Important Notice regarding references to Texas Department of Insurance (TDI) regulated business:

This UBH Network Manual generally applies to all types of business managed by UBH. There are some sections that note differences that may apply based on state law. This addendum highlights areas in which Texas state law may supersede the expectations set forth in the national manual. These differences apply to Texas Department of Insurance (TDI) regulated business. It is important to note that TDI regulations may not apply to all Texas residents, clinicians or facilities for a given case. For information specific to a particular case, please contact the Care Advocacy Center.

**Access to Care**

In all cases, we expect that you will respond within 24 hours to a member request for routine outpatient care for MH/SA services, a first appointment must be offered within 10 business days. EAP first appointments need to be scheduled within three business days. TDI regulated business requires appointments to be offered within 24 hours for urgent care whereas other UBH business allows for up to 48 hours for urgent care. Access for non-life-threatening emergencies is within six hours, and any life-threatening emergencies need to be seen immediately. Where more stringent time frames are required by state law, we require that the network adhere to those more stringent time frames.

**Appeals**

Please note that UBH adheres to Texas Department of Insurance regulations for all relevant Texas business unless otherwise indicated. In the case of appeals, UBH will notify treating clinicians and consumers about their appeal rights, including time frames and processes at the time of an adverse determination.

For non-urgent appeals, UBH generally requires you to submit appeal requests within 180 calendar days from the member’s receipt of the adverse determination letter. In Texas, state law may not limit the time for making such a request for some types of coverage.

For applicable Texas business, an appropriately licensed physician will be the peer reviewer for all levels of care involving clinical determinations. For coverage not regulated by Texas state law, an appropriate peer reviewer for the identified level of care and from the same or similar specialty will review the appeal.
Elements of a Clean Claim in Texas

The requirements relating to the element on disclosure of any other health care coverage were amended several years ago, especially when the answer is “No”. As a result of the change in the regulation, Elements of a Clean Claim, Required Physician and Non-Institutional Data Elements is amended to read as follows:

Disclosure of any other health benefit plans (CMS 1500, field 11 d):

If response is “Yes”,

(a) Then data elements specified in Coordination of Benefits or non-duplication of benefits elements are essential unless the physician or provider submits with the claim documented proof to the HMO or preferred provider carrier that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete the data:

(b) The data elements specified in Coordination of Benefits or non-duplication of benefits elements is essential when submitting claims secondary to payer HMOs or preferred provider carriers.

If response is “no”, the data elements are not applicable and therefore are not considered essential if the physician or provider has on file a document signed within the past 12 months by the patient or authorized person stating that there is no other health care coverage. The submission of the signed document is not an essential data element. A copy of the signed document is to be provided upon request by the HMO or PPO carrier.

More detailed information regarding elements of a clean claim is available on the Texas Department of Insurance website at http://www.tdi.state.tx.us.

As was indicated in initial UBH communications about House Bill 610, the prompt pay requirements apply only to claims submitted by contracted providers for covered services provided to insured of preferred provider benefits plans and to enrollees of health maintenance organizations. They do not apply to other claims, such as those submitted for services covered by self-insured plans.