TEXAS
Department of Aging
and Disability Services

COMMISSIONER
Chris Traylor

June 21, 2012

To: Community Based Alternatives Providers
Consumer Directed Services Agencies
Consumer Managed Personal Assistance Services Providers
Day Activity and Health Services providers
Consolidated Waiver Program Providers
Primary Home Care Providers

Subject: Information Letter No. 11-04 **Revised Version**
Billing Procedures for Individuals Who Move Between Fee-for-Service and STAR+PLUS Service Areas

The purpose of this letter is to provide clarification regarding billing procedures for Long-Term Services and Support (LTSS) providers to follow when individuals transfer from fee-for-service (FFS) to a STAR+PLUS service area or are aging out of the Medically Dependent Children Program (MDCP) into STAR+PLUS services. Major differences between the two types of service delivery models are:

- a 95-day filing deadline for the STAR+PLUS Managed Care Organization (MCO) instead of the 365-day filing deadline used for FFS claims;
- STAR+PLUS enrollment must be effective on the first day of the month;
- the Department of Aging and Disability Services (DADS) does not have Community Based Alternatives (CBA) contracts in STAR+PLUS service delivery areas; and
- STAR+PLUS services must be authorized by the MCO.

When an individual moves to a STAR+PLUS service area from FFS or ages out of the MDCP into STAR+PLUS, services must be authorized by the MCO to begin the day of the move or the individual's 21st birthday. Enrollment into the MCO must begin the first day of the month after the move or the individual's 21st birthday. For services authorized during an MCO enrollment, LTSS providers must follow the MCO's billing process. LTSS providers can confirm MCO enrollment by checking TexMedConnect - MESAV, and reviewing the Managed Care tab. Contact numbers for each MCO's billing process are:

Managed Care Organization	Service Areas	
Amerigroup All Service Areas: (866) 805-4589	Bexar El Paso Harris Jefferson Lubbock Tarrant Travis	(210) 737-5700 ext. 35352 (915) 842-8229 or (210) 737-5700 ext. 35352 (713) 218-5100 ext. 55446 (409) 835-7633 ext. 52026 (806) 748-4880 (817) 861-7722 (210) 737-5700 ext. 35352
HealthSpring All Service Areas: (877) 653-0331	Hidalgo Tarrant	
Molina All Service Areas: (866) 449-6849	Bexar Dallas El Paso Harris Hidalgo Jefferson	
Superior	Bexar Dallas Hidalgo Lubbock Nueces	(866) 615-9399 (877) 391-5921 ext. 22505 (877) 391-5921 (877) 391-5921 (800) 656-4817
United HealthCare All Service Areas: (888) 887-9003	Harris Jefferson Nueces Travis	

For services delivered during the timeframe between the individual's move or 21st birthday and the end of the month prior to the MCO enrollment, the LTSS provider must follow the STAR+PLUS Administrative Payment process. The STAR+PLUS Administrative Payment process is outlined below and the policy reference can be found in Chapter 5440 of the STAR+PLUS Handbook**.** Once the MCO authorizes the individual's STAR+PLUS services, the LTSS provider prepares Form 1500, Health Insurance Claim, and submits the form to the MCO before the 95-day filing deadline. LTSS providers who are not familiar with the Form 1500 can receive assistance and training from the MCOs using the contact phone numbers identified in the previous paragraph.

STAR+PLUS Administrative Payment Process

Within five business days of receiving Form 1500, the MCO verifies the provider was authorized to provide the services billed and the claim met the filing deadline. If the two provisions are met, the MCO sends the Form 1500 to the DADS STAR+PLUS Support Unit (SPSU). If the two provisions are not met, the MCO denies the claim.
Within five business days of receiving Form 1500, the SPSU completes the verification process, prepares Form 4116, State of Texas Purchase Voucher, and prints all needed documentation. The SPSU then faxes Form 4116, Form 1500, and all needed documentation to the

Medicaid/CHIP Financial Analyst. Within two business days of receipt, the Medicaid/CHIP Financial Analyst forwards the documents to the Managed Care Operations STAR+PLUS Specialist at the Health and Human Services Commission (HHSC).

Within two business days of receipt of the documents, the STAR+PLUS Specialist reviews and determines if the claim is paid, denied, or returned to the MCO for payment. Once the payment decision is made, the STAR+PLUS Specialist returns the documents to the Medicaid/CHIP Financial Analyst with the decision.

- If the decision is to deny the administrative payment, the Medicaid/CHIP Financial Analyst will notify the SPSU staff person who faxed the request by e-mail of the reason for denial. The SPSU will then notify the DADS provider who submitted the initial request of the decision. The SPSU uses Form 2067, Case Information, to notify the provider.

- If the decision is to pay the claim, the Medicaid/CHIP Financial Analyst sends the Form 4116 to the State Comptroller for payment and notifies the SPSU staff person who faxed the request by e-mail. The SPSU will then notify the DADS provider who submitted the initial request of the decision. As indicated in the previous paragraph, the SPSU uses Form 2067 to notify the provider.

  Please note that when the Medicaid/CHIP Financial Analyst sends Form 4116 to the State Comptroller for payment, there is an undetermined time frame before MCO receives payment. The MCO pays the provider within one week of receipt of payment from HHSC.

If you have questions regarding this letter, please contact the Community Services Policy line at (512) 438-3015.

Sincerely,

[signature on file]

Jon Weizenbaum
Deputy Commissioner