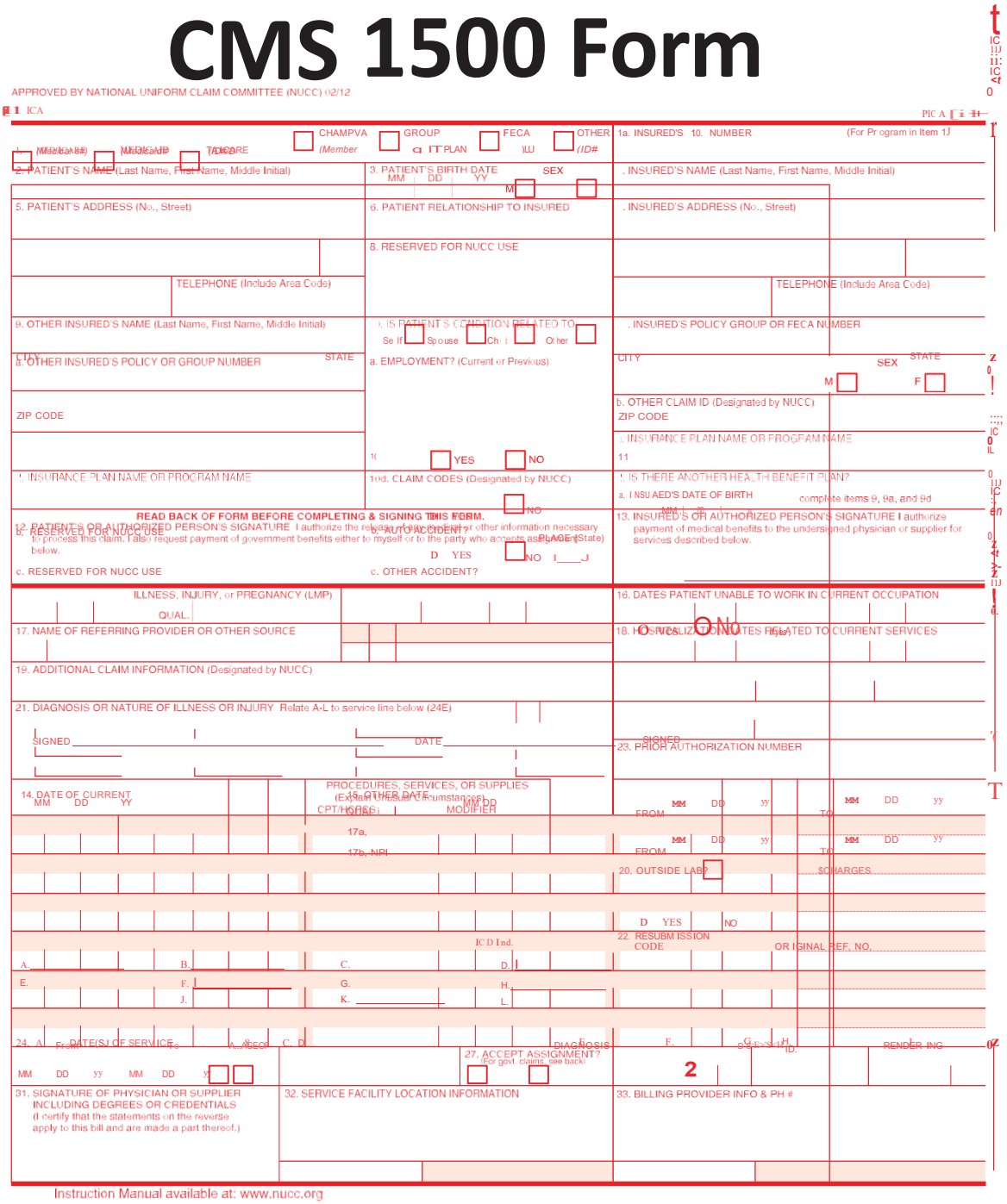
LTSS Claim Filing

- **Filing Deadline is 95 Days from the oldest date of service listed on the submitted claim**
- Electronically (EDI)
  - » Availity Clearinghouse
  - » Claims filed electronically must be filed using:
    - ◊ 837P (LTSS Home/Community Services) format
    - ◊ 837I format (Facility Respite only) format
  - » Community First Health Plans' Payer Identification as indicated below:
    - ◊ Community First Health Plans Payer ID: COMMF
    - ◊ Community First Health Plans Receiver Type: F
- Direct Submission of claim through Claims MD at **www.cfhp.com**
- EFT/ERA is available through PAYSPAN, providers can register at **www.payspanhealth.com/nps**

Claim Form to Use

- Long-Term Services and Supports providers must file paper claims on a CMS-1500. Nursing Facilities billing for Respite services must bill on a CMS-1450 form.
- Providers should bill their normal (usual and customary billed) charges only and not less than their CFHP contracted reimbursement rate. CFHP will reimburse providers based on their contract rate schedule. If a provider bills less than their contracted reimbursement CFHP will pay up to the provider's billed charge.
- Only claims including all required information will be considered clean claims and subject to adjudication in thirty (30) days or less.
- Claims not filled with all the required information may be rejected or denied back to the provider.

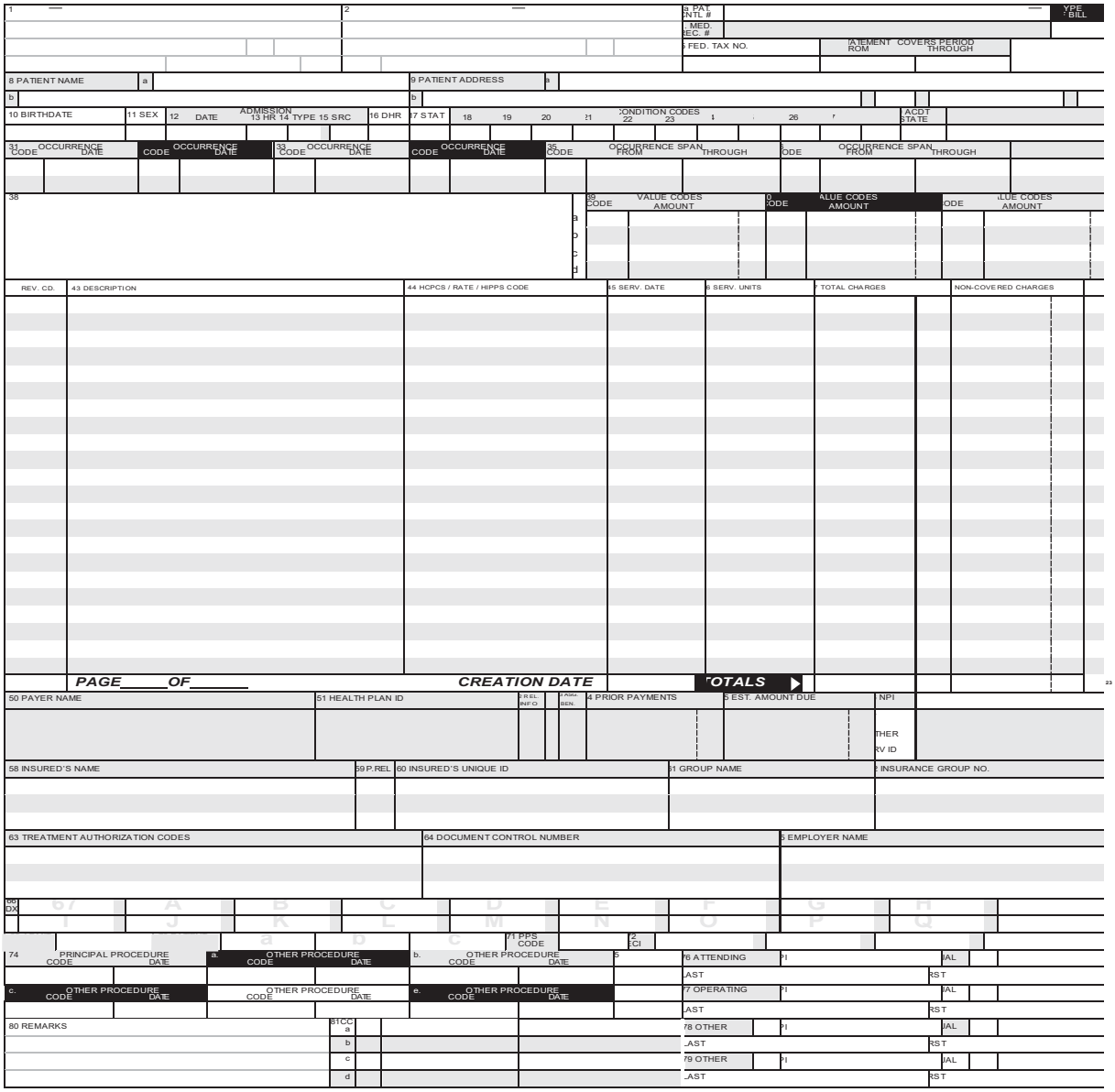
CMS 1500 Form



CMS 1500 Elements of a Clean Claim

- Field 1A = Required
- Field 2 = Required
- Field 3 = Required
- Field 4 = Required
- Field 5 = Required
- Field 6 = Required
- Field 7 = Required
- Field 9, 9A-9D = Conditional
- Field 10A-10C = Required
- Field 11 = Required
- Field 11A = Required
- Field 11B = Conditional
- Field 11C = Required
- Field 11D = Required
- Field 12 = Required
- Field 13 = Required
- Field 14 = Required
- Field 15 = Required
- Field 17 = Required
- Field 17A, 17B = Required
- Field 21 = Required
- Field 23 = Conditional
- Field 24A, 24B, 24C, 24D, 24E, 24F, 24G, 24J = Required
- Field 25 = Required
- Field 28 = Required
- Field 29 = Conditional
- Field 30 = Conditional
- Field 31 = Required
- Field 32, 32A, 32B = Required
- Field 33, 33A, 33B = Required

UB-04 CMS 1450



UB-04 CMS 1450 Elements of a Clean Claim

- Field 1 = Required
- Field 3A = Required
- Field 4 = Required
- Field 5 = Required
- Field 6 = Required
- Field 8A, 8B = Required
- Field 9 = Required
- Field 10 = Required
- Field 11 = Required
- Field 12 = Conditional
- Field 13 = Conditional
- Field 14 = Conditional
- Field 15 = Conditional
- Field 16 = Conditional
- Field 17 = Conditional
- Field 18-28 = Conditional
- Field 31-34 = Conditional
- Field 35, 36 = Conditional
- Field 39, 40, 41 = Required for inpatient only
- Field 42 = Required
- Field 43 = Required
- Field 44 = Required
- Field 45 = Required for Outpatient
- Field 46 = Required
- Field 47 = Required
- Creation Date and Totals = Required
- Field 50 = Required
- Field 54 = Conditional
- Field 56 = Required
- Field 57 = Conditional
- Field 58 = Required
- Field 59 = Required
- Field 60 = Required
- Field 61 = Required
- Field 63 = Conditional
- Field 66 = Required
- Field 67 = Conditional
- Field 69 = Required
- Field 71 = Required
- Field 74, 74A, 74B = Conditional
- Field 76 = Required
- Field 77 = Required
- Field 78 = Conditional
- Field 79 = Conditional
- Field 80 = Conditional
- Field 81 = Conditional

LONG-TERM SERVICES AND SUPPORTS BILLING PROCEDURES

CFHP requires all Providers rendering Long-Term Services and Support (LTSS), with the exception of Atypical Providers,1 to use the CMS 1500 Claim Form or the HIPAA 837 Professional Transaction when billing.

Providers using the Paper CMS 1500

- Providers billing on paper will provide complete information about the service event and will use the State Assigned Provider Identification (ID) to represent the Provider(s) involved in the service event. The Provider ID (Billing and/or Rendering) will be located in Block 33 on the paper form.
  - » If the Billing Provider and the Rendering Provider are the same, then the State Assigned Provider ID will be populated in Block 33.
  - » If the Rendering Provider is different than the Billing Provider, then the Billing Provider State Assigned Provider ID will be populated in Block 33, and the Rendering Provider State Assigned Provider ID will be populated in Block 24K.
  - » Under specific scenarios the additional usage of Block 17a (Referring Provider (Optional)) and Block 24k can be used to report additional information on Providers that are involved in the service event.

Providers using the Electronic HIPAA 837

- Providers billing electronically will comply with HIPAA 837 guidelines including the accurate and complete conveyance of information pertaining to the Provider(s) involved in the service event.

Atypical Providers*

- Atypical Providers will submit appropriate documentation to the MCO. The MCO must obtain sufficient documentation from the Atypical Provider to accurately populate a 837 professional encounter. Please refer to the HIPAA-compliant 837 Professional Combined Implementation Guide and the 837 Professional Companion Guide for further information. (See "Claims Processing Requirements" in Chapter 2, Claims, in the UMCM.)

* *Atypical Providers are LTSS providers that render non-health or non-medical services to STAR+PLUS Members. Examples include pest control services and building and supply services.*

Providers and MCOs will bill and report LTSS in compliance with the STAR Kids Billing Matrix (Matrix).

Providers

- LTSS Providers must use the "designated position" of the modifiers as indicated on the Matrix when filing claims.

MCOs

- MCOs must use the "designated position" of the modifiers as indicated on the Matrix when reporting encounters.

Nursing Facilities

- Nursing Facilities services pertaining to a member entering a Nursing Facility will be filed (paper or electronic) through the State's Claims Administrator under Traditional Medicaid (Fee for Service) following the claims submission guidelines applicable to Traditional Medicaid billing.
- Nursing Facilities services that do not involve a member entering a Nursing Facility (i.e. Respite Care) will conform to normal LTSS billing procedures.

The LTSS Bulletin posted on the Texas Medicaid Health Partnership website (www.tmhp.com) provides additional information and updates.

DAY ACTIVITIES AND HEALTH SERVICES

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5101	99					Day Activities and Health Services (DAHS) 3 to 6 hours	3-6 hours = 1 unit
S5101	99					DAHS over 6 hours	Over 6 hours = 2 units

Billing Tips

- If you are eligible for Attendant Care Enhancement Payments, you must bill at least amount you expect to be reimbursed.
- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

EMERGENCY RESPONSE

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5161	12	U3	U3			Emergency Response Services (Monthly)	1 month = 1 unit
S5160	12					Emergency Response Services (Installation and training)	1 unit per service

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

MINOR HOME MODIFICATIONS

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5165	12					Minor home modifications	1 unit per service
S5165	12	UC				Minor home modifications, CDS Option* effective 12/1/2020	1 unit per service

Billing Tips

- If you are eligible for Attendant Care Enhancement Payments, you must bill at least amount you expect to be reimbursed.
- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

CFC ATTENDANT CARE ONLY (CFC-PCS)

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1019	12	UD				CFC PCS Attendant care only – Agency Model	15 mins = 1 unit
T1019	12	U1				CFC PCS Attendant care only – SRO Model	15 mins = 1 unit
T1019	12	U3				CFC PCS Attendant care only - CDS Model	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

ATTENDANT CARE AND HABILITATION (CFC-HAB)

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1019	12	U9				CFC Attendant care and habilitation, Agency model	15 mins = 1 unit
T1019	12	U2				CFC Attendant care and habilitation, SRO model	15 mins = 1 unit
T1019	12	U4				CFC Attendant care and habilitation, CDS model	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

PERSONAL CARE SERVICES (PCS)

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1019	12	U6				C	15 mins = 1 unit
T1019	12	US				PCS – SRO model	15 mins = 1 unit
T1019	12	UC				PCS – CDS model	15 mins = 1 unit
T1019	12	UA	U6			PCS, BH condition – Agency model	15 mins = 1 unit
T1019	12	UA	US			PCS, BH condition – SRO model	15 mins = 1 unit
T1019	12	UA	UC			PCS – CDS model	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

NURSE DELEGATION AND SUPERVISION

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
G0162	12					RN assessment for delegation of PCS or CFC tasks	15 mins = 1 unit
G0162	12	U1				RN training and ongoing supervision of delegated tasks	15 mins = 1 unit

Community First Health Plans may require prior authorization for an RN assessment of a member to determine if health related tasks are delegable or may be an HMA. The assessment is limited to a maximum of 2 events per year of up to 12, 15 minute units (three hours), per event, using approved procedure code (G0162). Training and supervision of the member's attendant(s) is limited to a maximum of 12, 15 minute units (3 hours) per 30 days, using the appropriate procedure code (G0162) and modifier(UI).

Billing Tips

- If you are eligible for Attendant Care Enhancement Payments, you must bill at least amount you expect to be reimbursed.
- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

PRIVATE DUTY NURSING (PDN)

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1000	12	TE				PDN, LVN	15 mins = 1 unit
T1000	12	TE	UA			PDN, Specialized LVN	15 mins = 1 unit
T1000	12	TD				PDN, RN	15 mins = 1 unit
T1000	12	TD	UA			PDN, Specialized RN	15 mins = 1 unit
T1000	12	U3	TE			PDN, Independently Enrolled LVN	15 mins = 1 unit
T1000	12	U3	TE	UA		PDN, Independently Enrolled Specialized LVN	15 mins = 1 unit
T1000	12	U3	TD			PDN, Independently Enrolled RN	15 mins = 1 unit
T1000	12	U3	TD	UA		PDN, Independently Enrolled Specialized RN	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

OUT OF HOME RESPITE

Institutional Form

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Rev Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Description	Units
T1005	663		UA			Level 10: SE3	15 mins = 1 unit
T1005	663		U9			Level 9: RAD & SE2	15 mins = 1 unit
T1005	663		U8			Level 8: SSC, SE1, & RAC	15 mins = 1 unit
T1005	663		U7			Level 7: SSA, SSB, & RAB	15 mins = 1 unit
T1005	663		U6			Level 6: RAA	15 mins = 1 unit
T1005	663		U5			Level 5: CB2, CC1, & CC2	15 mins = 1 unit
T1005	663		U4			Level 4: BB2, CA2, PE1, IB2, PD2, CB1, & PD1	15 mins = 1 unit
T1005	663		U3			Level 3: PB2, BB1, PC1, PC2, IB1, CA1, & IA2	15 mins = 1 unit
T1005	663		U2			Level 2: BA1, PA2, IA1, PB1, BA2, & IA2	15 mins = 1 unit
T1005	663		U1			Level 1: PA1	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

OUT OF HOME RESPITE WITH PARTIAL VENTILATOR

Institutional Form

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Rev Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Description	Units
T1005	663		UA	U3		Level 10: SE3 w/partial vent	15 mins = 1 unit
T1005	663		U9	U3		Level 9: RAD & SE2 w/partial vent	15 mins = 1 unit
T1005	663		U8	U3		Level 8: SE1 & RAC w/partial vent	15 mins = 1 unit
T1005	663		U7	U3		Level 7: SSA, SSB, RAB, & SSC w/ partial vent	15 mins = 1 unit
T1005	663		U6	U3		Level 6: RAA w/partial vent	15 mins = 1 unit
T1005	663		U5	U3		Level 5: CC1 & CC2 w/partial vent	15 mins = 1 unit
T1005	663		U4	U3		Level 4: PE1, IB2, PD2, CB1, PE2, & CB2 w/partial vent	15 mins = 1 unit
T1005	663		U3	U3		Level 3: BB1, PC1, PC2, IB1, CA1, PD1, BB2, & CA2 w/partial vent	15 mins = 1 unit
T1005	663		U2	U3		Level 2: PA2, IA2, PB1, BA2, IA2, & PB2 w/partial vent	15 mins = 1 unit
T1005	663		U1	U3		Level 1: PA1 & BA1 w/partial vent	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

OUT OF HOME RESPITE WITH TRACHEOSTOMY

Institutional Form

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Rev Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Description	Units
T1005	663		UA	U5		Level 10: SE3 w/trach	15 mins = 1 unit
T1005	663		U9	U5		Level 9: RAD & SE2 w/trach	15 mins = 1 unit
T1005	663		U8	U5		Level 8: SE1 & RAC w/trach	15 mins = 1 unit
T1005	663		U7	U5		Level 7: SSA, SSB, RAB, & SSC w/trach	15 mins = 1 unit
T1005	663		U6	U5		Level 6: RAA w/trach	15 mins = 1 unit
T1005	663		U5	U5		Level 5: CC1 & CC2 w/trach	15 mins = 1 unit
T1005	663		U4	U5		Level 4: PE1, IB2, PD2, CB1, PE2, & CB2 w/trach	15 mins = 1 unit
T1005	663		U3	U5		Level 3: BB1, PC1, PC2, IB1, CA1, PD1, BB2, & CA2 w/trach	15 mins = 1 unit
T1005	663		U2	U5		Level 2: PA2, IA2, PB1, BA2, IA2, & PB2 w/trach	15 mins = 1 unit
T1005	663		U1	U5		Level 1: PA1 & BA1 w/trach	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

OUT OF HOME RESPITE WITH FULL VENTILATOR

Institutional Form

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Rev Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Description	Units
T1005	663		UA	U7		Level 10: SE2 w/full vent	15 mins = 1 unit
T1005	663		U9	U7		Level 9: RAD & SE2 w/full vent	15 mins = 1 unit
T1005	663		U8	U7		Level 8: RAB, SSC, SE1, & RAC w/full vent	15 mins = 1 unit
T1005	663		U7	U7		Level 7: SSA & SSB w/full vent	15 mins = 1 unit
T1005	663		U6	U7		Level 6: CC2 & RAA w/full vent	15 mins = 1 unit
T1005	663		U5	U7		Level 5: CB1, PE2, CB2, & CC1 w/full vent	15 mins = 1 unit
T1005	663		U4	U7		Level 4: PD1, BB2, CA2, PE1, IB2, & PD2 w/full vent	15 mins = 1 unit
T1005	663		U3	U7		Level 3: BB1, PC1, PC2, IB1, & CA1 w/full vent	15 mins = 1 unit
T1005	663		U2	U7		Level 2: IA1, PB1, BA2, IA2, & PB2 w/full vent	15 mins = 1 unit
T1005	663		U1	U7		Level 1: PA1, BA1, & PA2 w/full vent	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

PRESCRIBED PEDIATRIC EXTENDED CARE

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1025	99					Prescribed pediatric extended care, greater than 4 hours	4.25 hours or more = 1 unit
T1026	99					Prescribed pediatric extended care, up to 4 hours	1 hour = 1 unit
T2002	99					Non-emergency transportation	1 day = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

OUT OF HOME RESPITE IN A CAMP

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2027						Respite care, camp setting	15 mins = 1 unit

Billing Tips

- If you are eligible for Attendant Care Enhancement Payments, you must bill at least amount you expect to be reimbursed.
- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

ADAPTIVE AIDS (WAIVER)

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2028	12					Adaptive aid - NOS	1 unit per service
T2029	12					Adaptive aid – Medical equipment	1 unit per service
T2039	12					Adaptive aid – Vehicle modification	1 unit per service
T2028	12	UC				Adaptive aid – NOS, CDS option *effective 12/1/2020	1 unit per service
T2029	12	UC				Adaptive aid – Medical equipment, CDS option *effective 12/1/2020	1 unit per service
T2039	12	UC				Adaptive aid – Vehicle modification, CDS option *effective 12/1/2020	1 unit per service

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

TRANSITION ASSISTANCE SERVICES

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2038	12					Transition assistance services	1 unit per service

Billing Tips

- If you are eligible for Attendant Care Enhancement Payments, you must bill at least amount you expect to be reimbursed.
- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

FINANCIAL MANAGEMENT SERVICES

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2040	12	U8				Financial management service fee, PCS	Monthly fee
T2040	12	U5				Financial management service fee, CFC, non-MDCP	Monthly fee
T2040	12	U3				Financial management service fee, MDCP	Monthly fee
T2040	12	U4				Financial management service fee, CFC and MDCP	Monthly fee

Billing Tips

- If you are eligible for Attendant Care Enhancement Payments, you must bill at least amount you expect to be reimbursed.
- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

IN HOME RESPITE (ATTENDANT)

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
H2015	12	U1				Attendant, Agency model	15 mins = 1 unit
H2015	12	U1	US			Attendant, SRO	15 mins = 1 unit
H2015	12	U1	UC			Attendant, CDS option	15 mins = 1 unit
H2015	12	U1	UA			Attendant with RN delegation, Agency model	15 mins = 1 unit
H2015	12	U1	UA	US		Attendant with RN delegation, SRO	15 mins = 1 unit
H2015	12	U1	UA	UC		Attendant with RN delegation, CDS option	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

IN HOME RESPITE (LVN)

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
H2015	12	U3				LVN, Agency model	15 mins = 1 unit
H2015	12	U3	US			LVN, SRO	15 mins = 1 unit
H2015	12	U3	UC			LVN, CDS option	15 mins = 1 unit
H2015	12	U3	UA			Specialized LVN, Agency model	15 mins = 1 unit
H2015	12	U3	UA	US		Specialized LVN, SRO	15 mins = 1 unit
H2015	12	U3	UA	UC		Specialized LVN, CDS option	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

IN HOME RESPITE (RN)

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
H2015	12	U5				RN, Agency model	15 mins = 1 unit
H2015	12	U5	US			RN, SRO	15 mins = 1 unit
H2015	12	U5	UC			RN, CDS option	15 mins = 1 unit
H2015	12	U5	UA			Specialized RN, Agency model	15 mins = 1 unit
H2015	12	U5	UA	US		Specialized RN, SRO	15 mins = 1 unit
H2015	12	U5	UA	UC		Specialized RN, CDS option	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

FLEXIBLE FAMILY SUPPORT SERVICES (ATTENDANT)

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
H2015	12	99	U1			Attendant, Agency model	15 mins = 1 unit
H2015	12	99	U1	US		Attendant, SRO	15 mins = 1 unit
H2015	12	99	U1	UC		Attendant, CDS option	15 mins = 1 unit
H2015	12	99	U1	UA		Attendant with RN delegation, Agency model	15 mins = 1 unit
H2015	12	99	U1	UA	US	Attendant with RN delegation, SRO	15 mins = 1 unit
H2015	12	99	U1	UA	UC	Attendant with RN delegation, CDS option	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

FLEXIBLE FAMILY SUPPORT SERVICES (LVN)

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
H2015	12	99	U3			LVN, Agency model	15 mins = 1 unit
H2015	12	99	U3	US		LVN, SRO	15 mins = 1 unit
H2015	12	99	U3	UC		LVN, CDS option	15 mins = 1 unit
H2015	12	99	U3	UA		Specialized LVN, Agency model	15 mins = 1 unit
H2015	12	99	U3	UA	US	Specialized LVN, SRO	15 mins = 1 unit
H2015	12	99	U3	UA	UC	Specialized LVN, CDS option	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

FLEXIBLE FAMILY SUPPORT SERVICES (RN)

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
H2015	12	99	U5			RN, Agency model	15 mins = 1 unit
H2015	12	99	U5	US		RN, SRO	15 mins = 1 unit
H2015	12	99	U5	UC		RN, CDS option	15 mins = 1 unit
H2015	12	99	U5	UA		Specialized RN, Agency model	15 mins = 1 unit
H2015	12	99	U5	UA	US	Specialized RN, SRO	15 mins = 1 unit
H2015	12	99	U5	UA	UC	Specialized RN, CDS option	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

EMPLOYMENT SERVICES

1500 CMS Claim Form Field Number

24D	24B	24D	24D	24D	24D	N/A	24G
Code	Place of Service	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
H2023						Supported employment, Agency model	15 mins = 1 unit
H2023		US				Supported employment, SRO	15 mins = 1 unit
H2023		UC				Supported employment, CDS option	15 mins = 1 unit
H2025						Employment assistance, Agency model	15 mins = 1 unit
H2025		US				Employment assistance, SRO	15 mins = 1 unit
H2025		UC				Employment assistance, CDS option	15 mins = 1 unit

Billing Tips

- Always use the service codes and modifiers located on the Authorization Form received from CFHP Services Utilization Management. Failure to use these codes may result in denial or delay in payment.
- If you require an updated authorization with different service codes, modifiers, unit amounts or extension of date range, contact the Service Coordination Department.
- Codes with defined modifier requirements should be billed with each modifier in the appropriate field. Failure to do so may result in denial.
- If services are not rendered on consecutive days, a separate line item must be billed for each date of service.
- Always check member eligibility prior to providing services.
- If the claim covers multiple dates, the 95-day timely filing is based on the FIRST day of the date span. Claim appeals must be filed within one hundred twenty days (120) from the date of the Explanation of Payment.

GLOSSARY

Abuse–Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Medicaid Programs or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for healthcare. It also includes Member practices that result in unnecessary cost to the Programs.

Acute Care–Preventive care, primary care, and other medical care provided under the direction of a provider for a condition having a relatively short duration.

Adaptive Aid–A device necessary to treat, rehabilitate, prevent, or compensate for a condition resulting in a disability or a loss of function. An Adaptive Aid enables an individual to perform activities of daily living or control the environment in which he or she lives.

Agency Option (AO)–Standard service delivery provided by an agency.

Community First Choice (CFC)–Personal assistance services; acquisition, maintenance and enhancement of skills; emergency response services; and support management provided in a community setting for eligible Medicaid Members in STAR Kids who have received a Level of Care (LOC) determination from an HHSC-authorized entity.

Complex Need–A condition or situation resulting in a need for coordination or access to services beyond what a PCP would normally provide, triggering the MCO's determination that Care Coordination is required.

Consumer Directed Services (CDS) Option–Individuals manage day-to-day and business activities.

DADS–The Texas Department of Aging and Disability Services or its successor agency.

DARS–The Texas Department of Assistive and Rehabilitative Services or its successor agency.

DFPS–The Texas Department of Family and Protective Services or its successor agency.

DSHS–The Texas Department of State Health Services or its successor agency.

Dual Eligibles–Medicaid recipients who are also eligible for Medicare.

Electronic Visit Verification (EVV)–A telephone and computer-based system that replaces paper timesheets and electronically verifies that service visits occur and documents the precise time service provision begins and ends.

Employment Assistance–Assistance provided to an individual to help the individual locate paid employment in the community.

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

Home and Community Support Services Agency (HCSSA)–An entity licensed by DADS to provide home health, hospice, or personal care services provided to individuals in their own home or independent living environment.

Home and Community -Based Services (HCBS) Waiver–Specialized programs that provide Home and Community- Based LTSS as cost-effective alternatives to institutional care.

Individual Family Service Plan (IFSP)–The plan for services required by the Early Childhood Intervention (ECI) Program and developed by an interdisciplinary team.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)–An Intermediate Care Facility for Individuals with Intellectual Disabilities or related conditions that provides residential care and services for those individuals based on their functional needs.

ICF-IID Program–The Medicaid program serving individuals with intellectual disabilities or related conditions who receive care in intermediate care facilities other than a state supported living center.

Long-Term Services and Supports (LTSS)–Assistance with daily healthcare and living needs for individuals with a long- lasting illness or disability, including state plan services available to all members (i.e., personal care services, private duty nursing, Day Activity and Health Services (DAHS), Community First Choice (CFC) services, and STAR Kids MDCP services).

GLOSSARY, continued

Medically Dependent Children Program (MDCP)–A program that provides Home and Community-Based LTSS for individuals under the age of 21 with complex medical needs as a cost-effective alternative to living in a Nursing Facility.

Minor Home Modifications–Necessary physical modifications of a person's home to prevent institutionalization or support de-institutionalization. The modifications must be necessary to ensure health, welfare, and safety or to support the most integrated setting for a Member to remain in the community.

Personal Care Services (PCS)–Support services furnished to a Member who has physical, cognitive, or behavioral limitations related to the Member's disability or chronic health condition that limit the Member's ability to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health-maintenance activities.

Respite Care–Direct care services that relieve a primary caregiver temporarily from caregiving activities for a Member.

Service Responsibility Option (SRO)–Individuals manage day-today activities while the provider agency manages business activities.

Significant Traditional Provider (STP)–Primary Care Providers, long-term care providers, and pharmacy providers identified by HHSC as having provided a significant level of care to Fee-for-Service clients in Substitute Care. Disproportionate Share Hospitals (DSH) are also Medicaid STPs.

Transition Assistance Services–A service to help Members transition from the nursing home to the community.

Transition Planning–The process of anticipating and preparing for changes in life circumstances and healthcare services to ease an adolescent's shift to adulthood.

Transition Specialist–A CFHP employee or Subcontractor who works with adolescent and young adult Members and their support network to prepare the Member for a successful transition out of STAR Kids and into adulthood

UNIT–Measurement of billing increments per visit or per specified time. Refer to the appropriate slides for specific unit measurement

URAC (Utilization Review Accreditation Commission dba American Accreditation HealthCare Commission, Inc.)–The independent organization that accredits Utilization Review functions and offers a variety of other accreditation and certification programs for healthcare organizations.

Urban County–Any county with 50,000 or more residents.

Urgent Behavioral Health Situation–A behavioral health condition that requires attention and assessment within 24 hours but that does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.

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

Utilization Review–The system for retrospective, concurrent, or prospective review of the medical necessity and appropriateness of Healthcare Services provided, being provided, or proposed to be provided to a Member. The term does not include elective requests for clarification of coverage.

Value-Added Services–Additional services for coverage beyond the required services. Value-added Services may be actual Healthcare Services, Family Support Services, or positive incentives that HHSC agrees will promote wellness and improved health outcomes among Members. Value-added Services that promote wellness should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra Home Health Services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

Waste–Practices that are not cost-efficient.