UNIFORM MANAGED CARE MANUAL

CHAPTER 5.4.7.2
Authorization Member-Level Data Guidelines and Reporting Instructions

Version 2.0

Effective Date: September 1, 2021

Applicability of Chapter 5.4.7.2

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS, STAR Kids, STAR Health, and Medicare-Medicaid Program (MMP) Programs. In this chapter, references to "Medicaid Managed Care Program(s)" apply to the STAR, STAR+PLUS, STAR Kids, STAR Health, and MMP Programs, hereinafter collectively referred to as "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. The term "Authorization" includes all services that require an authorization including all inpatient hospitalizations.

The requirements in this chapter apply to all Programs referenced above, except where noted.

Purpose

The purpose of the proposed UMCM Chapter 5.4.7.2 deliverable is to improve HHSC contract oversight of Texas Medicaid MCO utilization review through identified authorization processing trends. HHSC has been charged by the Texas Legislature to contract with MCOs to administer its Medicaid program, to most Texas Medicaid beneficiaries, under both longstanding and evolving HHSC policies and guidance.

As part of comprehensive MCO contract and performance oversight, the Texas Government Code § 531.076, Review of Authorization and Utilization Review Processes, requires HHSC to review MCOs to ensure organizations use authorization and utilization review processes to prevent underutilization or overutilization of services.

Authorization Member-Level Data Guidelines

The 1996 Health Insurance Portability and Accountability Act (HIPAA) includes an Administrative Simplification directive to adopt standards to support the electronic exchange of administrative and financial health care transactions. This enables health information to be exchanged electronically and to adopt standards for those transactions.

The UMCM Chapter 5.4.7.2 Authorization Member-Level Data Guidelines and Reporting Instructions are not intended to be stand-alone requirements and must be used in conjunction with the Texas Medicaid Authorization for Managed Care Companion Guide, the Texas Medicaid Submission Guidelines – Authorization for Managed Care, and the associated American National Standards Institute (ANSI) ASC X12N IG.

The Texas Medicaid Submission Guidelines – Authorization for Managed Care is designed to assist MCOs with submitting X12 278 authorization transactions (concurrent authorizations are also included) that align with Texas Medicaid specific data and business requirements as defined by HHSC.

The Texas Medicaid Authorization for Managed Care Companion Guide is a resource to assist MCOs in successfully submitting batch EDI 278 Health Care Services - Request for Review and Response transactions related to authorization data with Texas Medicaid.

All services that require an authorization including all inpatient hospitalizations (both physical/medical and behavioral health) are in-scope.

The following services are out-of-scope:

- Fee-For-Service (FFS) Medicaid Services
- Pharmacy (except clinician administered drugs)
- Dental
- Value added services
- Non-Emergency Medical Transportation (NEMT)

Authorization Member-Level Data Report Submission Instructions

MCOs must send data which is mandatory on X12 278 Request as well as follow the requirements specified in the Texas Medicaid Authorization for Managed Care Companion Guide and the Texas Medicaid Submission Guidelines – Authorization for Managed Care.

All authorization transactions (including concurrent authorizations) that have been finalized within the MCO's system must be submitted at least weekly to TexMedCentral (naming convention listed below), including initial determinations and subsequent updates. Authorization Member-Level Data is accepted 24 hours a day, 7 days a week, 365 days a year, except during brief, pre-announced maintenance periods or during regular maintenance hours on TXMedCentral (occurs every Sunday from 6 p.m. to 11:59 p.m.).

Texas Medicaid & Healthcare Partnership (TMHP) limits authorization files to 75MB in size and 5,000 transactions per file, per batch (multiple ST-SE segments are allowed in a single batch GS-GE/ISA-IEA). If either limitation is exceeded, the submitted file will not be processed. If a file is submitted with more than 5,000 transactions, the entire file will be rejected and not processed by Texas Medicaid. Zipped files are preferred; however, do not zip multiple files together.

Multiple plan codes and/or multiple lines of business (e.g., MMP, STAR, STAR Kids, STAR+PLUS, STAR Health) may be sent within the same file. Submitters must follow Electronic Data Interchange (EDI) standards on batching authorization submissions.

TMHP does not support repetition of a simple data element or a composite data structure.

TMHP requests the following X12 delimiters:

- Sub-Element separator is denoted with colon (:)
- Element separator is denoted with asterisks (*)
- Segment separator is denoted with tilde (~)
- Repetition separator is denoted with pipe (|)

The file naming convention for X12 278 Request files with authorizations for encounters will be structured as ENCA<ID><JJJ><S> where:

- **ENC** is constant for Encounters
- **A** is constant for Authorization
- **ID** = Plan Code (MCOs that have multiple plan codes may use one of the appropriate plan codes in the file name)
- **JJJ** = Julian Date
- **S** = Sequence (This will allow for multiple submissions for a given Julian day)

Examples: ENCA7X001A.txt

ENCA9X001B.dat
ENCA9X001B.zip

All file names must include a file extension of .txt, .dat or .zip. File names must not contain spaces. If the filename does not have above extensions, it will not be picked up for processing.

Files must be dropped in Encounters 'Auth' subfolder in TXMedCentral with folder path <XXX>ENC/AUTH where:

- **XXX** = MCO Name Abbreviation

If support is required, please contact Texas Medicaid at MCOMailbox@tmhp.com.

References

The ANSI ASC X12N IGs are available for purchase at the Washington Publishing Company web site.

The Texas Medicaid Authorization for Managed Care Companion Guide and the Texas Medicaid Submission Guidelines – Authorization for Managed Care published by Texas Medicaid can be found on TXMedCentral in the MCOLAYUT directory.

Table 1. DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]	STATUS[1]
Baseline	2.0	September 1, 2021	Initial version Uniform Managed Care Manual Chapter 5.4.7.2, "Authorization Member-Level Data Guidelines and Reporting Instructions." Chapter 5.4.7.2 applies to contracts issued as a result of HHSC RFP numbers 529-12-0002, 529-10-0020, 529-13-0042, 529-15-0001, 529-13-0071, HHS0002877, HHS0002881, and Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.	Baseline

[1] Status should be represented as "Baseline" for initial issuances and "Revision" for changes to the Baseline version.

[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.