

# Provider Enrollment and Responsibilities

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## 2.1 Provider Enrollment

Providers of medical services must be currently enrolled as a Texas Medicaid provider as a prerequisite to becoming a CSHCN Services Program provider. This requirement is waived for providers of certain program services such as family support providers and medical foods. For information about Texas Medicaid enrollment requirements, or to complete an online enrollment, visit the TMHP website at [www.tmhp.com](http://www.tmhp.com). Providers can call the TMHP Contact Center at 1-800-925-9126 for additional information, or for help with completing the application.

**Refer to:** Section 5.1.2, “Claims Processed by the Department of State Health Services (DSHS)-CSHCN Services Program,” on page 5-3.

Section 24.2, “Medical Foods,” on page 24-2.

Chapter 34, “Transportation of Deceased Clients,” on page 34-1.

The National Provider Identifier (NPI) final rule, Federal Register 45, Code of Federal Regulations (CFR) Part 162, established the NPI as the standard unique identifier for health-care providers and requires covered health-care providers, clearinghouses, and health plans to use this identifier in Health Insurance Portability and Accountability Act (HIPAA)-covered transactions. An NPI is a 10-digit number assigned randomly by the National Plan and Provider Enumeration System (NPPES). An NPI number is required on all enrollment applications.

TMHP verifies NPIs with NPPES to ensure that the NPI is active. If the NPI is shown by NPPES to be inactive, TMHP will notify the provider by letter. The provider will be allowed a 60-day grace period to contact NPPES and resolve their NPI status. If the inactive NPI has not been reinstated within the 60-day grace period, TMHP will disenroll all TPIs associated with the inactive NPI.

To enroll in the CSHCN Services Program, a provider of medical care or services must complete the required CSHCN Services Program Provider Enrollment Application and enter into a written Provider Agreement with the CSHCN Services Program. These forms are supplied by TMHP Provider Enrollment for providers submitting claims to TMHP. Forms are available for download from the TMHP website at [www.tmhp.com](http://www.tmhp.com).

Providers may also enroll in the CSHCN Services Program online. A link to the provider enrollment application is provided on the TMHP website homepage at [www.tmhp.com](http://www.tmhp.com) and on the CSHCN Services Program website at [www.dshs.state.tx.us/cshcn/providers/](http://www.dshs.state.tx.us/cshcn/providers/).

Online enrollment has the following advantages:

- Applications are validated immediately to ensure that all fields have been completed.
- Most of the application can be completed online so that only a few forms need to be printed, completed, and mailed to TMHP. Forms that must be mailed are identified in the online application.
- Applicants can view incomplete and complete applications that have been submitted online.
- Some form fields are automatically completed, reducing the amount of information that has to be entered.
- Providers can complete the Provider Information Change (PIC) form online.
- Providers will receive e-mail notifications when messages or deficiency notices about their applications are posted online. Providers may opt out of e-mail communication and receive messages or deficiency letters by mail.

If not completed online, the enrollment application and other completed forms must be sent to TMHP Provider Enrollment at the following address:

Texas Medicaid & Healthcare Partnership  
Attn: Provider Enrollment  
PO Box 200795  
Austin, TX 78720-0795  
Fax: 1-512-514-4214

For assistance with the application process or to obtain enrollment forms, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413, which is available Monday through Friday, from 7 a.m. to 7 p.m., Central Time.

A CSHCN Services Program provider identifier is issued when all required forms and documentation have been received and the application process is completed. A provider *cannot* be enrolled if his or her license is due to expire within 30 days of the date of application. TMHP verifies license information provided with the enrollment. The provider identifier is a unique number assigned to each provider.

The provider's enrollment effective date will be 6 months before the date the enrollment application is received for all providers or the traditional Medicaid enrollment effective date, whichever is more current.

**Exception:** For dentists who are also requesting enrollment in a cleft/craniofacial team, the effective date is the approval date of the CSHCN Services Program Enrollment Approval Form.

### 2.1.1 Changes in Enrollment

When one of the following changes, a new enrollment application must be completed and submitted to the address above so that a new provider identifier can be assigned:

- Ownership—The new owner must take the following actions:
  - Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
  - Complete the CSHCN Services Program 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 listing of all of the provider identifiers affected by the change of ownership.
- Providers who join a new group or enroll as an individual must complete and submit a CSHCN Services Program Provider Enrollment Application to request enrollment in the new group or as an individual provider.

**Note:** Providers leaving group practices must send a signed letter to TMHP that states the date of termination within 10 days of 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 of the group or the individual provider leaving the group, and mailed to TMHP at the address shown above. Failure to provide this information may lead to administrative action by the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS)

- Physical address—If the new address is not within the same Medicare locality and Medicare has issued a new Medicare number, the provider must complete and submit a CSHCN Services Program Provider Enrollment Application in order to enroll the new location.
- Provider type—Providers must submit a separate CSHCN Services Program Provider Enrollment Application for each provider type enrollment requested. For example, a hospital may want to enroll as an ambulatory surgical center. A second application to enroll in the CSHCN Services Program as an ambulatory surgical center would be required.

New enrollment applications may be completed online or mailed to the address shown above.

### 2.1.2 Claim Filing

Potential new providers must follow all claims filing procedures while completing the enrollment process. This is particularly important when providing services to CSHCN Services Program clients before receiving a provider identifier.

Claims should be submitted without a provider identifier until notified by TMHP of the final enrollment determination. TMHP must receive all claims for CSHCN services within the required filing deadlines, regardless of enrollment status. Claims filed while waiting to receive a provider identifier are denied; however, having met the claim filing deadline, a provider can *resubmit* or *appeal* the claims for payment after the CSHCN Services Program provider identifier is assigned. The resubmitted claim may be considered for payment if TMHP receives it within 120 days from the date of the denial and it is on or after the provider enrollment effective date.

When a provider renders services to a CSHCN Services Program client before receiving a provider identifier and has questions about this requirement or enrollment, the provider may call the TMHP- CSHCN Services Program Contact Center at 1-800-568-2413.

**Refer to:** Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1.

### 2.1.3 Provider Enrollment Determinations

The CSHCN Services Program may approve a provider's application or deny, modify, suspend, or terminate a provider's approval to participate for the reasons listed in the *Texas Administrative Code* (TAC), CSHCN Services Program Rules 25§38.6(b)(1) through (2) at [www.sos.state.tx.us/tac](http://www.sos.state.tx.us/tac). Before taking action to deny, modify, suspend, or terminate the approval of a provider, the CSHCN Services Program shall give the provider written notice of an opportunity to request an administrative review of the proposed action within 30 days of the notice. If the provider does not respond in writing within the 30-day period, the provider is presumed to have waived the administrative review as well as access to a fair hearing, and the CSHCN Services Program's action is final. If the provider so requests, the CSHCN Services Program will conduct an administrative review of the circumstances on which the proposed denial, modification, suspension, or termination of provider program participation is based and give the provider written notice of the program decision and the supporting reasons within 10 days of receipt of the request for administrative review.

In addition, a fair hearing is available to any provider for the resolution of conflict between the CSHCN Services Program and the provider if the fair hearing is requested within 20 days of receipt of the administrative review decision.

**Refer to:** Chapter 7, "Appeals and Administrative Review," on page 7-1.

Providers excluded by Medicaid will be excluded by the CSHCN Services Program.

Descriptions of required enrollment forms are provided in the following sections. Forms are available on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

### 2.1.4 Provider Enrollment Application

The Provider Enrollment Application must be signed by the person who is applying for enrollment. If applying as a group, the application must be signed by an owner, officer, director, or principal. If the provider is unable to sign, a letter showing Power of Attorney must be attached to the Provider Enrollment Application.

#### 2.1.4.1 Types of Providers

There are four types of enrollment for providers in the CSHCN Services Program, as follows:

- *Individual.* This type of enrollment applies to an individual health-care professional who is licensed or certified in Texas, and who is seeking enrollment under the name, and social security or tax identification number of the individual.
- *Group.* This type of enrollment applies to health-care items or services provided under the auspices of a legal entity, such as a partnership, corporation, limited liability company, or professional association, where the individuals providing health-care items or services are required to be certified or licensed in Texas. The enrollment is under the name and tax identification number of the legal entity.

**Note:** For any group enrollment application, there must also be at least one enrolling performing provider.

- *Performing provider.* This type of enrollment applies to an individual health-care professional who is licensed or certified in Texas, and who is seeking enrollment under a group. The enrollment is under the tax identification number of the group, and payment is made to the group.
- *Facility.* This type of enrollment applies to situations in which licensure or certification applies to the entity. Although individuals working for, or with, the entity may be licensed or certified in their individual capacity, the enrollment is based on the licensure or certification of the entity. For this reason, facility enrollment does not require enrollment of performing providers. Examples of facilities include hospitals, independent diagnostic testing facilities, ambulatory surgical centers, renal dialysis facilities, and hospices.

#### 2.1.4.2 Provider Information Form (PIF-1), Principal Information Form (PIF-2), and Disclosure of Ownership Form

A PIF-1, PIF-2, and Disclosure of Ownership form must be completed by all providers or the owner, officer, director, or principal applying for CSHCN Services Program enrollment more than 1 year from their Texas Medicaid enrollment date. The Disclosure of Ownership form is submitted by all providers, excluding the performing providers of a group. This form provides the appropriate information to enroll the provider as a sole proprietor, corporation, partnership, or nonprofit organization. The PIF-1 must be

completed by all providers enrolling in the CSHCN Services Program. A separate PIF-2 must be completed by each principal of the provider before enrollment in the CSHCN Services Program. Principals of the provider include all of the following:

- An owner with a direct or indirect ownership or control interest of five percent or more.
- Corporate officers and directors
- Limited or nonlimited partners
- Shareholders of a professional corporation, professional association, limited liability company, or other legally designated entity.
- Any employee of the provider who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity.

These forms were designed across multiple state agencies to help meet the requirements set forth by the 75th Legislature's Senate Bill (S.B.) 30 to enhance the enrollment requirements for potential providers, meet federal requirements for enrollment, and improve the integrity of Texas State healthcare programs.

#### **2.1.4.3 Provider Agreement**

To participate in the CSHCN Services Program, all providers must complete a Provider Agreement with DSHS. The Provider Agreement must be signed by the provider applying for enrollment. By signing the Provider Agreement, the provider agrees to abide by CSHCN Services Program rules, policies, and procedures as a condition for participation. This form is included in the enrollment application.

#### **2.1.4.4 Request for Taxpayer Identification Number and Certification**

Federal Executive Orders 12549 and 12689 require HHSC to screen each potential provider to determine whether each has a right to obtain a contract in accordance with federal regulations on debarment, suspension, ineligibility, and voluntary exclusion. Each provider must also screen each of its providers who supply services to clients of Medicaid or other State healthcare programs. This form is required for all applicants.

The Internal Revenue Service (IRS) W-9 form is completed and submitted by all providers, excluding performing providers of a group.

#### **2.1.4.5 Provider's License**

Evidence of current licensure or certification is required to participate in the CSHCN Services Program. Not abiding by this license and certification update requirement may impact a provider's qualification for continued participation in the CSHCN Services Program.

An enrolling provider submits professional license information in Section A of the enrollment form. A copy of the license does not need to be sent with the enrollment application. TMHP verifies this information with the appropriate licensing board. Once enrolled in the CSHCN Services Program, a reminder letter will be automatically generated and sent to providers whose license will expire in 60 days.

A provider cannot be enrolled if his or her license is due to expire within 30 days of the date of application.

TMHP receives licensure information from the following licensing boards:

- Texas Medical Board
- Texas State Board of Dental Examiners
- Texas State Board of Examiners of Psychologists
- Texas Board of Nursing
- Texas State Board of Podiatric Medical Examiners

When the license is renewed, providers licensed by the boards listed above will not need to contact TMHP with renewal information. Providers that are licensed by a board not listed above must submit updated licensure and certification as it is renewed. Documentation should be sent to the address listed in Section 2.1, "Provider Enrollment," on page 2-2.

### 2.1.5 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

The CSHCN Services Program does not currently enroll FQHCs or RHCs as facilities. Providers at an FQHC or RHC must enroll as a physician group or a dental group. Physician groups may include physicians, advanced practice nurses, podiatrists, optometrists, behavioral health-care providers, and others. Dental groups may include dentists, orthodontists, and oral maxillofacial surgeons.

FQHCs and RHCs must be enrolled as a physician group, or a dental group in Texas Medicaid before they are eligible to enroll as a CSHCN Services Program provider.

### 2.1.6 Cleft/Craniofacial (C/C) Specialty Teams

Providers enrolled in the CSHCN Services Program who perform cleft/craniofacial procedures must also be members of a designated C/C specialty team. Providers enrolling as a member of a specialty team must provide additional information with their application.

**Refer to:** Section 22.1.2, “Specialty Team or Center,” on page 22-3.

**Note:** *Anesthesiologists and assistant surgeons are not required to be a member of a C/C specialty team. However, when a procedure is denied by the CSHCN Services Program because the primary surgeon is not a specialty team member, assistant surgeon claims are also denied. An anesthesiologist may be paid if the claim is resubmitted on appeal and all filing deadlines are met.*

#### 2.1.6.1 Requirements for Cleft/Craniofacial (C/C) Team Enrollment

A C/C team must include at least the following participants:

- Plastic surgeon or oral surgeon
- Otolaryngologist
- Primary care physician
- Orthodontist or a pediatric dentist
- Master's level licensed speech language pathologist
- Client educator
- Designated C/C team care coordinator who also may be one of the previously listed participants
- Administrator

Adjunct participants may be added as determined by the C/C team to meet the needs of individual clients.

C/C teams will ensure that each client has a C/C team care coordinator to assure that the focus of the service is client and family-oriented, and that the client/family and the C/C team jointly develop a comprehensive treatment plan.

The administrator is responsible for coordinating and maintaining C/C team records and assuring that the C/C team adheres to CSHCN Services Program rules and regulations.

C/C teams must complete the required information and attestation on the Required Information for Designation as a Team Member or Affiliated Provider of a CSHCN Services Program Comprehensive Cleft/Craniofacial Team form. Contact information, including address, telephone number, and e-mail address, must be included for the team administrator. This form is found on the CSHCN Services Program Provider web page at [www.tmhp.com](http://www.tmhp.com).

When changes occur to team membership, C/C teams must provide TMHP with updated information in a timely manner or at least every 2 years.

To facilitate statewide coverage, the CSHCN Services Program also may designate affiliated providers. Affiliated providers must be linked with a CSHCN Services Program-designated comprehensive team and must ensure coordination of client management as needed. At the time of application, affiliated providers must specify the comprehensive C/C team with which they are affiliated.

TMHP's provider enrollment staff maintains the most current list of C/C team providers with their associated teams. Contact TMHP-CSHCN Services Program Provider Enrollment at 1-800-568-2413 for additional information.

**Refer to:** Section 29.2.35.12, “Cleft/Craniofacial Procedures,” on page 29-104.

### 2.1.7 Transplant Specialty Centers

Facilities enrolled in the CSHCN Services Program that perform bone marrow, stem cell, or kidney transplants must also be a designated specialty transplant center. A facility that will be performing these transplants must provide additional information with their application.

A stem cell transplant facility must complete the “Required Information for Enrollment as a CSHCN Services Program Stem Cell Transplant Facility” form which can be found on the TMHP website at [www.tmhp.com](http://www.tmhp.com).

A bone marrow or stem cell transplant center must be compliant with all of the criteria specified in the most current "Guidelines for Clinical Centers" on the American Society for Blood and Marrow Transplantation (ASBMT) website at [www.asbmt.org/policystat/policy\\_op.html](http://www.asbmt.org/policystat/policy_op.html). For more information concerning requirements and approval for a stem cell transplant center, contact TMHP-CSHCN Services Program Provider Enrollment at 1-800-568-2413.

Renal transplants will only be considered for reimbursement when performed in a Medicaid-approved transplant center. For more information about how to obtain Medicaid approval as a transplant center, contact TMHP at 1-800-925-9126. The Centers for Medicare & Medicaid Services (CMS) maintains the list of certified and approved Texas transplant facilities on the CMS website at [www.cms.hhs.gov/ApprovedTransplantCenters](http://www.cms.hhs.gov/ApprovedTransplantCenters).

### 2.1.8 Out-of-State Providers

Out-of-state providers located in New Mexico, Oklahoma, Arkansas, or Louisiana and are within 50 miles of the Texas state border may be enrolled in the CSHCN Services Program.

Requests for medical services provided by an out-of-state provider more than 50 miles from the Texas state border must be submitted to TMHP at the address provided in Section 2.1, “Provider Enrollment,” on page 2-2.

For clients who would otherwise experience financial hardship or be subject to clear medical risk, the CSHCN Services Program may cover services that are within the scope of the program and provided by health-care providers in these areas.

All program policies and procedures apply, including the requirement that all providers be CSHCN Services Program participating providers. The limitations of this policy do not apply to coverage for or payment to CSHCN Services Program providers of selected products or devices including medical foods or hearing amplification devices, which are either always less costly or are only available from out-of-state sources.

**Refer to:** Section 3.1.4, “Services Provided Outside of Texas,” on page 3-3.

Section 5.1.5, “Claims Filing Deadlines,” on page 5-4.

### 2.1.9 Substitute Physician

TMHP may make payments to a physician for CSHCN Services Program-covered services that are provided by another physician who is acting as his or her substitute. Such a substitution arrangement may be either an informal reciprocal arrangement of 14 days or fewer, or a long-term arrangement (up to 90 days) involving per diem or fee-for-time compensation.

Substitute physicians are not required to enroll with the CSHCN Services Program.

### 2.1.10 Providers of Family Support Services

Providers of Family Support Services (e.g., respite care, home and vehicle modification) are enrolled and reimbursed by the DSHS-CSHCN Services Program instead of by TMHP. Enrollment applications are available on the CSHCN Services Program website at [www.dshs.state.tx.us/cshcn](http://www.dshs.state.tx.us/cshcn). Mail completed enrollment applications to:

CSHCN Services Program—Provider Enrollment  
Purchased Health Services Unit, MC-1938  
Texas Department of State Health Services  
PO Box 149347  
Austin, TX 78714-9347  
Fax: 1-800-441-5133  
or 1-512-458-7238

## 2.2 Provider Complaints Process

The CSHCN Services Program takes each provider complaint seriously. Depending on the level and nature of the complaint, the CSHCN Services Program works with the provider to resolve the issue.

The CSHCN Services Program provides due process for resolving all provider complaints. A complaint is defined as any dissatisfaction expressed by telephone or in writing by a provider, or on behalf of a provider, concerning the CSHCN Services Program. The definition of complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the provider's satisfaction. The definition also does not include a provider's oral or written dissatisfaction with an adverse determination or appeals regarding claim payments and denials.

Procedures governing the provider complaint process are designed to identify and resolve provider complaints in a timely and satisfactory manner. Most complaints are resolved within 30 calendar days. If the complaint cannot be resolved within 30 calendar days, the provider is notified in writing of the status of the complaint. Referrals to other departments, such as Provider Relations or Medical Affairs, are made when appropriate.

The TMHP Complaints Resolution Department handles all provider complaints for the CSHCN Services Program. Providers may submit their complaints by telephone, mail, or fax. Providers will receive an acknowledgement letter from TMHP within 5 business days of receipt of the complaint.

Complaints to TMHP may be submitted by using the following methods:

- By telephone to 1-800-568-2413
- By fax to 1-888-235-8399
- In writing to:

TMHP  
Complaints Resolution Department  
PO Box 204270  
Austin, TX 78720-4270

Questions regarding the complaint process or the status of a complaint should be directed to the TMHP- CSHCN Services Program Contact Center at 1-800-568-2413.

Providers who believe they did not receive due process regarding the complaint from TMHP may file a complaint with DSHS. Providers are encouraged to use the appeals process with TMHP before filing a complaint with DSHS.

Complaints to DSHS may be submitted using the following methods:

- By fax to 1-800-441-5133 or 1-512-458-7417
- In writing to:

CSHCN Services Program  
ATTN: Complaints  
Purchased Health Services Unit, MC-1938  
Texas Department of State Health Services  
PO Box 149347  
Austin, TX 78714-9347

## 2.3 Provider Responsibilities

**Important:** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in 25 TAC, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371. TAC rules can be found at [www.sos.state.tx.us/tac](http://www.sos.state.tx.us/tac).

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1617(a)(6)(A) for Medicaid providers, which also applies to CSHCN Services Program providers

as set forth in 25 TAC §38.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to, at all times, deliver health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

### 2.3.1 Information Change Requests

Providers must promptly advise TMHP Provider Enrollment of address changes (office or accounting), name changes, and tax identification number changes. Change information may be communicated in writing to TMHP on the “Provider Information Change Form,” which is available in Appendix B, “Forms,” on page B-129 and on the TMHP website. A W-9 is required if the provider is changing the mailing or accounting address by written communication sent to TMHP.

**Refer to:** “Instructions for Completing the Provider Information Change Form” on page B-128.

### 2.3.2 General Medical Record Documentation Requirements

TMHP routinely performs a retrospective review of all providers. This review may include comparing services billed to the client’s clinical record. The following requirements are general requirements for all providers. Any mandatory requirement not present in the client’s medical record subjects the associated services to recoupment.

**Note:** *This list is not all-inclusive. Additional and more specific requirements may apply to special services areas.*

Requirement	Mandatory/ Desirable
All entries are legible to individuals other than the author, dated (month, day, and year), and signed by the performing provider.	Mandatory
Each page of the medical record documents the client’s name and CSHCN Services Program client identification number.	Mandatory
Allergies and adverse reactions (including immunization reactions) are prominently noted in the record.	Mandatory
The selection of evaluation and management codes (levels of service) is supported by the client’s clinical record documentation. The American Medical Association’s (AMA’s) Current Procedural Terminology (CPT) descriptors of key/contributory components with level of service descriptions are used to evaluate the selection of levels of service.	Mandatory
Necessary follow-up visits specify the time of return by at least the week or month.	Mandatory
The history and physical documents the presenting complaint with appropriate subjective and objective information, e.g., medical and surgical history, current medications and supplements, family history, social history, diet, pertinent physical examination measurements and findings, etc.	Mandatory
The services provided are clearly documented in the medical record with all pertinent information regarding the client’s condition to substantiate the need for the services.	Mandatory
Medically necessary diagnostic lab and X-ray results are included in the medical record, and abnormal findings include an explicit notation of follow-up plans.	Mandatory
Unresolved problems are noted in the record.	Mandatory
Immunizations are noted in the record as complete or up-to-date.	Mandatory
Personal data includes the parent, guardian, or caretaker’s address, employer, home and work telephone numbers, sex, marital status, and emergency contacts.	Desirable

### 2.3.3 Retention of Records

The provider must maintain and retain all necessary records and claims to fully document the services and supplies provided to a client, for full disclosure to the CSHCN Services Program or its designee. These records and claims must be retained for a period of 5 years from the date of service, until the client's 21st birthday, or until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever occurs last.

Upon request, these records must be made available promptly to TMHP and representatives of the Office of Inspector General (OIG), HHSC, or DSHS. Upon request, the provider must submit copies of such records, at no cost, to representatives of these organizations.

If the provider places the required information in records that are in the custody of another legal entity, such as a hospital, the provider is responsible for obtaining a copy of such records at no cost, for use by TMHP or DSHS, as requested by one of these entities, during any investigation or study of the appropriateness of the claims submitted by the provider.

### 2.3.4 Utilization Review: General Provisions

Utilization review activities required by the CSHCN Services Program are accomplished through a series of monitoring systems developed to ensure that services are necessary and of the optimum quality and quantity. Both clients and providers are subject to utilization review monitoring. Utilization review procedures safeguard against unnecessary care and services, monitor quality, and ensure that payments are appropriate according to the payment standards defined by the CSHCN Services Program.

One goal of utilization review is to identify the provider whose practice patterns are not consistent with the CSHCN Services Program requirements and the scope of benefits.

Educating the provider is the principal approach to resolution of inappropriate use. This education must include either a provider representative visit or letter to assist with the technical aspects of the program or a physician visit, telephone call, or letter to explain program guidelines relative to medical necessity, intensity of service, and the appropriateness of the service. The purpose of the letter or the visit is to discuss the inappropriate practices so that the provider may institute measures to remedy the problem.

Depending on the intensity of the identified problem, the letter or visit may result in review of claims before payment. Medical staff develops parameters for prepayment review according to the identified problem. The purpose of the review is to provide additional information enabling the provider to understand the scope of benefits by correlating billing practices and medical policy as billing occurs. As part of the prepayment review process, providers may be required to submit documentation. The documentation is used to ascertain the medical necessity of the services rendered. Prepayment review occurs for a minimum of 6 months. Services not consistent with medical policy are adjudicated in accordance with the established policies.

Recoupment of excess payments for intensity of service not supported by the medical documentation may occur at any phase in the review process.

A provider is removed from prepayment review after achieving compliance with the established medical policy. A follow-up review is performed to monitor continued appropriate utilization of resources.

When the provider is consistently noncompliant with policies, the provider history is provided to the CSHCN Services Program for possible administrative sanctions.

### 2.3.5 Release of Confidential Information

The *Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations* are intended to protect individually identifiable health information by restricting disclosure of protected health information (PHI).

Information concerning the diagnosis, evaluation, or treatment of a client by a person licensed or certified to perform the diagnosis, evaluation, or treatment of any medical disorder is normally confidential information that the provider must disclose only to authorized persons. The client's signature is not required on the claim form for payment of a claim; however, TMHP strongly recommends that the provider obtain written authorization from the client before releasing confidential medical information. The client's authorization for release of such information is not required when the release is requested by and made to the DSHS-CSHCN Services Program or TMHP.

### 2.3.6 Waste, Abuse, and Fraud

HHSC is responsible for minimizing the opportunity for provider fraud and abuse. HHSC takes appropriate action to protect clients and the CSHCN Services Program when providers of services are suspected of committing waste, abuse, and fraud. HHSC is responsible for establishing criteria to identify cases of possible waste, abuse, and fraud and recouping all overpayments to a provider. Some circumstances may result in referring a provider for legal evaluation and possible prosecution while other circumstances may result in administrative sanctions.

Providers are responsible for the delivery of health-care items and services to CSHCN Services Program clients in full accordance with all applicable licensure and certification requirements, and in full accordance with accepted medical community standards and standards that govern occupations. Such standards include, without limitation, those related to medical record and claims filing practices, documentation requirements, and records maintenance. The requirement to follow all such standards in the CSHCN Services Program is incorporated by reference to the program's requirements, in 1 TAC section 371.1617(a)(6)(A).

Accepted medical community standards and standards that govern occupations include standards for coding and billing. CSHCN Services Program providers must follow the coding and billing requirements in the *CSHCN Services Program Provider Manual*. However, if coding and billing requirements for the particular service are not addressed in the provider manual, and if coding and billing requirements are not otherwise specified in program policy (such as in the provider bulletins or banner messages), then providers must follow the most current coding guidelines. These include the following:

- Current Procedural Terminology (CPT) as set forth in the American Medical Association's (AMA) most recently published CPT books, *CPT Assistant* monthly newsletters, and other publications resulting from the collaborative efforts of the AMA with medical societies.
- Healthcare Common Procedure Coding System (HCPCS) as developed and maintained by the federal government.
- National Correct Coding Initiative (NCCI), as set forth by CMS, and as explained in the NCCI Policy and Medicare Claims Processing Manuals. NCCI consists of procedure code combinations (pairs of procedure codes) that a provider must not bill together. One of the codes in the pair is considered a part of the primary procedure and not reimbursable to the same provider on the same date of service.

**Exception:** *NCCI outlines the use of modifiers, some of which are not currently recognized by the CSHCN Services Program.*

**Refer to:** Section 5.6.2.6, "Modifiers," on page 5-20.

- Current Dental Terminology (CDT) as published by the American Dental Association (ADA).
- *International Classification of Diseases*, 9th Revision, Clinical Modification (ICD9- CM)
- *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR).

To the extent that the above authorities do not conflict with any specific requirement stated in CSHCN Services Program policy, the requirements of these authorities are incorporated by reference into CSHCN Services Program policy. Failure to comply with these authorities may result in a provider or person being found to have engaged in one or more program violations, as identified in this section and also set forth in 1 TAC, Chapter 371.

### 2.3.7 Provider Certification/Assignment

Providers of the CSHCN Services Program are required to certify compliance with, or agreement to, various provisions of state laws and regulations. Upon submitting a signed claim to the TMHP-CSHCN Services Program, the provider certifies that the following provisions were upheld:

- Services were personally rendered by the *billing provider* or under the personal supervision of the billing provider.

**Exception:** *As allowed under substitute physician and telemedicine services rulings.*

**Refer to:** Section 29.2.36, "Telemedicine Services," on page 29-113.

Section 29.3.1, "Substitute Physician," on page 29-138.

- The information contained on the claim form is true, accurate, and complete.
- All services, supplies, or items billed were medically necessary for the diagnosis or treatment of the client.

- Medical records document all services billed.
- All billed charges are usual and customary for the services provided. The charges must not be higher than the fees that are charged to private pay clients.
- Services were provided without regard to race, color, sex, national origin, age, disability, political beliefs, or religion.
- Before providing services, providers should always discuss with, and inform clients and their families of their liability for services not a benefit of the CSHCN Services Program.
- The provider of medical care and services files a claim with the CSHCN Services Program, agreeing to accept CSHCN Services Program reimbursement as payment in full for services that are a benefit of the CSHCN Services Program. The CSHCN Services Program client, or others on the client's behalf, must not be billed for amounts above the amount the CSHCN Services Program paid on allowed services, or for services denied or reduced as a result of errors made in claims filing, claims preparation, missed filing deadlines, or failure to follow the appropriate appeal process. The client may be billed for services that are not a CSHCN Services Program benefit.
- The provider understands that endorsing or depositing a CSHCN Services Program check is accepting money from state or federal funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under state or federal laws.

Payment for services is made on behalf of clients to the provider of the service by TMHP in accordance with the limitations and procedures of the program.

If the claim is prepared by a billing service or printed by data processing equipment physically removed from the provider's office, it is permissible to print "Signature on File" in place of the provider's signature. The billing service must obtain and retain a letter on file signed by the provider authorizing the submission of his or her claims. Providers delegating signatory authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment.

### **2.3.8 Billing Clients**

CSHCN Services Program clients, parents, or guardians of children eligible for CSHCN Services Program benefits must not be billed for CSHCN Services Program covered services. CSHCN Services Program providers must agree to accept the CSHCN Services Program allowed amount of payment (regardless of payer) as payment in full for covered services provide to CSHCN Services Program clients. Providers may collect allowable insurance or health maintenance organization co-payment, in accordance with those plan provisions.

CSHCN Services Program providers must agree to accept the CSHCN Services Program allowed amount of payment (regardless of payer) as payment in full for covered services provided to CSHCN Services Program clients. A provider must not require a down payment, bill, or take recourse against an eligible client for a denied or reduced claim for services that are within the amount, duration, and scope of benefits of the CSHCN Services Program when the action is the result of any of the following provider errors:

- Failure to submit a claim, including claims not received by TMHP.
- Failure to submit a complete authorization or prior authorization request, on a program-approved form, within the established deadlines.
- Failure to submit a claim within the 95-day filing deadline.
- Filing an incorrect claim.
- Failure to resubmit a corrected claim or to appeal a claim within the 120-day correction and resubmission period.
- Errors made in claims preparation, claims submission, or in the correction and resubmission (appeal) process.
- Failure to submit a request for Administrative Review to the DSHS-CSHCN Services Program within 30 days of the date of the resubmission (appeal) denial.

A provider attempting to bill or recover money from a client is in violation of the above conditions and may be subject to exclusion from the CSHCN Services Program.

A provider may bill the client for:

- Any service that is not a benefit of the CSHCN Services Program, such as obstetrical care.
- All services incurred on noncovered days due to eligibility or inpatient hospital or inpatient rehabilitation day-limitations. Total client liability must be determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered day.

Each provider must furnish services to eligible CSHCN Services Program clients in the same manner, to the same extent, and of the same quality as services provided to other clients. Services made available to other clients must be made available to CSHCN Services Program clients when the services are benefits of the CSHCN Services Program.

Clients must not be billed for the completion of a claim form, even when it is a provider's office policy to do so.

**Refer to:** Chapter 4, "Authorizations and Prior Authorizations," on page 4-1.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement," on page 5-1.

Chapter 7, "Appeals and Administrative Review," on page 7-1.

## 2.3.9 Texas Family Code Compliance

### 2.3.9.1 Child Support

The *Texas Family Code*, §231.006, places certain restrictions on child support obligors. *Texas Family Code* §231.006(d) requires a person who applies for, bids on, or contracts for state funds to submit a statement that the person is not delinquent in paying child support. This law applies to an individual whose business is a sole proprietorship, partnership, or corporation in which the individual has an ownership interest of at least 25 percent of the business entity. This law does not apply to contracts or agreements with governmental entities or nonprofit corporations.

The law also requires that payments be stopped when notified that the contractor or provider is more than 30 days delinquent in paying child support. CSHCN Services Program payments are placed on hold upon notification that a provider is delinquent in child support payments. A provider application may also be denied or a provider agreement terminated when the provider is delinquent in paying child support.

### 2.3.9.2 Abuse and Neglect Reporting Requirements

DSHS and the CSHCN Services Program expect providers to comply with the provisions of state law as set forth in Chapter 261, *Texas Family Code*, related to the reporting of child abuse and neglect.

**Note:** *A professional may not delegate to or rely on another person to make the report of abuse or neglect.*

### 2.3.10 Clinical Laboratory Improvement Amendments (CLIA) of 1988

To be eligible for reimbursement by the CSHCN Services Program, all providers performing laboratory tests must be CLIA certified.

**Refer to:** Section 23.1.1, "Clinical Laboratory Improvement Amendments (CLIA) of 1988," on page 23-2.

## 2.4 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

