

Provider Enrollment and Responsibilities

1.1	Provider Enrollment	1-3
1.1.1	TMHP Provider Enrollment	1-3
1.1.2	Provider Enrollment Application Determinations.	1-5
1.1.3	Enrollment in Medicaid Managed Care Programs	1-5
1.1.4	Required Enrollment Forms	1-6
1.1.4.1	Texas Medicaid Provider Enrollment Application	1-6
1.1.4.2	HHSC Medicaid Provider Agreement	1-6
1.1.4.3	Provider and Principal Information Forms.	1-6
1.1.4.4	Disclosure of Ownership and Control Interest Statement	1-6
1.1.4.5	Internal Revenue Service (IRS) W-9 Form.	1-7
1.1.4.6	Medicaid Audit Information Form.	1-7
1.1.4.7	Corporate Board of Directors Resolution	1-7
1.1.4.8	Certificate of Good Standing (Board Corporation Act, Article 2.45)	1-7
1.1.4.9	Certificate of Formation or Certificate of Filing/Certificate of Incorporation	1-7
1.1.4.10	Certificate of Authority	1-7
1.1.4.11	Copy of License/Temporary License/Certification	1-7
1.1.4.12	Licensure Renewal	1-7
1.1.4.13	Medicare Participation	1-8
1.1.4.14	Group Information Changes	1-8
1.2	Payment Information	1-8
1.2.1	Using EFT.	1-8
1.2.2	Advantages of EFT	1-8
1.2.3	EFT Enrollment Procedures	1-8
1.2.4	Stale-Dated Checks	1-9
1.3	Provider Reenrollment	1-9
1.4	Provider Responsibilities.	1-9
1.4.1	Compliance with Texas Family Code	1-9
1.4.1.1	Child Support	1-9
1.4.1.2	Reporting Child Abuse or Neglect	1-10
1.4.1.3	Procedures for Reporting Abuse or Neglect	1-10
1.4.1.4	Procedures for Reporting Suspected Sexual Abuse	1-10
1.4.1.5	Training	1-11
1.4.2	Maintenance of Provider Information	1-11
1.4.2.1	NPI Verification	1-11
1.4.2.2	Online Provider Lookup	1-11
1.4.3	Retention of Records and Access to Records and Premises.	1-12
1.4.3.1	Payment Error Rate Measurement (PERM) Process	1-13
1.4.4	Release of Confidential Information	1-13
1.4.5	Compliance with Federal Legislation.	1-13
1.4.6	Tamper-Resistant Prescription Pads	1-14
1.4.7	Utilization Control — General Provisions.	1-14
1.4.8	Provider Certification/Assignment	1-15
1.4.8.1	Delegation of Signature Authority	1-15

- 1.4.9 Billing Clients1-16
 - 1.4.9.1 Client Acknowledgment Statement1-16
- 1.4.10 General Medical Record Documentation Requirements1-17
- 1.4.11 Informing Pregnant Clients About CHIP Benefits1-18
- 1.5 Medicare/Medicaid Waste, Abuse, and Fraud Policy1-18
 - 1.5.1 Reporting Waste, Abuse, and Fraud.1-24
 - 1.5.2 Suspected Cases of Provider Waste, Abuse, and Fraud1-24
 - 1.5.3 Employee Education on False Claims Recovery1-25
- 1.6 Texas Medicaid Limitations and Exclusions1-25

1.1 Provider Enrollment

1.1.1 TMHP Provider Enrollment

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).

Initial Texas Medicaid fee-for-service enrollment and reenrollment can be completed online. This includes the Texas Health Steps (THSteps) program for both medical and dental providers and case management for Children and Pregnant Women (CPW). A link to the provider enrollment application is provided on the TMHP website homepage at www.tmhp.com.

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.
- Applicants can view both 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.

To be eligible for Texas Medicaid reimbursement, a provider of medical services (including an out-of-state provider) must:

- Meet all applicable eligibility criteria.
- Be approved by HHSC for enrollment.
- Obtain an NPI from NPPES.
- File with TMHP the required Texas Medicaid enrollment application ensuring that the application is correct, complete, and includes all required attachments and additional information.
- Meet all applicable criteria for eligibility to enroll (Refer to “Out-of-State Medicaid Providers” on page 2-5 for criteria specific to out-of-state providers).

- Provide any additional information requested by TMHP, HHSC, or the HHSC Office of Inspector General in connection with the processing of the application.
- Be approved by HHSC for enrollment and enter into a written provider agreement with HHSC

Enrolling online promotes accurate submissions, decreases processing time, and enables immediate feedback on the status of the application.

As an alternative to applying for enrollment online, a provider may file a paper enrollment application with TMHP. Providers may download the Texas Medicaid Provider Enrollment Application at www.tmhp.com or request a paper application form by contacting TMHP directly at 1-800-925-9126. A paper enrollment application may also be requested from the following address. Completed paper enrollment applications must also be submitted to the following address:

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

Note: During the Texas Medicaid enrollment process, with HHSC approval, the Claims Administrator may waive the mandatory prerequisite for Medicare enrollment for certain providers whose type of practice will never bill Medicare (e.g., pediatrics, obstetrician/gynecologist [OB/GYN]).

Providers must maintain a valid, current license or certification to be entitled to Texas Medicaid reimbursement. Providers cannot enroll in Texas Medicaid if their license or certification is due to expire within 30 days of application. A current license or certification must be submitted, if applicable.

Refer to: “Copy of License/Temporary License/Certification” on page 1-7.

A provider identifier is issued when a determination has been made that a provider qualifies for participation.

Refer to: “Out-of-State Medicaid Providers” on page 2-5 for additional criteria that must be met for out-of-state providers to enroll in Texas Medicaid.

There are four types of enrollment for providers in Texas Medicaid, 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. An individual may also enroll as an employee, using the tax identification number of the employer. Certain provider types must enroll as individuals, including the following: dietitians, licensed vocational nurses, occupational therapists, registered nurses, and speech therapists.
- *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, and 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. 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. If a health-care professional is required to enroll as an individual, as explained above, but the person is an employee and payment is to be made to the employer, the health-care professional does not enroll as a performing provider. Instead, the health-care professional enrolls as an individual provider under the tax identification number of their employer.
- *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. However, certain provider types must enroll as facilities, including the following:
 - Ambulance and air ambulance
 - Ambulatory surgical center (ASC) and hospital-based ambulatory surgical center (HASC)
 - Birthing center
 - Catheterization lab
 - Chemical dependency treatment facility (licensed by the Texas Commission on Alcohol and Drug Abuse)
 - Consumer Directed Services Agency
 - County Indigent Health Care Program
 - Community mental health center
 - Comprehensive health center
 - Comprehensive outpatient rehabilitation facility/outpatient rehabilitation facility
 - Department of Assistive and Rehabilitative Services Division for Blind Services
 - Durable medical equipment (DME)
 - Durable medical equipment home health
 - Early Childhood Intervention
 - Federally Qualified Health Center (FQHC) (may also enroll as a dental group)
 - Freestanding psychiatric facility
 - Freestanding rehabilitation facility
 - Home Health/Home and community support services agency
 - Hospital/critical access hospital/out-of-state hospital
 - Military hospital

- Hyperalimentation
- Independent diagnostic testing facility/physiological lab
- Indian Health Services
- Independent laboratory
- Maternity services clinic
- Mental health/mental retardation case management
- Mental health rehabilitation case management
- Mental retardation diagnostic services case management
- Milk bank donor
- Personal care services
- Pharmacy
- Portable X-ray
- Radiation treatment center
- Radiological laboratory
- Renal dialysis facility
- Rural health center (RHC) (may also enroll as a dental group)
- School health and related services (SHARS)/non-school SHARS
- Service responsibility option
- Skilled nursing facility
- Vision medical supplier
- Women, Infant and Children

Providers must submit a separate Texas Medicaid Provider Enrollment Application for each enrollment type requested. For example, a health-care professional who is already enrolled with Texas Medicaid as an individual with his or her own practice, and who wishes to bill for services provided in connection with a group, must submit a separate enrollment application and be approved as a performing provider with the group. Similarly, a health-care professional who is enrolled as a performing provider with one group, but who wishes to bill for services provided in connection with another group, must submit a separate enrollment application and be approved as a performing provider with the other group.

Note: A separate provider identifier is issued for each enrollment type that is approved. The provider is authorized to use the provider identifier only to bill for services provided as indicated in the approved enrollment application. It is a program violation for a provider to use a provider identifier for any purpose other than billing for the types of services, and under the type of enrollment, for which that provider identifier was issued. Improper use of a provider identifier constitutes program abuse and/or fraud.

Refer to: "Medicare/Medicaid Waste, Abuse, and Fraud Policy" on page 1-18 for additional information.

1.1.2 Provider Enrollment Application Determinations

An application for provider enrollment may be approved, approved with conditions, or denied. The provider applicant is issued a notice of the enrollment determination.

When an application for enrollment is approved, with conditions, the applicant has no right of appeal or administrative review of the enrollment determination. The types of conditional enrollment include, among other things:

- An application may be approved for time-limited enrollment, meaning the provider is granted a contract to participate in Medicaid for a specific period of time. In this case, the provider is sent a notice that includes the termination date of the contract. It is the provider's responsibility, if the provider chooses to seek continued Medicaid participation, to file a complete and correct reenrollment application before the termination date of the provider's current contract. It is recommended that the provider submit a reenrollment application at least 60 days before the current contract termination date, to ensure that the reenrollment application is complete and correct before the termination date. This may avoid a lapse between the provider's current contract and the new contract, if a new contract is granted.
- An application may be approved subject to restricted reimbursement, meaning the provider is eligible to have only certain types of claims paid. This includes, among other things, reimbursement of only Medicare crossover claims (i.e., claims with respect to "dual eligible" recipients who are covered by both Medicare and Medicaid).

An application may be denied, in which case a denial notice that explains the basis for denial is sent. The notice also explains the right to make a written request for an administrative review of the denial decision, and the procedures for filing such a request. Any administrative review request must be received within 20 days of the date on the letter and filed in accordance with the instructions provided in the denial notice. HHSC will conduct the administrative review and render a final enrollment determination. The HHSC determination following administrative review is not subject to further appeal or reconsideration.

Claims submitted by newly-enrolled providers must be received within 95 days of the date the new provider identifier is issued, and within 365 days of the date of service. Providers with a pending application should submit any claims that are nearing the 365-day deadline from the date of service. Claims will be rejected by TMHP until a provider identifier is issued. Providers can use the TMHP rejection report as proof of meeting the 365-day deadline and submit an appeal.

Refer to: "Copy of License/Temporary License/Certification" on page 1-7.

Note that all claims for services rendered to Texas Medicaid clients who do not have Medicare benefits are subject to a filing deadline from the date of service of:

- 95 days for in-state providers
- 365 days for out-of-state providers

TMHP cannot issue a prior authorization before Medicaid enrollment is complete. Upon notice of Medicaid enrollment, by way of issuance of a provider identifier, the provider must contact the appropriate TMHP Authorization Department before providing services that require a prior authorization number to Medicaid clients. Regular prior authorization procedures are followed after the TMHP Prior Authorization Department has been contacted. Retroactive authorizations will not be issued unless the regular authorization procedures for the requested services allow for authorizations to be obtained after services are provided. For these services, providers have 95 days from the add date to obtain authorization for services that have already been performed. Providers should refer to the specific manual section for details on authorization requirements, claims filing, and any timeframe guidelines for authorization request submissions.

Providers who have not been assigned a provider identifier and have general claim submission questions may refer to Section 5, "Claims Filing" for assistance with claim submission. If additional general information is needed, providers may call the TMHP Contact Center at 1-800-925-9126 to obtain information. Due to HIPAA privacy guidelines, specific client and claim information cannot be provided. Providers who have already been assigned a provider identifier and have questions about submitting claims, may call the same number and select the option to speak with a TMHP Contact Center representative.

1.1.3 Enrollment in Medicaid Managed Care Programs

A Texas Medicaid provider who wishes to become a primary care provider for Primary Care Case Management (PCCM) clients must be an approved provider, by having at least one active Texas Provider Identifier (TPI), before the provider is eligible to enroll with PCCM.

To be reimbursed for services provided to other Medicaid Managed Care clients, a provider must first be an approved provider by having at least one active provider identifier. Then, the provider must enroll with the health plan in which the provider's patients are enrolled. Such providers may also be eligible to enroll in Medicaid Managed Care health plans as primary care providers.

Refer to: "Medicaid Managed Care" on page 7-5 for more information about PCCM and Managed Care enrollment.

1.1.4 Required Enrollment Forms

The following sections provide information on the forms required to enroll in Texas Medicaid.

1.1.4.1 Texas Medicaid Provider Enrollment Application

The Texas Medicaid Provider Enrollment Application must be submitted by all providers who want to enroll in Texas Medicaid, and it must be signed by the person who is applying for enrollment. If the applicant is an entity, a Principal of the entity must sign the application.

Refer to the checklist in the Texas Medicaid Provider Enrollment Application. This checklist explains, by provider type, the documents and information that must be provided with the application. Applications must be complete in order to process and issue a provider identifier. Each application/applicant is considered separate and should not be combined.

Note: *If enrolled in Medicare, the provider must submit a copy of the Medicare enrollment letter to enroll in Texas Medicaid. Otherwise the enrollment application will be considered incomplete.*

Providers can call the TMHP Contact Center at 1-800-925-9126, Option 2, for help with completing the application. Providers should retain a copy of the original application for future reference.

All pages of the application must be present even if the forms are left blank because they are not pertinent to the provider's situation. Providers will be notified of incomplete applications and will have 30 business days to provide the requested missing information. If the information is not provided within 30 business days, TMHP will terminate the enrollment process. If the provider wants to enroll at a later date, the provider should contact TMHP to determine if a new enrollment application must be submitted. Providers are required to review their enrollment application for correctness and completeness before submitting it to TMHP.

By signing the Medicaid enrollment agreement, a provider is certifying that all information submitted in connection with the application for enrollment is complete and correct. Any false, misleading, or incomplete information submitted in connection with an enrollment application constitutes a Medicaid program violation, and may result in administrative, civil, or criminal liability.

Refer to: "Medicare/Medicaid Waste, Abuse, and Fraud Policy" on page 1-18.

1.1.4.2 HHSC Medicaid Provider Agreement

The HHSC Medicaid Provider Agreement must be submitted by all providers who enroll in Texas Medicaid and must be signed by the provider who is applying for enrollment. If the applicant is an entity, a Principal of the entity who has the authority to bind the entity to the requirements of the HHSC Provider Agreement must sign the agreement. "Principal" is defined in the following section. (In the case of a corporation, see "Corporate Board of Directors Resolution" on page 1-7.)

If the provider is city or government-owned, the agreement must be signed by a person who is authorized under the city or government charter. This form is an agreement between HHSC and the provider performing services under the State Plan wherein the provider agrees to certain provisions as a condition of participation.

1.1.4.3 Provider and Principal Information Forms

The Provider Information Form (PIF-1) must be completed by, or on behalf of, all providers. If the provider is an entity, the PIF-1 must be completed on behalf of the entity. A separate Principal Information Form (PIF-2) must be completed by each principal of the provider.

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

Note: *This includes the on-site manager for each physical location of the provider in Texas.*

The person who signs the HHSC Medicaid Provider Agreement is certifying that all of the information in the application packet, including every completed PIF-1 and PIF-2, is complete and correct. This includes a certification that every person who is required to complete a PIF-2 has done so, and all required PIF-2's are included with the application.

1.1.4.4 Disclosure of Ownership and Control Interest Statement

The Disclosure of Ownership and Control Interest Statement must be submitted as part of the enrollment application for all types of enrollment, except in the case of a performing provider who is applying to join an already enrolled group. This form provides TMHP Provider Enrollment with the appropriate information to enroll the provider as a sole proprietor, corporation, partnership, or nonprofit organization. This information determines if other enrollment forms are required.

This form also contains questions that must be answered under federal law. Failure to provide complete and accurate information as instructed on this form will constitute an incomplete application, which may result in denial of enrollment. Incomplete or inaccurate infor-

mation on this form constitutes a violation of the rules of Medicaid and may also result in administrative, civil, or criminal liability.

Refer to: "Medicare/Medicaid Waste, Abuse, and Fraud Policy" on page 1-18.

Note: Providers are required to submit any change in ownership, corporate officers, or directors to TMHP Provider Enrollment within 10 calendar days of the change.

Refer to: "Maintenance of Provider Information" on page 1-11.

1.1.4.5 Internal Revenue Service (IRS) W-9 Form

The IRS W-9 Form must be completed and submitted for all types of enrollment, except in the case of performing providers seeking to join an already enrolled group.

1.1.4.6 Medicaid Audit Information Form

The Medicaid Audit Information Form is required by facilities such as hospitals, home health agencies, FQHCs, RHCs, and dialysis facilities.

1.1.4.7 Corporate Board of Directors Resolution

All providers who indicate that they are a corporation on the Disclosure of Ownership and Control Interest Statement are required to submit the Corporate Board of Directors Resolution. This form indicates the individual (by name) who is authorized by the corporation to sign the agreement forms. The secretary of the corporation must sign the Corporate Board of Directors Resolution and have it notarized. If a business is city or government-owned, this form is not required.

1.1.4.8 Certificate of Good Standing (*Board Corporation Act, Article 2.45*)

The Certificate of Good Standing must be submitted by all for profit corporations. A for profit corporation that is delinquent in Franchise Tax cannot be awarded a contract or granted a license or permit by the state or agency of the state. Providers must obtain the Certificate of Good Standing from the Comptroller's Office, which verifies that the corporation is not delinquent in Franchise Tax. Only an original or photocopy of a Certificate of Good Standing will be accepted (i.e., a printout from the Comptroller website will not be accepted). Corporations that are nonprofit with a "501(C)(3)" IRS exemption are not required to submit this form. These corporations must indicate this exemption by signing the appropriate line on the Disclosure of Ownership & Control Interest Statement and marking *exempt* on the W-9 form. Out-of-state providers who do not conduct business in Texas are also exempt from submitting this form.

1.1.4.9 Certificate of Formation or Certificate of Filing/Certificate of Incorporation

All providers that are legal entities must submit the Certificate of Formation or Certificate of Filing form. Obtain the form from the Office of the Secretary of State. The name on this form must match the legal name shown on the W-9 form. Out-of-state providers are exempt from submitting this form.

Texas Corporations formed prior to January 1, 2006, must submit their Certificate of Incorporation.

1.1.4.10 Certificate of Authority

The Certificate of Authority and any required certifications to provide certain services in Texas must be submitted when a corporation is registered in a state other than Texas. Obtain this form from the Office of the Secretary of State of Texas. It takes the place of the Certificate of Incorporation. The form identifies the legal name of the corporation and is proof that the corporation is registered to do business in Texas.

1.1.4.11 Copy of License/Temporary License/Certification

Providers who must be licensed or certified in Texas must submit a copy of their current license or certification, except in the case of doctors, nurses, dentists, psychologists, and chiropractors. TMHP directly obtains 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 Chiropractic Examiners
- Texas Board of Nursing
- Texas State Board of Podiatric Medical Examiners

Once enrolled in Texas Medicaid, a reminder letter will be automatically generated and sent to providers 60 days before the provider's license expires. When the license is renewed, providers licensed by the boards listed above will not need to contact TMHP with renewal information.

Providers who are licensed other than doctors, nurses, dentists, psychologists, and chiropractors will be sent a reminder letter to submit a copy of their license renewal 60 days before their current license expires.

Providers are also required to submit to TMHP, within 10 days of occurrence, notice that the provider's license or certification has been partially or completely suspended, revoked, or retired. Not abiding by this license and certification update requirement may impact a provider's qualification to continued participation in Texas Medicaid.

1.1.4.12 Licensure Renewal

Not abiding by the license and certification update requirement may impact a provider's qualification for continued participation in Texas Medicaid. If a provider's

license has expired, a termination letter will be sent to the provider, and all claims filed on and after the expiration date will be denied.

To have claims payments resumed, updated information must be sent to the applicable licensing board to renew the license. Payment will be considered for dates of service on or after the date of license renewal. Claims denied due to an inactive license may be appealed, and payment will be considered for dates of service on or after the date of return to active license status. Payment deadline rules for the fiscal agent arrangement must be met.

Refer to: "HHSC Payment Deadline" on page 5-11.

1.1.4.13 Medicare Participation

Under federal law, Medicaid is the payor of last resort, so Medicare covered services must first be billed to and paid by Medicare. Therefore, in order to be eligible to enroll in Texas Medicaid, a provider must be a Medicare participating provider. Certain types of providers, however, are not required to meet the Medicare participation requirement, including the following:

- OB/GYN providers
- Pediatric providers
- Family Planning providers
- Comprehensive Care Program (CCP) providers
- Children and Pregnant Women (CPW) program providers
- Licensed professional counselors (LPCs)
- Licensed marriage and family therapists (LMFTs)

Each provider seeking enrollment must include a valid and current Medicare number in the Texas Medicaid Provider Enrollment Application, and must include with the application a copy of the provider's notice of Medicare participation.

Each group and each performing provider of a Medicare group must have a current Medicare number, and the group enrollment application must include the current and valid Medicare number for the group and for each performing provider in the group, as well as a copy of the notice of Medicare enrollment for the group and for each performing provider in the group.

1.1.4.14 Group Information Changes

If additions or changes occur in a group's enrollment information (for example, a performing provider leaves or enters the group, changes an address, or a provider is no longer licensed) after the enrollment process is completed, the provider group must notify Texas Medicaid in writing within 10 calendar days of occurrence of the changes. Failure to provide this information may lead to administrative action by HHSC. Filing claims and receiving payment without having followed this requirement constitutes a program violation and may also result in administrative, civil, or criminal liability.

Refer to: "Medicare/Medicaid Waste, Abuse, and Fraud Policy" on page 1-18 for more information.

1.2 Payment Information

Texas Medicaid reimbursements are available to all enrolled providers by check or electronic funds transfer (EFT). Providers are strongly encouraged to utilize EFT, which allows for more rapid reimbursement.

1.2.1 Using EFT

As a result of the 76th legislature, House Bill (H.B.) 2085 recommends that all Texas Medicaid providers receive payment by EFT. EFT is a method for directly depositing funds into a designated bank account. EFT does not require special software, and providers can enroll immediately.

1.2.2 Advantages of EFT

Advantages of EFT include:

- Electronically-deposited funds are available more quickly than with paper checks.
- Providers do not have to worry about lost or stolen checks.
- TMHP includes provider and Remittance and Status (R&S) report numbers with each transaction submitted. If the bank's processing software captures and displays the information, both numbers would appear on the banking statement.

1.2.3 EFT Enrollment Procedures

The Electronic Funds Transfer (EFT) Authorization Agreement can be found in Appendix B, "Forms" on page B-1, of this manual and on the TMHP website at www.tmhp.com. Completed EFT forms can be faxed to 1-512-514-4214, or mailed to:

Texas Medicaid & Healthcare Partnership
Attn: Provider Enrollment
PO Box 200795
Austin, TX 78750-0795

To enroll for EFT, providers must submit a completed Electronic Funds Transfer (EFT) Authorization Agreement to TMHP. A voided check or letter on bank letterhead, containing the bank routing and account information, must be attached to the enrollment form. One completed form must be filled out for each billing provider identifier, including an original signature of the provider.

After the Electronic Funds Transfer (EFT) Authorization Agreement has been processed, TMHP issues a prenotification transaction during the next cycle directly to the provider's bank account. This transaction serves as a checkpoint to verify EFT is working correctly.

If the bank returns the prenotification without errors, the provider will begin receiving EFT transactions with the third cycle following the enrollment form processing. The provider will continue to receive paper checks until they begin to receive EFT transactions.

If the provider changes bank accounts, the provider must submit a new Electronic Funds Transfer (EFT) Authorization Agreement to TMHP Provider Enrollment. The prenotification process is repeated and, once completed, the EFT transaction is deposited to the new bank account.

Refer to: “Electronic Funds Transfer (EFT) Information” on page B-43.

“Electronic Funds Transfer (EFT) Authorization Agreement” on page B-44.

1.2.4 Stale-Dated Checks

Stale-dated checks (i.e., checks that are older than 180 days) that have not been cashed are voided and/or applied to any outstanding accounts receivable. If the balance on a stale-dated check after it has been applied to accounts receivable is over \$5,000, written notification is sent to the provider 30 days before the void occurs.

1.3 Provider Reenrollment

A new enrollment application must be completed and a new provider identifier must be issued when one of the following changes:

- **Medicare Number.** If Medicare has issued a new Medicare number, the provider must complete and submit a Texas Medicaid Provider Enrollment Application in order to enroll the new location or with a new group.
- **Change of Ownership.** The new owner must do the following:
 - Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
 - Complete a new Texas Medicaid 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 separate change of ownership and Texas Medicaid provider enrollment application for all of the provider identifiers affected by the change of ownership.
 - Submit any new enrollment application relating to a change in ownership to TMHP Provider Enrollment *within 10 calendar days of the change.*

Important: Providers must adhere to claim filing deadlines throughout the enrollment process. Claims should be submitted without a provider identifier until notified by TMHP of final enrollment determination.

Refer to: “Claims Filing Deadlines” on page 5-8.

- **Provider Status (individual, group, performing provider, or facility).** Providers leaving group practices must send a signed letter or a Provider Information Change Form

to TMHP that states 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. If the provider is joining a new group practice or enrolling as an individual, the provider must complete and submit a Texas Medicaid Provider Enrollment Application to request enrollment in the new group or as an individual provider.

- **Physical Address.** If a provider has changed an address and the address is within the same Medicare locality, the provider must update the address information within 10 days. Updates may be made using the online provider lookup update screen located in the administrator section of TMHP’s website at www.tmhp.com. Alternately the provider may update the address information by completing and submitting a Provider Information Change Form. A W9 is required if the provider is changing the mailing address using a PIC form. If the address is not within the Medicare locality and Medicare has issued a new Medicare number, the provider must complete and submit a Texas Medicaid Provider Enrollment Application in order to enroll the new location. Dental providers must complete a TMHP Dental Provider Enrollment Application for each practice location.
- **Change in Principal Information (as defined in Section 1.1.4.3 on page 6).** This includes a change in corporate officers or directors, professional association membership, and managing employees. The change must be reported to TMHP within 10 calendar days of when it occurs.

Refer to: “Online Provider Lookup” on page 1-11 for additional information.

1.4 Provider Responsibilities

1.4.1 Compliance with Texas Family Code

1.4.1.1 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/agreements with governmental entities or nonprofit corporations.

The required statement has been incorporated into the Texas Medicaid Provider Agreement.

The law also requires that payments be stopped when notified that the contractor/provider is more than 30 days delinquent in paying child support. Medicaid payments are

placed on hold when it is discovered that a currently enrolled provider is delinquent in paying child support. A provider application may be denied or terminated if the provider is delinquent in paying child support.

1.4.1.2 Reporting Child Abuse or Neglect

The *Texas Family Code* Sec. 261.101 states: (a) A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report as provided by this subchapter; (b) If a professional has cause to believe that a child has been abused or neglected, or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, *Penal Code*, and the professional has cause to believe that the child has been abused as defined by Section 261.001 or 261.401, the professional shall make a report no later than the 48th hour after the hour the professional first suspects that the child has been, or may be abused or neglected, or is a victim of an offense under Section 21.11, *Penal Code*. A professional may not delegate to or rely on another person to make the report. In this subsection, *professional* means an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health-care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers.

According to *Rider 19 of the General Appropriations Act*, 78th Legislative Regular Session, 1999, House Bill (H.B.) 1, all Medicaid providers shall comply with the provisions of state law as set forth in Chapter 261 of the *Texas Family Code* relating to investigations of reports of child abuse and neglect and the provisions of HHSC policy. Reimbursement shall only be made to providers who have demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 and HHSC policy. Provider staff shall respond to disclosures or suspicions of abuse or neglect of minors, by reporting to the appropriate agencies as required by law.

All providers shall adopt this policy as their own, report suspected sexual abuse of a child as described in this policy and as required by law, and develop internal policies and procedures that describe how to determine, document, and report instances of sexual or nonsexual abuse.

This information is also available on the HHSC and TMHP websites at www.hhsc.state.tx.us and www.tmhp.com.

1.4.1.3 Procedures for Reporting Abuse or Neglect

Professionals as defined in the law are required to report no later than the 48th hour after the hour the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

Nonprofessionals shall immediately make a report after the nonprofessional has cause to believe that the child's physical or mental health or welfare has been adversely affected by abuse.

A report shall be made regardless of whether the provider staff suspect that a report may have previously been made.

Reports of abuse or indecency with a child must be made to one of the following:

- Department of Family and Protective Services (DFPS) if the alleged or suspected abuse involves a person responsible for the care, custody, or welfare of the child (the DFPS Texas Abuse/Neglect Hotline, at 1-800-252-5400, operated 24 hours a day, 7 days a week)
- Any local or state law enforcement agency
- The state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred
- The agency designated by the court to be responsible for the protection of children

The law requires the report to include the following information if known:

- The name and address of the minor
- The name and address of the minor's parent or the person responsible for the care, custody, or welfare of the child if not the parent
- Any other pertinent information concerning the alleged or suspected abuse

Reports can be made anonymously.

A provider may not reveal whether the child has been tested or diagnosed with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS).

If the minor's identity is unknown (e.g., the minor is at the provider's office anonymously to receive testing for HIV or a sexually transmitted disease [STD]), no report is required.

1.4.1.4 Procedures for Reporting Suspected Sexual Abuse

All providers shall ensure that their employees, volunteers, or other staff report a victim of abuse who is a minor younger than 14 who has engaged in sexual activity with any individual to whom the minor is not married. Sexual activity would be indicated if the minor is pregnant or has a confirmed STD acquired in a manner other than through perinatal transmission.

Sexual activity may include, but is not limited to, the actions described in *Penal Code* §21.11(a) relating to indecency with a child; §21.01(2) defining *sexual contact*; §43.01(1) or (3)-(5) defining various sexual activities; §22.011(a)(2) relating to sexual assault of a child; or §22.021(a)(2) relating to aggravated sexual assault of a child.

Providers may voluntarily use the HHSC checklist for monitoring all clients younger than 14 who are unmarried and sexually active. The checklist, if used, as well as any report of child abuse, shall be retained as part of the client's record by each provider and made available during any monitoring conducted by HHSC.

Refer to: "Child Abuse Reporting Guidelines, Checklist for HHSC Monitoring" on page B-13.

1.4.1.5 Training

All providers must develop training for all staff on the policies and procedures in regard to reporting child abuse. New staff must receive this training as part of their initial training/orientation. Training must be documented. As part of the training, staff must be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

1.4.2 Maintenance of Provider Information

Providers must, within 10 calendar days of occurrence, report changes in address (physical location or accounting), telephone number, name, ownership status, tax ID, and any other information pertaining to the structure of the provider's organization (for example, performing providers). Changes in address, office telephone or fax number, and e-mail address should be updated online using the online provider lookup update page. Alternately, providers may update their address information using either the PIC Form on page B-82, or the Demographic Update (DU) Form on the TMHP website.

Refer to: "Online Provider Lookup" on page 1-11 for additional information.

Other changes (in name, ownership status, tax ID, etc.) must be reported in writing to TMHP Provider Enrollment. Failure to notify TMHP of changes affects accurate processing and timely claims payment. In addition, failure to timely report such changes is a violation of the rules of Medicaid, and may result in administrative, civil, or criminal liability.

Refer to: "Medicare/Medicaid Waste, Abuse, and Fraud Policy" on page 1-18.

The DU Form is only used to make changes to provider addresses on file with TMHP. Providers can use the DU Form on the TMHP website at any time via the *My Account* link. Providers must create a provider administrator account to access the DU Form on the secure pages of the TMHP website. Nonadministrator users must be assigned by the provider administrator. Only providers or their authorized representatives can access the provider administrator accounts to obtain and complete the DU

Form. Providers will be prompted to verify their address(es) and make necessary changes at least once a year.

After the PIC or DU Form has been completed, it can be faxed to 1-512-514-4214, Attn: Provider Enrollment, or mailed to the address below for processing.

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

Providers should keep a copy of the completed form for their records.

1.4.2.1 NPI Verification

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. TMHP will also close all PCCM panel reports for the disenrolled TPIs. Clients enrolled in these panel reports will be notified to choose a different primary care provider.

1.4.2.2 Online Provider Lookup

An online provider lookup is available on the public access portion of the TMHP website at www.tmhp.com. Provider information can be viewed by providers, clients, and anyone who accesses the TMHP website.

Providers can use the online update function to update their demographic information on the website. This allows users to view the most current information about the provider. To update demographic information online, authorized users log in to the TMHP website by clicking **Log In** on the homepage. Periodically, administrators will be required to verify their address when logging in to their account. This verification must be completed before the administrator can proceed to the secured portion of the website. The *My Account* page has a link to the Provider Demographic Update web page. Current information will be displayed with a button to allow editable fields to be changed. Demographic information may be updated only by authorized administrators. This authorization is controlled through the Permissions Management link, also located on the *My Account* page. Fields that can be updated online include the following:

- Address
- Telephone numbers
- Office hours
- Accepting new patients
- Additional sites where services are provided
- Languages spoken
- Additional services offered

- Medicaid waiver programs
- Client age or gender limitations
- Counties served

The provider's name, gender, specialty, subspecialty, and group or plan affiliation cannot be changed online. Contact TMHP Provider Enrollment at 1-800-925-9126, option 2, regarding changes to this information.

Clients using the online provider lookup will use drop-down boxes to select search criteria. An initial list will display all providers that meet the specified search criteria. Clicking on any name in that list will display the provider's specific information, including a map of the office location.

Links to health maintenance organization (HMO) websites are also provided, enabling clients to search each HMO's network of participating providers. The online provider lookup supports both English and Spanish language users, and search results can be printed.

1.4.3 Retention of Records and Access to Records and Premises

The provider must maintain and retain all necessary documentation, records, Remittance and Status (R&S) reports, and claims to fully document the services and supplies provided and delivered to a client with Texas Medicaid coverage, the medical necessity of those services and supplies, costs included in cost reports or other documents used to determine a payment rate or fee, and records or documents necessary to determine whether payment for those items or services was due and was properly made for full disclosure to HHSC and its designee. A copy of the claim or R&S reports without additional documentation will not meet this requirement.

The documentation includes the following, without limitation:

- Clinical medical patient records
- Other records pertaining to the patient
- Any other records of services, items, equipment, or supplies provided to the patient and payments made for those services
- Diagnostic tests
- Documents related to diagnosis
- Charting
- Billing records
- Invoices
- Treatments
- Services
- Laboratory results
- X-rays
- Documentation of delivery of items, equipment, and supplies

Accessible information must include information that is necessary for the agencies specified in this section to perform statutory functions.

The required information may also include, without limitation, business and accounting records with backup support documentation, statistical documentation, computer records and data, and patient sign-in sheets and schedules. Additionally, it includes all requirements and elements described in Title 1, *Texas Administrative Code* (TAC), §§371.1643(f), 371.1617(a)(2), and 371.1601 (definition of "failure to grant immediate access").

The provider is required to provide original documents and records, and accompanying business records affidavits, to representatives of the organizations, and their agents and contractors listed in this section. At the discretion of the requestor, the provider may be permitted to instead provide copies notarized with the required business records affidavit. Requested records must be provided promptly and at no cost to the state or federal agency. If the provider was originally requested to provide original documents and subsequent requests for copies of these records are made by the provider, any and all costs associated with copying or reproducing any portion of the original records will be at the expense of the provider. This applies to any request for copies made by the provider at any point in the investigative process until such time as the agency deems the investigation to be finalized. A method of payment for the copying charge, approved by the agency, would be used to pay for the copying of the records. If copies of records are requested from the provider initially, the provider must submit copies of such records at no cost to the requestor's organization.

The provider must provide immediate access to the provider's premises and records for purposes of reviewing, examining, and securing custody of records, documents, electronic data, equipment, or other requested items, as determined necessary by the requestor to perform statutory functions. Nothing in this section will in any way limit access otherwise authorized under state or federal law. If, in the opinion of the Inspector General or other requestor, the documents may be provided at the time of the request or in less than 24 hours or the Inspector General or other requestor suspects the requested documents or other requested items may be altered or destroyed, the request must be completed by the provider at the time of the request or in less than 24 hours as provided by the requestor. If, in the opinion of the Inspector General or other requestor, the requested documents and other items requested cannot be completely provided on the day of the request, the Inspector General or requestor may set the deadline for production at 24 hours from the time of the original request.

Failure to supply the requested documents and other items, within the time frame specified, may result in payment hold to the provider's Medicaid payments, recoupment of payments for all claims related to the missing records, contract cancellation, and/or exclusion from Texas Medicaid.

As directed by the requestor, the provider or person will relinquish custody of the requested documents and other items and the requestor will take custody of the records and remove them from the premises. If the requestor

should allow longer than “at the time of the request” to produce the records, the provider will be required to produce all records completed, at the time of the completion or at the end of each day of production, as directed by the requestor who will take custody of the requested items.

If the provider places the required information in another legal entity’s records, such as a hospital, the provider is responsible for obtaining a copy of these requested records for use by the requesting state and federal agencies.

These documents and claims must be retained for a minimum period of five years from the date of service or until all audit questions, appeal hearings, investigations, or court cases are resolved. Freestanding RHCs must retain their records for a minimum of six years, and hospital-based RHCs must retain their records for a minimum of ten years. These records must be made available immediately at the time of the request to employees, agents, or contractors of HHSC Office of Inspector General (OIG), the Texas Attorney General’s Medicaid Fraud Control Unit (MFCU) or Antitrust and Civil Medicaid Fraud Section, TMHP, DFPS, the Department of Aging and Disability Services (DADS), Department of State Health Services (DSHS), Department of Assistive and Rehabilitative Services (DARS), U.S. Department of Health and Human Services (HHS) representative, any state or federal agency authorized to conduct compliance, regulatory, or program integrity functions on the provider, person, or the services rendered by the provider or person, or any agent, contractor, or consultant of any agency or division delineated above. In addition, the provider must meet all requirements of 1 TAC, Part 15, §371.1643(f).

The records must be available as requested by each of these entities, during any investigation or study of the appropriateness of the Medicaid claims submitted by the provider.

1.4.3.1 Payment Error Rate Measurement (PERM) Process

CMS assesses Texas Medicaid using the PERM process to measure improper payments in Texas Medicaid. Providers will be required to provide medical record documentation to support the medical reviews that the federal review contractor will conduct for Texas Medicaid fee-for-service and PCCM Medicaid and State Children’s Health Insurance Program (SCHIP) claims.

Under the PERM process, if a claim is selected in a sample for a service that a provider rendered to a Medicaid client, the provider will be contacted to submit a copy of the medical records that support the medical review of the claim. All providers should check the TMHP system to ensure their current telephone number and addresses are correct in the system. If the information is incorrect or incomplete, providers must request a change immediately to ensure the PERM medical record request can be delivered. Client authorization for release of this information is not required.

Once a provider receives the request for medical records, the provider must submit the information electronically or in hard copy within 60-calendar days. It is important that providers cooperate by submitting all requested documentation in a timely manner because no response or insufficient documentation will count against the state as an error. This can ultimately negatively impact the amount of federal funding received by Texas for Medicaid.

1.4.4 Release of Confidential Information

Information about the diagnosis, evaluation, or treatment of a client with Texas Medicaid coverage by a person licensed or certified to perform the diagnosis, evaluation, or treatment of any medical, mental, or emotional disorder, or drug abuse, is confidential information that the provider may disclose only to authorized people. Family planning information is sensitive, and confidentiality must be ensured for all clients, especially minors.

Only the client may give written permission for release of any pertinent information before client information can be released, and confidentiality must be maintained in all other respects. If a client’s medical records are requested by a licensed Texas health-care provider or a physician licensed by any state, territory, or insular possession of the United States or any State or province of Canada, for purposes of emergency or acute medical care, a provider must furnish such records at no cost to the requesting provider. This includes records received from another physician or health-care provider involved in the care or treatment of the patient. If the records are requested for purposes other than for emergency or acute medical care, the provider may charge the requesting provider a reasonable fee and retain the requested information until payment is received.

The client’s signature is not required on the claim form for payment of a claim, but HHSC recommends the provider obtain written authorization from the client before releasing confidential medical information. A release may be obtained by having the client sign the indicated block on the claim form after the client has read the statement of release of information that is printed on the back of the form. The client’s authorization for release of such information is not required when the release is requested by and made to DADS, HHSC, DSHS, TMHP, DFPS, DARS, HHSC OIG, the Texas Attorney General’s MFCU or Antitrust and Civil Fraud Division, or HHS.

1.4.5 Compliance with Federal Legislation

HHSC complies with HHS regulations that protect against discrimination. All contractors must agree to comply with the following:

- Title VI of the *Civil Rights Act of 1964* (Public Law 88-352), Section 504 of the *Rehabilitation Act of 1973* (Public Law 93-112), *The Americans with Disabilities Act of 1990* (Public Law 101-336), Title 40, Chapter 73, of the TAC, all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. The laws provide in part that no persons in the

U.S. shall, on the grounds of race, color, national origin, age, sex, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service, or other benefits provided by federal and/or state funding, or otherwise be subjected to any discrimination

- *Health and Safety Code 85.113* as described in "Model Workplace Guidelines for Businesses, State Agencies, and State Contractors" on page G-2 (relating to workplace and confidentiality guidelines on AIDS and HIV)

Exception: *In the case of minors receiving family planning services, only the client may consent to release of medical documentation and information. Providers must comply with the laws and regulations concerning discrimination. Payments for services and supplies are not authorized unless the services and supplies are provided without discrimination on the basis of race, color, sex, national origin, age, or disability. Send written complaints of noncompliance to the following address:*

HHSC Commissioner
1100 West 49th Street
Austin, TX 78756-3172

Reminder: *Each provider must furnish covered Medicaid services to eligible clients in the same manner, to the same extent, and of the same quality as services provided to other patients. Services made available to other patients must be made available to Texas Medicaid clients if the services are benefits of Texas Medicaid.*

1.4.6 Tamper-Resistant Prescription Pads

Providers are required by federal law (Public Law 110-28) to use a tamper-resistant prescription pad when writing a prescription for any drug for Medicaid clients.

Providers must take necessary steps to ensure that tamper-resistant pads are used for all written prescriptions provided to Medicaid clients. Providers may also use compliant, non-written alternatives for transmitting prescriptions such as by telephone, fax, or electronic submittal. Pharmacies are required to ensure that all written Medicaid prescriptions submitted for payment to the Vendor Drug Program are written on a compliant tamper-resistant pad.

If a prescription is not submitted on a tamper-resistant prescription form, a pharmacy may fill the prescription in full on an emergency basis.

The pharmacy must then obtain a verbal, faxed, electronic, or compliant, written prescription from the prescriber within 72 hours after the date on which the prescription was filled.

Providers may purchase tamper-resistant prescription pads from the vendor of their choice.

Special copy-resistant paper is not a requirement for prescriptions printed from electronic medical records (EMRs) or ePrescribing generated prescriptions. These prescriptions may be printed on plain paper and will be

fully compliant with all three categories of the tamper-resistant regulations, provided they contain at least one feature from each of the three following categories:

- Prevents unauthorized copying of completed or blank prescription forms.
- Prevents erasure or modification of information written on the prescription form.
- Prevents the use of counterfeit prescription forms.

1.4.7 Utilization Control — General Provisions

Title XIX of the *Social Security Act*, Sections 1902 and 1903, mandates utilization control of all Texas Medicaid services under regulations found at Title 42 CFR, Part 456. Utilization review activities required by Texas Medicaid are completed through a series of monitoring systems developed to ensure the quality of services provided, and that all services are both medically necessary and billed appropriately. Both clients and providers are subject to utilization review monitoring. Utilization control procedures safeguard against the delivery of unnecessary services, monitor quality, and ensure payments are appropriate and according to Texas Medicaid policies, rules, and regulations. All providers identified as a result of utilization control activities are presented to HHSC OIG to determine any and all subsequent actions.

The primary goal of utilization control activity is to identify providers with practice patterns inconsistent with the federal requirements and Texas Medicaid scope of benefits, policies, and procedures. The use of utilization control monitoring systems allows for identification of providers whose patterns of practice and use of services fall outside of the norm for their peer groups. Providers identified as exceptional are subject to an in-depth review of all Texas Medicaid billings. These review findings are presented to the HHSC OIG to determine any necessary action. Medical records may be requested from the provider to substantiate the medical necessity and appropriateness of services billed to Texas Medicaid. Inappropriate service utilization may result in recoupment of overpayments and/or sanctions, or other administrative actions deemed appropriate by the HHSC OIG. There are instances when a training specialist may be directed to communicate with the provider to offer assistance with the technical or administrative aspects of Texas Medicaid.

At the direction of the HHSC OIG, a provider's claims may be manually reviewed before payment. Parameters are developed for prepayment review based on the specific areas of concern identified in each case. As part of the prepayment review process, providers are required to submit paper claims, rather than electronic claims, along with supporting medical record documentation (e.g., clinical notes, progress notes, diagnostic testing results, other reports, superbills, X-rays, and any related medical record documentation) attached to each claim for all services billed. This documentation is used to ascertain that the services billed were medically necessary, billed

appropriately, and according to Texas Medicaid requirements and policies. Services inconsistent with Texas Medicaid requirements and policies are adjudicated accordingly. Claims submitted initially without the supporting medical record documentation will be denied. Additional medical record documentation submitted by the provider for claims denied as a result of the prepayment review process is not considered at a later time. A provider is removed from prepayment review only when determined appropriate by the HHSC OIG. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns is performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions up to and including exclusion and contract cancellation, as deemed appropriate by the HHSC OIG as defined in the rules in 1 TAC §371.1643. Providers placed on prepayment review must submit all paper claims and supporting medical record documentation to the following address:

Texas Medicaid & Healthcare Partnership
Attention: Prepayment Review MC-A11 SURS
PO Box 203638
Austin, Texas 78720-3638

1.4.8 Provider Certification/Assignment

Texas Medicaid service providers are required to certify compliance with or agree to various provisions of state and federal laws and regulations. After submitting a signed claim to TMHP, the provider certifies the following:

- Services were personally rendered by the *billing provider* or under the personal supervision of the billing provider, if allowed for that provider type, or under the substitute physician arrangement.
- The information on the claim form is true, accurate, and complete.
- All services, supplies, or items billed were medically necessary for the client's diagnosis or treatment. Exception is allowed for special preventive and screening programs (for example, family planning and THSteps).
- Medical records document all services billed and the medical necessity of those services.
- All billed charges are usual and customary for the services provided. The charges must not be higher than the fees charged to private-pay patients.
- *The provider will not bill Texas Medicaid for services that are provided or offered to non-Medicaid patients, without charge, discounted or reduced in any fashion including, but not limited to, sliding scales or advertised specials. Any reduced, discounted, free, or special fee advertised to the public must also be offered to Texas Medicaid clients.*
- Services were provided without regard to race, color, sex, national origin, age, or handicap.

- The provider of medical care and services files a claim with Texas Medicaid agreeing to accept the Medicaid reimbursement as payment in full for those services covered under Texas Medicaid. The client with Medicaid coverage, or others on their behalf, must not be billed for the amount above that which is 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. However, the client may be billed for noncovered services for which Texas Medicaid does not make any payment. Before providing services, providers should *always* inform clients of their liability for services that are not a benefit of Texas Medicaid, including use of the Client Acknowledgment Statement.
- *The provider understands that endorsing or depositing a Texas Medicaid check is accepting money from federal and state funds and that any falsification or concealment of material fact related to payment may be grounds for prosecution under federal and state laws.*

Providers must not bill for, and agree not to bill for, any service provided for which the client bears no liability to pay (i.e. free services). The only exceptions to this ban on billing for services that are free to the user are:

- Services offered by or through the Title V agency when the service is a benefit of Texas Medicaid and rendered to an eligible client
- Services included in the Texas Medicaid client's individualized education plan (IEP) or individualized family service plan (IFSP) if the services are covered under the Title XIX state plan, even though they are free to the users of the services

Refer to: "Supervision" on page 36-9.

1.4.8.1 Delegation of Signature Authority

A provider delegating signatory authority to a member of the office staff or to a billing service *remains responsible* for the accuracy of all information on a claim submitted for payment. A provider's employees or a billing service and its employees are equally responsible for any false billings in which they participated or directed.

If the claim is prepared by a billing service or printed by data processing equipment, it is permissible to print "Signature on File" in place of the provider's signature. When claims are prepared by a billing service, the billing service must obtain and keep a letter on file that is signed by the provider authorizing claim submission.

1.4.9 Billing Clients

A provider cannot require a down payment before providing Medicaid-allowable services to eligible clients, bill, nor take recourse against eligible clients for denied or reduced claims for services that are within the amount, duration, and scope of benefits of Texas Medicaid if the action is the result of any of the following provider-attributable errors:

- Failure to submit a claim, including claims not received by TMHP
- Failure to submit a claim to TMHP for initial processing within the 95-day filing deadline (or the initial 365-day deadline, if applicable)
- Submission of an unsigned or otherwise incomplete claim such as omission of the Hysterectomy Acknowledgment Statement or Sterilization Consent Form with claims for these procedures
- Filing an incorrect claim
- Failure to resubmit a corrected claim or rejected electronic media claim within the 120-day resubmittal period
- Failure to appeal a claim within the 120-day appeal period. Errors made in claims preparation, claims submission, or appeal process
- Failure to submit a claim to TMHP within 95 days of a denial by Titles V or XX for family planning services
- Failure to submit a claim within 95 days from the disposition date from Medicare or a primary third party insurance resource
- Failure to obtain prior authorization for services that require prior authorization under Texas Medicaid

Providers must certify that no charges beyond reimbursement paid under Texas Medicaid for covered services have been, or will be, billed to an eligible client. Federal regulations prohibit providers from charging clients a fee for completing or filing Medicaid claim forms. Providers are not allowed to charge TMHP for filing claims. The cost of claims filing is part of the usual and customary rate for doing business.

Medicaid payment to physicians for covered services includes the incidental services such as completion of required forms submitted by a nursing facility to the physician for signature. It is not acceptable for the physician to charge Texas Medicaid clients, their family, or the nursing facility for telephone calls, telephone consultations, or signing forms. Medicaid payment is considered payment in full. The *visit reimbursement* includes the *incident to* required paperwork.

In accordance with current federal policy, Texas Medicaid and Texas Medicaid clients cannot be charged for the client's failure to keep an appointment. Only billings for services provided are considered for payment. Clients may not be billed for the completion of a claim form, even if it is a provider's office policy.

Letters of inquiry about client billing are sometimes sent to providers in lieu of telephone calls from TMHP representatives. In either case, it is mandatory that the questions

be answered with the requested pertinent information. Upon receipt, TMHP forwards these letters to HHSC. HHSC uses the information to resolve client billing/liability issues. It is mandatory that these letters be signed, dated, and returned within ten business days.

Refer to: "Outpatient" on page 25-19 for more information about spell-of-illness.

"Medically Needy Program (MNP)" on page 4-11.

"Private Pay Agreement" on page B-79.

1.4.9.1 Client Acknowledgment Statement

Texas Medicaid reimburses only for services that are medically necessary or benefits of special preventive and screening programs such as family planning and THSteps. Hospital admissions denied by the Texas Medical Review Program (TMRP) also apply under this policy. The provider may bill the client only if:

- A specific service or item is provided at the client's request.
- The provider has obtained and kept a written Client Acknowledgment Statement signed by the client that states:
 - "I understand that, in the opinion of (*provider's name*), the services or items that I have requested to be provided to me on (*dates of service*) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."
 - "Comprendo que, según la opinión del (*nombre del proveedor*), es posible que Medicaid no cubra los servicios o las provisiones que solicité (*fecha del servicio*) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que el Departamento de Salud de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el cliente solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

A provider is allowed to bill the following to a client without obtaining a signed Client Acknowledgment Statement:

- Any service that is not a benefit of Texas Medicaid (for example, personal care items).
- All services incurred on noncovered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on

the noncovered days. Spell of illness limitations do not apply to medically necessary stays for THSteps clients birth through 20 years of age.

- The reduction in payment that is because of the medically needy spend down MNP is limited to children 18 years of age or younger and pregnant women). The client's potential liability would be equal to the amount of total charges applied to the spend down. Charges to clients for services provided on ineligible days must not exceed the charges applied to spend down.
- All services provided as a private pay patient. If the provider accepts the client as a private pay patient, the provider must advise clients that they are accepted as private pay patients at the time the service is provided and responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the client signs written notification so there is no question how the client was accepted. Without written, signed documentation that the Texas Medicaid client has been properly notified of the private pay status, the provider cannot seek payment from an eligible Texas Medicaid client.
- The client is accepted as a private pay patient pending Texas Medicaid eligibility determination and does *not* become eligible for Medicaid retroactively. The provider is allowed to bill the client as a private pay patient if retroactive eligibility is not granted. If the client becomes eligible retroactively, the client notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Texas Medicaid claims. If the client becomes eligible, the provider *must* refund any money paid by the client and file Medicaid claims for all services rendered.

A provider attempting to bill or recover money from a client in violation of the above conditions may be subject to exclusion from Texas Medicaid.

Important: *Ancillary services must be coordinated and pertinent eligibility information must be shared. The primary care provider is responsible for sharing eligibility information with others (e.g., emergency room staff, laboratory staff, and pediatricians).*

1.4.10 General Medical Record Documentation Requirements

The *Administrative Simplification Act of the Health Insurance Portability and Accountability Act (HIPAA)* of 1996 mandates the use of national coding and transaction standards. HIPAA requires that the American Medical Association's (AMA) Current Procedural Terminology (CPT) system be used to report professional services, including physician services. Correct use of CPT coding requires using the most specific procedure code that matches the services provided based on the procedure code's description. Providers must pay special attention to the standard CPT descriptions for the evaluation and management services. The medical record must document the specific elements necessary to satisfy the criteria for the level of service as described in CPT. Reimbursement may be recouped when the medical

record does not document that the level of service provided accurately matches the level of service claimed. Furthermore, the level of service provided and documented must be medically necessary based on the clinical situation and needs of the patient.

HHSC and TMHP routinely perform retrospective reviews of all providers. HHSC ultimately is responsible for Texas Medicaid utilization review activities. This review includes 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.*

- Mandatory—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 patient's name and Texas Medicaid number
- Mandatory—A copy of the actual authorization from HHSC or its designee (e.g., TMHP) is maintained in the medical record for any item or service that requires prior authorization
- 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 AMA CPT descriptors of key/contributory components with level of service descriptions are used to evaluate the selection of levels of service
- Mandatory—The history and physical documents the presenting complaint with appropriate subjective and objective information
- Mandatory—The services provided are clearly documented in the medical record with all pertinent information regarding the patient's condition to substantiate the need and medical necessity for the services
- Mandatory—Medically necessary diagnostic lab and X-ray results are included in the medical record and abnormal findings have an explicit notation of follow-up plans
- Mandatory—Necessary follow-up visits specify time of return by at least the week or month
- Mandatory—Unresolved problems are noted in the record
- Desirable—Immunizations are noted in the record as *complete* or *up-to-date*
- Desirable—Personal data includes address, employer, home/work telephone numbers, sex, marital status, and emergency contacts

1.4.11 Informing Pregnant Clients About CHIP Benefits

Section 24, S.B. 1188, 79th Legislature, Regular Session, 2005, requires that Medicaid providers rendering services to a pregnant Medicaid client must inform the client of the health benefits for which the client or the client's child may be eligible under the Children's Health Insurance Program (CHIP).

CHIP is available to children whose families have low to moderate income, who earn too much money to qualify for Texas Medicaid, and who do not have private insurance. Some clients may have to pay an enrollment fee.

To qualify for CHIP, a child must be:

- A Texas resident
- 18 years of age or younger
- A citizen or legal permanent resident of the United States
- Must meet all income and resource guidelines

CHIP benefits include:

- Physician, hospital, X-ray, and lab services
- Well-baby and well-child visits
- Immunizations
- Prescription drugs
- Dental services
- Durable medical equipment (DME)
- Prosthetic devices (with a \$20,000 limit per 12-month period)
- Case coordination and enhanced services for children with special health-care needs and children with disabilities
- Physical, speech, and occupational therapy
- Home health services
- Transplants
- Mental health services
- Vision services
- Chiropractic services

Individuals may apply for CHIP by downloading and completing the application found on the CHIP page of the HHSC website at www.hhsc.state.tx.us/chip or by calling the toll-free CHIP number at 1-800-647-6558.

1.5 Medicare/Medicaid Waste, Abuse, and Fraud Policy

Federal and state regulations and statutes require Texas Medicaid, through the OIG, to have the ability to identify, investigate, sanction, and refer cases of suspected waste, abuse, and/or fraud in the Medicare, Medicaid, or other health and human services programs to prosecutors or licensure and certification boards and agencies.

Additionally, HHSC OIG is:

- Provided the authority to exclude from program reimbursement any provider that defrauds or abuses Texas Medicaid
- Required to exclude from Medicaid participation any individual who is receiving reimbursement under the Texas Medicaid Program and has been suspended from Medicare for conviction of a program-related crime or is not eligible to participate in Medicare when the Federal Office of the Inspector General for the HHS directs such action

Providers may also refer cases of waste, abuse, and fraud to the OIG for civil damages and penalties (previously referred to as civil monetary penalties), authorized by state statute. Providers (individual or corporate) may be assessed penalties in the amount that was paid, plus interest, plus up to double the amount paid, plus an amount not less than \$5,000.00 or more than \$15,000.00 for each violation that results in injury to an elderly or disabled person or a person 17 years of age or younger or not more than \$10,000.00 for each violation that does not result in injury to a person as described above.

The assessment for each violation is calculated using each line item detail and/or occurrence identified on a claim, cost report, or other document resulting in or supporting fraudulent or abusive billing. Additional civil damages and penalties may be assessed under the Federal Civil Monetary Penalties Law contained in the *Social Security Act* for submitting fraudulent or abusive billings. A provider with assessed civil damages and penalties may be excluded or barred from participating in Medicare, Medicaid, or both.

A provider and the provider's staff are responsible for maintaining a current understanding of the requirements for participation in Texas Medicaid and current policies, claims filing and processing procedures, and federal regulations affecting Texas Medicaid through the following means:

- *Provider education.* Attendance at TMHP educational workshops, group meetings, and training sessions.
- *Texas Medicaid publications.* Use of the *Texas Medicaid Bulletin*, R&S reports, and the *Texas Medicaid Provider Procedures Manual* to inform staff of policy changes, Medicaid directives, and claims processing procedures.
- *Identification and resolution of provider problems.* Correction of deficiencies in operations identified by TMHP, the providers, or HHSC and action to resolve them.

- *Adopted agency rules.* Knowledge of the adopted agency rules published in the 1 TAC, Part 15, including, but not limited to, those related to fraud and abuse contained in Chapter 371.
- *List of Excluded Individuals/Entities by Texas OIG.* List of excluded providers used by participating providers to ensure that newly hired staff or independent contractors and current employees are not excluded by the Texas OIG from participation in Texas Medicaid. Claims paid for services rendered by an excluded provider are subject to recoupment.
- *State and federal statutes.* Statutes pertinent to Texas Medicaid and fraud and abuse within Texas Medicaid.

In addition, providers are responsible for the delivery of health care items and services to Medicaid 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 Medicaid 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. Texas Medicaid providers must follow the coding and billing requirements of the *Texas Medicaid Provider Procedures Manual*. However, if coding and billing requirements for the particular service are not addressed in the TMPPM, and if coding and billing requirements are not otherwise specified in program policy (such as in the Provider Bulletins or banners), 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 most recently published "CPT books", "CPT Assistant" monthly newsletters and other publications resulting from the collaborative efforts of American Medical Association with the 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 use of modifiers some of which are not currently recognized by Texas Medicaid. See the list of modifiers utilized by Texas Medicaid in "Modifiers" on page 5-21.*

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

To the extent the above authorities do not conflict with any specific requirement stated in Medicaid policy, the requirements of these authorities are incorporated by reference into Medicaid 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 Title 1, *Texas Administrative Code (TAC)* Chapter 371.

A provider who delegates or otherwise allows signature authority for claims preparation or other activities to an office staff member or to a billing service is responsible for the provider's own actions and omissions; the actions and omissions of the provider's employees, contractors, and agents; and the accuracy of all information on a claim submitted for payment. This, however, does not absolve these other individuals for their participation in any documents provided to the state or designee with false, inaccurate, or misleading information; or pertinent omissions.

HHSC/OIG may impose one or any combination of administrative actions or administrative sanctions on Texas Medicaid providers or other persons when fraud, waste, or abuse is determined. Without limitation, other persons that may be sanctioned if determined to be in violation including those furnishing services or items directly or indirectly; those billing for services; those violating any of the provisions delineated in this section; and any affiliates of a provider or person violating any of the provisions delineated in this section. When administrative sanctions are imposed, the provider or person will be afforded the opportunity to appeal. There is no right of appeal associated with the imposition of administrative actions. The following is a list of administrative actions and sanctions.

Administrative sanctions include, without limitation:

- Exclusion from participation in the Titles V, XIX (Medicaid), and XX programs for a specified period of time, permanently, or indefinitely. Providers who are excluded from Texas Medicaid are automatically excluded from Titles V and XX.
- Suspension of Medicaid payments (payment hold) to a provider.
- Recoupment of Medicaid overpayments.
- Recoupment of Medicaid overpayments projected from a sampling process.
- Restricted Medicaid reimbursement for a specified period of time or indefinitely. Specific services will not be reimbursed to an individual provider during the time the provider is on restricted reimbursement; however, other services, as determined by the HHSC/OIG will be reimbursed.

- Cancellation of the Medicaid provider contract or provider agreement.
- Debarment or suspension under the authority of the CFR.

Administrative actions include:

- Transfer to a closed-end contract or provider agreement for a specified period of time or a provisional or probationary contract or provider agreement with variable case-by-case options applied to the terms and conditions.
- Attendance at provider education sessions.
- Prior authorization of selected services.
- Prepayment review.
- Post-payment review.
- Attendance in informal or formal provider corrective action meetings.
- Submission of additional documentation or justification that is not normally required to accompany submitted claims. Failure to submit legible documentation or justification requested will result in denial of the claim.
- Oral, written, or personal educational contact with the provider.
- Posting of a surety bond or providing a letter of credit.
- Having a subpoena served to compel an appearance for testimony or the production of relevant evidence, as determined by the HHSC/OIG.

People who induce, solicit, receive, offer, or pay any remuneration (including, but not limited to, bribes, kickbacks, or rebates) directly or indirectly in relation to referrals, purchases, leases, or arrangements of services covered by Medicare or Texas Medicaid may be in violation of state statutes and guilty of a federal felony offense. Current legislation allows for suspension of providers convicted of a criminal offense related to Medicare or Texas Medicaid. Statutes provide that committing a felony in the Medicaid or Medicare programs may involve punishment ranging from 5 to 99 years, or life in prison and an optional monetary fine. Inducements may include a service, cash in any amount, entertainment or any item of value.

Following is a nonexclusive list of grounds/criteria for the Inspector General's administrative enforcement and/or referral for criminal, civil, or licensure or certification investigation and judicial action regarding program violations by any provider or person. Violations result from a provider or person who knew or should have known the following were violations. The headings of each group listed below are provided solely for organization and convenience and are not elements of any program violation.

1) Claims and Billing.

- a) Submitting or causing to be submitted a false statement or misrepresentation, or omitting pertinent facts when claiming payment under the Texas Medicaid or other HHS program or when supplying information used to determine the

right to payment under the Texas Medicaid or other HHS program;

- b) Submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to obtain greater compensation than the provider is legally entitled to;
- c) Submitting or causing to be submitted a false statement, information or misrepresentation, or omitting pertinent facts to meet prior authorization requirements;
- d) Submitting or causing to be submitted under Title XVIII (Medicare) or a state health-care program claims or requests for payment containing unjustified charges or costs for items or services that substantially exceed the person's usual and customary charges or costs for those items or services to the public or the private pay patients unless otherwise authorized by law;
- e) Submitting or causing to be submitted claims with a pattern of inappropriate coding or billing that results in excessive costs to the Texas Medicaid or other HHS program;
- f) Billing or causing claims to be filed for services or merchandise that were not provided to the recipient;
- g) Submitting or causing to be submitted a false statement or misrepresentation that, if used, has the potential of increasing any individual or state provider payment rate or fee;
- h) Submitting or causing to be submitted to the Texas Medicaid or other HHS program a cost report containing costs not associated with Texas Medicaid or other HHS program or not permitted by Texas Medicaid or other HHS program policies;
- i) Presenting or causing to be presented to an operating agency or its agent a claim that contains a statement or representation that the person knows or should have known to be false;
- j) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for services or items furnished personally by, at the medical direction of, or on the prescription or order of a person who is excluded from Texas Medicaid, other HHS program, or Medicare or has been excluded from and not reinstated within Texas Medicaid, other HHS program, or Medicare;
- k) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for services or items that are not reimbursable by the Texas Medicaid or other HHS program;
- l) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for a service or item which requires a prior order or prescription by a licensed health-care practi-

tioner when such order or prescription has not been obtained;

- m) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program for an item or service substituted without authorization for the item or service ordered, prescribed or otherwise designated by the Texas Medicaid or other HHS program;
 - n) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program by a provider or person who is owned or controlled, directly or indirectly, by an excluded person; *and*
 - o) Billing or causing claims to be submitted to the Texas Medicaid or other HHS program by a provider or person for charges in which the provider discounted the same services for any other types of patient.
- 2) Records and Documentation.
- a) Failing to maintain for the period of time required by the rules relevant to the provider in question records and other documentation that the provider is required by federal or state law or regulation or by contract to maintain in order to participate in the Texas Medicaid or other HHS program or to provide records or documents upon written request for any records or documents determined necessary by the Inspector General to complete their statutory functions related to a fraud and abuse investigation. Such records and documentation include, without limitation, those necessary:
 - i) To verify specific deliveries, medical necessity, medical appropriateness, and adequate written documentation of items or services furnished under Title XIX or Title XX;
 - ii) To determine in accordance with established rates appropriate payment for those items or services delivered;
 - iii) To confirm the eligibility of the provider to participate in the Texas Medicaid or other HHS program; e.g., medical records (including, without limitation, X-rays, laboratory and test results, and other documents related to diagnosis), billing and claims records, cost reports, managed care encounter data, financial data necessary to demonstrate solvency of risk-bearing providers, and documentation (including, without limitation, ownership disclosure statements, articles of incorporation, by-laws, and corporate minutes) necessary to demonstrate ownership of corporate entities; *and*
 - iv) To verify the purchase and actual cost of products;
 - b) Failing to disclose fully and accurately or completely information required by the *Social*

Security Act and by 42 CFR Part 455, Subpart B; 42 CFR Part 420, Subpart C; 42 CFR §1001.1101; and 42 CFR Part 431;

- c) Failing to provide immediate access, upon request by a requesting agency, to the premises or to any records, documents, and other items or equipment the provider is required by federal or state law or regulation or by contract to maintain in order to participate in the Texas Medicaid or other HHS program (see subparagraphs (a) and (b) of this paragraph), or failing to provide records, documents, and other items or equipment upon written request that are determined necessary by the Inspector General to complete their statutory functions related to a fraud and abuse investigation, including without limitation all requirements specified in 1 TAC §371.1643(f) of this subchapter. "Immediate access" is deemed to be within 24 hours of receiving a written request, unless the requesting agency has reason to suspect fraud or abuse or to believe that requested records, documents, or other items or equipment are about to be altered or destroyed, thereby necessitating access at the actual time the request is presented or, in the opinion of the Inspector General, the request may be completed at the time of the request and/or in less than 24 hours;
 - d) Developing false source documents or failing to sign source documents or to retain supporting documentation or to comply with the provisions or requirements of the operating agency or its agents pertaining to electronic claims submittal; *and*
 - e) Failing as a provider, whether individual, group, facility, managed care or other entity, to include within any subcontracts for services or items to be delivered within Texas Medicaid all information that is required by 42 CFR §434.10(b).
- 3) Program-Related Convictions.
- a) Pleading guilty or nolo contendere, agreeing to an order of probation without adjudication of guilt under deferred adjudication, or being a defendant in a court judgment or finding of guilt for a violation relating to performance of a provider agreement or program violation of Medicare, Texas Medicaid, other HHS program, or any other state's Medicaid program;
 - b) Pleading guilty or being convicted of a violation of state or federal statutes relating to dangerous drugs, controlled substances, or any other drug-related offense;
 - c) Pleading guilty of, being convicted of, or engaging in conduct involving moral turpitude;
 - d) Pleading guilty or being convicted of a violation of state or federal statutes relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct relating to

- the delivery of a health-care item or service or relating to any act or omission in a program operated or financed by any federal, state, or local government agency;
- e) Being convicted in connection with the interference with or obstruction of any investigation into any criminal offense that would support mandatory exclusion under 1 TAC §371.1655 of this subchapter or any offense listed within paragraph (3) of this subsection regarding program-related convictions; *and*
- f) Being convicted of any offense that would support mandatory exclusion under 1 TAC §371.1655 of this subchapter.
- 4) Provider Eligibility.
- a) Failing to meet standards required for licensure, when such licensure is required by state or federal law, administrative rule, provider agreement, or provider manual for participation in the Texas Medicaid or other HHS program;
- b) Being excluded, suspended or otherwise sanctioned within any federal program involving the provision of health care;
- c) Being excluded, suspended or otherwise sanctioned under any state health-care program for reasons bearing on the person's professional competence, professional performance or financial integrity;
- d) Failing to fully and/or correctly complete a Provider Enrollment Agreement, Provider Re-enrollment Agreement or other enrollment form prescribed by the relevant operating agency or its agent for enrollment; *and*
- e) Loss or forfeiture of corporate charter.
- 5) Program Compliance.
- a) Failing to comply with the terms of the Texas Medicaid or other HHS program contract or provider agreement, assignment agreement, the provider certification on the Texas Medicaid or other HHS program claim form, or rules or regulations published by the Commission or a Medicaid or other HHS operating agency;
- b) Violating any provision of the Human Resources Code, Chapter 32 or 36, or any rule or regulation issued under the Code;
- c) Submitting a false statement or misrepresentation or omitting pertinent facts on any application or any documents requested as a prerequisite for the Texas Medicaid or other HHS program participation;
- d) Refusing to execute or comply with a provider agreement or amendments when requested;
- e) Failing to correct deficiencies in provider operations after receiving written notice of them from an operating agency, the commission or their authorized agents;
- f) Failing to abide by applicable federal and state law regarding handicapped individuals or civil rights;
- g) Failing to comply with the Texas Medicaid or other HHS program policies, published Texas Medicaid or other HHS program bulletins, policy notification letters, provider policy or procedure manuals, contracts, statutes, rules, regulations, or interpretation previously sent to the provider by an operating agency or the commission regarding any of the authorities listed above, including statutes or standards governing occupations;
- h) Failing to fully and accurately make any disclosure required by the *Social Security Act*, §1124 or §1126;
- i) Failing to disclose information about the ownership of a subcontractor with whom the person has had business transactions in an amount exceeding \$25,000 during the previous 12 months or about any significant business transactions (as defined by HHS) with any wholly-owned supplier or subcontractor during the previous five years;
- j) Failing, as a hospital, to comply substantially with a corrective action required under the *Social Security Act*, §1886(f)(2)(B);
- k) Failing to repay or make arrangements that are satisfactory to the commission to repay identified overpayments or other erroneous payments or assessments identified by the commission or any Texas Medicaid or other HHS program operating agency;
- l) Committing an act described in the *Social Security Act*, §1128A (mandatory exclusion) or §1128B (permissive exclusion);
- m) Defaulting on repayments of scholarship obligations or items relating to health profession education made or secured, in whole or in part, by HHS or the state when they have taken all reasonable steps available to them to secure repayment;
- n) Soliciting or causing to be solicited, through offers of transportation or otherwise, Texas Medicaid or other HHS program recipients for the purpose of delivering to those recipients health-care items or services;
- o) Marketing, supplying or selling confidential information (e.g., recipient names and other recipient information) for a use that is not expressly authorized by the Texas Medicaid or other HHS program; *and*
- p) Failing to abide by applicable statutes and standards governing providers.
- 6) Delivery of Health-Care Services.
- a) Failing to provide health-care services or items to Texas Medicaid or other HHS program recip-

- ients in accordance with accepted medical community standards or standards required by statute, regulation, or contract, including statutes and standards that govern occupations;
- b) Furnishing or ordering health-care services or items for a recipient-patient under Title XVIII or a state health-care program that substantially exceed the recipient's needs, are not medically necessary, are not provided economically or are of a quality that fails to meet professionally recognized standards of health care; *and*
 - c) Engaging in any negligent practice that results in death, injury, or substantial probability of death or injury to the provider's patients.
- 7) Improper Collection and Misuse of Funds.
- a) Charging recipients for services when payment for the services was recouped by the Texas Medicaid or another HHS program for any reason;
 - b) Misapplying, misusing, embezzling, failing to promptly release upon a valid request, or failing to keep detailed receipts of expenditures relating to any funds or other property in trust for a Texas Medicaid or other HHS program recipient;
 - c) Failing to notify and reimburse the relevant operating agency or the commission or their agents for services paid by the Texas Medicaid or other HHS programs if the provider also receives reimbursement from a liable third party;
 - d) Rebating or accepting a fee or a part of a fee or charge for a Texas Medicaid or other HHS program patient referral;
 - e) Requesting from a recipient in payment for services or items delivered within the Texas Medicaid or other HHS program any amount that exceeds the amount the Texas Medicaid or other HHS program paid for such services or items, with the exception of any cost-sharing authorized by the program; *and*
 - f) Requesting from a third party liable for payment of the services or items provided to a recipient under the Texas Medicaid or other HHS program, any payment other than as authorized at 42 CFR §447.20.
- 8) Licensure Actions.
- a) Having a voluntary or involuntary action taken by a licensing or certification agency or board that requires the provider or employee to comply with professional practice requirements of the board after the board receives evidence of noncompliance with licensing or certification requirements; *and*
 - b) Having its license to provide health care revoked, suspended, or probated by any state licensing or certification authority, or losing a license or certification, because of action based on assessment of the person's professional competence, professional performance, or financial integrity, non-compliance with Health and Safety Code, statutes governing occupations, or surrendering a license or certification while a formal disciplinary proceeding is pending before licensing or certification authorities when the proceeding concerns the person's professional competence, professional performance, or financial integrity.
- 9) Managed Care Organizations (MCOs) and Persons Providing Services or Items Through Managed Care.
- Note:** *This paragraph includes those program violations that are unique to managed care; paragraphs (1) through (8) and (11) of this section also apply to managed care.*
- a) Failing, as an MCO PCCM system, or an association, group or individual health-care provider furnishing services through an MCO, to provide to recipient enrollee a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;
 - b) Failing, as an MCO, a PCCM, or an association, group or individual health-care provider furnishing services through an MCO, to provide to an individual a health-care benefit, service or item that the organization is required to provide by state or federal law, regulation or program rule;
 - c) Engaging, as an MCO, in actions that indicate a pattern of wrongful denial or payment for a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;
 - d) Engaging, as an MCO, in actions that indicate a pattern of wrongful delay of at least 45 days or a longer period specified in the contract with an operating agency, not to exceed 60 days, in making payment for a health-care benefit, service or item that the organization is required to provide under its contract with an operating agency;
 - e) Engaging, as an MCO, a PCCM or an association, group or individual health-care provider furnishing services through managed care, in a fraudulent activity in connection with the enrollment in the organization's managed care plan of an individual eligible for medical assistance or in connection with marketing the organization's services to an individual eligible for medical assistance;
 - f) Discriminating against enrollees or prospective enrollees on any basis, including, without limitation, age, gender, ethnic origin or health status;
 - g) Failing, as an MCO, to comply with any term within a contract with a Texas Medicaid or other HHS program operating agency to provide

health-care services to Texas Medicaid or HHS program recipients; *and*

- h) Failing, as an MCO, reasonably to provide to the relevant operating agency, upon its written request, encounter data and/or other data contractually required to document the services and items delivered by or through the MCO to Texas Medicaid or other HHS program recipients.

10) Cost Report Violations.

- a) Reporting costs of noncovered or nonchargeable services as covered items; e.g., incorrectly apportioning or allocating costs on cost reports; including costs of noncovered services, supplies or equipment in allowable costs; arrangements between providers and employees, related parties, independent contractors, suppliers, and others that appear to be designed primarily to overstate the costs to the program through various devices (such as commissions or fee splitting) to siphon-off or conceal illegal profits;
- b) Reporting costs not incurred or which were attributable to nonprogram activities, other enterprises or personal expenses;
- c) Including unallowable cost items on a cost report;
- d) Manipulating or falsifying statistics that result in overstatement of costs or avoidance of recoupment, such as incorrectly reporting square footage, hours worked, revenues received, or units of service delivered;
- e) Claiming bad debts without first genuinely attempting to collect payment;
- f) Depreciating assets that have been fully depreciated or sold or using an incorrect basis for depreciation; *and*
- g) Reporting costs above the cost to the related party.

11) Kickbacks and Referrals.

- a) Violating any of the provisions specified in 1 TAC §371.1721(b) of this subchapter relating to kickbacks, bribes, rebates, referrals, inducements, or solicitation;
- b) As a physician, referring a Texas Medicaid or other HHS program patient to an entity with which the physician has a financial relationship for the furnishing of designated health services, payment for which would be denied under Title XVIII (Medicare) pursuant to §1877 and §1903(s) of the *Social Security Act* (Stark I and II). Neither federal financial participation nor this state's expenditures for medical assistance under the state Medicaid plan may be used to pay for services or items delivered within the program and within a relationship that violates Stark I or II. The Commission hereby references and incorporates within these rules the federal regulations promulgated pursuant to Stark I and

II, and expressly recognizes all exceptions to the prohibitions on referrals established within those rules;

- c) Failing to disclose documentation of financial relationships necessary to establish compliance with Stark I and II, as set forth in subparagraph (b) of this paragraph; *and*
- d) Offering to pay or agreeing to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered or enrolled as a provider or otherwise by a state health-care regulatory or health and human service agency.

Involvement in any of the aforementioned items may result in provider or individual exclusion or suspension from Texas Medicaid. Providers or individuals are notified in writing of action taken, including appeal and reinstatement procedures.

Providers and individuals who have been excluded from Texas Medicaid may be reinstated only by the HHSC OIG. If the OIG approves an individual's request for reinstatement, a written notice will be sent to that individual. The written notification will specify the date on which participation in Texas Medicaid will be effective.

Full investigation of criminal Medicaid fraud is the Texas Attorney General MFCU's responsibility and may result in a felony or misdemeanor criminal conviction.

1.5.1 Reporting Waste, Abuse, and Fraud

Individuals with knowledge about suspected Medicaid waste, abuse, or fraud of provider services must report the information to the HHSC OIG. To report waste, abuse, or fraud, go to www.hhs.state.tx.us and select **Reporting Waste, Abuse, and Fraud**. Individuals may also call the OIG hotline at 1-800-436-6184 to report waste, abuse, or fraud if they do not have access to the internet. All information provided is protected by the HHSC/OIG privacy statement. This means that the information provided will remain confidential.

Providers may voluntarily investigate and report matters involving possible fraud, waste, abuse, or inappropriate payments of Medicaid funds in their own office. Providers are required to report these activities to HHSC/OIG when identified. It is the intention of HHSC/OIG to endeavor to work collaboratively, and not adversarially, with providers who choose to self-report. To get additional information on self-reporting and to determine how to self-report, see the website oig.hhsc.state.tx.us/ProviderSelfReporting/Self_Reporting.aspx.

1.5.2 Suspected Cases of Provider Waste, Abuse, and Fraud

The HHSC OIG is responsible for minimizing the opportunity for provider waste, abuse, and fraud. HHSC takes appropriate action to protect clients and Texas Medicaid

when providers of services are suspected of committing waste, abuse, or fraud. HHSC OIG is responsible for establishing criteria for identifying cases of possible waste, abuse, or fraud and recouping all overpayments from a provider. Some circumstances may result in referral of a provider to the Texas Attorney General's MFCU or Antitrust and Civil Medicaid Fraud Section for further investigation, whereas other circumstances might result in administrative sanctions or actions deemed appropriate by the HHSC OIG.

1.5.3 Employee Education on False Claims Recovery

In accordance with the *United States Code* (USC), Title 42, §1396a(a)(68), and as a condition for receiving payments, any entity that receives or makes annual Medicaid payments of at least \$5,000,000 shall establish written policies for all employees of the entity as well as all employees of any contractor or agent of the entity (including management) that provide detailed information about the following laws and their role in preventing and detecting waste, fraud, and abuse in federal health-care programs:

- The federal *False Claims Act* (31 USC §§3729-3733)
- Administrative remedies for false claims and statements as provided in Chapter 38 of Title 31, USC
- Texas law relating to civil and criminal penalties for false claims (including Chapter 36 of the *Human Resources Code*; Section 35A.02 of the *Penal Code*; Title 1, Chapter 371, Subchapter G of the TAC; and other applicable law)
- Whistleblower protections under the above laws (including section 36.115 of the *Human Resources Code*)

The entity must also include, as part of the above written policies, detailed provisions regarding the policies and procedures of the entity for detecting and preventing fraud, waste, and abuse. In addition, the entity must also include in any employee handbook a specific discussion of the following:

- The above laws
- The entity's policies and procedures for detecting and preventing fraud, waste, and abuse
- The rights of employees to be protected as whistleblowers

TMHP mails letters annually to providers who received a minimum of \$5,000,000 in payments to attest that they have educated their staff on the *False Claims Act*. Providers who fail to return a signed attestation may be placed on vendor hold with Texas Medicaid.

1.6 Texas Medicaid Limitations and Exclusions

Medicaid pays for services on behalf of clients to the provider of service according to Texas Medicaid's limitations and procedures. TMHP does not make Medicaid payments directly to clients.

The following services, supplies, procedures, and expenses are not benefits of Texas Medicaid. This list is *not* all inclusive.

- Autopsies
- Biofeedback therapy
- Bladder stimulators (Pacemaker)
- Breast implants
- Cardiac rehabilitation programs
- Care and treatment related to any condition for which benefits are provided or available under Workers' Compensation laws
- Cellular therapy
- Chemolase injection (chymodiactin, chymopapain)
- Chemonucleolysis intervertebral disc
- Custodial care
- Dentures or endosteal implants for adults
- Dermabrasion
- Direct graduate medical education for teaching hospitals
- DME (except THSteps-CCP and home health)
- Dressings/supplies billed in physician's office
- Ergonovine provocation test
- Excise tax
- Fabric wrapping of abdominal aneurysms
- Hair analysis
- Heart–lung monitoring during surgery
- Histamine therapy–intravenous
- Hyperthermia
- Hysteroscopy for infertility
- Immunizations or vaccines unless they are otherwise covered by Texas Medicaid. (These limitations do not apply to services provided through the THSteps Program)
- Immunotherapy for malignant diseases
- Inborn errors of metabolism
- Infertility
- Inpatient hospital services to a client in an institution for tuberculosis, mental disease, or a nursing section of public institutions for the mentally retarded
- Inpatient hospital tests that are not specifically ordered by a physician/doctor who is responsible for the diagnosis or treatment of the client's condition
- Intestinal bypass surgery and gastric stapling for the treatment of morbid obesity

- Intra-gastric balloon for obesity
 - Intravenous embolization—cerebral, maxillary, and renal
 - Joint sclerotherapy
 - Keratoprosthesis/refractive keratoplasty
 - Laetrile
 - Mammoplasty for gynecomastia
 - More than \$200,000 per client per benefit year (November 1 through October 31) for any medical and remedial care services provided to a hospital inpatient by the hospital. If the \$200,000 amount is exceeded because of an admission for an approved organ transplant, the allowed amount for that claim is excluded from the computation. This limitation does not apply to clients eligible for THSteps-CCP
 - More than 30 days of inpatient hospital stay per spell of illness—each spell of illness must be separated by 60 consecutive days during which the client has not been an inpatient in a hospital
- Important:** THSteps-CCP provides medically necessary, federally allowable treatment for Medicaid/THSteps clients birth through 20 years of age. Some medical services that usually would not be covered under Medicaid may be available to CCP-eligible clients. An additional 30-day spell of illness begins with the date of specified covered organ transplant. No spell of illness limitation exists for Medicaid THSteps clients 20 years of age or younger.
- Obsolete diagnostic tests
 - Oral medications, except when billed by a hospital and given in the emergency room or the inpatient setting (hospital take-home drugs or medications given to the client are not a benefit)
 - Orthoptics (except THSteps-CCP)
 - Orthotics (except THSteps-CCP)
 - Outpatient and nonemergency inpatient services provided by military hospitals
 - Outpatient behavioral health services performed by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, non-LCSW social worker, or psychological associate regardless of physician or licensed psychologist supervision
 - Oxygen (except THSteps-CCP and home health)
 - Payment for eyeglass materials or supplies regardless of cost if they do not meet Texas Medicaid specifications
 - Payment to physicians for supplies is not an allowable charge. All supplies, including anesthetizing agents such as *Xylocaine*, inhalants, surgical trays, or dressings, are included in the surgical payment
 - Penile prosthesis
 - Podiatry, optometric, and hearing aid services in long term care facilities, unless ordered by the attending physician

- Private room facilities except when a critical or contagious illness exists that results in disturbance to other patients and is documented as such when it is documented that no other rooms are available for an emergency admission, or when the hospital only has private rooms
 - Procedures and services considered experimental or investigational
 - Prosthetic and orthotic devices (except THSteps-CCP)
 - Prosthetic eye or facial quarter
 - Psychiatric services:
 - Outpatient behavioral health services exceeding 30 visits per calendar year for which no prior authorization has been given
 - Reimbursement is not available for inpatient psychiatric hospital services, including physician fees, delivered to clients between 22 (21 in Texas) and 64 years of age
 - Outpatient behavioral health services in freestanding psychiatric hospitals for Medicaid (except THSteps-CCP and NorthSTAR Program clients in the Dallas Managed Care Service Area)
 - Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services
- Refer to:** “Licensed Marriage and Family Therapist (LMFT)” on page 29-1, “Licensed Clinical Social Worker (LCSW)” on page 28-1, “Licensed Professional Counselor (LPC)” on page 30-1, “Physician” on page 36-1, and “Psychologist” on page 38-1 for further information.
- Quest test (infertility)
 - Recreational therapy
 - Review of old X-ray films
 - Routine circumcision for clients age one year and older
 - Separate fees for completing or filing a Medicaid claim form. The cost of claims filing is to be incorporated in the provider’s usual and customary charges to all clients
 - Services and supplies to any resident or inmate in a public institution
 - Services or supplies for which benefits are available under any other contract, policy, or insurance, or which would have been available in the absence of Texas Medicaid
 - Services or supplies for which claims were not received within the filing deadline
 - Services or supplies not reasonable and necessary for diagnosis or treatment
 - Services or supplies not specifically provided by Texas Medicaid

- Services or supplies provided in connection with a routine physical examination, except in connection with family planning services, THSteps, or the Medicaid Managed Care programs
- Services or supplies provided in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member, or when prior authorized for specific purposes by TMHP (including removal of keloid scars)
- Services or supplies provided outside of the U.S., except for deductible and coinsurance portions of Medicare benefits as provided for in this manual
- Services or supplies provided to a client after a finding has been made under utilization review procedures that these services or supplies are not medically necessary
- Services or supplies provided to a Texas Medicaid client before the effective date of his or her designation as a client, or after the effective date of his or her denial of eligibility
- Services payable by any health, accident, other insurance coverage, or any private or other governmental benefit system, or any legally liable third party
- Services provided by an interpreter (except sign language interpreting services requested by a physician)
- Services provided by ineligible, suspended, or excluded providers
- Services provided by the client's immediate relative or household member
- Services provided by Veterans Administration facilities or U.S. Public Health Service Hospitals
- Sex change operations
- Silicone injections
- Social and educational counseling except for family planning and genetics education and counseling services
- Sterilization reversal
- Sterilizations (including vasectomies) unless the client has given informed consent 30 days before surgery, is mentally competent, and is 21 years of age or older at the time of consent (This policy complies with 42 CFR §441.250, Subpart F)
- Take-home and self-administered drugs except as provided under the vendor drug or family planning pharmacy services
- Tattooing
- Telephone calls with clients or pharmacies (except as allowed for case management)
- Thermogram
- Treatment for obesity
- Treatment of flatfoot conditions and the prescription of supportive devices (including special shoes), the treatment of subluxations of the foot and routine foot

care more than once every six months, including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygienic care

- Whole blood or packed red cells when available at no cost to the client

Refer to the applicable section in this manual for additional information.

