Emergency Preparedness

There are many resources available online that address emergency preparedness for people with disabilities and special needs. Here are three sites that are useful for emergency preparedness.

The American Red Cross has an entire section of its website, www.prepare.org, dedicated to helping people with disabilities and medical concerns prepare for disasters. Go to www.prepare.org/disabilities/disabilities.htm.

The Department of Homeland Security collaborated with several national groups to develop a brochure that outlines the steps people with disabilities and their families should take to prepare for emergencies before they occur. The brochure is available at www.ready.gov/america/downloads/disabilities.pdf or by calling 1-800-BE-READY. For a more concise version of the basic steps people with disabilities can take to prepare for emergencies, visit the Ready America website at www.ready.gov/america/getakit/disabled.html. This page prints on one page and contains useful links to more specific information.

As noted in a previous issue of the CSHCN Provider Bulletin, the CSHCN Services Program has a bilingual booklet on emergency preparedness for children with special health care needs available online at www.dshs.state.tx.us/cshcn/pdf/emer_plan.pdf. The bilingual version of the Emergency Information Form for Children with Special Needs is also available on the CSHCN Services Program website at www.dshs.state.tx.us/cshcn/pdf/emer_info_form.pdf. The form was developed by the American Academy of Pediatrics and the American College of Emergency Physicians, and modified by the Department of State Health Services.
Cultural Competency
Continuing Education Offerings*

The Office of Minority Health of the U.S. Department of Health and Human Services offers an e-training opportunity accredited for physicians, nurses, and pharmacists called, “A Family Physician’s Practical Guide to Culturally Competent Care.” The training covers three themes: Culturally Competent Care, Language Access Services, and Organizational Supports. Each theme contains three modules that must be completed in chronological order. Participants who receive a score of at least 70 percent on each module posttest can receive continuing education unit (CEU) or continuing medical education (CME) credit. Physicians can earn a maximum of 9.0 Category 1 credits toward the AMA Physician’s Recognition Award; nurse practitioners and registered nurses can receive 10.8 CEU credits; and pharmacists can receive a total of 9.0 contact hours (0.9 CEUs) of continuing education credit.

For more information, visit www.thinkculturalhealth.org or go directly to the course at https://cccm.thinkculturalhealth.org/default.asp. Those practitioners who would rather take a class in person instead of on-line can sign up for the course with the TMH Health Quality Institute, by calling 1-866-439-8863 or visiting the TMF website at www.tmf.org.

The American Medical Association (AMA) offers a health literacy educational kit titled, “Health Literacy: Help Your Patients Understand.” The kit includes a documentary and instructional video, a manual for clinicians, and additional educational resources that address topics such as health literacy, barriers faced by patients with low health literacy, and how to improve verbal and written communication with patients. The kit can be purchased through the AMA Bookstore, or by calling 1-800-621-8335 and mentioning item number 0P221002. Physicians who complete the course can receive a maximum of 2.5 AMA Physician’s Recognition Award Category 1 credits. For more information, visit the AMA website at www.ama-assn.org/ama/pub/category/9913.html.

*The Children with Special Health Care Needs Services Program and the Department of State Health Services provide this information for educational purposes only, and do not endorse any particular product.

Medical Home

The following is an excerpt from The Medical Home & Early Child Development in Primary Care by Calvin C. J. Sia, MD, Lynn B. Wilson, PhD, and Sharon Taba, MEd. To view the document in its entirety, visit the American Academy Pediatrics (AAP) website at www.aap.org/commpeds/cpti/MedicalHome%202006.pdf.

Introduction

Health care for children in the United States (U.S.) has shifted dramatically in the past decades—away from the “old morbidity” medical model that focused on disease and crisis care and even beyond the “new morbidity” medical model. Thus, besides acute infectious diseases and nutritional problems, the primary care physician must consider ever-changing family relationships and environmental influences affecting child health for all children, including social, behavioral, and mental health concerns. This requires a new approach, the “medical home,” that centers on wellness, prevention, and early intervention practices in the young child while promoting optimal child development physically, mentally, and socially within a comprehensive, integrated system of care.

This monograph provides a brief insight into the relationship between the medical home, community systems of services, and their role in enhancing early childhood development. Concepts outlined below emerged from meetings of the Asia/US Partnership, an ongoing international dialogue among pediatric professionals, seeking to improve early childhood outcomes by effectively applying the science of early childhood development to primary health care and to community systems of services with an aim to assuring universality, equity, and sustainability of services for young children.

As this new model of care has emerged, research within the field of neuro-science has achieved groundbreaking...
new knowledge related to early brain development that informs efforts in advancing new systems of care especially for young children. This research indicates that healthy outcomes for children become more likely when a child’s early life experiences involve relationships with adults that are nurturing, reciprocal, dependable, and stable. It emphasizes the importance of the child’s environment and the importance of removing children from exposure to “toxic stress.” The first years of a child’s life are critical to developing healthy brain circuitry that in turn becomes foundational for all subsequent brain development, and the medical home plays a critical role in maximizing this potential.

Translating this new knowledge into practice requires building new systems of care that meet the needs of the whole child in the earliest years. Applying lessons learned in delivering medical homes to children with special health care needs, implementing medical homes for all children with a focus on the earliest years encompasses promotion of health as well as acute and chronic care. It also offers a way to expand quality primary care for young children by emphasizing: well-child care and positive child development; families as primary decision-makers; family/professional partnerships; and, community-based integrated services to create inter-professional systems of care that encompass health, family support, and education at local, state, and national levels.

Recognizing the importance of early childhood development is a growing global phenomenon. Rich cross-cultural understanding of the diversity of early childhood development in community-based systems among nations and cultures around the world can “broaden the view” of possibilities and inform practice within all countries. Expanding the implementation of comprehensive, family-centered, community based services for young children, through efforts based on the medical home concept, can lead the way for developing low-cost, high-impact strategies that improve opportunity for all children and their families to access effective, integrated services with the aim that all young children will achieve optimal life outcomes.

Transition
What’s Health Got to Do with Transition?

The University of South Florida’s Department of Pediatrics recently announced the availability of “What’s Health Got to Do with Transition?,” a collection of resources about health care transition from adolescence to adulthood. It includes an information guide, student curriculum, and teacher’s guide, and is based on the premise that young people’s success in life is directly linked to their health. The materials are useful for patients, their families, and special educators.

The information guide is divided into ten easy-to-use and attractive chapters that address topics such as planning for change, the differences between pediatric and adult health care, finding adult providers, paying for care, and how to develop health-related skills.

The student curriculum and teacher’s guide provide everything needed for eight instructional units and contain lesson plans, classroom teaching tools, learning exercises, and exams. The curriculum can be used inside the high school as well as in a one-to-one teaching situation or in conjunction with a community education program.

To get copies of the information guide, go to www.usfpeds.hsc.usf.edu/adolescent/pdf/Information_Guide.pdf, or contact the University of South Florida College of Medicine, Department of Pediatrics at 1-813-259-8758.

The student curriculum and teacher’s guide are also available online through links on the Adolescent Resources Division’s page of the University of South Florida’s Pediatrics Department website, at www.usfpeds.hsc.usf.edu/adolescent. Both documents are copyrighted by the Florida Developmental Disabilities Council, Inc., but can be reproduced on a limited scale for educational or personal purposes, and only if full credit is given to the authors and the Florida Developmental Disabilities Council, Inc. The materials cannot be offered for resale.
Web-Based Training Available for Case Managers

The Department of State Health Services (DSHS) and the Center for Health Training invite case managers to participate in web-based training about the transition to adulthood for young adults with health conditions or disabilities. Case managers can be especially helpful in assisting with this challenging time in the lives of many young adults.

The training will teach case managers:
- The stages of transition
- Transition issues such as education and independent living
- Why early planning for transition is important
- Who may need assistance with transition
- What resources are available in the state of Texas

Take advantage of this opportunity to learn how to make the transition to adulthood a little easier for young adults with health conditions or disabilities!

Social workers, nurses, professional counselors, and educators can receive four hours of continuing education credits for this training through the Center for Health Training for a fee of $10.00. The Center for Health Training is an approved provider of continuing education by many professional organizations, including the Texas State Board of Social Worker Examiners and the Texas State Board of Examiners of Professional Counselors.

Refer to the Center for Health Training website at www.centerforhealthtraining.org/dshstt for additional information.

2007 CSHCN Services Program Provider Manual

The 2007 CSHCN Services Program Provider Manual Part I is now available for download from the Texas Medicaid & Healthcare Partnership (TMHP) website at www.tmhp.com and the DSHS-CSHCN website at www.dshs.state.tx.us/cshcn. The manual was mailed on compact disc (CD) to all currently enrolled CSHCN providers in January 2007. Providers who have not received the 2007 CSHCN Services Program Provider Manual Part I can request a CD by calling the TMHP-CSHCN Contact Center at 1-800-568-2413.

The 2007 CSHCN Services Program Provider Manual Part I supersedes all previously published editions. The CSHCN Services Program Provider Manual Part I is primarily intended for providers who submit claims to TMHP. The CSHCN Services Program Provider Manual Part II is intended primarily for providers who submit claims through, and are reimbursed by, the CSHCN Services Program directly. The CSHCN Services Program Provider Manual Part II is available for download from the DSHS-CSHCN website at www.dshs.state.tx.us/cshcn, and printed copies may be obtained by contacting the CSHCN Services Program at 1-800-252-8023.

The electronic version of the 2007 CSHCN Services Program Provider Manual Part I, in Adobe® Portable Document Format (PDF), provides a comprehensive search function and active hyperlinks to various chapters, sections, and index entries. The following are some helpful hints for using the electronic version:

- Bookmarks work as an interactive table of contents. If bookmarks are not visible after the manual is open, click on the Bookmarks tab in the document window. If the Bookmarks tab is not visible, click on the Show/Hide Navigation Pane button. When the bookmarks are visible, click on the plus or minus signs to the left of the Bookmark icons to expand or collapse the navigation selections. Click on the Bookmark icon or text to jump directly to the topic.
The table of contents is interactive. To jump to a specific topic listed within the table of contents, move the mouse over the number next to the content item and when the hand cursor changes to a pointed finger cursor (indicating that the item is hyperlinked), click on the item.

Hyperlinked cross references allow users to jump directly to the item being referenced. For instance, if a user encounters text that states, “Refer to Section 3.1 ‘Provider Enrollment,’ on page 3-2 for more information,” the user can click the referenced topic to jump directly to that part of the manual. To find out if an item is hyperlinked, move the mouse over the text, and if the hand cursor changes to a pointed finger cursor, then the item is hyperlinked to the reference.

Interactive index entries allow a user to click on the entry to jump directly to the referenced topic.

The “Find” function (Binoculars icon located in the toolbar) allows users to search for terms within the manual.

In addition to the buttons to move to the first page, previous page, next page, and last page, Acrobat Reader® has buttons for previous view and next view. This allows the user to jump back in the viewing history, much like the back button on an Internet browser.

Additional user help is available through the Adobe® Acrobat Help feature located on the toolbar.

**NUCC Releases Revised CMS-1500 Claim Form**

The National Uniform Claim Committee (NUCC) has released the revised version of the CMS-1500 claim form (version 08/05), which accommodates the reporting of the National Provider Identifier (NPI). TMHP will not accept the revised CMS-1500 claim form until April 2, 2007. Revised CMS-1500 claim forms received before April 2, 2007, will not be accepted for processing and will be mailed back to the address on the form.

Effective April 2, 2007, the current CMS-1500 claim form (version 12/90) will be discontinued, and only the revised CMS-1500 claim form (version 08/05) will be accepted. After April 2, 2007, providers must use the revised CMS-1500 claim form to refile claims, regardless of which version of the CMS-1500 claim form was used for prior submissions. Refer to the March/April 2007 Texas Medicaid Bulletin, No. 203 for more information and instructions about the NPI implementation.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.

**Formatting Correction for Rejected Transaction Reports**

On October 8, 2006, TMHP implemented a formatting correction to the Rejected Transaction Report, which is generated for claims that were submitted electronically and rejected by TMHP’s front-end processor. The Rejected Transaction Report notifies electronic submitters when claims are rejected and need additional action. Providers submitting claims through TDHconnect are not affected.

The change displays certain dates on the report in the correct year, month, and date (yyyymmdd) format. There are no additional changes to the format. Providers who receive this report through vendor software may want to notify their software vendors of this change. No other action on the part of the provider is necessary.

For more information, call the Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638.
Claims Processing to Transition to TMHP

Authorizations and Claims Submission for Services Provided by Advanced Practice Nurses

Effective for dates of service on or after January 5, 2007, advance practice nurses (APNs) must submit CSHCN Services Program claims and authorization requests to TMHP.

Claims should be submitted to:

Texas Medicaid & Healthcare Partnership
Attn: CSHCN Services Program Claims
PO Box 200855
Austin, TX 78720-0855

Authorizations can be mailed to:

Texas Medicaid & Healthcare Partnership
Attn: CSHCN Authorizations, MC-A11
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4222

Claims Submission for Services Provided by ACD Suppliers

Effective for dates of service on or after January 5, 2007, augmentative communication device (ACD) suppliers must submit CSHCN Services Program claims and requests for prior authorization to the TMHP-CSHCN department at TMHP.

Claims should be submitted to:

Texas Medicaid & Healthcare Partnership
Attn: CSHCN Services Program Claims
PO Box 200855
Austin, TX 78720-0855

Requests for prior authorization must be faxed to the TMHP-CSHCN department at 1-512-514-4222.

DSHS-CSHCN allows a 90-day grace period beginning January 5, 2007, during which time if providers submit claims and authorization requests to DSHS-CSHCN, DSHS will forward the authorization and claim submissions to TMHP for processing. At the end of the 90-day grace period, any authorization and claim submissions sent to DSHS are returned.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.

Getting Help

The TMHP-CSHCN Contact Center (1-800-568-2413) is available from 7 a.m. to 7 p.m., Monday through Friday. Contact Center agents can verify client eligibility, research claims, and provide general program information. Additionally, TMHP provider relations representatives offer a variety of educational services for CSHCN Services Program providers (see page 9).
Mandatory Enrollment for Third-Party Billers
All Third Party Billers Must Enroll and be Approved by June 30, 2007

Effective June 30, 2007, third-party billers (TPBs) will be required to contract with the Texas Health and Human Services Commission (HHSC) before submitting electronic claims. TPBs are persons, businesses, or entities (excluding state agencies) that submit claims on behalf of a provider but are not the provider or an employee of the provider. For these purposes, an employee is a person for whom the provider completes an Internal Revenue Service (IRS) Form W-2 showing annual income paid to the employee. All others meet the definition of TPB.

Enrollment for TPBs will begin February 11, 2007. Each TPB will be required to create an online account on the TMHP website at www.tmhp.com, submit the completed Biller Enrollment Packet to TMHP, and be approved by HHSC. The application, which will be available on the TMHP website in February 2007, must be printed, signed, notarized, and mailed to TMHP. Once enrolled, a TPB must submit a request to TMHP to submit claims for a provider. This request must be confirmed by the provider before the TPB can submit claims. A provider can confirm a request from a TPB by logging into their provider online account at www.tmhp.com. The ability of a TPB to submit claims for a provider can be terminated by either the provider or the TPB at any time.

Claims submitted by a TPB that has not enrolled and been accepted will be rejected in the future.

What Providers Should Do
Providers should create an online TMHP account now by following these steps:

2. Select Activate My Account.
3. Select Create a Provider/Vendor Administrator Account.
4. Follow the prompts.

After February 11, 2007, providers should do the following:

- Monitor their accounts for a Link/Approval Request from their TPBs.
- Approve or deny the Link/Approval Request using their TMHP accounts.
- Call the EDI Help Desk at 1-888-863-3638 for technical assistance.
- Notify the Office of Inspector General (OIG) at 1-800-436-6184 if a Link/Approval Request is received for a TPB with which they are not contracted.

What TPBs Should Do
TPBs should do the following on or after February 11, 2007:

1. Create an account on the TMHP website:
   b. Select Activate My Account.
   c. Select Create a Provider/Vendor Administrator Account.
   d. Follow the prompts.
2. Complete the online Biller Enrollment Packet.
3. Print, sign, have notarized, and mail the completed application to TMHP.
4. Monitor their TMHP accounts for an Active enrollment status.
5. Notify providers of their Active status and request that providers complete the Link/Approval Requests. Providers must approve or deny requests from their TMHP accounts.

Refer to the TMHP website after February 11, 2007, at www.tmhp.com for enrollment processes and forms.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.
Reenrollment with the Texas Medicaid and CSHCN Services Programs Required for Some Status Changes

This is a correction to an article published on the TMHP website at www.tmhp.com on October 23, 2006, titled, “Reenrollment with the Texas Medicaid Program Required for Some Status Changes.” The original article did not include information about the CSHCN Services Program. The following is the complete, corrected article.

As a reminder, some changes require a provider to reenroll with the Texas Medicaid and CSHCN Services Programs. Providers must complete a new enrollment application and be issued a new provider identifier when any of the following change:

- **Medicare number**—If Medicare has issued a new Medicare number, the provider must submit a completed Texas Medicaid Provider Enrollment Application to enroll the new location or with a new group.

- **Ownership**—The new owner must:
  - Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
  - Complete the Texas Medicaid Provider Enrollment Application and CSHCN Provider Enrollment Application.
  - Provide TMHP with a copy of the contract of sale (specifically, a signed agreement that includes the identification of previous and current owners in language that specifies who is liable for overpayments that were identified subsequent to the change of ownership, that includes dates of service before the change of ownership).
  - Provide a list of all provider identifiers affected by the change of ownership.
  - **Provider Status (individual, group, performing provider, or facility)**—Providers leaving group practices must send a signed letter on company letterhead to TMHP stating the date of termination. The letter should include the provider identifier, effective date of termination, and the group’s provider identifier. The letter should be signed by an authorized representative for the group or the individual provider leaving the group. If the provider is joining a new group practice or enrolling as an individual, the provider must submit a completed Texas Medicaid Provider Enrollment Application and CSHCN Provider Enrollment Application requesting enrollment into the new group or as an individual provider.

- **Physical address**—If a provider is changing an address within the Medicare locality, the provider must submit a completed Provider Information Change (PIC) Form. A W-9 is required if changing the mailing address. If the new address is not within the Medicare locality and Medicare has issued a new Medicare number, the provider must submit a completed Texas Medicaid Provider Enrollment Application and CSHCN Provider Enrollment Application to enroll the new location. Dental providers must complete a TMHP Dental Provider Enrollment Application for each practice location.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.

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Scheduled System Maintenance

System maintenance to the TMHP claims processing system is scheduled for:

- Sunday, Feb. 11, 2007, 6 p.m., to 11:59 p.m.
- Sunday, Mar. 11, 2007, 6 p.m., to 11:59 p.m.
- Sunday, April 15, 2007, 6 p.m., to 11:59 p.m.
- Sunday, May 27, 2007, 3 p.m., through Monday, May 28, 2007, 6 p.m.

During system maintenance, some of the secure pages of the TMHP website will be unavailable. Specific details about the affected features are posted on the TMHP website at www.tmhp.com.
TMHP Provider Relations Representatives

TMHP provider relations representatives offer a variety of services designed to inform and educate the provider community about the CSHCN Services and Texas Medicaid Programs’ policies and claims filing procedures. Technical support and training are also provided for TDHconnect software users. Provider relations representatives assist providers through telephone contact, onsite visits, and scheduled workshops. The map at right and the table below indicate the TMHP provider relations representatives and the areas they serve. Additional information, including a regional listing by county and workshop information, is available on the TMHP website at www.tmhp.com/Providers. (Click on the Regional Support link, and then choose the region.)

<table>
<thead>
<tr>
<th>Territory</th>
<th>Regional Area</th>
<th>Representative</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Amarillo, Childress, and Lubbock</td>
<td>Elizabeth Ramirez</td>
<td>1-512-506-6217</td>
</tr>
<tr>
<td>2</td>
<td>Midland, Odessa, and San Angelo</td>
<td>Mindy Wiggins</td>
<td>1-512-506-3423</td>
</tr>
<tr>
<td>3</td>
<td>Alpine, El Paso, and Van Horn</td>
<td>Isaac Romero</td>
<td>1-512-506-3530</td>
</tr>
<tr>
<td>4</td>
<td>Del Rio, Eagle Pass, and Laredo</td>
<td>Candice Myers</td>
<td>1-512-506-7271</td>
</tr>
<tr>
<td>5</td>
<td>Brownsville, Harlingen, and McAllen</td>
<td>Cynthia Gonzales</td>
<td>1-512-506-7991</td>
</tr>
<tr>
<td>6</td>
<td>Abilene, Brownwood, and Wichita Falls</td>
<td>Matthew Cogburn</td>
<td>1-512-506-7095</td>
</tr>
<tr>
<td>7</td>
<td>Brady, Round Rock, and Waco</td>
<td>Andrea Daniell</td>
<td>1-512-506-7600</td>
</tr>
<tr>
<td>8</td>
<td>Austin</td>
<td>Will McGowan</td>
<td>1-512-506-3526</td>
</tr>
<tr>
<td>9</td>
<td>Kerrville and San Antonio*</td>
<td>Mary Regalado-Poole</td>
<td>1-512-506-3422</td>
</tr>
<tr>
<td>10</td>
<td>Corpus Christi, San Antonio*, and Victoria</td>
<td>Jill Ray</td>
<td>1-512-506-3554</td>
</tr>
<tr>
<td>11</td>
<td>Cleburne, Denton, and Fort Worth</td>
<td>Rita Martinez</td>
<td>1-512-506-7990</td>
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<td>12</td>
<td>Corsicana, Dallas*, and Groesbeck</td>
<td>Sandra Peterson</td>
<td>1-512-506-3552</td>
</tr>
<tr>
<td>13</td>
<td>Dallas* and Whitesboro</td>
<td>Olga Fletcher</td>
<td>1-512-506-3578</td>
</tr>
<tr>
<td>14</td>
<td>Paris, Texarkana, and Tyler</td>
<td>Trilby Foster</td>
<td>1-512-506-7053</td>
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<tr>
<td>15</td>
<td>Beaumont and Lufkin</td>
<td>Gene Alred</td>
<td>1-512-506-3425</td>
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<tr>
<td>16</td>
<td>Bryan/College Station, Conroe, and Houston*</td>
<td>Linda Wood</td>
<td>1-512-506-7682</td>
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<td>17</td>
<td>Katy, Houston*, and Wharton</td>
<td>Rachelle Moore</td>
<td>1-512-506-3447</td>
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<td>18</td>
<td>Galveston and Matagorda</td>
<td>John Miller</td>
<td>1-512-506-3586</td>
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<tr>
<td>19</td>
<td>Austin, Houston*, and Waller</td>
<td>Stephen Hirschfelder</td>
<td>1-512-506-3446</td>
</tr>
</tbody>
</table>

* Dallas, Houston, and San Antonio territories are shared by two or more provider representatives. These territories are divided by ZIP codes. Refer to the TMHP website at www.tmhp.com for the assigned representative to contact in each ZIP code.
TMHP Needs Your NPI

Update Your NPI Information on the TMHP Website

The NPI final rule, Federal Register Title 45 Code of Federal Regulations (CFR) Part 162, establishes the NPI as the standard unique identifier for health care providers to be used in HIPAA-covered transactions. Use of the NPI in these transactions is federally-mandated to be effective by May 23, 2007.

NPI numbers are issued to providers by the National Plan and Provider Enumeration System (NPPES). Providers must inform payers of their assigned NPI for the purpose of processing HIPAA-covered transactions. Refer to the Centers for Medicare & Medicaid Services (CMS) website at www.cms.hhs.gov/NationalProvIdentStand for additional information.

All providers must notify TMHP of their NPIs before submitting claims for reimbursement.

In preparation for the federal deadline of May 23, 2007, TMHP is creating a webpage on the TMHP website at www.tmhp.com that will enable providers to report their NPI. Monitor future banner messages for the exact date of availability. Providers will be prompted on the webpage to supply their NPI and related data and attest to the accuracy of the data. By May 23, 2007, providers with assigned Texas Provider Identifiers (TPIs) must have attested to a corresponding NPI in order to submit claims for payment.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.

Helpful Hints for Using the TMHP Website

The TMHP website at www.tmhp.com was designed to streamline providers’ participation in the CSHCN Services Program. Through the website, providers can submit claims and appeals, download provider manuals and bulletins, verify client eligibility, view Remittance and Status (R&S) reports, and stay informed of current news and updates. Current news remains on the TMHP website homepage for ten business days and is then moved to the News Archive (available from the News Archive link on the left-hand side of the main page).

Some providers may find it easier to search the TMHP website using the site's Search function rather than navigating through the news and archive sections. To use the Search feature, providers must type the desired keywords into the Search box located in the upper right-hand corner of the homepage and click the green arrow or press Enter. To improve search results, providers can use logical operators (or, and, and not) or enclose search phrases in quotation marks. When phrases are enclosed in quotation marks, the search feature returns only those pages containing the exact phrase, rather than returning the pages containing one or more of the words in the phrase.

In addition to the website’s search feature, providers can use popular search engines, such as Google™, to easily find information applicable to their provider type. To use Google™ to search only the TMHP website, follow these steps:

1. In an Internet browser (e.g., Internet Explorer, Firefox), go to www.google.com.
2. In the search box, type site:www.tmhp.com followed by the keyword(s) to search for (see Example 1 on the following page).

Google™ displays a list of all the pages on the TMHP website that contain the keyword(s).

Providers can use Google’s advanced search (available by clicking on the Advanced Search link) to filter their
results by date, language, and file format. For example, providers can choose to display only those pages updated within the past three months (see Example 2, below). Providers can also exclude certain words or phrases from their results or specify where on the page the desired term should appear (for example, in the title of the page or in the body of the page).

Using these helpful hints, providers can find the information they need to stay informed.

For more information, call the TMHP-CShCN Contact Center at 1-800-568-2413, or contact the area provider relations representative for assistance. A list of provider relations representatives is available on the TMHP website at www.tmhp.com under Regional Support and also on page 9 of this bulletin.

Example 1. Use Google™ to search only the TMHP website.

Example 2. Using Google’s advanced search, providers can narrow their search results to easily find the information they need.
RSV Prophylaxis Policy Update

RSV prior authorization requirements have changed for clients with heart disease.

Prior authorization requirements for benefits for Respiratory Syncytial Virus (RSV) prophylaxis have been modified for clients of the CSHCN Services Program with heart disease. There is now a distinction between cyanotic and acyanotic congenital heart disease.

Palivizumab may be prior authorized for CSHCN beneficiaries younger than 24 months of age who have hemodynamically significant cyanotic congenital heart disease.

Palivizumab may be prior authorized for CSHCN beneficiaries younger than 24 months of age who have acyanotic congenital heart disease when the documentation submitted demonstrates:

- The presence of moderate to severe pulmonary hypertension; or,
- Active treatment for hemodynamically significant acyanotic heart disease within the six months preceding the start of the RSV season (i.e., treatment dates between April 1 and September 30) consisting of digitalis, diuretics, or supplemental oxygen; and,
- An International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code consistent with hemodynamically significant congenital heart disease to include:
  - Congenital anatomical cardiac defects, or
  - Cardiomyopathies of any etiology (see cardiac diagnoses, below)

The prior authorization requirements for clients with lung disease have not changed, and are shown in the table below.

The following table lists the most common lung disease diagnosis codes:

*Palivizumab may be prior authorized for other respiratory diagnoses with supportive documentation of medical necessity.

Refer to the November 2006 issue of the CSHCN Provider Bulletin for more information about RSV prophylaxis, including the diagnostic requirements for prior authorization that have not been modified.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.

Additional RSV Information

For surveillance information about RSV, call the DSHS Infectious Disease Control Unit at 458-7455. This number was previously published incorrectly on page 3 of the November/December 2006 Texas Medicaid Bulletin, No. 199, in an article titled “RSV Prophylaxis Benefits Change.”
Correction to Rotavirus and Tdap Vaccine Benefit Update

This is a correction to an article published on the TMHP website at www.tmhp.com on October 6, 2006, titled “CSHCN Providers-Rotavirus and Tdap Vaccine Benefit Update.” The article contained information about benefit changes for Rotavirus and the combined tetanus, diphtheria, and pertussis (Tdap) vaccines. The article included incorrect dates of service for the Tdap vaccine. The following is the complete, corrected article.

Effective December 1, 2006, for dates of service on or after February 21, 2006, the Rotavirus vaccine is a benefit of the CSHCN Services Program when administered according to the Advisory Committee on Immunization Practices (ACIP) recommendations.

Effective December 1, 2006, for dates of service on or after June 30, 2005, the combined tetanus, diphtheria and pertussis (Tdap) vaccine is a benefit of the CSHCN Services Program when administered according to ACIP recommendations.

Providers must submit claims for these vaccines when they are obtained from the Texas Vaccine for Children (TVFC) Program using the applicable procedure code (1-90680 or 1-90715) in addition to the related immunization administration procedure code. The CSHCN Services Program can only reimburse the administration fee for a vaccine obtained from the TVFC Program.

Procedure codes 1-90715 or 1-90860 may be reimbursed when one of the following conditions is met and the state-identified modifier U4 is billed with the vaccine toxoid:

- A provider who is not enrolled in the TVFC Program has purchased the vaccine
- The client does not meet the TVFC criteria
- TVFC resolutions do not match the ACIP’s general usage recommendations
- The provider purchases an ACIP-recommended vaccine that is not distributed by TVFC

Rotavirus vaccine was made available to enrolled TVFC providers on June 6, 2006. Claims with dates of service on or after June 6, 2006, are considered for reimbursement using modifier U4 if the vaccine was not obtained from the TVFC Program.

Tdap vaccine was made available to enrolled TVFC providers on December 21, 2005. Claims for dates of service on or after December 21, 2005, are considered for reimbursement when submitted using modifier U4 if the vaccine was not obtained from the TVFC Program.

The reimbursement fee for procedure code 1-90680 is $55.94 for dates of service between February 21, 2006, and June 5, 2006, (no modifier needed). The reimbursement fee for this procedure code is $55.94 for dates of service on or after June 6, 2006, if submitted with the U4 modifier.

The reimbursement fee for procedure code 1-90715 is $29.54 for dates of service between June 30, 2005, and December 20, 2005 (no modifier needed). The reimbursement fee for this procedure code is $29.54 for dates of service on or after December 21, 2005, if submitted with the U4 modifier.

Effective September 14, 2006, for dates of service on or after February 21, 2006, procedure code 1-90680 will process as informational-only for family nurse practitioner, pediatric nurse practitioner, physician and physician group, and hospital providers. These providers are eligible for a $5 administration fee for services performed in the office, home, or outpatient hospital setting.

Following implementation of the fee for 1-90680 on December 1, 2006, claims with dates of service on or after February 21, 2006, that include procedure code 1-90680 will be reprocessed and payments adjusted accordingly. Providers do not need to take any action in this process.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.
New Service Benefits

Skin Therapy Benefits
Effective December 1, 2006, for dates of service on or after December 1, 2003, diagnosis code 70901 (Vitiligo) is payable for procedure codes 2-96920, 2-96921, and 2-96922.

Claims submitted for dates of service on or after December 1, 2003, that include procedure codes 2-96920, 2-96921, and 2-96922 billed with diagnosis 70901 will be reprocessed and payments adjusted accordingly. No action on the part of the provider is necessary.

Ablate Heart Dysrhythm Focus Update
Effective December 21, 2006, for dates of service on or after January 1, 2004, procedure code 2-93651 is a benefit of the CSHCN Services Program when performed in an outpatient setting for the following provider types:

- Physician and physician group
- Radiological lab
- Physiological lab

Effective January 1, 2005, procedure code 2-93651 is a benefit for advance practice nurses.

Claims submitted for dates of service on or after January 1, 2004, that include procedure code 2-93651 will be reprocessed and payments adjusted accordingly. No action on the part of the provider is necessary.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.

2006 HCPCS Third Quarter Update

On October 18, 2006, TMHP implemented third quarter 2006 Healthcare Common Procedure Coding System (HCPCS) additions, changes, and deletions effective for dates of service on or after October 1, 2006. Deleted procedure codes are no longer considered for reimbursement by the CSHCN Services Program after September 30, 2006.

Claims submitted with HCPCS additions for dates of service on or after October 1, 2006, through October 17, 2006, were denied. To receive reimbursement, providers must appeal claims that were denied.

CSHCN Services Program Additions Table
The following is a complete list of procedure codes implemented for the CSHCN Services Program effective October 1, 2006:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Allowable</th>
</tr>
</thead>
<tbody>
<tr>
<td>L-K0738</td>
<td>MR</td>
</tr>
<tr>
<td>2-S2325</td>
<td>21.25 RVUs</td>
</tr>
<tr>
<td>8-S2325</td>
<td>3.40 RVUs</td>
</tr>
<tr>
<td>F-S2325</td>
<td>Group 3</td>
</tr>
<tr>
<td>1-S0147</td>
<td>NC</td>
</tr>
</tbody>
</table>

Note: Procedure code L-K0738 is manually reviewed. Authorization is required for the CSHCN Services Program.

Procedure Code Description Changes
The description for procedure code 1-S0316 has changed. Contact the appropriate copyright holder to obtain the procedure code description.

Power Operated Vehicles – CMS Update
On November 15, 2006, CMS released a list of procedure codes to be used for power operated vehicles (POVs), effective November 15, 2006. TMHP published additional information about the POV codes on the TMHP website at www.tmhp.com on November 20, 2006.

Details of the third quarter changes are available on the TMHP website at www.tmhp.com and were published in the 2007 HCPCS Special Bulletin, No. 200.

Billing with Modifiers 76 and 91
Modifier 91 was added as a new modifier with the 2000 HCPCS implementation and is used to indicate repeated clinical diagnostic laboratory tests. Since modifier 76 can also indicate a repeated procedure, providers should use modifier 91 when billing for repeated clinical diagnostic laboratory tests and modifier 76 when billing for repeated nonclinical laboratory tests.
2007 HCPCS Implementation

On January 1, 2007, TMHP implemented the annual HCPCS additions, changes, and deletions effective for dates of service on or after January 1, 2007. Deleted procedure codes are no longer a benefit of the CSHCN Services Program for dates of service after December 31, 2006.

Details of the affected changes to provider procedures were published in the 2007 HCPCS Special Bulletin, No. 200, which became available December 29, 2006, on the TMHP website at www.tmhp.com. Providers will be mailed a printed copy of the bulletin in February 2007.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.

DME Reminder

Services and Products Must Be Delivered to CSHCN Clients Prior to Claim Submission

Providers must complete, sign, and have the client or client’s representative sign a Documentation of Receipt for Durable Medical Equipment (DME) for all purchased DME before submitting a claim for payment. The Documentation of Receipt for Durable Medical Equipment (DME) can be found on page 23 of this bulletin and is available in the 2007 CSHCN Services Program Provider Manual Part I as well. The client’s signature indicates that the DME is the property of the client.

The form also requires the name of the DME and the date on which the client received it. The date of service that should appear on the claim is the date of delivery shown on the form. The DME supplier should retain this form and not submit it with the claim.

Providers must maintain a copy of this form in their files for the life of the piece of equipment or until the equipment is authorized for replacement.

CSHCN Services Require Authorization

Effective December 19, 2006, for dates of service on or after August 6, 2001, the following procedure codes require authorization for the CSHCN Services Program:

| Procedure Codes |
|-----------------|-----------------|-----------------|-----------------|
| 1-97012         | 1-97014         | 1-97016         | 1-97018         |
| 1-97020         | 1-97022         | 1-97024         | 1-97026         |
| 1-97028         | 1-97032         | 1-97033         | 1-97034         |
| 1-97035         | 1-97039         | 1-97110         | 1-97112         |
| 1-97113         | 1-97116         | 1-97124         | 1-97139         |
| 1-97140         | 1-97150         | 1-97504*        | 1-97520*        |
| 1-97530         | 1-97542         | 1-97703*        | 1-97750         |
| 1-97799         | 1-92507         |

*This code was discontinued effective January 1, 2006.

Claims submitted for dates of service on or after August 6, 2001, that contain the above procedure codes will not be reprocessed.

Effective December 19, 2006, for dates of service on or after January 1, 2006, procedure code 1-92508 requires authorization. Claims submitted for dates of service on or after January 1, 2006, that contain this procedure code will not be reprocessed.

Effective December 19, 2006, for dates of service on or after October 16, 2003, procedure code 1-97535 requires authorization. Claims submitted for dates of service on or after October 16, 2003, that contain this procedure code will not be reprocessed. No action on the part of the provider is required.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.
Pharmacological Management Benefits Revised

Effective for dates of service on or after October 31, 2006, outpatient behavioral health benefits have changed.

Procedure Code 1-M0064
Procedure code 1-M0064 indicates the client is stable but pharmacologic regimen oversight is necessary.

Pharmacologic regimen oversight, which is a brief office visit for the sole purpose of monitoring or changing prescriptions, refers to a lesser level of drug monitoring, such as monitoring, making simple dosage adjustments, or changing prescriptions, when the client is evaluated during a face-to-face visit and treated in the office setting.

Procedure Code 1-90862
Procedure code 1-90862 indicates pharmacological management. Procedure code 1-90862 is not intended to refer to a brief evaluation of the client’s state, simple dosage adjustment, or long-term medication.

Pharmacological management refers to the in-depth management of psychopharmacological agents, which are medications with serious side effects, and represents a skilled aspect of patient care for a client who has been determined to be mentally or physically unstable. Pharmacological management is intended for use for clients who are being managed primarily by psychoactive medications, antidepressants, or other types of psychopharmacologic medications.

Pharmacological management must be provided during a face-to-face visit with the client and any psychotherapy must be less than 20 minutes.

The focus of a pharmacological management visit is the use of medication for relief of the client’s signs and symptoms of mental illness. When the client continues to experience signs and symptoms of mental illness that necessitate discussion beyond minimal psychotherapy in a given day, the focus of the service is broader and is considered psychotherapy rather than pharmacological management.

Procedure codes 1-90862 and 1-M0064 describe a physician service and cannot be delegated to a nonphysician or ‘incident to’ a physician’s service. If APNs, whose scope of license permits them to prescribe, perform the service, APNs may use these codes. The service must only be billed when the physician or APN actually performs the service.

The CSHCN Services Program does not reimburse for procedure code 1-90862 or 1-M0064 for actual administration of medication or for observation of client taking an oral medication. The administration and provision of oral medications are noncovered services.

Documentation Requirements
All documentation must support that the service was reasonable and medically necessary for the billed diagnosis.

Documentation of medical necessity for pharmacological management (procedure code 1-90862) must address all of the following information in the client’s medical record in legible format:

- Date
- Diagnosis
- Medication history
- Current symptoms and signs that include presenting mental status or physical symptoms that indicate the client requires a medication adjustment (current presenting mental status or physical signs that indicate the client is in an unstable state of mind or body)
- Problems, reactions, and side effects, if any, to medications
- Description of optional minimal psychotherapeutic intervention (less than 20 minutes), if any
- Any medication modifications
- The reasons for medication adjustments, changes, or continuation
- Desired therapeutic drug levels, if applicable
- Current laboratory values, if applicable
- Anticipated physical and behavioral outcome(s)
Documentation of medical necessity for a brief office visit for the sole purpose of monitoring or changing prescriptions (procedure code 1-M0064) must address all of the following information in the client’s medical record:

- The client is evaluated and determined to be stable but continues to have a psychiatric diagnosis that requires close monitoring of therapeutic drug levels or the client requires evaluation for prescription renewal, a new psychiatric medication, or a minor medication dosage adjustment.
- The provider has documented the medication history in the client’s records with current signs and symptoms and new medication modifications with anticipated outcome.

Billing
Pharmacological management is limited to one service per day per client by any provider, in any setting. Procedure code 1-M0064 is limited to the office setting.

Procedure code 1-M0064, when billed with procedure code 1-90862 on the same date of service, is denied. Procedure codes 1-M0064 and 1-90862 are denied as part of any evaluation and management (E/M) service when billed on the same date of service by the same provider.

Procedure codes 1-M0064 and 1-90862 are denied as part of any psychotherapy service when billed for the same date of service by the same provider.

Limitations for procedure code 1-M0064 or 1-90862 may be appealed with documentation supporting medical necessity.

Pharmacological management procedure codes 1-90862 and 1-M0064 do not count against the 30-encounter annual limitation for outpatient behavioral health services.

Procedure code 1-90862 is no longer a payable in an independent laboratory.

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.

Claims Processing Updates and Errata

ASC/HASC Fee Schedule Update
TMHP has identified an error in the current Ambulatory Surgery Center/Hospital Ambulatory Surgical Center (ASC/HASC) Fee Schedule located on the TMHP website at www.tmhp.com. Procedure code F-41899 with modifier EP was incorrectly listed with a group rate of 5. The correct group rate for this procedure code is group 4. The fee schedule on the website has been corrected. Claims submitted for procedure code F-41899 with modifier EP were correctly processed with group 4 pricing. No action on the part of the provider is necessary.

CLIA Waived Test Modifier QW
The following is a correction to a banner message that first appeared on the August 11, 2006, R&S report about the Clinical Laboratory Improvement Amendment (CLIA) waived test QW modifier. The banner message incorrectly listed the effective date as September 26, 2006. The corrected effective date is October 5, 2006. The following is the complete, corrected message.

Effective October 5, 2006, for dates of service on or after June 1, 2004, the CLIA waived test QW modifier has been added to procedure codes 5-83880, 5-84450, 5-85576, and 5-86701.

Claims submitted for dates of service from June 1, 2004, through October 5, 2006, that include the modifier QW have been reprocessed and payments adjusted accordingly. No action on the part of the provider is necessary.

Filing Deadline Update for Surgical Procedure Code 36833
The following is a correction to a bulletin article that appeared in the August 2006 CSHCN Provider Bulletin, No. 59, titled “Surgical Procedure Code 36833,” located on page 9. The bulletin article should have indicated an appeal

See “Updates” on page 22
Physician-administered drugs and biologicals are reimbursed by the CSHCN Services Program as access-based fees under the Medicaid Physician Fee Schedule in accordance with Title 1 Texas Administrative Code (TAC) §355.8085. Physicians and other providers are reimbursed for physician-administered drugs and biologicals at the lesser of the usual and customary or billed charges and the Medicaid fee established by HHSC. The Medicaid fee is an estimate of the provider's acquisition cost for the specific drug or biological. This reimbursement methodology does not apply to blood factor product used in the treatment of hemophilia and related coagulation disorders.

The following guidelines are used in fee payment decisions for physician-administered drugs and biologicals on or after October 1, 2006:

- Vaccines and infusion drugs furnished through an item of implanted durable medical equipment (DME) are based on the lesser of documented provider acquisition/invoice cost (if available) or 89.5 percent of the average wholesale price (AWP).

- Certain, specific drugs studied by the OIG and the General Accounting Office (GAO) are based on the lesser of documented provider acquisition/invoice cost (if available) or the recommended percentages of AWP resulting from those studies (Table 1 in §20 of Chapter 17 of the Medicare Claims Processing Manual, Pub. 100-04).

- The remaining drugs and biologicals not listed after the first two bullets above that are covered by Medicare, are based on the lesser of documented provider acquisition/invoice cost (if available) or 106 percent of average sales price (ASP).

- Those remaining drugs and biologicals not listed after the first two bullets above that are not covered by Medicare, are based on the lesser of documented provider acquisition/invoice cost, or one of the following:
  - 89.5 percent of AWP if the drug or biological is considered a new drug or biological (i.e., approved for marketing by the Food and Drug Administration within 12 months of implementation as a benefit of the Texas Medicaid and CSHCN Services Programs).
  - 85.0 percent of AWP if the drug or biological does not meet the above definition of a new drug.

HHSC reserves the option to use other data sources to determine Medicaid and CSHCN Services Program fees for drugs and biologicals when AWP or ASP calculations are determined to be unreasonable or insufficient.

Payments for drugs and biologicals are excluded from the 2.5 percent Medicaid payment reduction.

Outpatient prescriptions are covered under the Vendor Drug Program (VDP). The reimbursement methodology for pharmacy services is located at 1 TAC §§355.8541–355.8551. Effective October 13, 2003, the dispensing fee was reduced by 2.5 percent (1 TAC §355.8551).

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.
Therapeutic Dental Procedures Changing for CSHCN Providers

This is a correction to the article published on the TMHP website at www.tmhp.com on October 6, 2006, about changes to the therapeutic dental policy for the CSHCN Services Program. The article incorrectly stated that the following procedure codes were a benefit of the CSHCN Services Program: D2712, D2799, D3221, D4220, D5867, D5875, D6982, D7412, D7415, D7473, D7482, D7490, D7671, and D9970. The following is the complete, corrected article.

Effective for dates of service on or after December 1, 2006, the following changes for therapeutic dental benefits have been implemented.

Procedure code D2971 is a benefit for clients 13 years of age and older. No additional limitations apply to this procedure code.

Procedure code D7283 is a benefit for clients 1 year of age and older with a maximum fee of $25.00. This procedure code does not require prior authorization.

Procedure code D9242 is a benefit and may be reimbursed in addition to procedure code D9241 for conscious sedation services. Procedure code D9242 is limited to two hospital calls or sedation procedures per rolling year, any provider.

Procedure code D2920 may be eligible for reimbursement to the same provider who applied the original crown cementation.

Reimbursement for procedure code D3110 is allowed when billed with the following procedure codes for the same tooth, on the same day, by the same provider:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Procedure Codes</th>
<th>Procedure Codes</th>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>D2150</td>
<td>D2160</td>
<td>D2161</td>
</tr>
<tr>
<td>D2330</td>
<td>D2331</td>
<td>D2332</td>
<td>D2335</td>
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<td>D2390</td>
<td>D2391</td>
<td>D2392</td>
<td>D2393</td>
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<td>D2510</td>
<td>D2520</td>
<td>D2530</td>
<td>D2542</td>
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<tr>
<td>D2543</td>
<td>D2544</td>
<td>D2610</td>
<td>D2620</td>
</tr>
</tbody>
</table>

Procedure code D3110 is denied when billed with procedure code D2952, D2953, D2954, D2955, D2957, D2980, D2999, D3220, D3221, D3230, D3240, D3310, D3320, or D3330 for the same tooth, on the same day, by the same provider.

Procedure code D3120 is denied when billed with procedure code D3220, D3221, D3230, D3240, D3310, D3320, or D3330 for the same tooth, on the same day, by the same provider.

Procedure code D3220 may be reimbursed within the six months preceding a root canal or retreatment of a root canal (procedure codes D3310, D3320, D3330, D3346, D3347, or D3348).

Procedure code D3410, D3421, D3425, or D3426, performed after a root canal or retreatment of a previous root canal, may be reimbursed separately.

Pre- and post-operative photographs are required for procedure code D4210, D4211, D4270, D4271, D4273, D4275, D4276, D4355, or D4910 and must be maintained by the dentist in the client’s record.

Pre- and post-operative photographs are required for procedure code D4240, D4241, D4245, D4266, or D4267 when medical necessity is not evident on the radiograph.
Procedure codes D4266 and D4267 have specific criteria for medical necessity as specified on the following page:

- Medical necessity for *third molar* sites includes but is not limited to:
  - Medical or dental history documenting need due to inadequate healing of bone following third molar extraction, including date of third molar extraction
  - Secondary procedure several months post-extraction
  - Position of the third molar pre-operatively
  - Post-extraction probing depths to document continuing bony defect
  - Post-extraction radiographs documenting continuing bony defect
  - Bone graft and barrier material used
- Medical necessity for *other than third molar* sites includes but is not limited to:
  - Medical or dental history documenting co-morbid condition, e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injury(ies)
  - Intra- and/or extra-oral radiographs of treatment site(s)
  - Intraoral photographs, if not evident radiographically. Intraoral photographs would be optional unless requested preoperatively by HHSC and/or its agent
  - Periodontal probing depths
  - Number of intact walls associated with an angular bony defect
  - Bone graft and barrier material used

Procedure code D4341 is denied if billed within 21 days of procedure code D4355.

Procedure code D4341, D4342, or D4355 is denied if billed for the same date of service with any of the following procedure codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1210</td>
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<tr>
<td>D1220</td>
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<tr>
<td>D1201</td>
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<td>D1203</td>
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<td>D1205</td>
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<td>D1351</td>
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<td>D1510</td>
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<td>D1525</td>
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<tr>
<td>D4210</td>
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<tr>
<td>D4211</td>
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<tr>
<td>D4240</td>
</tr>
<tr>
<td>D4241</td>
</tr>
<tr>
<td>D4245</td>
</tr>
</tbody>
</table>

Procedure code D4910 is eligible for reimbursement only if any of the following procedure codes have been billed within 90 days prior to procedure code D4910: D4240, D4241, D4260, D4261, or by evidence through patient records of periodontal therapy while the client was not eligible for the CSHCN Services Program.

Procedure code D5670 is denied as part of procedure code D5211, D5213, D5281, or D5640. Procedure code D5671 is denied as part of procedure code D5212, D5214, D5281, or D5640.

The following procedure codes are not considered medically necessary:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6058</td>
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<tr>
<td>D6059</td>
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<td>D6060</td>
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<tr>
<td>D6061</td>
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<tr>
<td>D6079</td>
</tr>
<tr>
<td>D6094</td>
</tr>
<tr>
<td>D6194</td>
</tr>
</tbody>
</table>

Documentation of only one virgin abutment tooth and the need of at least one tooth requiring a crown are not needed to support medical necessity for a Maryland bridge.

Procedure code D7280 no longer requires prior authorization. The maximum fee for procedure code D7280 is reduced to $62.50.

Procedure code D9910 is limited to once per year.

The facility reimbursement for dental rehabilitation and restoration services, billed under procedure code F-41899, has changed to an access-based fee of $630.00 (based on Medicare group 4 pricing).

Individual and group dental providers (county indigent health care providers, prosthetsists, orthotists, federally
qualified health centers, and Texas Health Steps providers) are not reimbursed by the CSHCN Services Program for therapeutic dental procedure codes.

Procedure code D5212 is denied as part of a mandibular reline and rebase but may be considered for separate reimbursement from a maxillary reline and rebase.

Additionally, the following age restriction changes are effective for dates of service on or after December 1, 2006:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Current Age Limitation (In years)</th>
<th>New Age Limitation (In years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5952</td>
<td>0–20</td>
<td>0–12</td>
</tr>
<tr>
<td>D5951, D5954, D5958, D5959, D5960, D7460, and D7461</td>
<td>0–20</td>
<td>None</td>
</tr>
<tr>
<td>D2794 and D5955</td>
<td>0–20</td>
<td>13 and older</td>
</tr>
<tr>
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<td>1–20</td>
<td>1 and older</td>
</tr>
<tr>
<td>D2920, D2930, D2932, D2999, D3110, D3120, D3220, D3230, D3240, D3910, D3999, D4320, D4321, D5730, D5928, D5929, D5931, D5934, D5935, D5936, D5986, D7241, D7250, D7272, D7280, D7320, D7340, D7350, D7899, D7972, D9920, and D9950</td>
<td>1–20</td>
<td>1 and older</td>
</tr>
<tr>
<td>D7471</td>
<td>13–20</td>
<td>None</td>
</tr>
<tr>
<td>D7140, D7261, D7411, D7413, D7414, D7440, D7441, D7450, D7451, and D7472</td>
<td>1 and older</td>
<td>None</td>
</tr>
<tr>
<td>D7111</td>
<td>1 and older</td>
<td>16 and older</td>
</tr>
<tr>
<td>D2140, D2150, D2160, D2161, D2330, D2331, D2520, D2530, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D5899, D9951, and D9952</td>
<td>1–20</td>
<td>13 and older</td>
</tr>
<tr>
<td>D4381, D5953, D4210, D4211, D4240, D4249, D4260, D4266, D4267, D4270, D4271, D4341, D4355, D4381, and D4999</td>
<td>13–20</td>
<td>13 and older</td>
</tr>
<tr>
<td>D6548, D6781, D6782, D6783, D6976, and D6977</td>
<td>13 and older</td>
<td>16 and older</td>
</tr>
<tr>
<td>D2953 and D2955</td>
<td>4–20</td>
<td>4 and older</td>
</tr>
<tr>
<td>D3920 and D3950</td>
<td>4–20</td>
<td>6 and older</td>
</tr>
<tr>
<td>D2410, D2420, D2430, D2510, D2910, D2952, D2954, D2960, D2961, D2962, D2971, D2980, and D5862</td>
<td>4–20</td>
<td>13 and older</td>
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<tr>
<td>D6056 and D6057</td>
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<td>16 and older</td>
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<td>D3460, D6010, D6040, D6050, D6055, D6080, D6090, D6095, D6100, D6199, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6790, D6791, D6792, D6920, D6930, D6940, D6950, D6970, D6971, D6972, D6973, D6975, D6980, and D6999</td>
<td>16–20</td>
<td>16 and older</td>
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<tr>
<td>D2915</td>
<td>None</td>
<td>6 and older</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Current Age Limitation (In years)</td>
<td>New Age Limitation (In years)</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>D2934 and D7283</td>
<td>None</td>
<td>1 and older</td>
</tr>
<tr>
<td>D5110, D5120, D5410, D5411, D5510, D5810, D5811, D5850, and D5851</td>
<td>3–20</td>
<td>1 and older</td>
</tr>
<tr>
<td>D5710, D5711, D5731, D5750, D5751, D7291, and D7310</td>
<td>4–20</td>
<td>1 and older</td>
</tr>
<tr>
<td>D7282</td>
<td>4 and older</td>
<td>1 and older</td>
</tr>
<tr>
<td>D4910 and D4920</td>
<td>6–20</td>
<td>13 and older</td>
</tr>
<tr>
<td>D5140, D5520, D5820, and D5821</td>
<td>3–20</td>
<td>6 and older</td>
</tr>
<tr>
<td>D5130 and D5610</td>
<td>3–20</td>
<td>3 and older</td>
</tr>
<tr>
<td>D2931</td>
<td>1–20</td>
<td>6 and older</td>
</tr>
<tr>
<td>D2950, D2951, D3310, D3320, D3330, D3346, D3347, D3348, D3351, D3352, D3353, D3410, D3421, D3425, D3426, D3430, D3450, D3470, D3920, D3950, D5860, and D5861</td>
<td>4–20</td>
<td>6 and older</td>
</tr>
<tr>
<td>D5211, D5212, D5421, D5422, D5620, D5630, D5640, D5650, and D5660</td>
<td>6–20</td>
<td>6 and older</td>
</tr>
<tr>
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<td>7–20</td>
<td>6 and older</td>
</tr>
<tr>
<td>D5213, D5214, and D5281</td>
<td>9–20</td>
<td>6 and older</td>
</tr>
</tbody>
</table>

For more information, call the TMHP-CSHCN Contact Center at 1-800-568-2413.

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**Updates** *(Continued from page 17)*

Deadline of 120 days instead of 180 days. The following is the complete, corrected article.

Effective for dates of service on or after March 1, 1999, procedure code 2/8/F-36833 is a benefit of the CSHCN Services Program with an allowable relative value unit (RVU) of 17.76 and an ASC/HASC group rate of 4.

To be considered for payment, providers must appeal claims with procedure code 2/8/F-36833 that were denied as not a benefit prior to the 120-day appeal deadline.

**Immune Globulin Services Incorrectly Denied for Multiple Dosages**

TMHP has identified an issue impacting claims that included immune globulin procedure codes 1-J1567 and 1-J1566 submitted for dates of service on or after January 1, 2006, for the CSHCN Services Program. These claims may have been improperly denied when billed with multiple dosages.

Claims submitted for dates of service on or after January 1, 2006, that include these procedure codes and that received improper denials will be reprocessed and payments adjusted accordingly. No action on the part of the provider is required.

**Hylan Injections Claims Reprocessed**

TMHP has identified an issue impacting claims that include procedure code 1-J7320 for the CSHCN Services Program. Although procedure code 1-J7320 was added as a benefit with the 2006 HCPCS implementation effective for dates of service on and after January 1, 2006, the procedure code has been denied as a discontinued code.

Claims submitted for dates of service from January 1, 2006, through November 30, 2006, that include procedure code 1-J7320 will be reprocessed and payments adjusted accordingly. No action on the part of the provider is necessary.
# Documentation of Receipt for Durable Medical Equipment (DME)

This form must be kept in the client’s file for ALL Durable Medical Equipment, Orthotics and Prosthetics, and Prescription Shoes. **DO NOT SUBMIT THIS FORM WITH YOUR CLAIM.**

For help completing this form, call the TMHP-CSHCN Contact Center at 1-800-568-2413.

*Please print or type requested information below.*

## Client Information:

<table>
<thead>
<tr>
<th>First name:</th>
<th>Last name:</th>
<th>CSHCN number: 9-_________00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth:</td>
<td>Diagnosis (ICD-9-CM):</td>
<td></td>
</tr>
<tr>
<td>Address/City/ZIP:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Equipment Information:

<table>
<thead>
<tr>
<th>Item</th>
<th>Number Received</th>
<th>Description (Include Model Number for DME)</th>
<th>Manufacturer’s Serial Number (for DME only)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

## Certification:

I certify that on ____________ (mm/dd/yyyy):
- The client received the equipment as prescribed by the physician.
- The equipment has been properly fitted to the client and/or meets the client’s needs.
- The client, the parent or guardian of the client, and/or the primary caregiver of the client has received training and instruction regarding the proper use and maintenance of the equipment.

Print or type Receiver’s name:

Signature of client, parent or client representative: Date:

Print or type Supplier/Provider name:

Signature of DME Supplier/Provider: Date:

---

**THE RECEIVING PARTY AND DME SUPPLIER MUST SIGN AND DATE THIS FORM AT THE TIME THE EQUIPMENT IS ACTUALLY RECEIVED/DELIVERED.**

Refer to the *CSHCN Provider Manual–Part I* for instructions on completing this form.
Electronic Funds Transfer (EFT) Information

Electronic Funds Transfer (EFT) is a payment method to deposit funds for claims approved for payment directly into a provider’s bank account. These funds can be credited to either checking or savings accounts, provided the bank selected accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, ensuring funds are directly deposited into a specified account.

The following items are specific to EFT:

- Pre-notification to your bank takes place on the cycle following the application processing.
- Future deposits are received electronically after pre-notification.
- The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider’s account during the weekly cycle.
- Specific deposits and associated R&S reports are cross-referenced by both Texas Provider Identifier (TPI) and R&S number.
- EFT funds are released by TMHP to depository financial institutions each Friday.
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Please contact your financial institution regarding posting time if funds are not available on the release date.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer’s withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn should work out the best way to serve their customer’s needs.

In all cases, credits received should be posted to the customer’s account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. You must return a voided check or deposit slip with the agreement to the TMHP address indicated on the form.

Call the TMHP Contact Center at 1–800–925–9126 for assistance.
Electronic Funds Transfer (EFT) Authorization Agreement
*Enter ONE Texas Provider Identifier (TPI) per Form*

**NOTE:** Complete all sections below and attach a voided check or a photocopy of your deposit slip.

<table>
<thead>
<tr>
<th>Type of Authorization:</th>
<th>☐ NEW</th>
<th>☐ CHANGE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Nine–Character Billing TPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Accounting Address</td>
<td>Provider Phone Number</td>
</tr>
<tr>
<td>( ) ext.</td>
<td></td>
</tr>
<tr>
<td>Bank Name</td>
<td>ABA/Transit Number</td>
</tr>
<tr>
<td>Bank Phone Number</td>
<td>Account Number</td>
</tr>
<tr>
<td>Bank Address</td>
<td>Type Account (check one)</td>
</tr>
<tr>
<td>( )</td>
<td>Checking</td>
</tr>
</tbody>
</table>

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its health insuring contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

---

Authorized Signature | Date
---|---
Title | Email Address (if applicable)
Contact Name | Phone

**Return this form to:**
Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin TX 78720–0795

---

**DO NOT WRITE IN THIS AREA — For Office Use**
Input By: | Input Date:
## Provider Information Change Form

Traditional Medicaid, Children with Special Health Care Needs (CSHCN), and Primary Care Case Management (PCCM) providers can complete and submit this form to update their provider enrollment file. Print or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address at the bottom of the page.

### Check the box to indicate a PCCM Provider

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
</table>

### 9-digit Texas Provider Identifier (TPI):

<table>
<thead>
<tr>
<th>Provider Name:</th>
</tr>
</thead>
</table>

### List any additional TPIs that use the same provider information:

<table>
<thead>
<tr>
<th>TPI:</th>
<th>TPI:</th>
<th>TPI:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TPI:</th>
<th>TPI:</th>
<th>TPI:</th>
</tr>
</thead>
</table>

### Physical Address*  

<table>
<thead>
<tr>
<th>Accounting/Mailing Address**</th>
<th>Secondary Address</th>
</tr>
</thead>
</table>

### City:  

<table>
<thead>
<tr>
<th>City:</th>
</tr>
</thead>
</table>

### State:  

<table>
<thead>
<tr>
<th>ZIP:</th>
</tr>
</thead>
</table>

### Phone:  

<table>
<thead>
<tr>
<th>Phone:</th>
</tr>
</thead>
</table>

### Fax:  

<table>
<thead>
<tr>
<th>Fax:</th>
</tr>
</thead>
</table>

### Email:  

<table>
<thead>
<tr>
<th>Email:</th>
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</thead>
</table>

### Type of Change: (Check the appropriate box below.)

- Change of physical address, telephone, and/or fax number
- Change of billing/mailing address, telephone, and/or fax number
- Change/Add secondary address, telephone, and/or fax number
- Change of provider status (e.g., termination from plan, moved out of area, specialist)
  
  *Explain in the Comments field*

- Other (e.g., panel closing, capacity changes, and age acceptance)

### Comments:

Enter comments here.

### Tax Information—Tax Identification (ID) Number and Name for the Internal Revenue Service (IRS)

<table>
<thead>
<tr>
<th>Tax ID Number:</th>
<th>Effective Date:</th>
</tr>
</thead>
</table>

### Exact name reported to the IRS for this Tax ID:

Enter name here.

### The signature and date are required or the form will not be processed.

<table>
<thead>
<tr>
<th>Provider Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Mail or fax the completed form to:

| Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment  
| PO Box 200795  
| Austin, TX 78720-0795 |

| Fax: 1-512-514-4214 |

### Notes:

- The physical address cannot be a PO Box. Traditional Medicaid providers who change their ZIP code must submit a copy of the Medicare letter along with this form.

**All providers who make changes to the Accounting/Mailing address must submit a copy of the W-9 Form along with this form.**