



MANUAL	HHSC UNIFORM MANAGED CARE MANUAL	Chapter 2.3	PAGE 1 OF 15
CHAPTER TITLE	UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	EFFECTIVE DATE March 1, 2015	
		Version 2.1	

DOCUMENT HISTORY LOG

STATUS¹	DOCUMENT REVISION²	EFFECTIVE DATE	DESCRIPTION³
Baseline	2.0	March 1, 2015	Initial version of Uniform Managed Care Manual Chapter 2.3, "Uniform Managed Care Nursing Facility Claims Manual." This chapter 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 I is modified to conform to UMCM Chapter 2.0 "Uniform Managed Care Claims Manual." Section II is modified to clarify the meaning of "Days." Section VI is modified to conform to UMCM Chapter 2.0 "Uniform Managed Care Claims Manual." Section VII is modified to add examples to the definition for Adjusted Claim. Section VIII A is modified to clarify that MCOs must adjudicate claims for Unit Rate separately from claims for Add-on Services. Section VIII B is modified to clarify that an Adjusted Claim must have a separate claims number from the previously Adjudicated-Paid claim. Section XIV is modified to clarify the language and to correct a typographical error. Section XIX is modified to conform to UMCM Chapter 2.0 "Uniform Managed Care Claims Manual."

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represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions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.



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	2 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

TABLE OF CONTENTS

I.	APPLICABILITY OF CHAPTER 2.3	3
II.	PURPOSE	3
III.	STATUTORY AND REGULATORY AUTHORITY	3
IV.	INFORMATIONAL RESOURCES	4
V.	BACKGROUND	4
VI.	CLAIMS DEFINITIONS	5
VII.	CLAIMS PROCESSING AND REPORTING CLASSIFICATIONS.....	6
VIII.	CLAIMS PROCESSING REQUIREMENTS.....	7
IX.	REMITTANCE AND STATUS REPORTS	10
X.	PERFORMANCE REQUIREMENTS AND TIMEFRAMES	11
XI.	INTEREST PAYMENTS	11
XII.	THREE HUNDRED AND SIXTY-FIVE DAY PROVIDER CLAIM FILING DEADLINE	12
XIII.	MCO FINANCIAL SETTLEMENTS WITH PROVIDERS	12
XIV.	PROVIDER EDUCATION AND CLAIMS CODING/PROCESSING GUIDELINES.	13
XV.	INTERNAL CLAIMS AUDITING	13
XVI.	HIPAA COMPLIANCE IN REMITTANCE FORMATS.....	14
XVII.	SUBCONTRACTOR CLAIMS PROCESSING.....	14
XVIII.	SYSTEM/SUBCONTRACTOR CHANGES.....	14
XIX.	DATA RETENTION	15
XX.	REPORTING REQUIREMENTS	15



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	3 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

I. APPLICABILITY OF CHAPTER 2.3

Section I
Modified by
Version 2.1

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR+PLUS (including the Medicare-Medicaid Dual Demonstration) Program. References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to STAR+PLUS. The term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Medicare-Medicaid Plans (MMPs) and any other entities licensed or approved by the Texas Department of Insurance (TDI). For purposes of this chapter, the term "MCO" also includes an MCO's subcontractor that performs claims processing functions.

II. PURPOSE

Section II
Modified by
Version 2.1

This chapter establishes the Claims Processing requirements for Nursing Facility Unit Rate services and Nursing Facility Medicare Coinsurance, and timelines that must be used by MCOs. For claims processing requirements for Nursing Facility Add-on Services, refer to UMCM Chapter 2.0, "Claims Manual."

These requirements are based on the authorities noted below. The requirements apply to claims for Nursing Facility Unit Rate services and Nursing Facility Medicare Coinsurance unless otherwise noted.

The term and spelling of “Provider” means contracted Network Providers, and “provider” means all providers, Network and Out-of-Network, except when used to identify positions, headings, and index.

Unless otherwise stated, all required timeframes are based on "Days" as defined in Attachment A of the Contract to mean calendar days.

III. STATUTORY AND REGULATORY AUTHORITY

Statutory and regulatory authority for this chapter includes, without limitation:

- 42 U.S.C. § 1396a(a)(37) [§ 1902(a)(37) of the Social Security Act]
- 42 U.S.C. § 1396u-2(f) [§ 1932(f) of the Social Security Act]
- Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	4 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

- 42 C.F.R. § 433.139
- 42 C.F.R. § 438.242
- 42 C.F.R. § 447.45
- 42 C.F.R. § 447.46
- 45 C.F.R. §§ 160 –164
- Texas Insurance Code § 843.349 (e) and (f)
- 1 Tex. Admin. Code § 353.4
- Texas Government Code Chapter 533, including §533.00251, §533.002515, §533.00252
- 1 Tex. Admin. Code, Part 15, Chapter 355

IV. INFORMATIONAL RESOURCES

- 28 Tex. Admin. Code Chapter 21, Subchapter T, “Submission of Clean Claims”
- Texas Insurance Code Chapter 843, Subchapter J, “Payment of Claims to Physicians and Providers”
- 28 Tex. Admin. Code § 21.2826 waives the application of certain statutes and rules regarding prompt payment of claims as to Medicaid and CHIP managed care plans. HHSC has developed its own Claims Processing requirements that are informed by, but are not governed by, the Texas Department of Insurance requirements, unless noted in the statutory and regulatory authorities above.
- 40 Tex. Admin. Code Chapter 19, Subchapter AA Vendor Payment, including 40 Tex. Admin. Code §19.2604 and 40 Tex. Admin. Code §19.2609, are Department of Aging and Disability Services rules informing the Nursing Facility claims payment process.

V. BACKGROUND

MCOs that contract with HHSC are contracted on a “value based purchasing” basis. Under the “value based purchasing” approach, HHSC focuses on whether or not the MCOs processed the claims appropriately and timely. MCOs must deliver the services and meet the performance standards included in the Contracts between HHSC and the MCOs. This chapter provides the performance standards and filing requirements for appropriate and timely Claims Processing for Medicaid Nursing Facility Unit Rate services and Medicare coinsurance claims.

The MCO must administer an effective, accurate, and efficient claims payment process in compliance with HHSC claim rules and regulations; applicable state and



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	5 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

federal laws, rules, and regulations; the MCO's Contract with HHSC; and the Uniform Managed Care Manual.

VI. CLAIMS DEFINITIONS

Section VI
Modified by
Version 2.1

1. **Deficient Claim:** A claim submitted by a provider for Services rendered to a Member that does not contain the data necessary for the MCO to Adjudicate and accurately report and process the claim.
2. **HHSC-Designated Portal:** The portal through which nursing facility providers participating in the STAR+PLUS Medicaid managed care program may submit claims to any participating managed care organization as required by Texas Government Code § 533.00251(c)(7).
3. **Medicare Coinsurance:** The State's Medicare coinsurance obligation for a qualified Dual Eligible Member's Medicare-covered stay in a Nursing Facility.

For purposes of this chapter, the term "Medicare Coinsurance" does not include the State's cost-sharing obligation for a Dual Eligible Member's Medicare-covered Nursing Facility Add-on Services.

4. **Nursing Facility Add-on Services:** The types of services that are provided in the Facility setting by the Provider or another network provider, but are not included in the Nursing Facility Unit Rate, including but not limited to emergency dental services; physician-ordered rehabilitative services; customized power wheel chairs; and augmentative communication devices.
5. **Nursing Facility Daily Rate:** The payment rate to nursing facilities as defined by 40 Tex. Admin. Code §19.2601.
6. **Nursing Facility Unit Rate:** The types of services included in the Nursing Facility Daily Rate, 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.
7. **Processing or Claims Processing:** The action(s) taken on a claim by the MCO.
8. **Received Date:** For Nursing Facility Unit Rate claims, the Received Date is the date on which the Nursing Facility Provider submits the claim to the MCO or the



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	6 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

HHSC-Designated Portal. For Nursing Facility Medicare Coinsurance claims, the Received Date is the date on which the claim is received by the MCO or the HHSC-Designated Portal, whichever occurs first.

Additional definitions are found in the MCO's Contract, including Attachment A, and this and other Chapters of the Uniform Managed Care Manual.

VII. CLAIMS PROCESSING AND REPORTING CLASSIFICATIONS

Section VII
Modified by
Version 2.1

MCOs are responsible for reporting the disposition of claims by the following HHSC classifications.

- 1. Adjudicated-Paid Claim:** A Clean Claim for which a payment has been made to the provider.
- 2. Adjudicated-Denied Claim:** A Clean Claim that has been denied for payment.
- 3. Clean Claim:** A claim for services rendered to a Member with the data necessary for the MCO to adjudicate and accurately report the claim.
- 4. Deficient-Denied Claim:** A claim denied for the purpose of obtaining additional information. A claim may be denied if it does not contain accurate and complete data in all claim fields that are required to Adjudicate as a Clean Claim.
- 5. Deficient-Pended Claim:** A claim pended for the purpose of obtaining additional information. A claim may be pended if it does not contain accurate and complete data in all claim fields that are required to Adjudicate as a Clean Claim.
- 6. Adjusted Claim:** A Claim that has been previously Adjudicated as a Clean Claim by the MCO and has had a subsequent payment adjustment.

Examples of Adjusted Claims include the following.

- If a primary explanation of benefits (EOB) is needed, the MCO may deny the claim, request the EOB from the provider, and adjust the original claim with the EOB.
- If a non-covered benefit is retrospectively approved to be a covered benefit, the MCO may deny the claim, and upon retrospective approval, the MCO may adjust the claim.



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	7 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

c. If the State retroactively changes rates, the MCO may adjust claims that were previously paid.

7. Rejected Claim: A claim: (1) filed with the HHSC-Designated portal or the MCO for services rendered to a patient who was not a Member of the MCO at the time of service, (2) that was filed with the MCO in error (wrong carrier), or (3) for which the MCO is not responsible for processing but the claim is for a Member of the MCO as of the date of service.

Examples of rejected claims include:

a. The MCO Member was assigned to a risk group as of the date of service, and the HHSC Claims Administrator processes claims for such Members.

b. The services are paid directly by the HHSC Claims Administrator to the provider and not by the MCO as described in the HHSC/MCO Contract. (These services are not included in the Capitation Payment to the MCO.)

8. Other Unprocessed Claims: A claim that has been received but has not yet been assigned a claim classification. This includes claims that are in a queue to be entered into the Claims Processing/Adjudication System.

9. Appealed Claim: A claim that has been previously Adjudicated as a Clean Claim and the provider is appealing the disposition through written notification to the MCO and in accordance with the appeal process as defined in the MCO Provider Manual.

10. Duplicate Claim: Any claim submitted by the provider that was included in a previously submitted claim by that provider for the same service provided to the same Member according to the maximum number of units of this service per day as set out in the Texas Medicaid Provider Procedure Manual. The term does not apply to Adjusted Claims, Appealed Claims, or claims submitted by a provider at the request of the MCO.

11. Claim Type: Nursing Facility Unit Rate services and Nursing Facility Medicare Coinsurance for Long-Term Services and Supports reported on an 837 institutional (837i) transaction.

VIII. CLAIMS PROCESSING REQUIREMENTS

A. Processing and Payment Requirements



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	8 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

Section VIII A
Modified by
Version 2.1

The MCO must require its providers to submit claims electronically to the MCO or the HHSC-designated portal.

No later than 10 days after the Received Date of a Clean Claim, the MCO must: (1) pay the total amount of the claim, or part of the claim or (2) deny the entire claim, or part of the claim, and notify the provider defining the reasons why the claim will not be paid.

Payment is considered paid on the date of: (1) the date of issue of a check for payment and its corresponding Remittance and Status (R&S) Report or explanation of payment to the provider by the MCO, or (2) electronic transmission, if payment is made electronically.

The MCO must submit a request for additional information necessary to allow Adjudication of a Deficient Claim from the provider within 10 days from the Received Date. The MCO must adjudicate Deficient-Pended or Deficient-Denied Claims for which additional information is requested within 10 days from the date of receipt of the requested information.

The MCO must process to Adjudicated-Denied status any Deficient-Pended or Deficient-Denied Claims for which requested additional information is not received within 10 days from the date the information was requested from the provider.

Once an initial claim has been adjudicated to an Adjudicated-Paid or an Adjudicated-Denied status, MCOs will automatically adjust claims to reflect adjustments to such things as: Nursing Facility Daily Rates, Provider Contracts, Service Authorizations, Applied Income, and Level of Service (RUG). Claims that are in progress should complete adjudication before processing any adjustments. MCOs can only adjust an adjudicated claim. MCOs may not require Providers to submit updated claims once a claim is an Adjudicated-Paid Claim.

The MCO must make every effort to avoid making more than one request to the provider for additional information in connection with a specific claim. MCO claim procedures must include processes intended to prevent a provider claim from being repeatedly Deficient-Denied for reasons that were present on the original claim submission.

Whenever possible, the MCO should identify each applicable reason code and specific information requirements to inform the provider of the precise data fields and issues related to each claim. At a minimum, MCO claim systems that employ a



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	9 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

preset hierarchy of Deficient-Pended or Deficient-Denied reasons must provide sufficient information to the provider regarding the primary issue related to a claim.

The MCO must withhold all or part of payment for a claim submitted by a provider: (1) excluded or suspended from the Medicare, Medicaid, or CHIP Programs for Fraud, Abuse, or Waste; (2) on full or partial payment hold under the authority of HHSC or its authorized agent(s); (3) with debts, settlements, or pending payments due to HHSC, or the state or federal government; or (4) if the provider's claim for Nursing Facility Unit Rates does not comply with Section XIV's criteria for processing Clean Claims.

The MCO may not directly or indirectly charge or hold a Member or a Network or non-network provider responsible for a fee for the adjudication of a claim.

MCOs must provide accurate and complete Encounter Data for all Covered Services, including Value-added Services. The Encounter Data must follow the format, rules, and data elements as described in the 837 Institutional Combined Implementation Guide or 837 Institutional Companion Guide. This information should be extracted from the MCO claim files for submission to HHSC. It is expected that MCO Claims Processing for electronic systems will comply with the requirements of the 837 transactions. This will produce consistent and verifiable data, whether self-reported by the MCO or produced by HHSC from the Encounter Data warehouse. The intent is to have uniform claims' data that can and will be verified both at the claim and Financial Statistical Report level, with the control file being the Encounter Data File.

The MCO is subject to the requirements related to coordination of benefits for secondary payors in the Texas Insurance Code Section 843.349 (e) and (f), and for Medicaid MCOs, 42 CFR §433.139.

The MCO must notify the provider in writing that the provider has 120 days from the date of disposition to appeal. The MCO must process an Appealed Claim and Adjudicate the claim within 30 days from the date of receipt of appeal. A provider may appeal any disposition of a claim.

The MCO may deny any claims for Nursing Facility Unit Rates or Medicare Coinsurance that include Nursing Facility Add-on Services as defined in UMCM, Chapter 2.0, "Claims Manual." MCOs may direct providers to submit claims for Unit Rate separately from claims for Add-on Services. Reporting requirements found in the MCO's Contract and this and other Chapters of the Uniform Managed Care Manual apply.



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	10 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

B. Claims System Requirements

Section VIII B
Modified by
Version 2.1

The MCO must maintain an automated Claims Processing System that registers the Received Date, the detail of each claim transaction (or action) at the time the transaction occurs, and has the capability to report each claim transaction by date and type to include interest payments. This information must be at claim and line detail level, and maintained online and in archived files, as appropriate, per contractual record retention requirements. All claim data must be easily sorted and produced in formats as requested by HHSC. The claims system must maintain adequate audit trails and report accurate claims performance measures to HHSC. For an MCO to adjust an Adjudicated-Paid or an Adjudicated-Denied claim, the Adjusted Claim must have a unique identifier not included on the previously Adjudicated-Paid claim.

The MCO must offer its Providers and Subcontractors the option of submitting and receiving claims information through electronic data interchange (EDI) that allows for automated processing and Adjudication of claims. Electronic claims must use HIPAA-compliant electronic formats.

The MCO is responsible for its own claim system performance and reporting and that of its Subcontractors.

C. Provider-administered Drugs

A national drug code (NDC) and Healthcare Common Procedure Coding System (HCPCS) procedure code must be included on all medical claims for provider-administered drugs. If such a claim is missing the NDC information, or the NDC is not valid for the corresponding HCPCS code, then the MCO must deny or reject the entire claim or claim line item for failing to comply with Clean Claim standards.

IX. REMITTANCE AND STATUS REPORTS

For all MCOs, the R&S Report or other remittance communication must be provided in the 835 electronic format and include detailed information to allow the provider to easily identify the claim, such as: claim number, date of service, billed services, Member name, Member ID number, and reason code.



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	11 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

X. PERFORMANCE REQUIREMENTS AND TIMEFRAMES

HHSC may impose remedies, including liquidated damages if the MCO does not process and finalize claims according to the following performance requirements and timeframes.

1. Within 10 days of the Received Date, adjudicate 98 percent of all Clean Claims by Program and by Service Area.
2. Within 90 days of the Received Date, adjudicate 99 percent of all Clean Claims by Program and by Service Area.
3. Within 30 days of the date the MCO receives the appeal adjudicate 98 percent of all Appealed Claims by Program and by Service Area.
4. The MCO is required to finalize all claims, including Appealed Claims, within 24 months from the date of service.
5. These requirements are subject to change due to changes in HHSC requirements, federal and state laws, rules, or regulations.

XI. INTEREST PAYMENTS

The MCO is subject to remedies, including liquidated damages, if the MCO does not pay providers interest at an 18 percent annual rate, calculated daily, for the full period in which the Clean Claim, or portion of the Clean Claim remains unadjudicated beyond the 10-day Claims Processing deadline.

The principal amount on which the interest payment will be calculated is the amount due but unpaid at the contracted rate for the service.

The MCO must keep an accurate and sufficient audit trail for each interest payment and its corresponding claims documentation and provide a detailed report to HHSC upon request.



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	12 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

XII. THREE HUNDRED AND SIXTY-FIVE DAY PROVIDER CLAIM FILING DEADLINE

A provider must file a claim with the MCO within 365 days from the date of service. If a claim is not received by the MCO within 365 days, the MCO must deny the claim unless excepted from the claims filing deadline. The provider must file the 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 R&S Report or explanation of payment from the other carrier or contractor. (See below and the Texas Medicaid Provider Procedures Manual (TMPPM) Section 6.1.4, "Claims Filing Deadlines" for exceptions).

If the provider files with the wrong health plan or the wrong HHSC portal within the 365 day submission requirement and produces documentation to that effect, the MCO must honor the initial filing date and process the claim without denying the resubmission for the sole reason of passing the filing timeframe. The provider must file the 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 R&S Report or explanation of payment from the other carrier or contractor.

When a service is billed to a third-party insurance resource other than the MCO, the claim must be refiled and received by the MCO by the later of (1) 365 days after the date of service, or (2) 95 days after the date on the R&S Report or explanation of payment from the other carrier or contractor. The MCO will determine, as a part of its provider claims' filing requirements, the documentation required when a provider refiles these types of claims with the MCO.

XIII. MCO FINANCIAL SETTLEMENTS WITH PROVIDERS

There should be no need for special settlements except for advance draws by providers against future payments, unless agreed to by both the MCO and the provider by contract. The intent of this provision is to preclude MCOs from settling with providers for service rendered or for interest payments due to inaccurate or untimely processing of claims by the MCO or its Subcontracted Claims Processor.

The MCO should inform providers that the HHSC/MCO Contract allows for the resolution of disputes through binding arbitration or litigation according to the MCO's Provider contracts.



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	13 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

XIV. PROVIDER EDUCATION AND CLAIMS CODING/PROCESSING GUIDELINES

Section XIV
Modified by
Version 2.1

An MCO's claims and adjudication requirements may not exceed or be more restrictive than the following DADS claims adjudication requirements.

- The Nursing Facility resident must be Medicaid eligible for the dates of service billed;
- The Nursing Facility resident must be in the Nursing Facility for the dates of service billed;
- The Nursing Facility resident must have a current Medical Necessity determination for the dates of service billed; and
- The Nursing Facility Provider had to be in good standing for the dates of service billed (i.e., not on vendor payment hold for any reason).

The MCO's claims filing requirements must be clearly set out in the MCO Provider Manual.

The MCO must make available to contracted Network Providers its claims coding and processing guidelines. The information furnished to the Provider should be specific to codes and processing guidelines for particular Programs and provider types.

The MCO must provide contracted Network Providers written notice at least 90 days prior to the MCO implementing any changes to these guidelines, unless changes mandated by HHSC require a shorter notice period.

The MCO's Provider Services staff must train Provider staff on an individual and group basis at time intervals appropriate to each Provider.

XV. INTERNAL CLAIMS AUDITING

The MCO must maintain appropriate levels of claims auditing staff to quickly identify processing errors and trends. The MCO's claims audit procedures must comply with accepted industry practices, processes and standards.

The MCO must provide adequate training and supervision to audit staff and Claim Processors. The claims audit reports should be reviewed with MCO management to ensure that Claims Processing and management systems are adjusted as needed for continuous quality improvement. The claims auditing function should report to the highest level of claims operations, or to a higher executive management position.



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	14 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

All MCO claims data, processing, performance, and functions are subject to audit by HHSC, HHSC's designated agent, or federal or state audit entities.

XVI. HIPAA COMPLIANCE IN REMITTANCE FORMATS

The MCO must comply with HIPAA EDI requirements in claims and remittance transactions.

XVII. SUBCONTRACTOR CLAIMS PROCESSING

A violation of the HHSC Claims Processing requirements by a Subcontractor or delegated entity will be a violation by the MCO. The MCO must ensure that each Subcontractor complies with all HHSC-required procedures, classifications, and claims systems requirements, including timely submission to the MCO of all HHSC required Claims Processing reports or data.

The MCO must notify HHSC of a Subcontractor's violation of the claims policies and procedures within 30 days of identifying any violation. The MCO must provide any additional information relevant to the Subcontractor's violation upon HHSC's request. The MCO is responsible for preparing and implementing a corrective action plan and for monitoring the Subcontractor until the Subcontractor is fully in compliance with HHSC's Claims Processing and reporting requirements.

XVIII. SYSTEM/SUBCONTRACTOR CHANGES

The MCO must notify HHSC of major claims systems changes in writing no later than 180 days prior to implementation. The MCO must provide an implementation plan and schedule of proposed changes at the time of this notification for HHSC's approval to ensure Claims Processing functions are not adversely impacted during the transition period.

The MCO must notify HHSC in writing no later than 180 days prior to the MCO's intention to terminate a Subcontract with a Claims Processor or immediately upon receiving notification from the Subcontracted Claims Processor of its intent to terminate any Subcontract. The MCO is required to provide an implementation plan and schedule of proposed changes at the time of this notification for HHSC's



MANUAL	Chapter	PAGE
HHSC UNIFORM MANAGED CARE MANUAL	2.3	15 OF 15
CHAPTER TITLE	EFFECTIVE DATE	
UNIFORM MANAGED CARE NURSING FACILITY CLAIMS MANUAL	March 1, 2015	
	Version 2.1	

approval. The MCO may be required to submit additional information related to any change of Subcontractor.

XIX. DATA RETENTION

Section XIX
Modified by
Version 2.1

The MCO's claims system must maintain online and archived files. The MCO must keep an online automated claims payment history for the most current 18 months. The MCO must store archival data that is easily retrievable, for a minimum period of 5 years after the Contract Expiration Date or until the resolution of all litigation, claims, financial management reviews, or other state or federal reviews, investigations, or audits pertaining to the Contract, whichever is longer.

If the MCO's claims system is upgraded or replaced, the MCO is required to ensure that all historical claims data are accurately converted and stored in the new or upgraded system after such changes in accordance with the record retention requirements.

XX. REPORTING REQUIREMENTS

See Uniform Managed Care Manual Chapters 5.6.1.8, "Nursing Facility Claims Summary Report" and 5.6.1.9, "Nursing Facility Claims Summary Report Instructions."