DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	2.0	April 1, 2019	Initial version Uniform Managed Care Manual Chapter 3.35, "Uniform Critical Elements Requirements." This chapter applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003; 529-13-0042, 529-13-0071, and 529-15-0001. 42 CFR 438.10(c)(4) requires HHSC to develop definitions for common managed care terms and for MCOs to use these State-developed managed care terms in their Member materials.
Web Posting Date: 01/25/2019			

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.
[2] Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision

Applicability of Chapter 3.35

This chapter applies to Managed Care Organizations (MCOs) or Dental Contractors participating in the Texas Medicaid Managed Care Programs STAR, STAR+PLUS, STAR Kids, STAR Health, and/or Texas Medicaid Dental Services and the Children's Health Insurance Program, including CHIP Perinatal and CHIP Perinatal Newborn, and/or Texas CHIP Dental Services. In this chapter, references to "CHIP" or the "CHIP Managed Care Program(s)" apply to the Children's Health Insurance Program. References to "Medicaid" or the "Medicaid Managed Care Program(s)" apply to the STAR, STAR+PLUS, STAR Kids, STAR Health, and the Medicaid Managed Care Dental programs. The term "MCO" includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, and any other entities licensed or approved by the Texas Department of Insurance. References to dental programs apply to CHIP dental and Medicaid Managed Care dental, and Dental Contractors includes entities licensed and approved by TDI.

Managed Care Terminology

The below terms and definitions must be included in all Member handbooks as a glossary for Members to reference. This requirement is based on 42 C.F.R. § 438.10(c)(4). These terms and definitions must also be included on MCO websites as required by UMCM Ch. 3.32. Other than the prescribed use of such definitions for the Member Handbook as required under 42 C.F.R. 438.10, these definitions do not affect the obligations of either the MCO or HHSC. These definitions have no effect on the definitions included under Attachment A, the Uniform Terms and Conditions of the MCO contracts.

Appeal - A request for your managed care organization to review a denial or a grievance again.

Complaint - A grievance that you communicate to your health insurer or plan.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Durable Medical Equipment (DME) - Equipment ordered by a health care provider for everyday or extended use. Coverage for DME may include but is not limited to: oxygen equipment, wheelchairs, crutches, or diabetic supplies.

Emergency Medical Condition - An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.

Emergency Medical Transportation - Ground or air ambulance services for an emergency medical condition.

Emergency Room Care - Emergency services you get in an emergency room.

Emergency Services - Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services - Health care services that your health insurance or plan doesn't pay for or cover.

Grievance - A complaint to your health insurer or plan.

Habilitation Services and Devices - Health care services such as physical or occupational therapy that help a person keep, learn, or improve skills and functioning for daily living.

Health Insurance - A contract that requires your health insurer to pay your covered health care costs in exchange for a premium.

Home Health Care - Health care services a person receives in a home.

Hospice Services - Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization - Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care - Care in a hospital that usually doesn't require an overnight stay.

Medically Necessary - Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network - The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Non-participating Provider - A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider instead of a participating provider. In limited cases, such as when there are no other providers, your health insurer can contract to pay a non-participating provider.

Participating Provider - A Provider who has a contract with your health insurer or plan to provide covered services to you.

Physician Services - Health-care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.

Plan - A benefit, like Medicaid, which provides and pays for your health-care services.

Pre-authorization - A decision by your health insurer or plan that a health-care service, treatment plan, prescription drug, or durable medical equipment that you or your provider has requested, is medically necessary. This decision or approval, sometimes called prior authorization, prior approval, or pre-certification, must be obtained prior to receiving the requested service. Pre-authorization isn't a promise your health insurance or plan will cover the cost.

Premium - The amount that must be paid for your health insurance or plan.

Prescription Drug Coverage - Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs - Drugs and medications that by law require a prescription.

Primary Care Physician - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health-care services for a patient.

Primary Care Provider - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health-care services.

Provider - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health-care professional, or health-care facility licensed, certified, or accredited as required by state law.

Rehabilitation Services and Devices - Health-care services such as physical or occupational therapy that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.

Skilled Nursing Care - Services from licensed nurses in your own home or in a nursing home.

Specialist - A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care - Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Apelación. Una petición de la organización de atención médica administrada para volver a revisar una denegación o querella.

Queja. Una querella que usted comunica a su seguro o plan médico.

Copago. Una cantidad fija (por ejemplo, 15 dólares) que usted paga por un servicio de atención médica cubierto, normalmente cuando recibe el servicio. Esta cantidad puede variar según el tipo de servicio de atención médica cubierto.

Equipo médico duradero (DME). El equipo ordenado por un proveedor de atención médica para su uso diario o por un periodo extendido. La cobertura de DME puede incluir los siguientes artículos, entre otros: equipo de oxígeno, sillas de ruedas, muletas o artículos para la diabetes.

Problema médico de emergencia. Una enfermedad, lesión, síntoma o afección lo suficientemente grave como para que cualquier persona razonable busque atención inmediata para evitar daños.

Transporte médico de emergencia. Servicios de una ambulancia por tierra o aire para atender una afección médica de emergencia.

Atención en la sala de emergencias. Los servicios de emergencia recibidos en una sala de emergencia.

Servicios de emergencia. La evaluación de una afección médica de emergencia y el tratamiento para evitar que la afección empeore.

Servicios excluidos. Los servicios de salud que su seguro o plan médico no paga o cubre.

Querella. Una queja hecha a su seguro o plan médico.

Servicios y aparatos de habilitación. Servicios de salud, como terapia física u ocupacional, que ayudan a una persona a mantener, aprender o mejorar habilidades y funciones necesarias en la vida diaria.

Seguro médico. Un contrato que requiere que su aseguradora médica pague sus costos de atención médica cubiertos a cambio de una prima.

Atención médica a domicilio. Los servicios de atención médica que una persona recibe en su propio hogar.

Servicios para pacientes terminales. Los servicios que proporcionan comodidad y apoyo a las personas en las últimas etapas de una enfermedad terminal y sus familias.

Hospitalización. La atención que se da en un hospital que requiere que el paciente sea ingresado y por lo general requiere pasar allí la noche.

Atención a pacientes ambulatorios. La atención que se da en un hospital que normalmente no requiere pasar allí la noche.

Médicamente necesario. Los servicios o artículos que se necesitan para prevenir, diagnosticar o tratar una enfermedad, lesión, afección, enfermedad o sus síntomas y que cumple estándares médicos aceptados.

Red. Los centros, proveedores y abastecedores a los que su seguro o plan médico ha subcontratado para que ofrezcan servicios de atención médica.

Proveedor no participante. Un proveedor que no tiene un contrato con su seguro o plan médico para brindarle a usted servicios cubiertos. Puede que sea más difícil obtener autorización de su seguro o plan médicos para recibir servicios de un proveedor no participante en lugar de un proveedor participante. En contados casos, como cuando no hay otros proveedores, su seguro médico puede subcontratar y pagar por sus servicios a un proveedor no participante.

Proveedor participante. Un proveedor que tiene un contrato con su seguro o plan médico para ofrecerle a usted servicios cubiertos.

Servicios de un médico. Servicios de atención médica que un médico titulado (doctor en medicina, MD, o doctor en medicina osteopática, DO) ofrece o coordina.

Plan. Un beneficio, como Medicaid, que ofrece y paga servicios de atención médica.

Autorización previa. La determinación de su seguro o plan médico de que un servicio médico, plan de tratamiento, receta médica o equipo médico duradero que usted o su proveedor ha pedido es médicamente necesario. Esta determinación o autorización, a veces llamada en inglés *prior authorization*, *prior approval* o *pre-certification*, debe obtenerse antes de recibir el servicio solicitado. La autorización previa no es garantía de que su seguro o plan médico cubrirán los costos.

Prima. La cantidad que debe pagarse por su seguro o plan médico.

Cobertura de medicamentos recetados. Un seguro o plan médico que ayuda a cubrir los costos de fármacos y medicamentos recetados.

Medicamentos recetados. Fármacos o medicamentos que, por ley, requieren de receta médica.

Médico de atención primaria. Un médico (doctor en medicina, MD, o doctor en medicina osteopática, DO) que ofrece o coordina directamente una variedad de servicios de atención médica a un paciente.

Proveedor de atención primaria. Un médico (doctor en medicina, MD, o doctor en medicina osteopática, DO), enfermero especializado en atención primaria, enfermero clínico especializado o médico asistente, como lo permite la ley estatal, que ofrece, coordina o ayuda a un paciente a acceder a una variedad de servicios de atención médica.

Proveedor. Un médico (doctor en medicina, MD, o doctor en medicina osteopática, DO), profesional de la salud o centro de salud autorizado, certificado o acreditado según lo exige la ley estatal.

Servicios y aparatos de rehabilitación. Servicios de atención a la salud como terapia física u ocupacional, que ayudan a la persona a mantener, recuperar o mejorar habilidades y funciones de la vida diaria que se han perdido o dañado porque la persona está enferma, lesionada o discapacitada.

Servicios de enfermería especializada. Servicios a cargo de enfermeros titulados a domicilio o en un centro de reposo.

Especialista. Un médico especialista que se enfoca en un área específica de la medicina o un grupo de pacientes para diagnosticar, controlar, prevenir o tratar ciertos tipos de síntomas y afecciones.

Atención urgente. La atención dada a una enfermedad, lesión o afección lo suficientemente grave como para que una persona razonable busque atención de inmediato, pero no tan grave como para acudir a la sala de emergencias.